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MEDICAID REFORM 101: MORE THAN JUST BLOCK GRANTS

PART 5 OF 5 – BRINGING IT ALL TOGETHER – THE POTENTIAL IMPACT OF MEDICAID REFORM ON TENNESSEE

BOTTOM LINE

The major reforms to Medicaid expected in the coming months or years could significantly alter TennCare, a program that provides health care coverage to over 20% of all Tennesseans. This brief brings together Parts 1 through 4 of this series to summarize TennCare's funding history and the range of potential impacts of federal reform efforts on our state.

We analyzed 6 hypothetical **block grant** and **per capita cap** scenarios and compared them to actual federal funding over the last 5 years. The 5-year effect of the various scenarios ranged from a +2% increase in federal funding to a -6% reduction – with **5 of the 6 scenarios generating fewer federal dollars for Tennessee**. Our analysis shows that **federal details still to be determined about the base year and the growth factor will matter immensely**.

How any changes in federal financing actually impact the state will hinge on a number of factors. The factors include (1) how successful state reforms are at making health care more cost-effective, (2) how successful state reforms are at making costs more predictable, and (3) external factors arguably outside policymakers' control. If successful at offsetting any federal losses, the state could have the opportunity to expand TennCare, cut taxes, or make new investments in other areas. If federal reforms put too great a burden on states, however, Tennessee's policymakers may face difficult decisions about raising state revenues, cutting spending for other programs, or scaling back TennCare.

THE SYCAMORE INSTITUTE'S "MEDICAID REFORM 101" SERIES:

PART 1: Key federal Medicaid reform design elements

PART 2: Summary of recent federal proposals

PART 3: Key TennCare reform design elements

PART 4: Summary of recent TennCare proposals

PART 5: Analysis of the potential impact on Tennessee

$100-$900 BILLION

The range of federal reductions over a 10-year period associated with various federal Medicaid reform proposals.

INTRODUCTION

The previous briefs in this series summarize both state and federal reform efforts. This brief summarizes TennCare's funding history and describes the range of potential impacts that federal reform efforts could have on our state. This 5-part series provides a framework and context for changes to Medicaid and TennCare that may be adopted by state and federal policymakers in the coming months and years.

IMPACT ON FEDERAL FUNDING

Federal reform efforts are aimed at reducing federal spending. The nonpartisan Congressional Budget Office (CBO) has analyzed several alternatives to reforming Medicaid at the federal level. Under all scenarios, federal spending would be reduced by hundreds of billions of dollars over a 10-year period. The estimates of federal reductions range from a low of

about -$100 billion under a block grant that grows with National Health Expenditures (NHE) to -$600 billion under a per capita cap that grows with inflation (i.e. CPI-U). [1] The federal fiscal year (FFY) 2016 House budget resolution assumed that Medicaid reforms would reduce the federal government's Medicaid liability by -$904 billion over 10 years [2], and the FFY 2015 resolution assumed -$732 billion in federal spending reductions over 10 years. [3]

TENNCARE IN THE CONTEXT OF THE STATE BUDGET

These federal dollars are, of course, a source of state revenue for the TennCare program. In order to better understand how these federal reductions may impact Tennessee's own budget, this section and the infographic on the next page provide background on TennCare's funding.

31%

of the TOTAL STATE BUDGET is spent on TennCare.

51%

of the state's FEDERAL REVENUES are spent on TennCare.

23%

of the STATE'S OWN TAX DOLLARS are spent on TennCare.

In the most recent year for which actual expenditure information is available (state FY 2014-2015), the TennCare program was the single largest department in the state budget – accounting for 31% of the total budget including all revenue sources. **TennCare, however, is predominantly funded by federal dollars.** As covered in the first brief in this series, this is driven by the federal medical assistance percentage (FMAP), which determines the federal Medicaid match rate. Tennessee's FMAP is about 65%. In fact, 61% of total spending on TennCare is picked up by the federal government. In FY 2014-2015, 51% of all federal dollars flowing into the state were spent on TennCare. In contrast, 23% of state dollars were spent on TennCare, making it the 2nd largest department behind K-12 Education when considering state dollars alone.

