THE SYCAMORE INSTITUTE

MEDICAID REFORM 101: MORE THAN JUST BLOCK GRANTS

PART 1 OF 5 – KEY FEDERAL MEDICAID REFORM DESIGN ELEMENTS

BOTTOM LINE

The White House and both houses of the U.S. Congress are now controlled by Republicans, who are planning changes to the Medicaid program. **While the buzz has been about "block grants," proposed reform efforts encompass so much more.**

This brief summarizes key elements and design options of proposals to reform Medicaid at the federal level. This, along with our follow-up briefs on state reform efforts and potential impact to Tennessee, provides context for actions that may be taken at both the federal and state levels over the coming months and years.

Washington, DC lawmakers are looking to save federal dollars by reforming Medicaid. The idea is that constraining federal Medicaid dollars paid to states will incentivize state governments to restructure their programs towards cost-savings using new program designs. The options are many. At this point, there are more questions than answers. For example, how will federal spending be controlled – through lump-sum block grants or per capita caps? Would states be allowed to scale back eligibility or benefits for certain populations, or would some populations continue to be guaranteed some minimum level of benefit?

How Congress approaches these design questions could have significant implications for Tennessee's ability to control its own spending on TennCare and for how state policymakers approach their own reforms. The other 4 briefs in this series explore these issues further.

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

INTRODUCTION

Ideas to reform federal Medicaid requirements and financing pre-date the Affordable Care Act (ACA), passed in 2010. These proposals all share the goal of reducing federal spending and, in exchange, provide states with more flexibility to control costs. Following the ACA's Medicaid eligibility expansions and federal Medicaid spending increases, however, these ideas have been touted more than ever by Republicans as a way to reduce federal deficits. With the election of President Donald Trump and a continued Republican majority in both the U.S. House of Representatives and Senate, proposals including these ideas may well become law. This brief summarizes the specific design elements that are likely to be discussed as federal reforms are being considered. Our follow-up briefs summarize specific recent federal proposals, state reform efforts, and potential impact to Tennessee. 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.

BACKGROUND

Medicaid is a health insurance program established in 1965 targeted at low-income Americans and individuals with disabilities and is jointly funded by the federal and state governments.

What is the goal of Medicaid? Broadly speaking, Medicaid is intended to provide health insurance, increase access to care, and improve health outcomes for vulnerable populations. These include people for whom private coverage is inaccessible because of cost and/or because of coverage restrictions that existed before the Affordable Care Act. The specific goals of Medicaid, however, have evolved over time as new populations and benefits have been added.

Who and what does Medicaid currently cover? Federal Medicaid law includes mandatory and optional standards for both eligibility and benefits. This means that, at a minimum, states must provide federally-mandated benefits to mandatory eligibility populations without imposing any limits or wait lists. States have the ability to get a waiver from a number of federal program requirements (see Part 3 in this series). Tennessee's Medicaid program, TennCare, operates under a waiver and largely serves populations required under federal Medicaid law: low-income children, low-income pregnant women, low-income mothers, and low-income aged, blind, or disabled individuals.

As an example of how program goals have evolved over time, Medicaid eligibility was originally restricted to aged, blind, and disabled individuals and parents and children receiving public assistance when it was established in 1965. Amendments in 1984 and 1985 expanded mandatory eligibility to all pregnant women eligible for public assistance. In 1988, all pregnant women and children with incomes below the poverty line were added – a threshold that was raised to 133% in 1989. And finally, in 2010, the ACA expanded mandatory eligibility to all individuals under 138% of the poverty line. A Supreme Court decision in 2012 made the ACA's Medicaid eligibility expansion optional. [1]

How is Medicaid currently financed? Medicaid is considered an entitlement because anyone meeting eligibility criteria is entitled to enroll and receive all covered benefits. As an entitlement, spending on Medicaid is tied to the cost of providing covered benefits to these enrollees. The federal government covers a state-specific portion of these costs (i.e. the federal medical assistance percentage (FMAP)). States are eligible to receive the FMAP for expenses that align with any of the federal mandatory and optional standards described above. The FMAP is more generous for lower-income states and for enrollees added under state Medicaid eligibility expansions allowed for under the ACA. Across the country, state-specific FMAPs range from a high of about 75% to a floor of 50%. At 65%, Tennessee's FMAP is the 17th highest in the country. [2] It is important to understand that federal contributions under the FMAP are unlimited. States cover the remaining portion of their Medicaid costs. For Tennessee, that state matching requirement is 35%.

FMAP

The state-specific rate at which the federal government covers the cost of providing benefits to Medicaid enrollees. These federal contributions are unlimited.

Tennessee's is

65%.

Entitlements are different from discretionary grant programs, another common federal funding mechanism. The federal funding available for each discretionary grant program – including block grants – is capped by the U.S. Congress' annual appropriations process. Discretionary grants are awarded to states as a fixed amount of funding for some specific purpose. Although these grants may include state matching fund requirements, once states spend their discretionary grant funding for the year, no additional federal funds are available regardless of whether the state spends more of its own funds than required or whether more need exists.

TENNCARE FINANCING 101

FEDERAL GOVERNMENT

- Congress and/or the federal Centers for Medicare and Medicaid Services (CMS) set national rules about mandatory and optional Medicaid eligibility and benefits.
- The federal government covers about 65% of most TennCare costs.

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TENNESSEE

- The General Assembly and/or the TN Division of Health Care Finance & Administration set specific parameters for TennCare eligibility and benefits within federal rules.
- Tennessee covers about 35% of most costs, some of which is contributed via assessments or taxes paid by TennCare providers.
- The state sets and makes capitated payments to insurance companies for providing benefits to all TennCare enrollees via a "waiver."
- The state also makes select payments directly to certain kinds of providers, like hospitals that provide uncompensated care to the uninsured.

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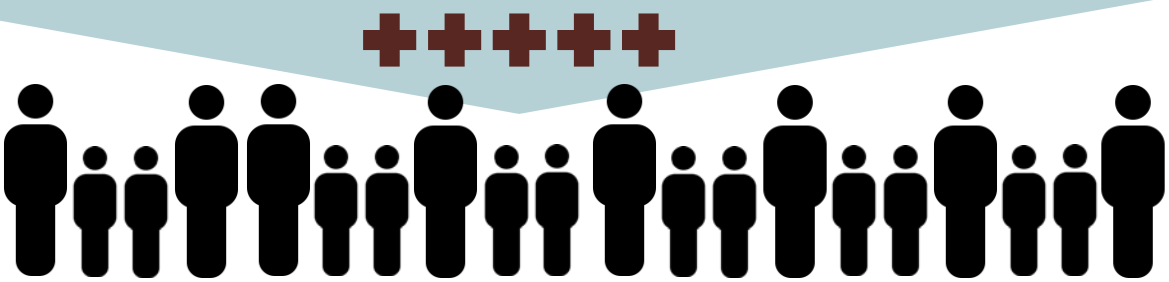
HEALTH INSURANCE COMPANIES

- Medicaid managed care organizations (MCOs) provide insurance coverage to TennCare enrollees consistent with state-set benefits.
- MCOs manage the costs of TennCare enrollees within the payment rates provided by TennCare.
- MCOs negotiate and make payments to health care providers.

$$$

HEALTH CARE PROVIDERS

- Health care providers deliver care directly to TennCare enrollees.
- Some providers pay assessments or taxes to help the state cover its portion of TennCare costs.



TENNCARE ENROLLEES

What are the unintended consequences of the FMAP? To fulfill their share of spending on Medicaid and trigger the drawdown of more federal dollars, states are able to use sources of revenue that are not, in the purest sense, state taxpayer dollars. The most common of these are taxes or assessments levied on Medicaid providers. Providers pay the state a tax for participating in Medicaid. The state uses that tax towards its Medicaid program (which in turn pays those same providers who paid the tax), which triggers the federal match. Some argue that the financing structure of Medicaid combined with these sorts of state expenditure flexibilities create an incentive for states to spend evermore federal dollars.

