



TennCare Timeline: Major Events and Milestones from 1992 to 2016

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What is TennCare?

TennCare is Tennessee's Medicaid managed care demonstration program. Beginning in 1994, this comprehensive health reform program has used the Medicaid program to both expand services to the Medicaid population and insurance coverage to individuals who are determined to be uninsured or uninsurable using a system of Managed Care Organizations (MCOs). The program is managed by the Bureau of TennCare under the direction of a Deputy Commissioner of Health (<http://www.state.tn.us/tenncare/>). The history, conceptual design, and modifications of this comprehensive reform program have been reviewed and analyzed by many of the studies referenced at the end of this report and the documents available at the Center for Medicare and Medicaid Services (CMS) Web site: <http://www.cms.hhs.gov/medicaid/1115/tn1115tc.asp>.

Prelude to TennCare:

In the early 1990s, states were increasingly required to expand their Medicaid programs with "unfunded" or "incompletely funded" federal mandates through their state budgets. The traditional fee-for-service state Medicaid models experienced serious medical inflation driven by increased costs and service utilization. The option to cutback state Medicaid programs in response to the escalation of medical costs, contemplated by many states, would have a counter effect of reduced federal funding or federal Medicaid program matches.

Tennessee's Medicaid program, similar to the programs in other states, was plagued with the twin problems of escalating costs (from approximately \$692 million in fiscal year 1988-1989 to almost \$2.7 billion by fiscal year 1993-1994) and an increasing Medicaid eligible population (from 694,000 covered lives in 1990 to 1.1 million by 1994). A projected state budget deficit of over \$250 million was attributed largely to escalating Medicaid spending. Looming on the horizon was the threat of an end of supplemental revenues of over \$400 million generated by a special tax on hospitals and nursing homes. Reauthorization of this special tax by the State Legislature, scheduled for 1994, was unlikely due to heavy lobbying against the tax by interest groups.

1992

A task force appointed by Governor Ned McWherter identified three options to present to the State Legislature: 1) increase state taxes; 2) reduce health care services or provider reimbursement rates without a major change to the current Medicaid financing model; or 3) engage in a serious reform to both the health care delivery and financing systems - or TennCare. The timing of the impending financial crisis coincided with the window of opportunity for Governor McWherter to push through his vision of expanded access to Medicaid.

1993

- **April 1993:**

Developed by David Manning (Commissioner of Finance and Administration) and Manny Martins (Director of the Medicaid Bureau), the TennCare concept as a Section 1115 waiver demonstration program was approved by the State Legislature.

- **June 1993:**

Tennessee's Section 1115 waiver demonstration program was submitted to the Health Care Financing Administration (HCFA) for review. Tennessee's ability to show a credible statewide managed care network hinged upon the participation of Blue Cross Blue Shield of Tennessee (BCBST).

- **November 1993:**

HCFA approved the Section 1115 waiver as a 5 year demonstration project. Included in the waiver were exemptions from the drug coverage mandates of the Medicaid drug rebate program.

Providers and managed care organizations received letters from the state regarding the January 1, 1994 start date for TennCare.

- **December 1993:**

Managed care organizations responded to the formulary guidelines, but most did not plan to start on January 1, 1994 with a drug formulary. Many opted to continue with the "open formulary" coverage of the Medicaid program.

1994

- **January 1994:**

TennCare was implemented on January 1, 1994, with an enrollment cap of 1.775 million. Organizationally, the state was divided into twelve (12) grand regions established by the Community Health Agency Act to coordinate TennCare services. Twelve chartered managed care organizations (MCOs), including 8 HMOs and 4 PPOs, were licensed by the state to participate in TennCare.

Only two MCOs, Access MedPlus and BCBST, elected to operate in the entire state. They together enrolled approximately two-thirds of the TennCare eligible population. BCBST alone had one-half of the statewide total enrollment.

State payments to the MCOs were based upon a capitation system derived from a statewide global health care budget. The MCOs were responsible for contracting and negotiating fee schedules with providers from their capitation. BCBST was the only MCO paying providers on a fee-for-service basis, while others paid on a capitation basis.

- **June 1994:**

All TennCare enrollees were covered under plans with closed drug formularies.

The MCOs contracted with Pharmacy Benefit Managers (PBMs) for a range of services including formulary management, drug utilization review, rebate management, disease-state management programs, etc.

- **August 1994:**
Tennessee Medical Association (TMA) filed a lawsuit against the Bureau of TennCare (Tennessee Medical Association v. Manning, No. 93-3939-1 slip op. at 6-9, Tenn Ct. Ch. Div., August 8, 1994). The lawsuit alleged that the “cram-down” practice of forcing physicians to accept TennCare patients violated the Medicaid Act. The legal action did not eventually prevail.
- **December 1994:**
Enrollment was closed for the “Uninsured” category.

1995

- The TennCare annual budget rose to \$3.3 billion (\$1.1 billion from the state and \$2.2 billion from the federal government). To reduce expenditures without cutting enrollment, the state lowered capitation rates and opted to eliminate subsidies to Academic Medical Centers (AMCs).
- Participating HMOs were required to agree to an 18 month non-cancelable contract.
- TennCare planned to identify duplications and ineligibles in the current enrollment.
- The new Governor, Don Sundquist, appointed a citizen TennCare review commission, the Tennessee Business Roundtable, to advise him on TennCare.
- A Deputy Commissioner position in the Department of Commerce and Insurance (DCI) was created to ensure greater oversight and financial accountability for all TennCare plans. All MCOs (both HMOs and PPOs) were required to file financial reports with the DCI.
- The lawsuit Tennessee Medical Association v. Manning filed by the Tennessee Medical Association in August 1994 to halt the implementation of TennCare was dismissed by the court. TMA's lawsuit alleged violations of federal laws regarding the TennCare payment methodology and a violation of the state Administrative Procedure Act (APA) regarding the adoption of MCO payment rates.
- Three new departments were created or designated to share responsibility in monitoring the TennCare program: TennCare Bureau, the TennCare Division within DCI, and the Comptroller of the Treasury.
- BCBSST bought the University of Tennessee Health Plan.
- RxCare and BCBSST began negotiations that would eventually bring 90 percent of TennCare enrollees under one drug formulary.
- TennCare Pharmacy Committee was formed to address pharmacy issues.

- Two new AIDS drugs were approved by the FDA, which would greatly impact the pharmacy program and TennCare in general.

1996

- Phoenix Healthcare bought the right to serve TennCare enrollees through Health Source.
- **May 1996:**
In Daniels v. Wadley handed down on May 15, 1996, the U.S. District Court for the Middle Tennessee held that actions taken by MCOs to deny or terminate ineligible Medicaid recipients' access to covered health plan services constituted state actions that triggered federal due process notice and hearing requirements.
- **June 1996:**
TennCare capitation rates increased by 9.5 percent from July 1995 through June 1996
- **July 1996:**
The TennCare Partners program was created on July 1, 1996, to carve out the delivery of all behavioral health services from the existing TennCare program. TennCare Partners would begin contracting directly with two separate, capitated behavioral health organizations (BHOs) to provide behavioral health services to all TennCare enrollees. The BHOs would also cover the seriously and persistently mentally ill (SPMI) adults and for children with severe emotional disturbance (SED). In creating TennCare Partners, the state redirected non-Medicaid block grant funding into capitated payments to the BHOs for the first time.

