MEDICAID LEADERSHIP INSTITUTE
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MEDICAID FELLOW PROFILE

Pioneering Care Management Solutions for Tennessee's Medicaid Program

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IN BRIEF

As the CEOs of the largest health insurers in their states, Medicaid directors are positioned to influence the delivery of higher-quality, more cost-effective services across the health care system. This profile details Tennessee's innovative health care transformation process and the critical role of the state's Medicaid director Darin Gordon in the statewide restructuring. It also describes the *Medicaid Leadership Institute*, a unique fellowship program designed to enhance the capacity of Medicaid directors to maximize the potential of publicly financed health care.

Patti Killingsworth says her boss, Tennessee Medicaid director Darin Gordon, is always looking for the next challenge. She recalls walking out of the state Capitol with him in 2008 moments after the Legislature unanimously passed a bill that Killingsworth and Gordon had worked on for months. The new law integrated long-term care into Medicaid managed care, a breakthrough achievement. Instead of celebrating, Gordon turned to her and said, "We have a lot of work to do."

"Before we finish one thing, he's looking at what we need to do next to deliver better quality care to the people we serve," says Killingsworth, the assistant commissioner of the state Department of Finance and Administration and chief of long-term care. "It's a blessing and a curse," she adds with a laugh.

Now Gordon, the Department's deputy commissioner, and Killingsworth are taking the logical next step, one that many policy experts consider a holy grail in publicly financed health care. They are preparing the way to integrate Medicare and Medicaid benefits for low-income, chronically ill, mostly elderly patients covered by both programs. Tennessee, which pioneered Medicaid managed care in the mid-1990s with its TennCare program, is one of 15 states that received a $1 million grant earlier this year to explore the integration concept further.

Nationally, individuals who are dually eligible for Medicare and Medicaid make up 15 percent of Medicaid beneficiaries but account for 39 percent of Medicaid spending, according to the Centers for Medicare & Medicaid Services (CMS). The 9.2 million dual eligibles cost the federal and state governments about $300 billion a year.

Gordon and Killingsworth currently are talking to CMS' Medicare-Medicaid Coordination Office seeking a waiver to allow Tennessee to integrate Medicare benefits for all 135,000 dual eligibles in TennCare's managed care program, which covers a total of 1.2 million people. Gordon says no other state has proposed to do so on this scale. Beneficiaries dually eligible for Medicare and Medicaid "would no longer have to figure out who to call for help," Gordon says. "They'd be able to call their health plan to access whatever care they need – physical, behavioral, or long-term service and supports. It becomes a more seamless experience for them. If this makes sense, we don't want to pilot it. We want to deploy


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it to everyone." Senior officials in the federal Medicare-Medicaid Coordination Office are interested in Tennessee's progress and are looking at ways to partner with the state, in particular to share lessons with additional states.

Gordon worked on developing the state's dual-eligible integration model as a 2010-2011 Fellow in the *Medicaid Leadership Institute*, a professional development program for state Medicaid directors run by the Center for Health Care Strategies and funded by the Robert Wood Johnson Foundation. He received personal leadership coaching through the Institute, and worked on the dual-eligible project as his on-the-job practicum.

Of course, winning federal approval for moving dual eligibles into managed care plans is far from a done deal, given the commitment of federal officials and patient advocacy groups to assuring quality of care and patient rights. But if Gordon and his team make it happen, it would be the latest achievement in a series of major Medicaid transformations during Gordon's five years as TennCare director. He is one of the longest-serving Medicaid directors in the country, and one of the few to serve under governors of different parties. Republican Gov. Bill Haslam retained Gordon when he succeeded Democratic Gov. Phil Bredesen.

"It's unusual for an official at that level to go from one governor to the next, not to mention the change of parties," says Republican State Rep. Glen Casada, who chairs the House Health and Human Resources Committee. "That tells you Darin is very good at what he does and would be very hard to replace."

Under his leadership, Tennessee's Medicaid program, which now costs about $9 billion a year, has experienced spending growth of three percent or less over the last several years, significantly lower than the national average. That stands in sharp contrast to the period from the late 1990s to the mid-2000s, when TennCare's enrollment and costs grew rapidly. The state faced tough choices about what to do, given its commitment to expanding coverage to the uninsured.

Even before he took over as TennCare director in 2006, Gordon played an important role in stabilizing the program's finances as chief financial officer for TennCare. Gordon worked with his bosses, Gov. Bredesen and Commissioner Dave Goetz, to pare back program eligibility and pharmacy costs. When they started, the state had the highest number of prescriptions per beneficiary of any Medicaid program in the country.

They accomplished cost and efficiency gains by bidding out TennCare contracts to two managed care organizations in each part of the state – moving away from a more open system involving many more plans – and returning the managed care plans to full financial-risk contracts.

Then, in 2006 as TennCare director, Gordon tackled the next quality and cost problem on his and Goetz's checklist. He led the way in integrating behavioral health with physical health services, making managed care plans responsible for both. In many states the two types of services still are "carved out" and handled by different contractors. "We decided there was something wrong having two separate entities responsible for the same person, depending on whether the issue was behavioral or physiological," Gordon says.

Before moving ahead with integration, many meetings with stakeholders were required to reassure them that the goal was to serve TennCare beneficiaries better, and that patient safety and financial protections were in place. After Tennessee merged these

responsibilities, Gordon says, "we started hearing good stories about clinics wanting a behavioralist at the clinic and plans starting to pay for that staffing. The system began to work in a more coordinated way."