The graphic on the previous page provides an overview of how Medicaid and TennCare are financed. See Parts, 3, 4, and 5 in this series for additional background on TennCare.

STATED GOALS OF FEDERAL MEDICAID REFORM

reduce
FEDERAL SPENDING

increase
PROGRAM DESIGN FLEXIBILITY

The 2 primary goals of federal Medicaid reform that have been articulated by nearly all proposals in recent years are:

1. To reduce federal spending on Medicaid and
2. To provide states with more flexibility to tailor their Medicaid programs and implement innovative approaches.

In addition to these, federal policymakers have signaled a handful of other goals, including:

- To improve access to care for the most vulnerable, which some proposals imply or state are the original eligibility groups for which the program was established in 1965;
- To improve the quality of care in Medicaid programs;
- To improve access to providers in the Medicaid program; and
- To reduce fraud, waste, and abuse. [3] [4] [5] [6]

KEY DECISION POINTS FOR FEDERAL MEDICAID REFORM

This section summarizes both the key decision points that must be addressed in accomplishing the 2 primary goals above. Part 2 in this series summarizes how specific recent proposals by Congressional Republicans have approached these design choices.

To accomplish the dual goals outlined above, recent reforms (see Part 2) rely on constraining federal spending in order to incentivize states to restructure their programs through new program design flexibilities. This approach is in the lieu of the alternative: providing flexibilities to allow states to restructure their programs in order to produce cost-savings that reduce federal spending.

The Congressional Budget Office (CBO) and the Medicaid Payment and Access Commission (MACPAC), both nonpartisan advisors to Congress, have laid out key design choices that would need to be addressed in reform efforts to cap federal contributions to states. All of these decision points affect any reform's impact on federal spending, state spending, and coverage. [7] [8] These decision points are broken down into two broad categories: federal financing and state benefit design.

FEDERAL FINANCING

Basic Structure: What would the basic structure be for limiting federal contributions to state Medicaid spending? Four basic structures have been discussed:

1. Under a **block grant**, states would receive a lump sum from the federal government to to help cover Medicaid costs. The funding under a block grant would not change based on changes in enrollment.
2. Similar to a block grant, a **capped allotment** would be driven by a lump sum cap for all Medicaid costs. Under this structure, however, states would draw funds down from the allotment *up to* a cap based on their own spending triggered by some kind of match requirement. The funding cap under a capped allotment would not change based on changes in enrollment. Although, the amounts actually drawn down by a state could be affected by enrollment. The Children's Health Insurance Program (CHIP) is financed via a capped allotment.
3. **Per capita caps** would apply a cap on federal Medicaid contributions on a per enrollee basis. The funding under a per capita cap would change as enrollment changes. Lawmakers would need to decide if a state would be subject to a single per capita cap for all enrollees or if different caps would be applied to different eligibility categories.
4. Under a **shared savings** approach, the federal government would continue to provide unlimited contributions driven by the FMAP, but a spending target would be set on a per enrollee basis, similar to a per capita cap. A portion of any savings achieved between actual spending and the target could be kept by the state. If spending exceeded the target, a state would have to take on a larger share than would normally be required under the FMAP.

BLOCK GRANT VS. PER CAPITA CAPS

per capita caps would allow federal support to change with enrollment while block grants would not

Spending Categories: Medicaid dollars are spent on different categories of activities – including, for example, traditional health care benefits, nursing home care, administrative costs, and direct payments to certain hospitals for their uncompensated care costs. A fixed federal contribution of any kind – whether a block grant or per capita caps – would be based on some base level of spending. Would that base include all state Medicaid spending currently matched by the federal government, or would it treat some categories differently? For example, reforms could choose to continue reimbursing some costs as they are today (e.g. separate payments related to hospitals' uncompensated care costs), end reimbursement for some activities entirely (e.g. optional benefits), or apply different reform structures to different categories of spending (e.g. block grant support for long-term services and supports while placing a per capita cap on traditional health care benefits).

Eligibility Categories: Would the structure apply to all Medicaid eligibility categories or would some categories be excluded or treated differently? For example, financing could remain the same as today for low-income individuals who are elderly or have disabilities; while support for low-income pregnant women and children could be converted to a block grant.

Base Year: What year would serve as the base year for determining a grant, cap, or spending target? Some time period would have to be identified as the starting point for calculating the base level of spending on which a state's federal funding limits would be determined. Using a past year, for example, would essentially preserve states' past Medicaid decisions (e.g. coverage of optional eligibility populations and/or benefits and provider payment levels); while a future year could create an unintended incentive for states to change their program designs and provider payments to maximize the base for their federal cap.

Cap Growth: How would a cap on federal contributions under any of the 4 basic structures grow from year to year? All proposals share a goal of saving federal dollars. They would accomplish this by constraining the annual growth in federal contributions to states to a rate less than estimated under the current structure. Some options include general inflation, health care cost growth, or economic growth.

State Differences: How would reform account for state differences in spending and program design? For example, some state programs may be relatively more generous in the benefits offered and populations covered than others. Additionally, some states may already be relatively good at controlling costs. A reform effort could include some mechanism to try to smooth out these differences.

State Contribution: To what extent would states need to share in the costs? For example, Congress could retain an FMAP-like requirement under which a state would continue to have to cover some minimum percentage of overall costs. Another option would be imposing a maintenance-of-effort requirement under which states would have to continue spending at least as much as they do today.

ACA Expansions: How would reforms treat the eligibility expansions allowed for under the ACA? Would federal policymakers choose to end funding altogether for expansion populations? Alternatively, the base level of spending for determining a cap could include current spending on new enrollees only in states that have chosen to expand their Medicaid programs, or it could provide an opportunity for all states to expand before imposing a federal cap. Furthermore, would a cap account for the enhanced federal match rate available under the ACA for expansion populations?

STATE BENEFIT DESIGN

State Flexibility: How much flexibility would states be given to define eligibility, benefit design, and cost-sharing requirements? Would state flexibility reforms apply to all eligibility categories uniformly, or would different eligibility categories be treated differently? Even with financing reforms, federal requirements related to eligibility and benefits could conceivably remain the same. Any flexibilities, however, could be more narrowly focused on specific populations while retaining current federal standards for certain, potentially more vulnerable eligibility categories.

Federal Accountability: To what extent will states have to continue to collect, analyze, and report data and/or quality measures to the federal government in exchange for federal dollars? New requirements could, for example, help state and federal officials track the impact that reforms might have on coverage, access to care, quality, and health outcomes.

PARTING WORDS

The years of work ahead to reform Medicaid at both the federal level and in Tennessee are sure to be full of trade-offs. Accomplishing the goals of reducing federal spending while increasing state flexibility comes with a number of choices that federal policymakers will have to address. These choices, of course, will drive the choices that our own state's lawmakers will then have to make using their own goals to guide their action. And at all levels, these choices will have to be weighed with other goals – such as preserving access to care for the most vulnerable.

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MEDICAID REFORM 101: MORE THAN JUST BLOCK GRANTS

PART 2 OF 5 – A SUMMARY OF RECENT FEDERAL PROPOSALS

BOTTOM LINE

This paper summarizes the key features of recent federal proposals in order to better understand how reforms might impact Tennessee's ability to control its own spending on TennCare and how state policymakers approach their own reforms.

Recent Congressional proposals provide broad outlines of what federal reforms may look like but lack legislative language and at least some key details. **These recent federal proposals largely rely on a per capita cap structure that would cap federal funding for all enrollees but would allow federal contributions to vary with enrollment. They also offer states significant new program design flexibilities but retain mandatory eligibility and benefits for vulnerable elderly and disabled populations.** This means that federal contributions for the protected populations would be constrained without the federal flexibilities states could use to reduce the costs associated with these populations. To prevent additional state spending that would result from the loss of federal dollars, states could (1) use their flexibilities with other populations to limit benefits to free up federal dollars or (2) limit enrollment to free up their own dollars for the costs of these protected populations. Our other briefs in this series explore how Tennessee might approach its own reforms and the potential impact on the state.