Each MCO was to be paired with one of the two BHOs (Premier Behavioral Systems of Tennessee, LLC and Tennessee Behavioral Health, Inc.). BCBST, due to its statewide presence, has members in both BHOs.

1997

- **January 1, 1997:**
All TennCare PPOs were required to be licensed as HMOs and use primary care gatekeepers for their TennCare enrollees. All four PPOs (BCBST, HealthNet, OmniCare and PHP) were converted to HMOs.
- **April 1997:**
Enrollment was opened to uninsured children (without income restrictions) age 17 and older whose parents did not have access to workplace insurance.
- **May 1997:**
Enrollment was opened on May 21 to “dislocated workers.” Cost sharing was required for individuals with incomes above the poverty level.

A new TennCare Director of Quality was hired to manage a staff of 18. The new Director, together with an External Quality Review Organization (EQRO), began to monitor three areas: access to care, quality of care, and outcomes measurement.

- **June 1997:**

MCO capitation rates were increased 13 percent across all categories. The increase also included a behavioral health carve-out capitation rate of \$7.53 per member per month (PMPM).

- **July 1997:**

From July 1996 - July 1997, the rates increased 4 percent overall with 1 percent set aside in a \$40 million adverse selection pool. Plans and providers believed that the 4 percent increase would prove to be inadequate given the scope of the benefit package and the view that the state had not adequately adjusted rates to account for adverse selection.

Consulting firm William Mercer was commissioned by the state to compare encounter data with expenditure data to determine the overall adequacy of the capitation rates.

TennCare contracted with local health departments under a one year \$21 million contract to develop outreach programs targeting potential eligible individuals and conduct eligibility verification.

Specialists were still under-represented in MCO provider panels included: otolaryngology, neurosurgery and orthopedics. Orthopedics had "boycotted" participation in TennCare since its inception. The providers reportedly refused to join plan networks because they do not wish to subject themselves to difficulties of contracting and obtaining payment from the MCOs. Some specialists treated TennCare members as out-of-network providers on an individual basis, which provided better flexibility and higher payments.

- **August 1997:**

In the first nine months of 1997, TennCare MCOs lost more than \$20 million according to the State Comptroller's Office. Concerns arose regarding the long-term financial viability of TennCare MCOs if their financial difficulties continue.

- **November 1997:**

An amendment was passed to change the effective date of the Child Health Insurance Program (CHIP) to include TennCare. Under the CHIP program TennCare was eligible for an enhanced federal match at 75 percent to cover low-income children. The additional federal money made available through CHIP also enabled Tennessee to expand enrollment and decrease cost-sharing for certain groups.

1998

- TennCare failed to identify incarcerated youth and lost approximately \$55,000 in federal matching funds for payments made to behavioral health organizations.

- TennCare had not monitored graduate medical schools to ensure that requirements related to graduate medical education payments (approximately \$48 million in fiscal year 1998) were met.
- Behavioral health drugs were carved-out and became the financial and clinical responsibility of the TennCare Bureau.
- **January 1998:**
Enrollment as of January 1, 1998 was approximately 1.2 million. All participating TennCare plans agreed to reopen to new enrollment to 18 year olds and all uninsured children whose parents' incomes were below 200 percent of the federal poverty level, regardless of their access to workplace insurance.
- **February 1998:**
John B. v. Menke was filed with the U.S. District Court. The class action suit was brought on behalf of all TennCare enrollees under the age of 21, alleging the state had failed to meet its obligations under the Early and Periodic, Screening, Diagnosis and Treatment (EPSDT) mandate of the federal law, governing the provision of medical services to Medicaid eligible children.
- **July 1998:**
Rosen v. Commissioner of Finance and Administration was filed, with the plaintiffs (TennCare insured and uninsurables) alleging that the state had failed to put in place an adequate system for providing due process hearing regarding premium assessment, premium disputes, denial of TennCare eligibility, and termination of TennCare eligibility.

The state carved-out behavioral health pharmaceuticals.

- **December 1998:**
Newberry v. Menke a/k/a Newberry v. Goetz, was approved in the U.S. District Court for the Middle District of Tennessee by Judge Robert Echols. The suit called for Tennessee to pursue a "budget neutral" stay-at-home program for the elderly, in addition to the TennCare MCOs paying more home health costs for the poor, disabled and elderly.

1999

- In the Grier case, originally filed in 1979, the plaintiffs challenged the state's appeal process as it related to the denial of medical services under Medicaid. The consent decree in 1999 resolved this challenge by requiring TennCare to fill 14 days of prescription drug supply regardless of whether the drug was on the approved drug list.
- **March 1999:**
PriceWaterhouseCoopers LLP, an international consulting firm retained by the Tennessee Office of the Comptroller, presented an evaluation of the soundness of the

rates paid under the TennCare program. Per the analysis, rates currently paid to the MCOs were determined to be approximately \$11 PMPM lower than the amount considered to be actuarially sound, and an increase was required to keep the program viable. PriceWaterhouseCoopers estimated that corrections to the rate methodology would result in increases in the capitation rates ranging from 5 percent to 35 percent, with a best estimate of 20 percent. Increasing capitation payments would result in an estimated deficit of approximately \$16 PMPM.

TennCare paid hospitals at a significantly lower level than other insurance payers. Supplemental payments made to the hospitals every year since the inception of TennCare covered only a portion of the short-fall in their provider payments. However, rural acute care hospitals encountered significant financial stress due largely to underpayments by TennCare.

Mental health safety net providers experienced significant losses under TennCare. A current analysis of the behavioral health plans also indicated ongoing financial stress due to low capitation payments to BHOs by the TennCare Partners Program.

- **April 1999:**
The state assumed control of Xantus Health Plan of Tennessee (formerly Phoenix) after Xantus reported a negative net worth of \$24 million in 1998. Reasons for poor financial performance included the acquisition of HealthNet and its outstanding debt.
- **May 1999:**
Payment Requirements were added to the Tennessee Code Annotated (Section 56-32-226 (b)), which mandated that 90 percent of claims for payment for services delivered to a TennCare enrollee be paid by MCOs within 30 days of the receipt of such claims.
- **September 1999:**
The state entered into a consent decree with the plaintiffs of the Rosen v. Commissioner of Finance and Administration lawsuit. Early on in the litigation, the plaintiffs applied for, and the district court granted, a preliminary injunction ordering the state to reinstate all members of the plaintiff class who had been denied TennCare coverage without receiving due process of law. The state sought to comply with that injunction and in an agreed order entered on September 13, 1999, the court approved the procedures for a reinstatement scheme agreed to by the parties. The state agreed to identify all uninsured and uninsurable who had been terminated and send them notices offering re-enrollment to those who replied. Those who did not respond were to receive a second notice.
- **November 1999:**
Xantus came under state receivership.
- **December 1999:**
BCBST warned the state that its continued participation in TennCare would depend upon its ability to break even although the plan reported a small profit of \$1.8 million for 1999.