Then Gordon took on his most ambitious project up to that point – integrating long-term care into TennCare's managed care plans. At the time, long-term care was highly fragmented. His agency handled nursing home services, another state agency administered home- and community-based care, and TennCare managed care contractors were responsible for certain home health services.

Before the new program took effect in 2010, 83 percent of the state's Medicaid-funded elderly and disabled long-term care recipients were in nursing homes and only 17 percent were in home- and community-based services. "We were providing care in the most expensive setting and weren't making good use of limited resources," Gordon says.

Gordon and his staff launched a major stakeholder engagement effort, holding numerous meetings with politically powerful nursing home operators as well as AARP officials and other senior citizen advocates. "Initially it was shocking to the stakeholders because long-term care services had never interacted with managed care in our state," he says.

He and his staff told the nursing home leaders this was an opportunity for them to diversify into different areas of service. They told advocates for seniors that Tennessee, as one of the most institutionally dependent states in the country, had nowhere to go but up in rebalancing how we provide long-term services and supports. That convinced AARP. "It was an incredibly comprehensive stakeholder engagement, but, in the end, we had really good partners all around in making this successful," he says.

The Long-Term Care Community Choices Act passed unanimously in 2008, and was implemented statewide in 2010. "This was

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brand new to Tennessee, and Darin and his staff did an excellent job in educating the community and legislators and shepherding the bill through," Casada says.

Within one year, the ratio of nursing home care to home- and community-based care shifted from 83-17 to 68-32 and has continued to "rebalance" accordingly. The expansion of non-institutional care has been funded entirely by redirecting existing long-term care funding based on how enrollees choose to utilize services. "It has created a more seamless system for users, and allowed them to utilize the level of services they need," Gordon says. "Folks are very pleased with what this system does."

Dave Goetz, who left his Tennessee post in 2010 and is now vice president for state government solutions at Optum, a division of UnitedHealth Group, says Gordon and his staff succeeded in pushing through the new system because they really listened to the stakeholders. "Everyone knows Darin is one of the most honest and straightforward people they'll ever deal with," he says. "You know you can trust him and his team to be good partners and do what they said they'd do. That's really critical."

Goetz also credits the *Medicaid Leadership Institute* for helping Gordon and his colleagues through the implementation of the long-term care integration project. "Darin could talk not just to fellow Medicaid directors but to national experts," he says. "That makes your end product better."

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Gordon agrees that it was invaluable for him and his staff to be able to meet with peers and experts around the country to hear the best thinking on a wide range of policies and practices. But what surprised him was how much he got from the *Institute's* leadership training component, which paired him with a personal coach, George Sweazey. His top staff also received training, including participation in an all-day leadership session with Ed O'Neil, director of the Center for the Health Professions at University of California, San Francisco, whose organization provides the leadership coaches and training for the *Institute's* Fellows.

Gordon says that like him, his colleagues were surprised by how valuable they found the training in such areas as dealing with conflict, handling change, and overcoming personal weaknesses. "They came in with low expectations, but they all said it was the best day they had and they wished they had some of this coaching earlier in their careers. This is a collective lift that will benefit our program for years to come, long after my service has ended."

Personally, he found it helpful to consult with Sweazey about the challenges of transitioning from one governor's administration to another, and having to work with a new set of people. "It will be tough not to have the coach any more," he says. "But I know if I called him out of the blue for some quick help, he would provide it."

In addition to his Medicaid work, Gordon serves as his state's main adviser on implementation of the federal Affordable Care Act. He's heading up planning for Tennessee's health insurance exchange, the marketplace for individuals and small-group purchasers mandated by the health reform law. That's a delicate task given the opposition of the reform law and its requirement to establish exchanges by some.

After he and his staff spent a year holding meetings around the state sounding out stakeholders on the exchange concept, his office recently issued a report indicating that key groups prefer a state-operated exchange rather than one run by the federal government. "Our inclination is that the state retain control and that we run our own exchange," he says. Gov. Haslam and the Republican-controlled Legislature will make the final decision.

Meanwhile, Gordon worries about the impact of continued state budget pressures on TennCare members and health care providers. He says that until recently, through good management of TennCare, Tennessee avoided onerous measures like provider rate cuts that many other state Medicaid programs have had to implement.

"But as each year goes on, the things we're looking at from a reduction perspective get more difficult," he says, particularly as the big Medicaid expansion mandated by the Affordable Care Act in 2014 looms. "How can we adjust benefits to live on the reduced state money we have available?" he asks. "There are only so many optional benefits. Can we stop covering pharmacy for this population? You can put in appropriate controls, but those benefits need to exist."

He and other experts hope that improving the coordination of care for expensive dual-eligible beneficiaries through a new managed care program will help improve care and ensure the most efficient use of limited resources as Tennessee's previous Medicaid innovations have done. While it is a thorny challenge, Killingsworth thinks Gordon is the person who can successfully lead this effort. "Darin is a tremendous leader," she says.

Author Harris Meyer is a Washington State-based freelance journalist who has been writing about health care policy and delivery since 1986.

About the Medicaid Leadership Institute

The *Medicaid Leadership Institute* is a unique opportunity for Medicaid directors to participate in an intensive leadership development curriculum designed to cultivate the skills necessary to transform their Medicaid programs into national models for high-quality, cost-effective care. The Institute is an initiative of the Robert Wood Johnson Foundation directed by the Center for Health Care Strategies, a nonprofit health policy resource center dedicated to improving health care quality for low-income children and adults, people with chronic illnesses and disabilities, frail elders, and racially and ethnically diverse populations experiencing disparities in care. For more information, visit www.MedicaidLeaders.org.