Key Observations about TennCare Spending: There are a few key trends that stand out when looking back at TennCare spending over time:

- TennCare spending has been growing.
- Total TennCare expenditures per enrollee have been growing.
- Annual changes in TennCare spending both in total and on an enrollee basis have been volatile – particularly in comparison to inflation.

Drivers of TennCare Spending: Some of the years that look particularly striking were the result of **active management** of the program by the state's policymakers. For example, the only drop in total TennCare spending since FY 1994-1995 was the result of a large disenrollment of optional eligibility populations in 2005 – a topic covered in Part 3.

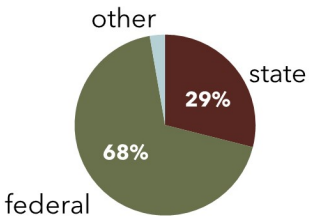
In addition, there are a number of factors arguably **outside the control of policymakers** that drive some of these TennCare spending trends – including underlying health care costs, demographic trends like the aging of the population, changes in the broader state or national economy, and larger public health trends and emergencies.

The **growth of health care costs** in the U.S. has notoriously outstripped inflation and growth in the economy for decades. One driver of this trend is the introduction of costly new treatments. For example, new specialty drugs have been introduced in recent years to treat Hepatitis C. While they may produce savings for certain populations in the long-run by curing Hepatitis C, they are very expensive in the short run ($84,000 for a 12-week course of Solvaldi, for example). The latest available TennCare actuarial report, in fact, noted that all the savings that the state has been able to achieve in non-pharmacy benefits is expected to be offset by increased pharmacy costs "attributed to breakthrough drugs such as the Hepatitis C drugs that have recently become available." [4] [5]