In Mid-December, BCBST announced its intention to withdraw from TennCare effective June 30, 2000. Since July 1, 1999 the state had invoked the "public exigency" provision of its contract with BCBST, requiring the company to continue administering TennCare benefits until June 30, 2001. BCBST administered TennCare benefits for over 40 percent of the entire TennCare enrollment of 1.3 million. It was the only plan with an adequate network of physicians, hospitals and other health care providers.

2000

- Xantus owed physicians and hospitals \$80 million in unpaid claims.
- William Mercer reported to the state that funding TennCare to an actuarially sound basis would cost the state at least \$100 million more than the \$132 million in new state money that Sundquist proposed in his \$18.2 billion budget for fiscal year 2000-2001.
- BCBST continued to move forward with its decision to no longer participate in TennCare as of July 1, 2000.
- Dual eligible individuals (enrollees with both Medicare and TennCare) had pharmacy benefits carved out from the private MCOs and became the financial and clinical responsibility of the TennCare Bureau.

- **January 2000:**

The Grier Consent Decree was signed. The Decree significantly limited the ability of MCOs to effectively managed care.

- **March 2000:**

Access MedPlus was placed under state supervision.

- **May 2000:**

Access MedPlus was placed under involuntary supervision, and assets were frozen by the state. The Nashville-based MCO had more than 325,000 TennCare enrollees. Since February, 2000, Access had failed to balance its books, paid claims in an untimely manner; and could not determine if it met capitalization requirements.

Vanderbilt University in Nashville sued Access MedPlus to recover outstanding claims of approximately \$6 million.

Active recruitment was initiated to bring new MCOs into the program

- **July 2000:**

Pharmacy benefits for dual eligibles were carved out of the MCO program.

- **October 2000:**

On 10/30/2000, BlueCross BlueShield of Tennessee, in order to accommodate the Grier Consent Decree from District Court Judge John Nixon, eliminated the BCBST medical necessity review for contracted medical services and prescription drugs for BlueCross BlueShield of Tennessee TennCare beneficiaries.

- **November 2000:**

The pharmacy provisions of the Grier Consent Decree were scheduled for implementation, which stipulated a 14-day supply of non-covered drugs.

- **December 2000:**

Access MedPlus filed a \$160 million lawsuit against the state alleging that the state failed to pay the MCO in an "actuarially sound manner" since TennCare's inception in 1994. Inadequate capitation rates, according to the lawsuit, resulted in underpayments to the company of approximately \$160 million over the past six years. In addition, Access MedPlus cited that expanded rights of enrollees to appeal decisions, under Grier alone, would cost the company an additional \$80 million per year.

2001

- TennCare enrollment exceeded 1.4 million.
- TennCare faced a \$342 million shortfall for 2001.
- Universal Care of Tennessee, Inc. was interested in participating in TennCare. The affiliate of California-based Universal Care, Inc. announced that it had signed a provider agreement with TriStar Health Systems, Inc. – HCA, the health care company's regional network of 11 hospitals. Universal had a goal of enrolling 100,000 individuals in the Middle Tennessee area.
- Geographic service area changes occurred among several MCOs in TennCare. Better Health Plans of Tennessee, Inc., a new MCO, opted to participate only in the West Tennessee area. BCBST's plan, Blue Care, was available only in East Tennessee. Access MedPlus continued to operate in all three regions as long as the MCO did not exceed the state's enrollment limits. OmniCare's presence in Nashville was discontinued, but they were available in all of West Tennessee. Xantus, still under state supervision, moved out of East and West Tennessee, but continued to serve Middle Tennessee.
- **January 2001:**
BCBST, by far the largest MCO covering almost half of all TennCare patients, threatened to pull out of TennCare by June 30 because of rising costs.
- **February 2001:**
BCBST agreed to continue participation until 2002, cutting the size of its MCO by half and serving only East Tennessee.

- **March 2001:**
MedSouth Healthcare, a 19 member physician group with six clinics in rural West Tennessee, notified Access MedPlus that it would only care for children and some pregnant women after March 31, 2001, primarily due to difficulty in referring patients for specialty care.

Access MedPlus hired USA Managed Care Organization to provide a backup network of physicians.

- **July 2001:**
Governor Don Sundquist's proposed fiscal budget was anticipated to increase from \$3.4 billion to \$3.7 billion. Much of the increase would raise reimbursement rates for private MCOs and BHOs and cover the 80,000 new enrollees expected to join TennCare in the next fiscal year. The Governor also proposed major spending increases for long term care and community-based care for the elderly and disabled, and services for TennCare children in state custody. The total cost of the program improvements were projected at \$160 million.

- **July 2001:**
Two new MCOs, Better Health Plans and Universal Care, began operating in the East and Middle grand divisions, respectively.

- **October 2001:**
TennCare officially cancelled its contract with Access MedPlus. The state also developed a backup plan named TennCare Select, administered by BCBST and owned by the state. TennCare Select utilized the current BCBST network. All members of Access MedPlus were transferred into TennCare Select. Members in East Tennessee had 90 days, beginning November 1, to choose another health plan in their region if they did not want to become members of TennCare Select.

An analysis of the Grier Consent Decree, covering charges from January 1999 through September 2001, was performed by PriceWaterhouseCoopers to determine the financial and administrative impact of the Grier Decree's provisions.

- **December 2001:**
TennCare sent letters to approximately 10,000 uninsured and uninsurable members informing them to update their eligibility status. About 670,000 of TennCare's members qualified for the program as "uninsured and uninsurable," and the TennCare Bureau was responsible for tracking their eligibility.

2002

- Governor Don Sundquist advocated for a state income tax for the second consecutive year, citing TennCare costs as the primary reason for the need to increase state revenues. The income tax proposal was defeated for the second time.