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 state TennCare reform design elements

PART 4: Summary of recent TennCare proposals

PART 5: Analysis of the potential impact on Tennessee

INTRODUCTION

The previous brief in this series summarizes the key design elements that federal lawmakers are likely to discuss when considering Medicaid reform. Within the framework of these design elements, this brief summarizes specific recent federal proposals. Our follow-up briefs summarize state reform efforts and potential impact to Tennessee. 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.

See our first brief for background on the Medicaid program.

KEY FEATURES OF FEDERAL MEDICAID REFORM PROPOSALS

- Proposals predominantly rely on a capped federal contribution to state Medicaid costs through **categorical per capita caps** to replace the current unlimited FMAP; one provides a state option for a **capped block grant**.
- **Growth in federal contributions would be limited** to a pre-determined growth factor that is less than current anticipated growth in Medicaid costs.
- Particularly **vulnerable populations may retain federally-mandated eligibility and benefit coverage** – including populations that are elderly or have a disability.
- Proposals allow states to **cross-subsidize the costs for aged and disabled** eligibility groups using any savings achieved with program design flexibilities for adult and child eligibility groups.
- In many cases, states would be provided with the ability to exercise flexibility without going through a long waiver-approval process. **Some or all federally-mandated benefit and eligibility requirements for some populations may be repealed.**
- States may also be allowed to impose **cost-sharing**, **work requirements**, **limited benefits**, and **enrollment caps** for some or all eligibility populations.

RECENT FEDERAL MEDICAID REFORM PROPOSALS

Our first brief in this series summarizes the key design elements that federal lawmakers must address in tackling Medicaid reform. The tables that are displayed on the following pages summarize 2 recent proposals within the context of these design options. Although fairly comprehensive, these proposals do not include legislative language, so our summaries include the details as they are presented in each plan.

In addition to these 2 proposals, other proposals have been included in the federal FY 2015 and 2016 budget resolutions passed in the U.S. House of Representatives, which lay out federal budgetary goals for the year and at least 4 additional years. Budget resolutions are not legally binding, and they do not include specific legislation. However, both the FY 2015 and 2016 House resolutions included broad assumptions about Medicaid reform underlying each resolution's desired budgetary goals. Both resolutions assumed that the Medicaid program would be reformed into an allotment or block grant accompanied by state "freedom and flexibility" and a repeal of the ACA's eligibility expansion. [1] [2] [3] [4]

MAKING MEDICAID WORK is a proposal for Medicaid reform put forward by the Republican-led U.S. House Energy & Commerce and Senate Finance Committees in May of 2013. [5]

<table>
<tr><th colspan="8">MAKING MEDICAID WORK
(May 2013)</th></tr>
<tr><th colspan="8">FEDERAL FINANCING</th></tr>
<tr><th>Basic Structure</th><th>Spending Categories</th><th>Eligibility Criteria</th><th>Base Year</th><th>Cap Growth</th><th>State Differences</th><th>State Contribution</th><th>ACA Expansions</th></tr>
<tr><td rowspan="4">State-specific per capita caps</td><td rowspan="2">Caps would apply to all medical assistance and non-benefit expenditures.

Separate payments would be made for GME, DSH, Medicare-Medicaid dual eligible enrollees, partial Medicaid enrollees, and "other appropriate exclusions."</td><td rowspan="2">Each state would have four different caps based on four broad Medicaid eligibility categories: aged, blind and disabled, children, and adults.

If a state were able to constrain its costs for one eligibility category below the federal cap, they could use any difference to offset costs in another eligibility category where costs may exceed the cap. This “risk corridor” would allow states to “determine how to protect vulnerable populations such as the disabled from unpredictable spending.”</td><td rowspan="4">Caps would be based on costs for each state in "the most recent year."</td><td rowspan="4">The caps would grow by “a realistic exogenous” growth factor. If a state’s costs were slower than the growth factor, the cap would be rebased every five years.</td><td rowspan="4">Caps for states with costs in the top 25% of all states would grow slower than the growth factor; while caps for states with costs in the lowest 25% of all states would grow faster.</td><td rowspan="4">States would be required to continue investing at least as much as would be required under the FMAP towards Medicaid costs (e.g. 35% in Tennessee). The proposal, however, would reduce states’ ability to use taxes on Medicaid providers to fund the state’s share.</td><td rowspan="4">The proposal does not explicitly address the ACA expansion beyond allowing states to cap enrollment for “high income” populations if states’ costs exceed a “state-determined budget target.”</td></tr>
<tr></tr>
<tr><td colspan="2">The Secretary would establish special provisions for waiver programs. Although no details are provided, this could conceivably take the form of an overarching block grant, capped allotment, or consolidated per capita cap for all enrollees under a waiver.</td></tr>
<tr><td colspan="2">The proposal would also allow states to receive a defined federal allotment (i.e. a block grant or capped allotment) for long-term care services and supports.</td></tr>
<tr><td colspan="6">States could also be eligible for bonus payments for performance on measures related to cost reduction, access, and quality which could be used for public health initiatives.</td></tr>
<tr><th colspan="8">STATE BENEFIT DESIGN</th></tr>
<tr><th colspan="7">State Flexibility</th><th>Federal Accountability</th></tr>
<tr><td colspan="7">The plan appears to include near maximum flexibility in tailoring eligibility and benefit design for all populations except those with disabilities, who would be guaranteed all current law benefits. Some of the explicit allowable flexibilities outlined in the plan for states’ use include:
• Caps on enrollment for “high income” recipients;
• Reform of the waiver process to set time limits on CMS approval and to allow for programmatic innovations that have been approved in one state to be automatically approved for other states;
• Value-based insurance that structures beneficiaries’ out-of-pocket costs to create incentives for certain kinds of care or providers;
• Premium support for the purchase of a private health insurance plan offered in the individual market or by an employer;
• Limited benefit and primary care-only plans;
• “Unique care coordination and benefit design approaches” for high-cost, complex enrollees;
• Accounts that reward enrollees for healthy behaviors;
• Enforceable cost-sharing requirements for any services and for enrollees at any income level;
• Premiums for “certain Medicaid populations;”
• High deductible plans with pre-funded accounts; and
• Greater flexibility for states to implement payment reform.</td><td>The proposal would require that Medicaid providers transparently publish price information and that states provide more data on provider quality. States would also be required to report to the federal government on measures related to access, costs, and care quality.</td></tr>
</table>

A BETTER WAY TO FIX HEALTH CARE is an outline of reforms across the health care sector – including Medicaid – proposed by the U.S. House Republican Caucus under the leadership of Speaker Paul Ryan in June of 2016. [6]

<table>
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(June 2016)</th></tr>
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<tr><td>Federal Medicaid allotment based on state-specific per capita caps</td><td>Caps would apply to medical assistance costs and non-benefit expenditures.

Separate payments would be made for GME, DSH, and "other appropriate exclusions."</td><td>Each state would have four different caps based on four broad Medicaid eligibility categories: aged, blind and disabled, children, and adults.

Although not explicitly stated, the alltoment approach driven by underlying per capita caps would imply that federal dollars could be spread across the different eligiblity groups at state discretion regardless of the eligibility group-specific cap.</td><td>Caps would be based on costs in 2016, updated for inflation.</td><td rowspan="2">The caps would grow at "a rate slower than current law."