TENNCARE

FUNDING & ENROLLMENT HISTORY

FY 1994-1995

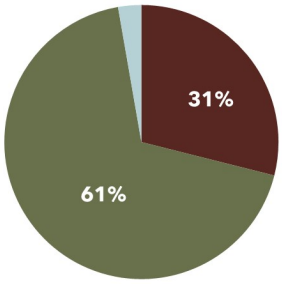


$3.0 BILLION

1.2M ENROLLEES

$2,500 / ENROLLEE

FY 2004-2005

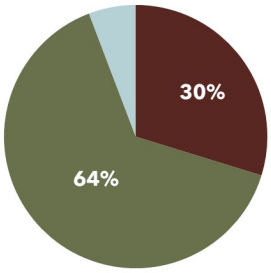


$8.6 BILLION

1.3M ENROLLEES

$6,400 / ENROLLEE

FY 2005-2006

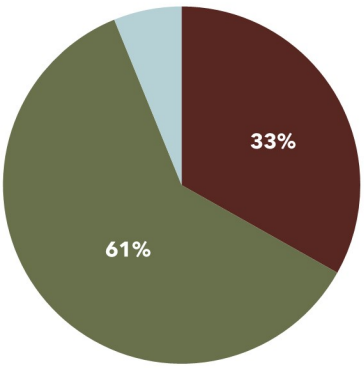


$6.9 BILLION

1.2M ENROLLEES

$6,900 / ENROLLEE

FY 2014-2015



$10.1 BILLION

1.4M ENROLLEES

$7,000 / ENROLLEE

SHARE OF TOTAL STATE BUDGET

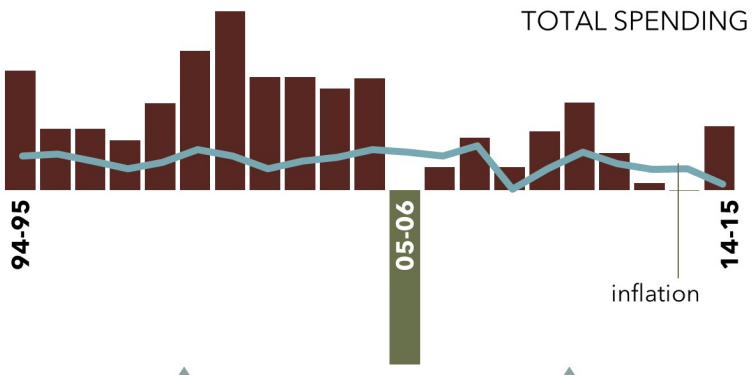
13% of all state dollars

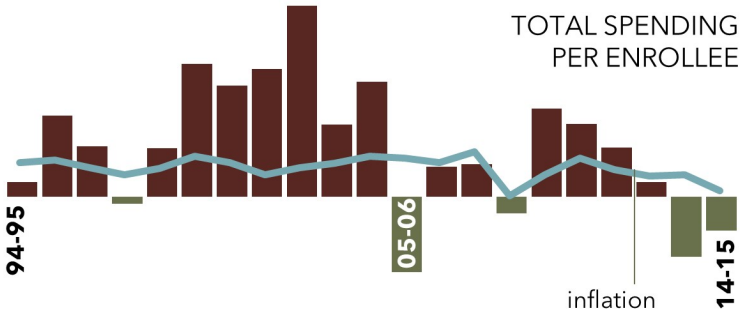
24% of all state dollars

19% of all state dollars

23% of all state dollars

ANNUAL GROWTH vs. INFLATION





EXTERNAL INFLUENCERS

Demographic Trends like the aging of the population

Economic Trends like downturns and recessions

Health Care Costs including expensive new treatments

Public Health Trends like the opioid epidemic

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Additionally, TennCare costs tend to spike during **economic downturns** when more individuals may meet the income eligibility standards of the program. For example, in FY 2008-2009 in the midst of the Great Recession, enrollment in TennCare jumped by 4% – which, at the time, was the highest annual enrollment increase the program had experienced in a decade.

Another driver of volatile TennCare costs, although to a lesser extent than the other 2 factors, has been **larger public health trends** and emergencies. A timely example is the increased misuse and abuse of opioids. According to TennCare, the rate and number of babies born with Neonatal Abstinence Syndrome (NAS) among TennCare enrollees quadrupled between 2008 and 2014 – a phenomenon tied to the rise in prescription drug and opioid misuse. TennCare has determined that the average cost of care for babies with NAS is 10 times higher in the first year than for normal birth weight infants - $49,000 versus $5,000, respectively. In 2014, TennCare treatment for babies with NAS totaled $51 million. The additional annual treatment costs associated with the increase in NAS among babies covered by TennCare between 2008 and 2014 was as much as $35 million. [6]

Structured as an entitlement program, Medicaid costs can be unpredictable. Medicaid is an entitlement under which coverage of many treatments are guaranteed to all who are eligible – even when treatment costs or the number of enrollees spike. This structure ensures that all low-income, aged, and disabled adults and children meeting eligibility criteria are guaranteed access to TennCare's coverage of needed health care services, including big new breakthroughs. The flipside of this coin, however, is that states are often required to cover these costs without exception – making states' costs relatively unpredictable and arguably impacting other parts of a state's budget. In its current structure, however, the federal government picks up the lion's share of this bill for Tennessee, which shields the state from some of the unpredictable spikes in cost.

Most of the federal reform proposals summarized in Part 2 in this series are explicitly designed to make the federal portion of this spending more predictable. However, **making the federal share more predictable could potentially shift responsibility for cost volatility to the state**. For this reason, most federal proposals also include significant new flexibilities that states can use to produce cost-savings needed to offset some or all of these federal funding reductions.

WRAPPING OUR HEADS AROUND THE POTENTIAL CHANGE TO FEDERAL TENNCARE REVENUES

IMPACT ANALYSIS IS CHALLENGING.

Current federal proposals lack key details, and Medicaid costs generally are volatile.

As state policymakers approach TennCare reform, a chief question on their minds will likely be: Exactly how much savings, if any, would Tennessee need to generate to offset the loss of federal dollars? The answer is not easy. At this point, federal reform proposals are not fully fleshed out, and as the CBO estimates above denote, the details will matter. Furthermore, because Medicaid costs can be so volatile as outlined above, predicting costs under current law into the future as a point of comparison is very difficult and potentially open to interpretation.

Because of these limitations, rather than trying to project how federal funding may change in the future relative to projections of federal funding under current law, we took a look back. We analyzed actual federal TennCare funding over the last 5 years relative to federal funding under 6 reform scenarios – both a block grant and a categorical per capita cap indexed to various growth rates. **The findings of this approach illustrate of how federal reforms could impact Tennessee's federal TennCare revenues. The impact on federal revenues would drive how much savings the state would need to generate through its own reforms to avoid overall cost increases in the program.**

Method: Using FY 2009-2010 as the base year, each analysis provides the estimated difference between what was actually received from the federal government over the 5-year period for TennCare and what may have been provided under different scenarios. These differences are presented in both absolute dollar terms and as a percentage of total federal funding actually received for the subset of spending we looked at.