- The Sundquist Administration obtained relief from CMS. Sundquist's agreement with CMS removed a cap on federal matching money originally negotiated by the McWherter administration that would have kept the state from collecting \$170 million additional dollars from the federal government.
- **February 2002:**
The Sundquist Administration filed a major waiver modification plan with CMS on Feb. 12, 2002. The new demonstration program would have three major products – TennCare Medicaid, TennCare Standard, and TennCare Assist. There would also be six distinct eligibility categories, two of which were Medicaid and the remainder were demonstration eligible (<http://www.cms.hhs.gov/medicaid/1115/tnwaiverfeb11fnl.pdf>).
- **April 2002:**
Universal Care of Tennessee's contract with the TennCare Bureau was scheduled to terminate effective April 30, 2002. The TennCare Bureau cited Universal's failure to demonstrate sufficient financial capital, failure to demonstrate minimum net worth requirements, and failure to pay claims timely and accurately. The contract termination would be suspended, if Universal could resolve cited problems by April 19, 2002. Otherwise, enrollees of Universal Care of Tennessee would be transferred to TennCare Select on May 1, 2002.
- **May 2002:**
The state legislature mandated that TennCare update its computer systems by December 31, 2003.
- **June 2002:**
The Department of Commerce and Insurance received from TLC (a major MCO in West Tennessee) a revised plan of corrective actions relative to its net worth deficiency as of March 31, 2002. TLC also signed Amendment Number 1 to the Amended and Restated Contractor Risk Agreement which stated that beginning May 1, 2002, TLC would no longer be at risk for medical expenses incurred by its TennCare enrollees through December 31, 2003.
- **July 2002:**
TennCare implemented its "Stabilization Plan" on July 1, 2002, to provide MCOs an 18 month time frame through December 31, 2003 to operate under an ASO-type non-risk arrangement in which MCOs were paid an administrative fee and costs of health care services were "passed through" to the State. The plan's objective was to allow a period of time to establish greater financial stability, and maintain continuity of the current managed care structure for enrollees.

A new and modified TennCare waiver was implemented and it replaced the original TennCare waiver that was in effect since January 1, 1994. TennCare was divided into two programs: one for Medicaid eligibles (TennCare Medicaid) and one for demonstration eligibles (TennCare Standard); each program was to have its own benefit structure.

A majority of the initial changes in the waiver were in the area of eligibility. New TennCare applicants were being allowed to enroll for two reasons: a) Medicaid eligibility, and b) a determination of "medically eligible" due to their inability to obtain insurance plus a family income below the poverty level. An addition to the program was TennCare Standard, a plan to subsidize low-income working families.

TennCare also expanded its coverage to include women with breast and cervical cancer through the federal Breast and Cervical Cancer Prevention and Treatment Act (BCCPT) of 2000.

- **October 2002:**

TennCare allocated \$100 million among 100 hospitals that provided more than 95 percent of the hospital care to TennCare patients. The hospital payments would be made quarterly beginning in October, 2002 and constituted part of the state's new 5-year federal waiver that started July 1, 2002. Payments would be divided among 3 groups of hospitals: a) safety net hospitals (\$50 million), b) children's hospitals (\$5 million), and c) other essential hospitals (\$45 million). Hospitals eligible for the payments must experience a high volume of TennCare or TennCare unreimbursed costs and be contracted with at least one TennCare MCO in addition to TennCare Select.

Doral Dental of Tennessee, LLC entered into a new 3 year contract with TennCare under a dental carve-out. Dental screenings and treatment were offered to TennCare children under the age of 21. Adult dental benefits were limited to emergency services. Doral would assume administration of the entire TennCare dental program, provider networks, claims processing and benefits management. The state would pay Doral a maximum of \$6 million in the first year for administration. Payments for enrollee care would be made outside of the administrative fee.

- **December 2002:**

U.S. District Judge William Haynes handed down a decision that prevented the state from implementing a revised benefit plan and called for the reinstatement of every person who was disenrolled from TennCare through the re-determination process since July 1, 2002. On December 29, 2002, approximately 140,000 enrollees disenrolled since July 1 were reinstated.

2003

- **January 2003:**

Effective January 1, 2003, the state assumed 100 percent financial risk for covered benefits.

TennCare enrollment totaled 1,311,942 (942,973 of Medicaid eligible plus 368,969 of uninsured and uninsurable individuals).

Approximately 240,000 individuals had completed the re-determination process. Almost 80,000 were found to be eligible for Medicaid, and more than 135,000 were found to be eligible for TennCare Standard.

The Grier Consent Decree was generating approximately 8,000 pharmacy appeals per month through the TennCare Solutions Unit. PriceWaterhouseCoopers estimated that MCO compliance with the consent decree would cost approximately \$50 million per year.

Net worth deficiencies were found in Universal Care of Tennessee, TLC, Xantus and Premier. Premier, one of the two BHOs, came under administrative supervision of the Department of Commerce and Insurance.

- **April 2003:**

A single drug formulary was slated for implementation on April 1, 2003. The plan would simplify prescribing process. It would also ensure access to quality pharmacy services by all TennCare members and preserve their due process and appeal rights.

- **June 2003:**

Contract with Universal was terminated on June 1, 2003, and Universal's enrollees moved to TennCare Select, a subsidiary of BlueCross and BlueShield of Tennessee for enrollees of a failed MCO.

- **July 2003:**

On July 1, 2003, all pharmacy services were carved out to a single Pharmacy Benefits Manager. Pharmacy Lock-in was approved for certain members to receive all of their prescriptions from a single pharmacy. Lock-in procedures were anticipated to reduce costs from duplications, and from improved quality oversight.

TennCare's Centers of Excellence project was launched with Applied Health Outcomes (AHO) administering three disease-specific Centers of Excellence (diabetes, asthma and cardiovascular). TennCare had received over \$1 million from pharmaceutical manufacturers to fund the project which included disease management interventions, quality improvement, cost containment strategies, and outcomes research. A major goal was to provide physicians with evidence-based data to show the best treatment algorithms to follow for specific disease states.

- **August 2003:**

The State's contract with Xantus (a larger MCO operating in middle Tennessee) was terminated and Xantus' enrollees moved to TennCare Select.

- **November 2003:**

First Health Services Corporation was selected by the TennCare Bureau to serve as the Pharmacy Benefits Manager (PBM) for TennCare. The state signed a three year contract with a value of \$14,193,000 over the three year period.

- **December 2003:**

TennCare had not yet implemented the new MIS system as expected to identify and track TennCare fraud and abuse.

McKinsey and Company released Part 1 of its two part report assessing the viability of TennCare over the next 5 years and identifying several strategic options for helping ensure the program's financial viability. Consulting services for McKinsey and Company were funded by Blue Cross Blue Shield of Tennessee, the Farm Bureau, Hospital Corporation of America, Vanderbilt University and 22 hospitals within the Tennessee Hospital Association. The report indicated that by 2008, TennCare would incur total costs of approximately \$12.2 billion, with \$3.8 billion in state spending (equivalent to 36 percent of total state appropriations). The primary cost drivers in descending order of significance were pharmacy, professional services, outpatient services and increased enrollment.

2004

- TennCare transferred to a new computer system nine months past the legislative deadline. The State Comptroller John Morgan indicated that 75 percent of the management issues highlighted in the state audits over the years were related to inadequate information management systems.
- Tennessee Justice Center filed a motion for a contempt-of-court hearing in the John B consent decree suit regarding the proposed changes to the TennCare waiver.
- **February 2004:**
The McKinsey Report concluded that relatively small net savings were associated with the reduction in coverage by replacing TennCare with a smaller Medicaid program. The significant savings associated with reducing coverage for 260,000 enrollees would likely be offset with the loss of the Section 1115 waiver and the loss of federal matching dollars. The current federal match rate is 64.81 percent with the state paying the remaining 35.19 percent of the total TennCare costs.