The proposal does not address any future rebasing.</td><td rowspan="2">The proposal does not explicitly address any specific approach to state differences.</td><td rowspan="2">The proposal does not explicitly address a state's obligation to contribute towards Medicaid costs.</td><td>States that expanded Medicaid eligibility under that ACA would receive an allotment based on current levels of spending for these enrollees, but over time, the enhanced FMAP associated with these costs would be phased down to the normal FMAP. States would also be allowed to spend these dollars on other, more vulnerable populations with the goal of "transitioning many of the able-bodied adults from Medicaid into commercial coverage."</td></tr>
<tr><td>Includes a state option for a block grant</td><td>A block grant would include all spending categories.</td><td>A block grant would provide a lump-sum for all eligible enrollees.</td><td>A block grant would be based on "current" spending.</td><td>Under a block grant, for states that have expanded Medicaid eligibility, some portion of the allotment would be phased out under the assumption that the expansion population would be transitioned into other non-Medicaid coverage.</td></tr>
<tr><th colspan="7">STATE BENEFIT DESIGN</th></tr>
<tr><th colspan="6">State Flexibility</th><th>Federal Accountability</th></tr>
<tr><td colspan="6">Although not explicitly stated for the per capita cap option, the plan appears to limit flexibility around both eligibility and benefit design for both elderly and disabled enrollees under both financing options. Some of the design flexibilities outlined below could be used by states to generate savings in expenses for adults and children in order to offset any costs above the category-specific cap for aged and disabled enrollees. Some of the explicit allowable flexibilities outlined in the plan for states' use include:
• Work or job training requirements for able-bodied adults;
• Premium assistance or limited benefit plans for "work-capable" adults;
• "Reasonable, enforceable" premiums for most non-disabled adult enrollees;
• Cost-sharing subsidies for eligible adults enrolled in an employer plan;
• Incentives for wellness and healthy behaviors;
• Broad new flexibilities for populations and benefits that are currently optional under federal law, including premiums, limited benefit packages, waiting lists, and enrollment caps;
• Automatic renewals of waivers that have been renewed twice by CMS in the past; and
• Reform of the waiver process to set time limits on CMS approval.</td><td rowspan="2">States would be required to report to the federal government on measures related to access, costs, and care quality.</td></tr>
<tr><td colspan="6">Under the block grant option, states would receive "maximum flexibility" around eligibility and program design for non-disabled, non-elderly enrollees. The plan would preserve current benefit requirements for all elderly and disabled enrollees.</td></tr>
</table>

PARTING WORDS

The years of work ahead to reform Medicaid at both the federal level and in Tennessee are sure to be full of trade-offs. Accomplishing the goals of reducing federal spending while increasing state flexibility comes with a number of choices that federal policymakers will have to address. These choices, of course, will drive the choices that our own state's lawmakers will then have to make using their own goals to guide their action. And at all levels, these choices will have to be weighed with other goals – like preserving access to care for the most vulnerable.

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MEDICAID REFORM 101: MORE THAN JUST BLOCK GRANTS

PART 3 OF 5 – KEY TENNCARE REFORM DESIGN ELEMENTS

BOTTOM LINE

Anticipated federal changes to Medicaid will most likely alter how TennCare is financed, the populations it covers, and the benefits it offers. This brief provides a **brief history of TennCare** for context and summarizes the **key design options** that Tennessee state lawmakers will likely need to address if federal changes are enacted.

State lawmakers would, first and foremost, need to define their goals for using new program design flexibilities in the context of a new financing structure. For example, one possible goal could be to generate savings in order to offset reduced federal dollars and avoid more state spending than would be expected under the current Medicaid structure. In adopting policies to accomplish their goals, policymakers should also acknowledge both the positive and negative impacts that any changes could have on access to care and outcomes and for whom.

Depending on the flexibilities provided by the federal government, state policymakers could conceivably approach their goal by changing **eligibility**, **benefits**, **enrollee responsibilities**, and **provider payments**. Our other briefs in this series explore specific recent TennCare proposals, recent federal reform proposals, and the potential impact on Tennessee.

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

reduced

FEDERAL SPENDING

increased

PROGRAM DESIGN FLEXIBILITY

INTRODUCTION

The previous briefs in this series summarize both the key design elements that federal lawmakers are likely to discuss when considering Medicaid reform and specific recent federal proposals. These proposals share the goals of **reducing federal spending** and providing states with more **flexibility**. This brief provides historical context for TennCare reform efforts and outlines the key design choices that Tennessee state policymakers may have to address if federal changes are enacted. Our follow-up briefs summarize specific recent state proposals and the potential impact that federal reforms could have on Tennessee. 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.

TENNCARE BACKGROUND & HISTORY

Medicaid is a health insurance program largely targeted at low-income Americans and individuals with disabilities and is jointly funded by the federal and state governments. Federal Medicaid law includes mandatory and optional standards for both eligibility and benefits. This means that, at a minimum, states must provide federally-mandated benefits to mandatory

eligibility populations without imposing any limits or wait lists. See Part 1 in this series for more information on the history of Medicaid and the current structure of Medicaid financing.

TennCare operates under a

MEDICAID WAIVER.

Under current law, waivers provide states with some flexibility to tailor their programs. Under the TennCare waiver, for example, all enrollees receive their care via private health insurance companies.

The federal Medicaid program provides opportunities for states to customize their Medicaid programs and still receive federal match – known as the the **federal medical assistance percentage (FMAP)** – for their expenditures. In additional to allowing optional eligibility populations and optional benefits, Medicaid also allows for deviations from other Medicaid program requirements around provider choice and statewide uniformity. In 1994, Tennessee began operating TennCare under what is known as an **1115 waiver**. 1115 refers to the section of the federal Social Security Act which allows the U.S. Department of Health and Human Services' Centers for Medicare and Medicaid Services (**CMS**) to provide these types of waivers.

When TennCare was launched in 1994, it used existing flexibilities in federal law to enroll all TennCare beneficiaries in plans administered by private health insurance companies – known as **managed care organizations (MCOs)**. MCOs received a capitated payment and were responsible for managing enrollees' costs within those payments. The savings that were expected to be generated by this novel approach (at the time) allowed Tennessee to expand Medicaid coverage to optional populations with an overall enrollment cap of about 1.8 million. The optional populations included "uninsurable" individuals and uninsured individuals not otherwise eligible for employer or government insurance. In its first year, TennCare covered over 300,000 additional uninsured individuals who were otherwise not eligible for Medicaid. This was considered the most expansive Medicaid eligibility in the country at the time. Many of these newly-eligible individuals with incomes above poverty were required to pay premiums and other cost-sharing requirements like copayments. After its launch, new enrollment for certain optional eligibility populations open and closed several times to respond to cost pressures and emerging needs. For example, in December 1994, less than 1 year into the launch of TennCare, enrollment was closed for the optional uninsured category. (1)

Within just a few years, MCOs were losing money on TennCare enrollees, and by the early 2000s, rising pharmaceutical and medical care costs were causing the state to face hundreds of millions of dollars in budget shortfalls to fully fund the program. Federal funding under the waiver was capped – at least partially contributing to the state's shortfalls. During this time, efforts were made to modify eligibility, limit certain benefits, and disenroll some beneficiaries, but some of these efforts were halted and reversed by legal challenges.

In 2005, Tennessee received approval from CMS to modify its waiver to eliminate eligibility for some adults and limit benefits for others, while preserving benefits for children. By the end of 2006, an estimated 170,000 were disenrolled from TennCare. (2)

Today, TennCare still uses MCOs to administer benefits. In fact, Tennessee is 1 of only 2 states that enroll all of its Medicaid enrollees in an MCO. Many states exclude certain populations – like those dually eligible for both Medicare and Medicaid, for example. TennCare largely serves populations required under federal Medicaid law (low-income children, low-income pregnant women, low-income mothers, and low-income aged, blind, or disabled individuals), but includes some optional categories – including certain uninsured children under 19 who would otherwise lose TennCare eligibility. (3)

CMS' waivers are time-limited, which means that the state has to renew its waiver about every 5 years, at which time the federal government can tweak existing requirements or add new

ones. In late December 2016, the TennCare waiver was renewed by CMS through June 2021. TennCare has not been expanded to the optional eligibility category under the ACA.