FY 2009-2010 was selected as the base year because it was the first year in which medical and behavioral health services were integrated for all TennCare enrollees. Because of this, prior years' managed care actuarial data, which were used for the per capita cap analysis, were not comparable to later years' data in which services were integrated.

In both analyses, the federal contributions would grow based on three different factors that have been discussed in the context of federal reforms. All of these rates of growth have been less than the growth in health care generally and Medicaid specifically (a stated goal of various federal proposals):

- An annual federal allotment indexed to **inflation** – otherwise known as the change in the consumer price index for all urban consumers (i.e. CPI-U) [7];
- An annual federal allotment indexed to **the economy** (i.e. gross domestic product or GDP) [8]; and
- An annual federal allotment that grows with **the economy and national population changes** (i.e. per capita GDP).

A WORD OF CAUTION

This section is intended to give an idea about how changes to the way that Medicaid is financed could impact Tennessee's federal TennCare revenues. The impacts shown are simply illustrative and do not reflect the policy interventions and program management actions that might be taken by state policymakers in response to federal changes.

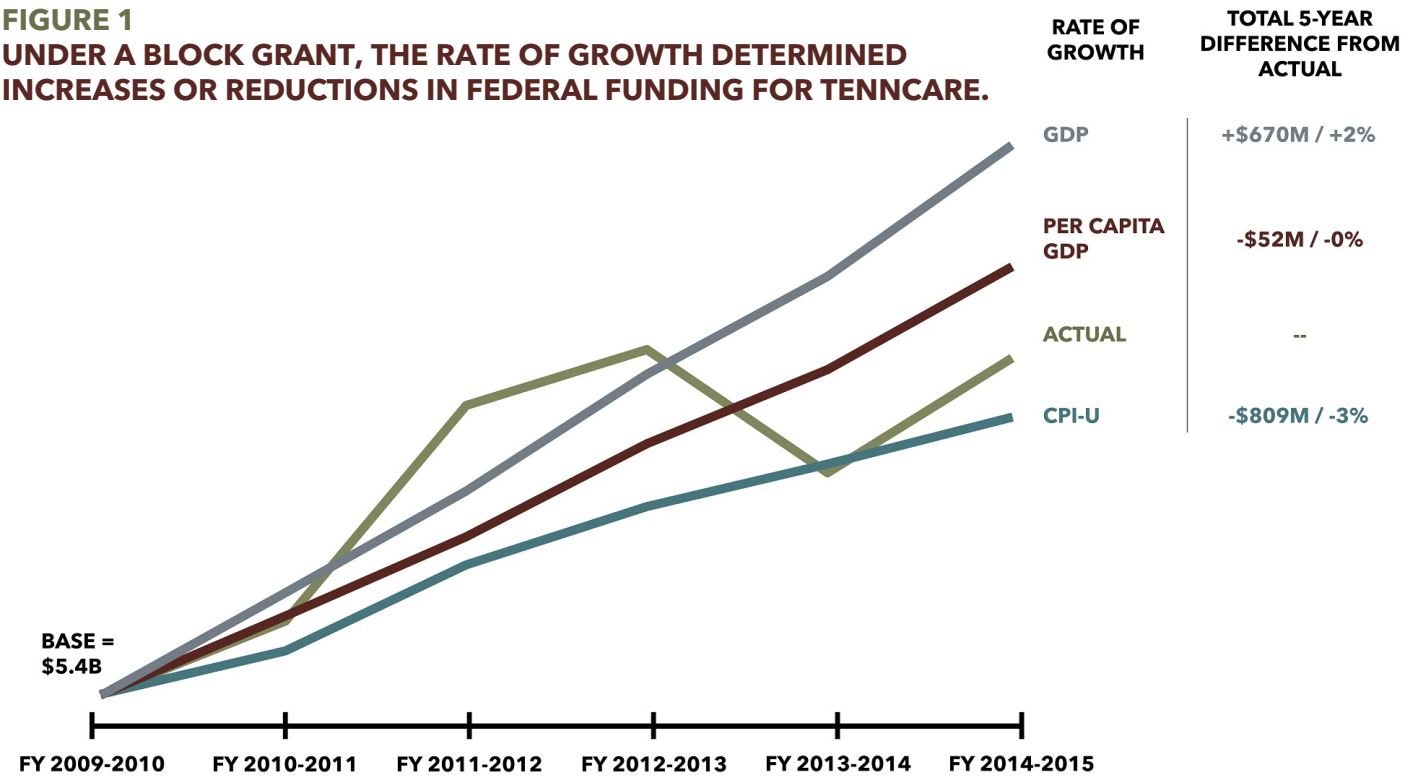
For both FY 2009-2010 and FY 2010-2011, we deducted an estimate of the federal dollars associated with a temporary boost in federal funding that states received under the American Recovery and Reinvestment Act (ARRA) during the Great Recession. Because this was a deviation from the normal FMAP received by states, including it in the base year, in particular, would have unfairly inflated the base year for the purposes of these analyses. [9] [10]