The new Governor Phil Bredesen addressed the State Legislature regarding his TennCare reform plan which would preserve the foundation of the program and maintain adequate benefits for as many enrollees as possible, include those currently eligible as uninsurable and uninsured.

Tennessee Code Annotated, Section 71-5-102 was amended to include a new subsection, Section (d), which would provide the Bureau of TennCare with the authority to develop and implement initiatives to control the costs of the program as permitted under federal law and the TennCare waiver.

- **July 2004:**
The TennCare Bureau as amended in the Tennessee Code Annotated, Title 71, Chapter 5, Part 1, "...may implement and maintain a pharmacy lock-in program designed to address member abuse, over utilization and quality of care issues."

BHO procurement resulted in a full risk arrangement in the East Grand Region with a new BHO. The Middle and West Regions continued with the existing contract with AdvoCare, a subsidiary of Magellan Health Services.

- **August 2004:**

Governor Bredesen announced that the state would submit a finalized TennCare waiver application to CMS. A draft reform waiver was released on August 19th to the TennCare Oversight Committee of the General Assembly and to the general public for comment. Public comments were gathered over a 30 day period through a series of public meetings. The revised waiver reform addressed preserving benefits for women, children and the disabled; imposing pharmacy benefit limitations; establishing a return to risk-sharing with the MCOs; eliminating fraud and abuse; and establishing an Advisory Commission to review the ongoing performance of TennCare.

- **September 2004:**

Governor Bredesen submitted Tennessee's proposal for an amendment to the TennCare waiver. The proposal sought the approval of CMS for significant restructuring of TennCare as a means to reduce costs and preserve enrollment.

- **November 2004:**

Governor Bredesen announced plans to dissolve TennCare and return to Medicaid. The Governor noted increasing costs, reduced federal funds and litigation from the Tennessee Justice Center advocacy group, which had stymied efforts to reform the program.

The Tennessee Justice Center filed motions in U.S. District Court to suspend litigation involving several lawsuits for two years in order to preserve the TennCare program. Bredesen noted that he would suspend dissolution of the program. If litigation negotiations failed, the state would again move forward with a return to Medicaid by mid-2005.

2005

- **January 2005:**

U.S. District Judge William J. Haynes, Jr. ruled that the state could not implement the proposed changes to the waiver without his approval. The Bredesen Administration stated that they would look at removing all pharmacy and nursing home benefits if the court blocked the state's ability to implement the proposed changes. Both benefits are optional under Medicaid.

On Jan. 10, 2005, Governor Bredesen announced another TennCare overhaul, eliminating 323,000 adults from the program and imposing across-the-board benefit limits on the 396,000 adults left in the program, while preserving full benefits for the 612,000 children on TennCare.

On Jan. 24, Governor Bredesen created a task force to shore up safety net for ex-TennCare enrollees with a May 1 deadline. The Task Force, chaired by Dr. Kenneth S.

Robinson, Commissioner, Tennessee Department of Health, would prepare a final report that includes recommendations for a strong safety net provider system to service those disenrolled from TennCare along with the other uninsured in the state. There would be an effort to maximize the efforts of existing safety net providers to avoid duplications of services, and to enhance the infrastructure to areas of the state that lack a safety net provider.

- **February 2005:**

On Feb. 2, the Task Force on the Healthcare Safety Net met for the first time and was told that the State could not provide data on the 323,000 adults to be cut from TennCare

Governor Bredesen received the second part of a two-part report by the independent consultant McKinsey and Company. The report outlined potential strategies for reforming TennCare. The 25 reform options outlined in the second part of the report fall in the following five broad categories: 1) **Coverage** (adjusting the type, amount, scope and duration of benefits), 2) **Enrollment** (re-examining who qualifies for the program), 3) **Care Management** (better managing healthcare delivery), 4) **Pharmacy** (controlling growth in pharmaceutical spending), and 5) **MCO Optimization** (restructuring the system of managed-care organizations that serve as middlemen between providers and patients).

- **March 2005:**

On March 16, U.S. District Court Judge William Haynes, Jr. offered nine (9) cost-cutting changes to TennCare. Neither Gordon Bonnyman of the Tennessee Justice Center nor state lawyers welcomed the judge's TennCare ideas arguing that the judge had "overstepped" his authority.

On March 24, the federal agency CMS approved Governor Bredesen's overhaul plan

On March 28, U.S. District Judge William Haynes, Jr. halted all TennCare cuts until completion of hearing in his court to determine if the State has the authority to move forward.

TennCare announced a decision to triple the total contract to First Health Services Corporation, the pharmacy benefits management company, despite its failure to perform to state standards during the first 15 months of the agreement. Maximum earnings under the agreement would increase from \$15.9 million to \$45 million. Since the effective date of the contract, January 1, 2004, TennCare had withheld payments for failure to meet contract terms. During the first 15 month period of the agreement, drug costs increased by \$395 million or 18 percent. The new contract would have stronger penalties and eliminate several contractual weaknesses.

- **April 2005:**

On April 12, 2005, a 3-judge panel of the 6th U.S. Circuit Court of Appeals in Columbus, OH said that Judge Haynes overstepped his authority when he stopped the state from making the cuts. TennCare announced plans to cut enrollment by 323,000 beginning in midsummer of 2005

United American Healthcare Corporation of Tennessee, Inc. (formerly OmniCare) and a subsidiary of UAHC, Inc., received notice on April 20th of an order for administrative supervision from the Commission of the State of Tennessee's Department of Commerce and Insurance.

Doral Dental's \$18 million contract with TennCare would not be renewed in the summer of 2005. A new bid process would be issued due to the number of questions regarding the company's relationship with a state Senator.

Effective April 29, 2005, the TennCare Bureau and Department of Human Services will no longer process applications filed after the close of business for enrollment to non-pregnant adults who are 21 and over for the Medically Needy eligibility category. New applications will no longer be processed for TennCare Standard, which include individuals who are classified as uninsurable. The only eligibility group that may enroll in TennCare Standard are children under age 19 who qualify as Medicaid Rollovers.

- **May 2005:**

TennCare indicated its plans to send letters to individuals regarding TennCare disenrollment beginning June 1.

U.S. 6th Circuit Court of Appeals in Columbus, Ohio lifted a federal district court order that prevented the State of Tennessee from moving forward with its TennCare disenrollment plan. The court decision blocked a recent ruling by U.S. District Judge William Haynes, Jr. that required the state to change its procedures from notifying TennCare enrollees who were to be disenrolled from the program and how appeals were to be handled. The 6th Circuit Court of Appeals also agreed to provide an expedited appeal, with a hearing set for May 24, 2005 and a final decision by June 1st. The Appeals Court also invited CMS to participate in the hearing.