GOALS FOR TENNCARE REFORM

As with any major public policy undertaking, the first step in TennCare reform would be for our state policymakers to define the goals, which would help guide key design decisions and provide parameters for tracking the effort's success and outcomes. The goals for a redesign of TennCare under likely federal reform scenarios would need to address three aspects: **(1) the state's costs under reform, (2) access to health insurance coverage and for whom under a reformed TennCare, and (3) impacts on quality and health outcomes and for whom**. Each of these, of course, affect one another, but each should be clearly defined to help guide design choices and understand both the positive and negative impacts that changes could have on current enrollees.

COST, ACCESS, QUALITY

The broad areas under which state policymakers would need to define goals for TennCare reform.

Cost: What is the goal related to state TennCare costs? One of the explicit goals of federal reform efforts is to constrain federal spending on Medicaid below current projections in order to produce federal savings and to place financial pressure on states to institute cost-saving innovations. Although these proposals provide greater flexibility in program design, the financing structure is designed to be more predictable and, therefore, *less* flexible. As state policymakers use these new program design flexibilities, the state would need to approach a TennCare redesign by defining a desired goal for state funding in the face of new federal funding realities. For example, would the goal be to offset reductions in federal support so that state spending remains no more than projections under the current structure? Or would policymakers be willing to take on additional state spending to maintain access and benefits for all individuals currently enrolled?

Access: What is the goal related to access – including access to health insurance and access to health care – and for whom? Federal efforts have placed a particular focus on preserving and even improving access to coverage, benefits, *and* providers for the most vulnerable. State lawmakers would need to decide if they also share this goal or if they hope to maintain access to TennCare for *all* current enrollees or, as is the case in one recent TennCare reform proposal, expand access to TennCare for new enrollees? If state decision-makers choose to focus on preserving access for a subset of the current TennCare population, they should articulate how others may be impacted. For example, in TennCare's FY 2017-2018 budget hearing with the Governor, TennCare Director Wendy Long stated that federal reform could provide an opportunity to provide "a skinnier benefit to a broader base of the population." [4]

Quality: Going a step beyond access, what is the goal related to the quality of care provided and the health outcomes achieved by enrollees? For example, in the face of competing demands related to cost-savings, it may be that state policymakers would want to maintain or even improve current levels of quality and outcomes for the most vulnerable of current enrollees.

Evidence suggests that a healthier population leads to a more productive state with a healthier economy. [5] [6] [7] So, although goals could be targeted towards specific subsets of the current TennCare population, it would also be important to acknowledge the desired goals or likely impacts on access and health status for any populations for which benefits or eligibility might change or be scaled back.

KEY DECISION POINTS FOR TENNCARE REFORM

Once clear goals have been established, a number of key design elements would need to be addressed by Tennessee's lawmakers, depending on the degree of flexibility provided under federal reforms. These include:

Eligibility: How would eligibility for TennCare change, if at all? State decision-makers could choose to retain current eligibility. However, if federal requirements for mandatory eligibility for certain groups were lifted, eligibility could be limited or restructured to produce cost-savings to the program. Conversely, if savings were produced from other measures, TennCare eligibility could conceivably be expanded.

Covered Benefits: How would the benefits that are currently covered by TennCare change? Limiting what is covered for some or all eligibility groups could, for example, produce cost-savings to the program.

Enrollee Responsibilities: What role should enrollees play in reducing TennCare costs? TennCare could, for example, require enrollees to pay premiums and require some out-of-pocket spending for health expenses for deductibles and co-pays (i.e. cost-sharing). Increased cost-sharing alone could reduce program costs both by directly shifting some of the costs of health care directly to enrollees and by reducing the utilization of health care. Cost-sharing could also create incentives for enrollees to shop for lower-cost care. Furthermore, subsidies to offset some of these enrollee costs through premium support and health savings account-like strategies could potentially be used to create incentives for certain healthy behaviors or desired activities or to create disincentives for certain costly forms of care.

Furthermore, enforcement mechanisms could be put in place that tie enrollees' payment of premiums or participation in required activities (e.g. job training) to TennCare eligibility. If enrollees are locked out of the program for non-compliance or gain employment with an income too high for TennCare eligibility, these design elements could reduce program costs by effectively reducing enrollment.

These various enrollee responsibilities could vary by eligibility group, but all of these choices should be made with an eye towards how they might impact access and health outcomes and for whom.

Provider Payments: What role should health care providers play in reducing TennCare costs? Payments to providers could be reduced, or they could be reformed in an effort to incentivize more efficient, less costly delivery of care. In 2013, Governor Haslam launched the Tennessee Health Care Innovation Initiative to reform TennCare payment towards rewarding quality and outcomes. The Initiative produced over $11 million in savings in its first year. [8] To what extent can and will reform efforts build on these successes?

PARTING WORDS

If the U.S. Congress and President Trump act to make concrete changes to federal Medicaid law, Tennessee's policymakers may have an opportunity to make significant reforms to TennCare. Depending on the flexibilities provided, policymakers could make changes to nearly every aspect of the program from who is eligible to how providers in the program are paid. In undertaking such an enormous task, decision-makers will need to define clear goals. Because these decisions could require significant trade-offs, policymakers will also need to acknowledge both the positive and negative impacts that changes could have on enrollees.

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MEDICAID REFORM 101: MORE THAN JUST BLOCK GRANTS

PART 4 OF 5 – A SUMMARY OF RECENT TENNCARE REFORM PROPOSALS

BOTTOM LINE

This brief summarizes recent TennCare reform proposals, which may provide insight into the kinds of changes that Tennessee's policymakers may consider if federal changes to Medicaid are enacted.

Bills introduced and proposals discussed over the last 2 years have proposed reforming TennCare to include a **wider range of benefit options** – including more limited or catastrophic-only benefits packages – for TennCare enrollees. These options would be coupled with **increased financial exposure for enrollees** in order to encourage healthy behaviors and lower cost care. Because of the context in which they were discussed, these proposals do not address eligibility limitations. These proposals also lack detail on at least one key program design aspect related to financing, benefits, or both. In the face of concrete changes in federal law, however, these details would likely be better defined. Our other briefs in this series explore recent federal reform proposals and the potential impact on the state.

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

INTRODUCTION

The previous briefs in this series summarize federal Medicaid reform efforts and the key design choices that Tennessee state policymakers may have to address if federal changes are enacted. This brief summarizes specific TennCare reform proposals – including recent legislation introduced in the Tennessee General Assembly. Our follow-up brief summarizes the potential impact that federal reforms could have on Tennessee. 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.

RECENT TENNESSEE GENERAL ASSEMBLY LEGISLATION

The following pages summarize recent proposals that would reform how TennCare delivers benefits and to whom. Because of their timing, all of the Tennessee-specific efforts presumed the current federal Medicaid financing structure under which the state would seek a waiver to either convert Tennessee's federal medical assistance percentage (FMAP) to a federal block grant or create a demonstration program with considerable new flexibilities. In many cases, the federal government may be unable to approve such changes under federal law. The features of each proposal are presented in line with the state design options laid out in Part 3 in this series.

KEY FEATURES OF RECENT TENNCARE REFORM PROPOSALS

- Recent reform efforts have all been proposed in the context of the **current uncapped federal Medicaid financing structure**.
- Most of the proposals rely on **introducing new financial responsibilities for enrollees** like paying premiums and cost-sharing – often with greater subsidization via health savings accounts for certain choices and healthy behaviors.
- Some of the proposals introduce new benefit design options into the program like **high-deductible plans**.
- Many of the proposals **lack detail on multiple key program design elements** related to TennCare eligibility, benefits, enrollee responsibilities, provider payments, or assumptions about federal financing.

Two recent efforts to expand access to TennCare – including the Governor's Insure Tennessee proposal and recent work by the Three Star Healthy Task Force – provide insights into state-specific approaches to reform.