Limitations: The total 5-year difference under various scenarios is simply an illustration. The actual federal revenues reflect the decisions that were made by state policymakers within the context of current law. In the face of a different federal financing structure and additional administrative flexibilities, these decisions would likely have been different. This means that the estimate of the difference shouldn't be construed as a pure cost-shift.

Additionally, these analyses do not account for any federal reforms that might try to address the variation in costs across different states.

An appendix of the data and our results is available separately on our website.

FIGURE 1
UNDER A BLOCK GRANT, THE RATE OF GROWTH DETERMINED INCREASES OR REDUCTIONS IN FEDERAL FUNDING FOR TENNCARE.



Actual Federal TennCare Revenues vs. An Illustrative Federal Block Grant Indexed to Various Growth Rates

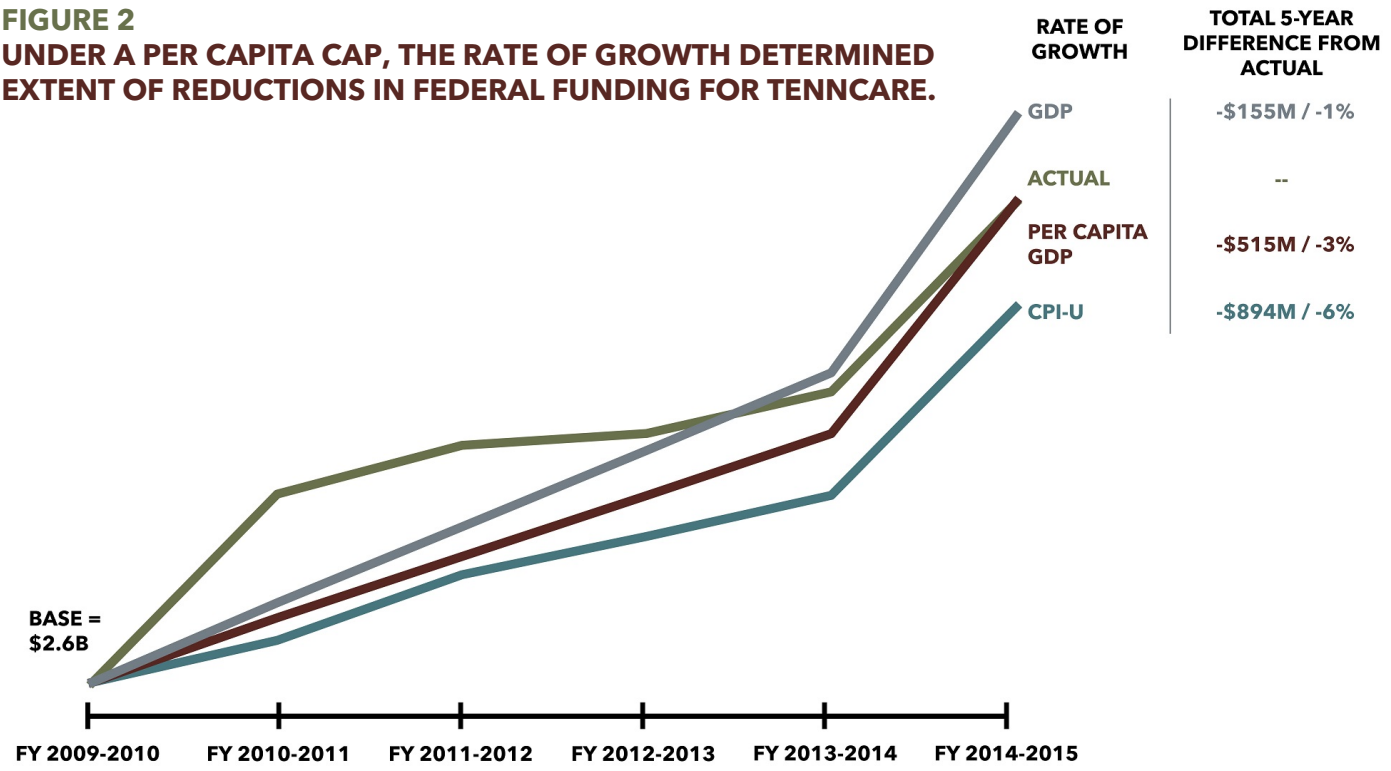
Note: FYs 2009-2010 and 2010-2011 federal funding has been reduced to account for the temporary enhanced FMAP available during the Great Recession. The inclusion of these dollars would unfairly inflate the base year for the purposes of this analysis.
Source: The Sycamore Institute's analysis using TennCare funding data from the FY 2011-2012 – FY 2016-2017 Budgets