On May 27, the 6th U.S. Circuit Court of Appeals ruled that the state's procedures for cutting people from TennCare are constitutionally sound because they protect the enrollees' due-process rights. The ruling came just three days after attorneys for the state and enrollee advocates debated the case before 6th Circuit judges.

- **June 2005:**

CMS approved on June 8 benefit caps for up to 396,000 adults who will remain on TennCare that included: 1) a five prescription pharmacy limits for some adults, 2) elimination of some optional services such as private-duty nurses for adults, and 3) the right to charge small copays on some enrollees. It is the second phase in federal approvals needed for Gov. Phil Bredesen's plan to drastically overhaul the financially troubled public insurance program. The first phase was announced on March 24.

The State told federal Medicaid officials on June 28 that Tennessee was withdrawing its request for permission to stop covering gastric-acid reducers, commonly used to treat indigestion, and antihistamines, commonly used for allergies and breathing problems.

Earlier, Gov. Phil Bredesen had promoted the elimination of these drugs — which account for an eighth of TennCare's drug cost — as an innovative way to manage costs. Requiring all enrollees to purchase these drugs over the counter could save TennCare \$280 million in state and federal dollars a year, TennCare estimated early last year. State Finance Commissioner Dave Goetz said the decision not to eliminate the drugs was made to clear a complicated and difficult proposal off the table so it didn't slow down federal authorities who are considering TennCare changes. Those federal overseers can now focus on approving the state's other outstanding TennCare overhaul proposals — such as limiting doctor visits and hospital stays, Goetz said.

- **July-August 2005:**

Disenrollment of **190,000** TennCare Standard adults began. Pharmacy benefit limits implemented. State obtained substantial relief from most onerous provisions of Grier Consent Decree.

- **September 2005:**

On 9/1/05, BCBST reinstated medical necessity review for contracted medical services which was allowed under the relief from the Grier Consent Decree provided by the Nixon court. The final version of the ruling was issued in November, 2005.

Gov. Phil Bredesen announced Friday, September 30, \$5.7 million in grants to be awarded to 60 faith-based, community-based, rural and federally funded health centers across the state. Bredesen described the participating centers as part of a \$104 million network of programs to benefit uninsured patients and ease the transition for roughly 190,000 adults who are being disenrolled from TennCare. The funding was recommended by a task force Bredesen created in January to examine how to bolster Tennessee's health care safety net.

- **October 2005:**

Federal officials notified TennCare Bureau that the risk-sharing contracts negotiated with MCOs earlier this year meet the federal threshold for \$20 million in enhanced federal matching funds. “The 3-year period of no-risk contracts and the era of stabilization is over,” said J.D. Hickey in a Media Release dated October 21, 2005. Hickey also announced that the TennCare Bureau will begin recruiting new MCS to serve Middle Tennessee.

- **November 2005:**

The State issued a “Request for Information” to recruit new managed care organizations for Middle Tennessee. These new MCOs would assume greater risk and integrate regular health care and mental health services for most enrollees.

- **December 2005:**

Governor Phil Bredesen and TennCare officials announced a series of actions to roll back the original plans to limit benefits for those on TennCare and some who have been cut off. These included postponing the limits on the number of hospital days, doctor or clinic visits and other non-pharmacy services covered by TennCare. They also include the extension until June 30 of several benefits such as home nursing services for eligible TennCare patients, programs to help former TennCare patients pay the costs of cancer treatment, medication and some other services related to organ transplantation, hemophilia and kidney dialysis. However, prescription drug limits will remain in place.

2006

- **Feb. 2006:**

Another round of cuts to TennCare benefits was built into the programs budget for next year and the proposed cuts are expected to save the program \$55 million. The General Assembly will vote on the state budget at the end of the current session and the federal agency CMS must also approve these cuts. If approved, TennCare patients would be limited 12 doctor visits per year and 20 days of hospitalization.

- **March 2006:**

Commissioner David Geotz of Tennessee Department of Finance and Administration wrote on March 3, 2006 to CMS to propose a further amendment to the amendments approved by CMS on March 24, 2005 and June 8, 2005. The purpose of this request was to “propose a form of “soft limits” on prescription drugs to provide an additional safety valve for TennCare enrollees who have an urgent need for prescriptions over and above the existing limits.” Critics of drug limits remain critical of the proposal arguing that the proposed rules were still stricter than other states’ rules.

- **July 2006:**

TennCare Director J.D. Hickey announced his resignation on July 7. His new job will be chief executive officer at Qualifacts, a software company co-founded by Bredesen in 2000. Bredesen remains the majority owner, but the company has said it will not do business with the state.

- **Dec. 2006:**

TennCare officials gave Gov. Phil Bredesen a \$7.4 billion proposed budget Tuesday, (Dec. 5, 2006) a slight increase over last year that reflects savings on prescription drugs and fewer people in the health care program for the poor and disabled. The budget request is a far cry from the first half of this decade, when TennCare funding increased by hundreds of millions of dollars per year and pushed the state into a fiscal crisis. TennCare officials say they now have more money to spend on preventive care, including weight-loss and anti-smoking programs. Faced with a swelling TennCare budget, the legislature last year backed Bredesen's proposal to cut the TennCare rolls.

An estimated 170,000 people lost coverage, and roughly 1.2 million people are still in the system.

Tennessee hospitals will get \$131 million in fiscal 2007 to help cover the cost of providing care to the poor and uninsured under legislation that cleared Congress in the early hours of Saturday, Dec. 9. The provision restoring what's known as disproportionate-share hospital payments in Tennessee for one year was part of a sweeping tax bill passed in the Republicans' last hours in control of the House and Senate. Tennessee gave up its share of these payments in the early 1990s when it created TennCare, the state's expanded version of Medicaid, but the state lobbied to have the funds restored after it scaled back the program.

TennCare patients facing hospitalization or death may be able to get additional drugs they need beginning in February, officials announced Tuesday, Dec. 19. Currently, most adult TennCare enrollees are limited to five prescriptions per month, plus any medications from a list of more than 400 medications that do not count against the limit. The changes — expected to cost \$3 million a year — would give enrollees access to an additional 600 medications, if their doctor says it's necessary to avoid dire consequences.

Darin J. Gordan, TennCare Director and Deputy Commissioner of Tennessee Department of Finance and Administration submitted amendments to TennCare Code Annotated Section 7-15-144 to revise the definition of “medical necessity” for TennCare. Under the new rule, doctors are required to provide the "least costly" treatment that is "adequate" for their TennCare patients, a policy change that critiques believe will interfere with doctor-patient relationship and give insurance companies too much power in medical decision making.