INSURE TENNESSEE was proposed by Governor Bill Haslam in late 2014 as a mechanism for expanding eligibility for TennCare under the Affordable Care Act. Although the proposal did not pass the General Assembly, it may provide insights into how the administration might approach a reform of TennCare if given additional flexibilities. (1)

The **THREE STAR HEALTHY TASK FORCE**, appointed by Speaker Beth Harwell in 2016 to explore options for increasing access to TennCare, has not publically released a proposal on paper. In public hearings of the Task Force that staff of the Sycamore Institute have attended, however, the Task Force has indicated interest in a number of elements that would be new to TennCare with the goal of providing more cost-effective coverage under the program. Although work has largely focused on expanding eligibility to uninsured individuals with certain behavioral health diagnoses, in their most recent meeting after the election, Chairman Cameron Sexton (R-Crossville) broached the topic of applying the concepts they've discussed to more expansive TennCare reform. (2)

In addition to these efforts, 3 bills were introduced in the 109th Tennessee General Assembly (2015-2016) related to TennCare reform.

109TH GENERAL ASSEMBLY – SB 742/HB 1116 was introduced in 2015 by Senator Brian Kelsey (R-Germantown) and Representative Jerry Sexton (R-Bean Station). The bill was not acted on. (3)

109TH GENERAL ASSEMBLY - SB 1351/HB 1271 was introduced in 2015 by Senator Randy McNally (R-Oak Ridge) and Representative Eddie Smith (R-Knoxville). The bill was not acted on. (4)

109TH GENERAL ASSEMBLY - SJR 88 was introduced in 2015 by Senator Mark Green (R-Clarksville). The resolution was passed and signed into law in May of 2015. Joint resolutions, however, express the views or sentiments of the Legislature and cannot require Executive action. (5) (6)

ALEC'S MEDICAID BLOCK GRANT ACT is a model law drafted for states' use in 2014 by the American Legislative Exchange Council (ALEC), an organization of state legislators across the country that advocate for limited government and free markets. The model law has not been specifically introduced in the Tennessee General Assembly, but it might provide some detail on how Tennessee might approach TennCare reform under a capped federal contribution. (7)

INSURE TENNESSEE				
Eligibility	**Covered Benefits**	**Enrollee Responsibilities**	**Provider Payments**	**Assumptions about Federal Reform**
Expands eligibility to individuals up to 138% of the federal poverty level as allowed under the Affordable Care Act under a 2-year pilot.	Under the "Volunteer Plan," newly eligible employed enrollees would receive a subsidy to purchase employer-sponsored insurance (ESI) with benefits defined by the employer. Other newly eligible enrollees would receive the Healthy Incentives Plan, which would cover the same benefits covered under TennCare currently.	Volunteer Plan enrollees would be responsible for any difference between the subsidy and the premium and any cost-sharing like deductibles and co-pays. Healthy Incentives Plan enrollees would receive a Healthy Incentives for Tennesseans (HIT) account to pay premiums (depending on their income) and certain co-pays. The amounts in the accounts would vary based on specific enrollee choices (e.g. participation in an annual health assessment) and healthy behaviors. Enrollees would be responsible for any difference between the amount in their account and actual costs for premiums and cost-sharing. Some of these responsibilities would be enforceable - either by disenrolling individuals or by allowing providers to deny services for failure to pay co-pays.	Does not include specific information about provider payments, but was billed as building on the state's payment and delivery system reform initiative already underway.	Based on the enhanced FMAP financing structure provided for under the ACA's eligiblity expansion. Includes an opt-out provision in the event that state costs associated with the expansion are more than expected.
THREE STAR HEALTHY TASK FORCE				
Eligibility	**Covered Benefits**	**Enrollee Responsibilities**	**Provider Payments**	**Assumptions about Federal Reform**
Expands eligibility to uninsured individuals with certain behavioral health diagnoses.	Specific covered benefit changes have not been publically discussed.	Provides enrollees with accounts to pay out-of-pocket costs. Enrollees would be responsible for any difference between the amount in the account and actual out-of-pocket costs. Includes work or job training requirements. Some or all enrollee responsibilities would be enforceable by barring individuals from reenrolling for some defined period of time.	With the exception of expanded access to telehealth, specific provider payment reforms have not been publically discussed.	At the time many of the details were publically discussed, assumed the current FMAP financing structure.

SB 742 (KELSEY) / HB 1116 (SEXTON)				
Eligibility	**Covered Benefits**	**Enrollee Responsibilities**	**Provider Payments**	**Assumptions about Federal Reform**
Retains current TennCare eligibility	Covered benefits would vary by plan chosen by enrollee. Plans would represent a range of TennCare-approved options competing for enrollment. Options would reflect "a broad continuum of consumer flexibility" – including "limited-benefit" plans, "full-service" managed care plans, "self-directed plans," and "medical home networks." "	Provides all current enrollees with risk-adjusted subsidies to pay for health plan premiums and cost-sharing via Personal Health Accounts. Cost-sharing structure would vary by plan chosen by enrollee. Enrollees would be responsible for any difference between the amount in the Personal Health Account and actual costs for premiums and cost-sharing.	Allows medical home networks to serve as a health plan option, but is otherwise silent on changes to provider payments.	Does not include specific assumptions about federal financing, but given the context, is likely based on the current FMAP financing structure.
SB 1351 (McNALLY) / HB 1271 (SMITH)				
Eligibility	**Covered Benefits**	**Enrollee Responsibilities**	**Provider Payments**	**Assumptions about Federal Reform**
Retains current TennCare eligibility and expands eligibility to all individuals under 138% of the federal poverty level.	Does not include specific provisions related to covered benefits, enrollee responsibilities, or provider payments, but notes that a block grant would allow Tennessee to innovate and expand TennCare eligibility with the same amount of funding as is currently spent.			Assumes a conversion of current federal medical assistance funding to a block grant. Does not include explicit assumptions about how federal contributions under a block grant waiver would grow annually.
SJR 88 (GREEN)				
Eligibility	**Covered Benefits**	**Enrollee Responsibilities**	**Provider Payments**	**Assumptions about Federal Reform**
Retains current TennCare eligibility and allows voluntary participation in the "TennCare Opt Out" pilot by any current TennCare enrollees. The fiscal note estimates that the pilot program would service an estimated 17,200 males age 21-44 eligible for Temporary Assistance for Needy Families (TANF).	Participants in the pilot project would receive catastrophic-only coverage with a high deductible paired with an electronic benefits transfer (EBT) card.	Provides all participating enrollees with an EBT card to pay premiums and out-of-pocket expenses. Enrollees would be responsible for any difference between the amount on the EBT card and the deductible - including the direct purchase of primary care services and medications. According to the fiscal note, the deductible would be $6,350 and the EBT card contribution would be $1,576.	Participating enrollees would directly pay for primary care services, which would allow for faster payment and lower claims processing costs for providers incentivizing them to offer enrollees lower prices.	Does not include specific assumptions about federal financing of the pilot, but given the context, is likely based on the current FMAP financing structure.

ALEC's MEDICAID BLOCK GRANT ACT				
Eligibility	**Covered Benefits**	**Enrollee Responsibilities**	**Provider Payments**	**Assumptions about Federal Reform**
Sets up a state commission that would be responsible for filling in many of the details within the broad structure laid out in the model law. Sets up a task force to advise the commission. It would be made up of 12 members – including 8 appointed by the Governor, the Lt Governor, the Speaker of the House, and the Chairs of the Senate and House Finance Committees, the Senate Health & Welfare Committee, and the House Health Committee.				
Eligibility of acute care benefits would be limited to existing Medicaid enrollees and individuals under age 19 in foster care and receiving supplemental security income (SSI).	Benefits would be administered "through the most cost-effective means" as determined by the commission, including using different benefit delivery models for different populations or different parts of the state. Does not address specific covered benefits beyond a requirement for maternity benefits.	Provides sliding scale subsidies for health plan premiums and cost-sharing via health savings accounts. Subsidies would also vary based on specific enrollee choices (e.g. enrollment in a high deductible plan) and behaviors. Cost-sharing structure would vary by plan chosen by enrollee. Enrollees would be responsible for any difference between the subsidy and actual costs for premiums and cost-sharing.	Does not include any specific provisions related to provider payments.	Does not include specific assumptions about the structure of federal reforms.
Addresses long-term services and supports (LTSS) and home and community-based services (HCBS) separately. LTSS eligibility would be restricted to a state-defined income threshold and individuals under age 19 in foster care and receiving supplemental security income (SSI). The model law does not specifically address HCBS eligibility.	Does not address the coverage of specific LTSS benefits. Allows the commission to develop home- and community-based services (HCBS) packages "designed to prevent the overutilization of services."	Provides sliding scale subsidies, which would vary by disability and functional status, for the purchase of LTSS from authorized providers. Enrollees would be responsible for any difference between the subsidy and actual costs for LTSS. The commission could establish maximum subsidy amounts or other cost-containment measures to ensure that support for LTSS does not exceed a state's desired budget. Requires that the parents/guardians of children receiving institutional long-term care or HCBS pay a fee; although failure to pay the fee could not affect the child's eligibility. Similarly, requires adult children of individuals receiving institutional long-term care services or HCBS help pay for their parent's care. Failure to pay could not affect the parent's eligibility.	Does not include any specific provisions related to LTSS/HCBS provider payments.	