ANALYSIS 1 – AN ILLUSTRATIVE BLOCK GRANT: Figure 1 above shows the outcome of our analysis of an illustrative block grant that would have provided a single lump-sum payment to Tennessee in lieu of the FMAP. **The 5-year impact of a block grant of this kind ranges from a loss of -$809 million (or a -3% cut) in federal funding under a block grant that grew at the same rate as inflation to an increase of +$670 million (or a +2% increase) in federal dollars under a block grant that grew with the national economy.**

Observations: The findings above show that **the growth factor can have a significant impact**. We also found that **the base year can also have a big impact** under a block grant, which doesn't account for changes in enrollment. We replicated our analysis using other hypothetical base years – including FY 2004-2005 and FY 2005-2006. In FY 2004-2005, both TennCare enrollment and costs had peaked, which led to program rollbacks beginning in FY 2005-2006. Using FY 2004-2005 as the base year and allowing it to grow by per capita GDP, Tennessee would have received about +16% more from the federal government than what was actually received during the 10-year time period. In contrast, shifting the base year one year to FY 2005-2006 after TennCare rollbacks had been implemented resulted in a -8% federal funding cut under the same block grant scenario.

Methods/Limitations: In addition to the limitations discussed on the previous page, the analysis assumes that the state's entire federal share of TennCare costs would be converted to a block grant. In all likelihood, a block grant wouldn't be that simplistic and might carve out separate funding streams for different purposes or populations. It is unclear how these carve-outs might impact federal funding, and the details of the final policy proposal will matter a lot.

FIGURE 2
UNDER A PER CAPITA CAP, THE RATE OF GROWTH DETERMINED EXTENT OF REDUCTIONS IN FEDERAL FUNDING FOR TENNCARE.



Actual Federal TennCare Revenues for MCO Capitated Payments for Adults/Children & Disabled Enrollees vs. An Illustrative Categorical Per Capita Cap Indexed to Various Growth Rates

Note: FYs 2009-2010 and 2010-2011 federal funding has been reduced to account for the temporary enhanced FMAP available during the Great Recession. The inclusion of these dollars would unfairly inflate the base year for the purposes of this analysis. This analysis only includes MCO capitated payments for two categories of TennCare enrollees, which represents about half of total TennCare spending.
Source: The Sycamore Institute's analysis using Actuarial Reviews of the TennCare Program for FY2010-2011 through FY 2014-2015.

ANALYSIS 2 - AN ILLUSTRATIVE CATEGORICAL PER CAPITA CAP: Figure 2 above shows the outcome of our analysis of an illustrative federal per capita cap under which federal funding would have been determined based on separate caps for adults/children and disabled enrollees. **The 5-year impact of a per capita cap of this kind ranges from a loss of -$894 million (or a -6% cut) in federal funding under caps that grew at the same rate as inflation to a loss of -$155 million (or a -1% cut) in federal dollars under caps that grew with the national economy.** Due to our methods and limitations in the available data discussed below, this analysis only illustrates how about half of program spending might be impacted by a per capita cap.