2007

- **July 2007:**

The current TennCare waiver was set to expire June 30, 2007 and the U.S. Centers for Medicare and Medicaid Services is asking the state to agree to a new condition that would place additional caps on payments for hospitals that care for people with no health insurance. TennCare officials are reluctant to do so because they say other states with similar waivers — such as Massachusetts, California and Florida — are not subject to the additional ceiling. CMS has given the state until Aug. 15 to reach some kind of agreement. If a compromise isn't made by then, Governor Bredesen said he plans to intervene.

- **October 9, 2007:**

TennCare has received federal approval to continue operating in its current form for three more years, Gov. Phil Bredesen announced today. In the past three years, TennCare has paid more than \$1.7 billion to hospitals from a pool of money designated to assist with charity care and Medicaid losses. The purpose of the payments is to assist

with uncompensated care costs. The new waiver places a cap of \$540 million on these supplemental payments to hospitals.

2008

- **January 2008:**

TennCare placed the managed care contracts up for competitive bid for the East and West Region. The competitive bid process for the Middle Region was completed in 2007.

- **January 15, 2008:**

TennCare announced today that it will ask the federal court to lift a long-standing injunction that currently operates to prevent about 154,000 TennCare recipients from undergoing the annual eligibility check mandatory for all other TennCare enrollees. The injunction, entered in 1987 in a case known as *Daniels*, invalidated the old Medicaid program's process for checking the Medicaid eligibility of a particular group of enrollees and has resulted in the State Comptroller repeatedly citing TennCare for allowing potentially ineligible enrollees to remain on the program.

- **February 2008:**

U.S. District Judge John T. Nixon agreed to let the state drop prisoners from its TennCare rolls, but the status of thousands more enrollees remains under legal review. The agreement between the state and TennCare advocates will lead to an estimated 1,100 prisoners being removed from state's expanded Medicaid program. The state Correction Department is already responsible for providing health care to prisoners. The inmates were kept on TennCare because of a **1987** ruling that banned the state from checking the eligibility of people who at one time qualified for a federal cash assistance program called Supplemental Security Income, or SSI.

- **April 22, 2008:**

The TennCare Bureau announced today that BlueCross BlueShield of Tennessee (BCBST) and UnitedHealth Plan of River Valley, Inc. (United) are the prevailing bidders in both the East and West grand regions of the state for TennCare's managed care organization (MCO) contracts. The MCO contractors will accept full financial risk to participate in Tennessee's Medicaid program and will be paid set monthly rates, or capitated payments, to manage and deliver care to approximately 173,500 TennCare members each in the West region and approximately 199,500 TennCare members each in the East region. The new contracts also establish an integrated medical and behavioral health care system for members in those regions, following the same integration strategy established in the Middle region last year.

- **September 1, 2008:**

Blue Cross Blue Shield of Tennessee and AmeriChoice began their respective operations as integrated MCOs for both the East and West Grand Regions. The two West Tennessee MCOs began serving their assignment enrollees without several major providers agreeing to accept contract offers. These include [UT Medical Group](#), the largest physicians' organization in the city, [Methodist Le Bonheur Healthcare](#) and [the Regional Medical Center at Memphis](#), a hospital that provides the region's only burn and trauma services. Saint Francis Healthcare had reached an agreement with AmeriChoice but not with BlueCross

2009

- **January 8, 2009:**

U.S. District Court Senior Judge John T. Nixon ruled on Thursday (01/08/2009) that TennCare officials can for the first time in over 20 years begin reviewing the eligibility of about 150,000 people who are the subject of a decades-old lawsuit, starting a process which could save the state millions of dollars a year. TennCare officials had earlier asked to be released from the terms of a 1987 injunction which forbade the state from reviewing eligibility of the plaintiffs in the lawsuit, known as the "Daniels case." The state currently spends about \$400 million annually on the Daniels plaintiffs, and hopes to save some money – possibly as much as \$200 million a year – by dropping those who no longer eligible.

- **July 23, 2009:**

TennCare announced today federal officials have approved changes to Tennessee's long-term care program, which brings the state one step closer to total implementation of the Long Term Care Community Choices Act of 2008. The Centers for Medicare and Medicaid Services (CMS) approved an amendment to the TennCare waiver that will allow managed care organizations to coordinate all of the care a TennCare member needs, which will now include medical, behavioral and long-term care.

2010

- **February 1, 2010:**

Governor Phil Bredesen's farewell state budget plan, presented to the General Assembly Monday (2/1/2010) night in a "state of the state" address, calls for cutting \$200.7 million in state spending from TennCare. He also said he adopted almost all of the budget reductions proposed by TennCare, including the elimination of occupational, physical and speech therapies; limits on X-rays; and a \$10,000 annual cap on payments for inpatient hospital care. The cuts to TennCare would save Tennessee \$174 million altogether, Bredesen said. The annual cap on inpatient care alone would save \$51 million. But Bredesen said hospitals and other care providers would shoulder much of the cuts.

- **February 8, 2010:**

The Tennessee Hospital Association's board voted Monday (02 08 2010) to approve a one-year "coverage fee" of 1% - 2% that would raise money for hospitals scheduled to receive less funding from TennCare. The unusual move — which means hospitals essentially will lobby the legislature to tax them — is meant to offset some of the \$370 million in TennCare cuts proposed by Bredesen as part of next year's budget. Because the federal government sends Tennessee two dollars to three dollars for every dollar the state spends on TennCare, hospitals estimate that the Bredesen's cuts to TennCare could take as much as \$1.5 billion out of Tennessee's health-care system.

- **March 2010:**

The Boston Globe reported (March 1, 2010) that BlueCross BlueShield of Tennessee (BCBST) lost \$96 million managing health care for TennCare in 2009 – more than double what the insurer expected. The losses were more than twice what BlueCross expected and could reach \$135 million this year, according to a report to legislators, dated 01/20/2010. To offset the projected loss, BCBST will cut reimbursements to thousands of specialty physicians and to some hospitals by 14 percent and is counting on an emergency room diversion program to save costs.

Approximately 100,000 children and adults lose TennCare coverage after the Bredesen administration obtained federal court approval to end automatic enrollment to keep people on TennCare who were receiving federal disability benefits.

President Barack Obama signed into law the Patient Protection and Affordable Care Act, giving states incentives to expand their Medicaid programs and requiring States to establish health insurance exchanges.

2011

- **January 30, 2011:**

Tennessee is preparing to cut \$300 million in TennCare spending by limiting doctor and hospital visits, according to a public notice to be published in newspapers this weekend. The move would also eliminate coverage of physical, occupational and speech therapy, and adult enrollees would no longer have coverage for podiatrists or physicians' assistant services. The benefit cuts were originally planned by former Democratic Gov. Phil Bredesen in 2010, but they were delayed through a combination of federal stimulus money, prescription refunds and a temporary fee on hospitals. The proposed cuts are part of the new Republican Gov. Bill Haslam's plan to close what he has estimated to be a \$1 billion budget gap in the state.