PARTING WORDS

If the U.S. Congress and President Trump act to make concrete changes to federal Medicaid law, Tennessee's policymakers may have an opportunity to make significant reforms to TennCare. Although proposals and legislation put forward in the 2015-2016 sessions of the Tennessee General Assembly were done in a much different federal context than is expected this year, they share some common elements. Namely, instead of offering enrollees a standard benefit plan, they would be provided with additional options – including high-deductible or catastrophic-only coverage – coupled with funds to help offset out-of-pocket costs. These benefit designs are aimed at generating savings by more directly involving enrollees in health care spending.

Depending on the key features of any final federal reforms, it is likely that additional program design elements would need to be defined by Tennessee policymakers. For example, federal financing reforms could require further TennCare design changes beyond those recently introduced in order to offset the potential loss of federal dollars without increasing state spending. This could necessitate decisions about how these changes would apply to different TennCare eligibility groups.

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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.

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$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.

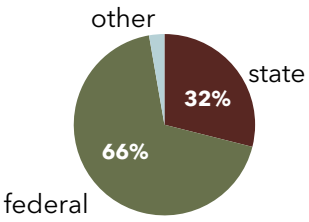
In addition, there are a number of factors arguably **outside the control of policymakers** that drive some of these TennCare spending trends – including underlying health care costs, demographic trends like the aging of the population, changes in the broader state or national economy, and larger public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

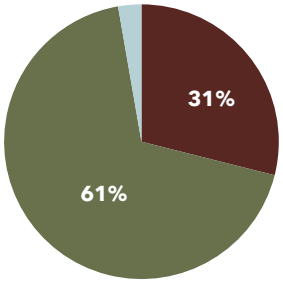


$3.1 BILLION

1.2M ENROLLEES

$2,600 / ENROLLEE

FY 2004-2005

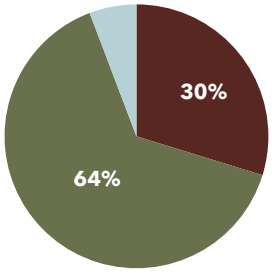


$8.6 BILLION

1.3M ENROLLEES

$6,400 / ENROLLEE

FY 2005-2006

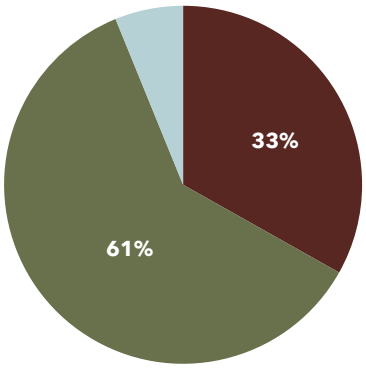


$6.9 BILLION

1.2M ENROLLEES

$5,900 / ENROLLEE

FY 2014-2015



$10.1 BILLION

1.4M ENROLLEES

$7,000 / ENROLLEE

SHARE OF TOTAL STATE BUDGET

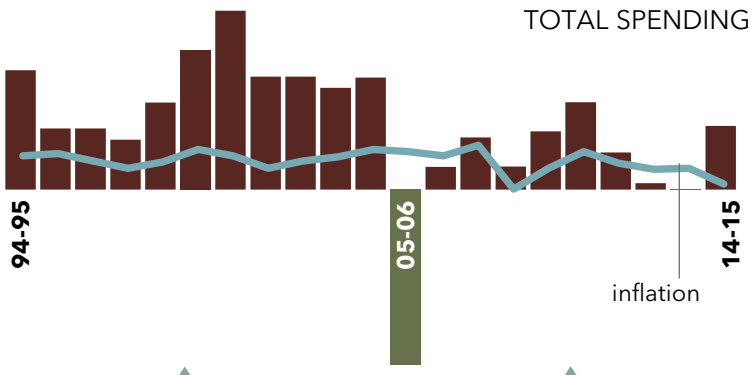
15% of all state dollars

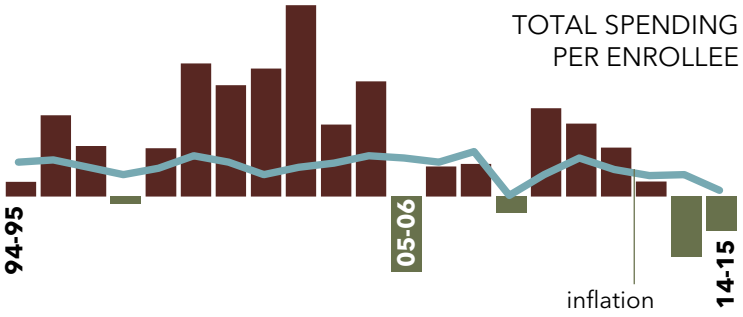
24% of all state dollars

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

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.

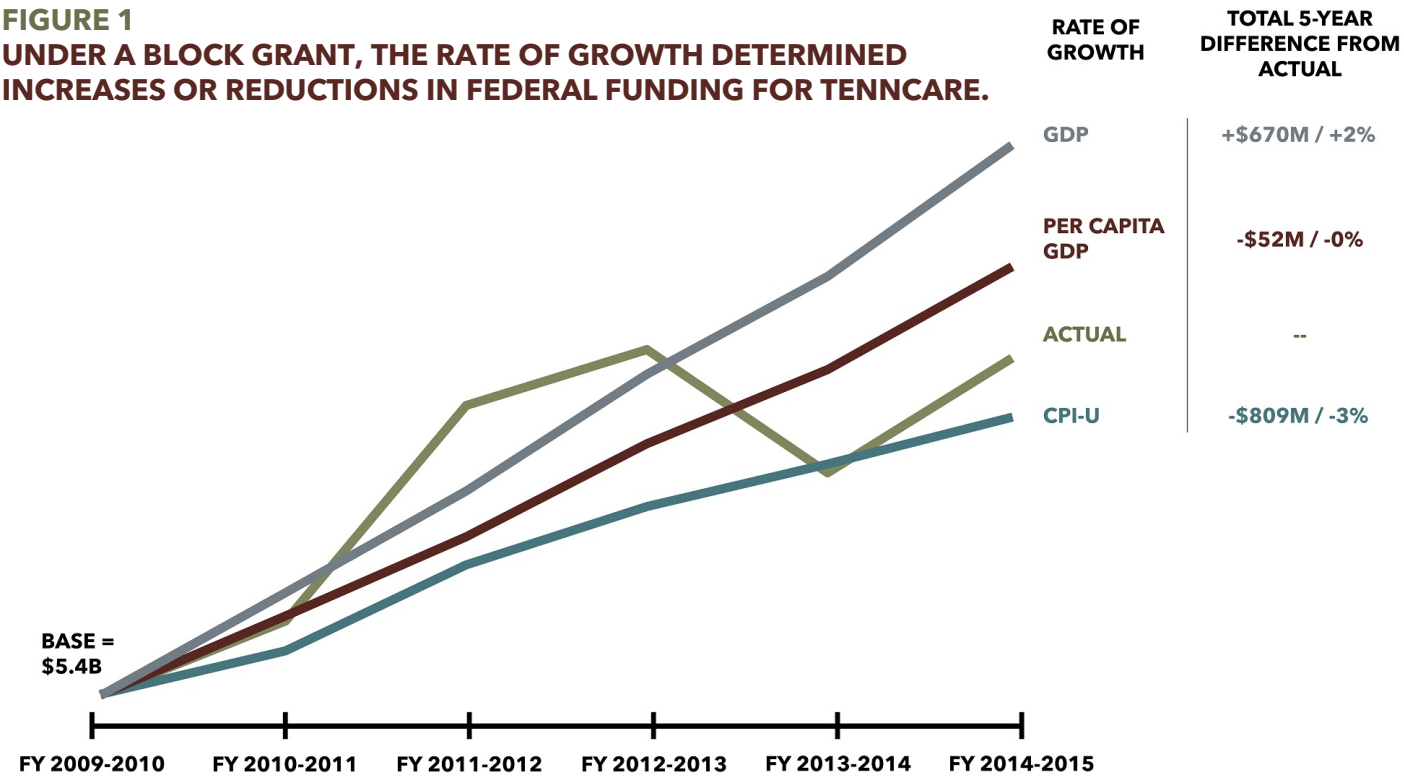
For both FY 2009-2010 and FY 2010-2011, we deducted an estimate of the federal dollars associated with a temporary boost in federal funding that states received under the American Recovery and Reinvestment Act (ARRA) during the Great Recession. Because this was a deviation from the normal FMAP received 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