Observations: This analysis echoes the previous one in that the growth rate matters, with a difference of nearly three-quarters of a billion dollars between the most generous growth pattern and the least generous of these 3 scenarios.

Methods/Limitations: Per capita cap proposals have largely relied on setting separate funding caps based on different eligibility categories like adults, children, aged, and disabled. Although growth in each cap would be limited, the total federal allotment would change with enrollment. To model a cap that uses these same 4 categories, we explored using the Center for Medicare and Medicaid Services' (CMS) Medicaid Analytic eXtract (MAX) data files, which report each state Medicaid program's per capita costs by these 4 categories. However, the data reported for Tennessee had large variations from one year to the next inconsistent with patterns supported by the state's own budget information. We were not comfortable using this data set without being able to explain and control for those inconsistencies.

Instead, this analysis uses TennCare's actuarial reviews of the payments made to managed care organization (MCOs) for providing care to TennCare enrollees. These reports include the average per person costs and enrollment by several eligibility categories – including "Medicaid (TANF & Related)" and "Disabled," among other optional populations and individuals eligible for both Medicare and Medicaid. [11] [12] [13] [14] [15] This analysis uses the "Medicaid (TANF & Related)" and "Disabled" categories of enrollees to estimate the impact of a per capita cap because they appear to most closely track to the 4 categories mentioned in recent federal proposals. It is unknown how a more refined cap would change these estimates. The federal portion of these costs were estimated by applying the annual FMAP (adjusted to control for ARRA in FY 2009-2010 and FY 2010-2011) to the average per person cost.

Because of the focused nature of this analysis on these particular enrollees, this only illustrates how a portion of total federal TennCare revenues would be impacted. Over the period analyzed, the federal spending captured in this analysis represented about half of all federal TennCare revenues, so this analysis only illustrates how about half of program spending might be impacted by a per capita cap. Excluded from this analysis was spending on optional eligibility categories, long-term services and supports including nursing home care, services for individuals with intellectual disabilities, supplemental payments made directly to hospitals, and TennCare administrative costs.

Furthermore, the hypothetical federal revenues TennCare would receive under this analysis were driven by actual enrollment in those years. In reality, these amounts would increase or decrease if policy decisions impacting eligibility and enrollment were implemented in the face of the new federal financing realities.

WHAT DID WE LEARN?

- 5 of the 6 scenarios that we looked at generated fewer federal dollars for Tennessee.
- There was a wide range of reductions within these results.
- The following details affected the magnitude of the reductions: the basic structure (i.e. block grants vs. per capita cap), the base year, and the growth rate.

POTENTIAL IMPACTS ON TENNESSEE

A block grant or per capita cap would make federal funding more predictable – regardless of whether funding is less or more generous than it is today under different scenarios. However, the actual costs for TennCare would not necessarily become predictable unless state policymakers either implement approaches that make the underlying costs of care less volatile using new federal flexibilities or cede some ability to respond to emerging needs. Ultimately, the range of potential outcomes that Tennessee could experience will depend on the details of federal reform efforts, how Tennessee policymakers approach reform themselves, and other trends arguably outside the control of state or federal decision-makers. The infographic on the next page simplifies and illustrates the range of potential outcomes that Medicaid reform could have on Tennessee.

Under certain scenarios, Tennessee could potentially experience lower costs for TennCare. For example, a more generous block grant or per capita cap could allow Tennessee to offset its own spending with more federal dollars – depending on state contribution requirements.

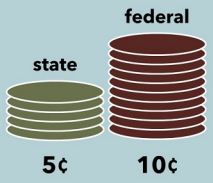
As outlined in Part 4 of this series, Tennessee policymakers have some ideas about how to make TennCare more efficient and cost-effective if given new flexibilities. The extent to which these proposals would produce cost-savings is unknown as the fiscal notes associated with the various bills didn't include these kinds of estimates – partially because they were introduced under the current Medicaid structure. [16] [17] [18] However, if these efforts brought down the underlying costs associated with covering TennCare patients – whether through more cost-effective delivery, better health outcomes, or cost-shifting to enrollees and/or providers – the state could experience lower TennCare costs.