- **March 2011:**

Republican governor Bill Haslam said the 2011-12 budget that starts July 1 includes “real cuts” but added, “we would have had a much different-looking budget and our cuts to

TennCare would have been a lot harder” without the Tennessee Hospital Association’s agreement. Haslam spoke in mid-March during a roundtable discussion with reporters after presenting his first budget to the Republican-controlled General Assembly.

2012

- **February 2012:**

The John B. consent decree ends with court approval: A federal judge on Tuesday, February 14, 2012, dismissed a long-running lawsuit over medical and dental treatment for the 750,000 children on TennCare, more than a third of all children in the state.

- **December 10, 2012:**

Tennessee Governor Bill Haslam told a meeting of the Nashville Rotary Club on Monday, December 10, 2012, that the state of Tennessee will not be establishing a health care exchange to implement Obamacare.

2013

- **March 2013:**

Gov. Bill Haslam announces he will not pursue a Medicaid expansion available under the Affordable Care Act. He will pursue a "third way."

- **December 2013:**

The governor and fellow administration officials spent months in talks with HHS Secretary Sebelius and her top aides on his plan to use the federal money to essentially buy newly eligible Medicaid enrollees into the online insurance marketplaces known as exchanges. But unlike Arkansas, which won approval to do just that, Haslam is demanding flexibility to better control enrollees' behavior through charging them higher co-payments when they unnecessarily use expensive services like hospital emergency rooms or indulge in unhealthy habits like smoking. Haslam also wants to reform provider reimbursements and reward providers for patient outcomes and quality care instead of simply paying them to perform specific services. And on another front, Haslam is questioning "wrap-around" services now required for "medically fragile" enrollees. The governor revealed that he had written Sebelius during a speech Monday to the Nashville Rotary Club. Last month, Sebelius said that while she and her staff have had conversations with Haslam and TennCare officials, Tennessee had yet to actually submit anything in writing. Haslam has previously said most of that had been covered in various conversations (Timefreepress.com, 12/10/2013).

2014

- **June 2014:**

The federal director of Medicaid programs Marilyn Tavenner puts Tennessee on notice for failing to provide services as required by the Affordable Care Act, a problem TennCare has blamed on a faulty \$35 million computer system. State officials have also blamed the delays on the federal government, since the state has been sending TennCare applicants the federally run health care insurance exchange, Healthcare.gov.

- **July 2014:**

Three nonprofit legal firms filed suit against TennCare, calling Tennessee the worst state in the nation for fulfilling its Medicaid obligations.

- **August 2014:**

Governor Haslam pledges to submit this fall a "Tennessee Plan" to expand coverage.

- **September 2014:**

U.S. District Court Judge Todd J. Campbell ordered Tennessee's state Medicaid program to take responsibility for long-delayed applications, calling for the agency to hold hearings for people who have waited months to find out whether they will receive coverage.

- **December 14, 2014:**

Bill Haslam announced today the new Insure Tennessee plan, a two-year pilot program that would provide health care coverage to up to 200,000 of previously uninsured Tennesseans. Tennesseans 21 to 64 years old and with income under 138% of federal poverty line will be offered a choice of the Healthy Incentives Plan (a special program under Tennessee) or the Volunteer Plan (a voucher plan to help workers to purchase employer-sponsored health plans).

- **December 2014:**

Tennessee was awarded a Round Two SIM Model Test Award to implement and test its health care payment and delivery system reform focusing on primary care transformation, episodes of care, and long-term services and supports. See more at: <https://www.tn.gov/tenncare/article/tenncare-timeline#sthash.PBRuV040.dpuf>.

2015

- **January 9, 2015:**

Gov. Bill Haslam is calling a special session of the legislature to hear his answer to Medicaid expansion: "Insure Tennessee," a two-year pilot program that would provide health care to more than 200,000 Tennesseans who lack direct access to coverage.

- **January 13, 2015:**

TennCare decided to end its contract with Northrop Grumman and would hire a new vendor to build a new computer system for determining Medicaid eligibility. The Bureau of Tennessee announced Monday it was taking the action because of months of delays and missed benchmarks by Northrop Grumman. The decision was based on an audit report by KPMG. The behind-schedule \$35.7 million computer system was a primary factor that led to a federal lawsuit.

- **February 2015:**

The Tennessee General Assembly convened a special session, called by Governor Haslam, to consider a joint resolution on Insure Tennessee. Following two days of hearings, the Tennessee Senate Health and Wellness Committee voted 7-4 against the implementation Insure Tennessee, ending the special session.

- **April 18, 2015:**

The State submitted a waiver amendment request to CMS to extend funding of the supplemental payment pools, primarily used to offset the costs of uncompensated care, which was set to expire on December 31, 2015. The State requested extension of funding through the end of the current waiver approval period on June 30, 2016.

- **June 23, 2015:**

The State submitted a waiver amendment request to CMS to implement the ECF CHOICES program to provide managed long-term services and supports to individuals with intellectual and developmental disabilities.

- **July 23, 2015:**

The State submitted a waiver amendment request to CMS to close enrollment for the Standard Spend Down eligibility category. See more at: <https://www.tn.gov/tenncare/article/tenncare-timeline#sthash.PBRuV040.dpuf>.

2016

- **April 12, 2016:**

House Speaker Beth Harwell announced Tuesday, April 12, 2016, the creation of a legislative task force that will look at ways to improve access to care. The move was billed as an attempt to increase access to care for the working poor.

- **June 2016:**

- Darin Gordon, the state's longest serving director of TennCare, stepped down in June 2016 to join the private sector.
- Dr. Wendy Long, the longtime chief medical officer of [TennCare](#), succeeded Darin Gordon as director. In her new role, Dr. Long became the director of TennCare and deputy commissioner of Health Care Finance and Administration.
- TennCare would be expanded via a phase-in program that places priority on veterans and people with mental health or substance abuse disorders under a proposal from the health care task force commissioned by House Speaker Beth Harwell. The proposal from the 3-Star Healthy Task Force outlines a two-step program that encourages people to develop relationships with physicians, get behavioral health treatment in tandem with physical health treatment and includes a work and education component to help people into positions lucrative enough to finance commercial coverage.

A list of TennCare Directors since 1994:

- **January 1994–April 1995:** Manny Martins, TennCare Director
- **April 1995–May 1996:** Rusty Seibert, TennCare Director
- **May 1996–March 1998:** Theresa Clarke, TennCare Director
- **March 1998–January 1999:** Dr. Wendy Long, TennCare interim director
- **January 14, 1999–January 31 1999:** Glen Jennings, TennCare acting director
- **February 1, 1999–September 1999:** Brian Lapps, TennCare Director
- **September 1999–June 2000:** John Tighe, TennCare Director
- **June 2000–June 2002:** Mark Reynolds, TennCare Director
- **July 2002–early July 2004:** Manny Martins returned as TennCare Director
- **July 2004–July 2006:** J. D. Hickey, TennCare Director
- **July 2006–June 2016:** Darin Gordon, TennCare Director
- **June 2016–Present:** Dr. Wendy Long, TennCare Director

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