Lower costs would provide an opportunity to reduce state taxes, increase funding for other state programs, expand TennCare benefits and/or eligibility, or boost TennCare provider payments.

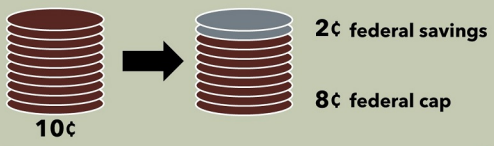
WHAT COULD MEDICAID REFORM MEAN FOR TENNESSEE?

CURRENT MEDICAID FINANCING STRUCTURE

TENNCARE COST: 15¢



CAPPED FEDERAL MEDICAID FINANCING



LOWER COSTS FOR TENNESSEE

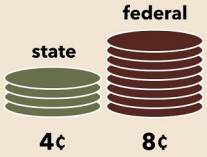
HIGHER COSTS FOR TENNESSEE

If TennCare costs fall...

If TennCare costs remain the same...

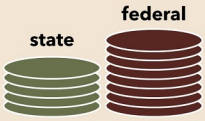
If TennCare costs increase...

COST: 12¢



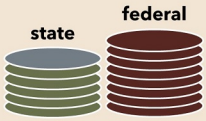
Tennessee's costs would fall.

COST: 13¢



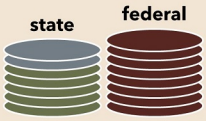
Tennessee's costs would remain unchanged.

COST: 14¢



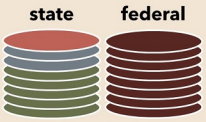
Some federal savings would become Tennessee's costs.

COST: 15¢



Federal savings would become Tennessee's costs.

COST: 16¢



Tennessee would take on both federal savings and overall cost increases.

Potential Policy Responses:

State tax cuts
New investments in other programs
Higher provider payments under TennCare
More TennCare benefits
Expanded TennCare eligibility

Potential Policy Responses:

State tax hikes
Reduced investments in other programs
Lower provider payments under TennCare
Fewer TennCare benefits
More restrictive TennCare eligibility

DETAILS OF FEDERAL REFORM

GOALS AND DETAILS OF TENNESSEE'S REFORMS

EXTERNAL FACTORS
broader health system trends and treatments, economic trends, public health emergencies

If TennCare costs decrease, the state will not necessarily save money under capped federal financing. In order to produce savings for state taxpayers, overall TennCare savings would have to be more than the revenue losses associated with any federal savings.

KEY

- **state dollars**
- **federal dollars**
- **federal savings under capped financing**
- **new cost increases**

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At the other end of the spectrum, Tennessee could face higher costs under federal financing reform. According to CBO's analysis of a range of federal reform options, "many states would find it difficult to offset [federal revenue] losses solely through the potential efficiencies" associated with new incentives for Medicaid enrollees to use lower-cost, higher-value care and to make healthier choices.[1] Furthermore, the various federal financing scenarios start reducing federal dollars fairly quickly – in some scenarios, in the first year. This would necessitate state reforms that generate savings quickly. **If federal financing changes are too burdensome for Tennessee, our state policymakers would have to make difficult decisions about raising state taxes, reducing spending in other areas, or making deeper cuts to TennCare.**

Furthermore, current federal funding is flexible in its response to external factors that can drive TennCare costs. Although a per capita cap would allow federal funding to respond to changes in enrollment driven by economic trends, both approaches would make federal funding less responsive to trends in health care costs or public health crises. According to the CBO analysis, federal savings could "leave states at greater risk than they are now for changes in the health care marketplace and in the broader economy."[1]

PARTING WORDS

Opponents of financing reforms might argue that, without actually bringing the underlying costs of care down and making those costs somehow more predictable – a factor influenced not just by Medicaid – reductions in federal revenues could produce costs for states and frequent changes to state programs to fit within constrained federal resources. This could impact enrollees and providers alike. Proponents of Medicaid reform, however, might argue that federal funding *should* create pressures on states to make needed changes to keep their costs – and taxpayers' contributions – more in line with the growth in prices or the economy. **With changes in store and the stakes high (at both ends of the spectrum), recognizing the inevitable trade-offs, defining the goals and parameters for state reform efforts early, and acknowledging both the positive and negative impacts that changes could have on enrollees will be important.**

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