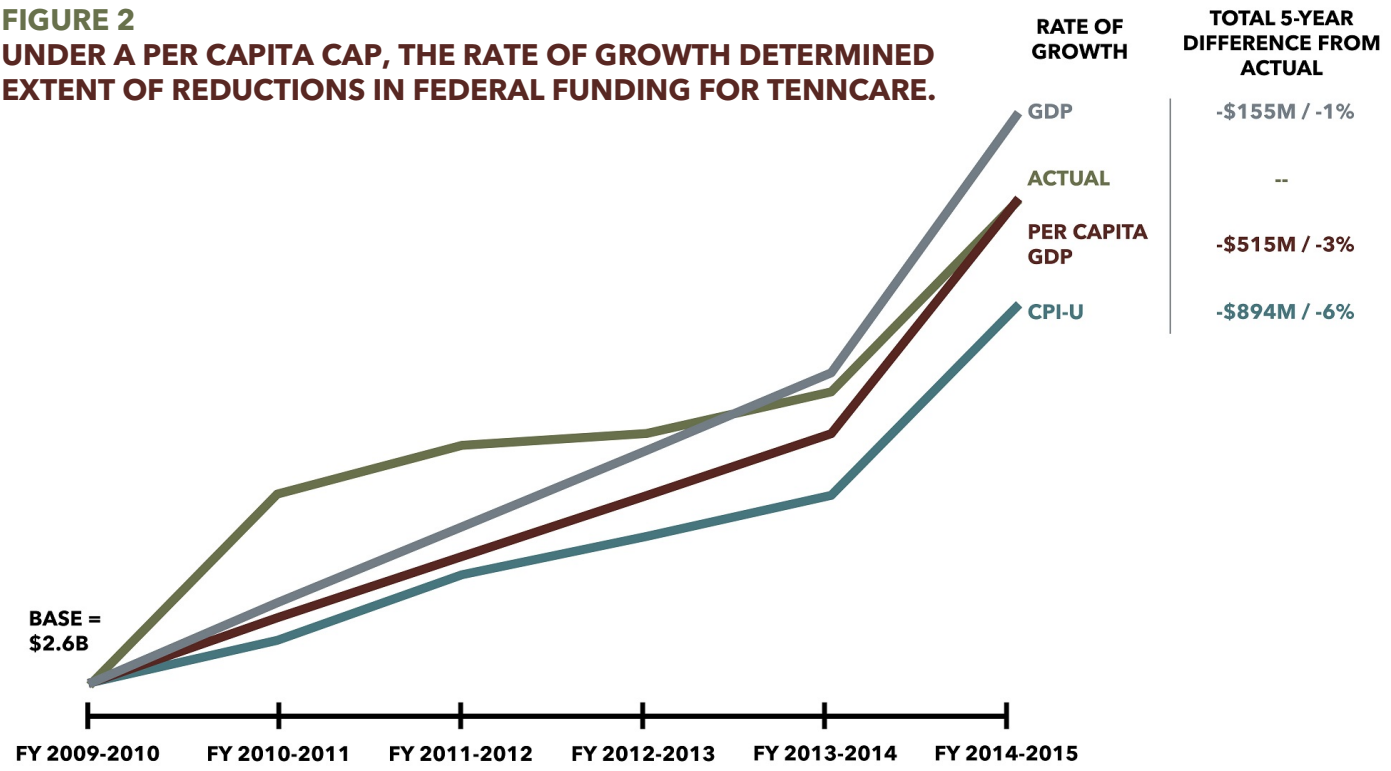
Note: FYs 2009-2010 and 2010-2011 federal funding has been reduced to account for the temporary enhanced FMAP available during the Great Recession. The inclusion of these dollars would unfairly inflate the base year for the purposes of this analysis.
Source: The Sycamore Institute's analysis using TennCare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

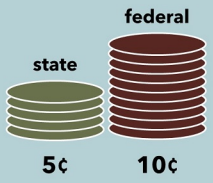
As outlined in Part 4 of this series, Tennessee policymakers have some ideas about how to make TennCare more efficient and cost-effective if given new flexibilities. The extent to which these proposals would produce cost-savings is unknown as the fiscal notes associated with the various bills didn't 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.

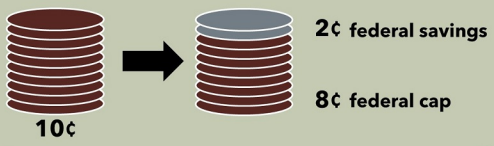
WHAT COULD MEDICAID REFORM MEAN FOR TENNESSEE?

CURRENT MEDICAID FINANCING STRUCTURE

TENNCARE COST: 15¢



CAPPED FEDERAL MEDICAID FINANCING



LOWER COSTS FOR TENNESSEE

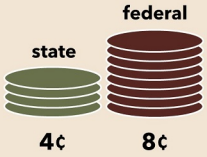
HIGHER COSTS FOR TENNESSEE

If TennCare costs fall...

If TennCare costs remain the same...

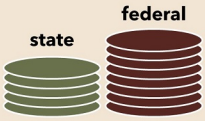
If TennCare costs increase...

COST: 12¢



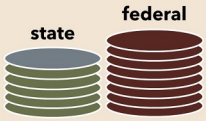
Tennessee's costs would fall.

COST: 13¢



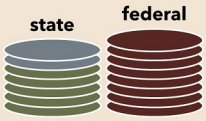
Tennessee's costs would remain unchanged.

COST: 14¢



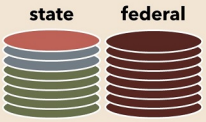
Some federal savings would become Tennessee's costs.

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.**

**This brief was updated on Dec. 12, 2017 to correct data errors in the graphic on page 3.*

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MEDICAID REFORM 101: MORE THAN JUST BLOCK GRANTS

APPENDIX A – GLOSSARY OF KEY TERMS

THE SYCAMORE INSTITUTE

ACA: Also known as the Affordable Care Act or Obamacare.

AFFORDABLE CARE ACT: Also known as the ACA or Obamacare. The ACA is the law passed by the U.S. Congress in 2010, which made significant changes to the individual health insurance market. In the context of Medicaid, it also included a new eligibility category for state Medicaid programs – allowing states to receive an enhanced FMAP to cover all adults with incomes up to 138% of the federal poverty line (FPL) not already eligible for Medicaid.

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

ALLOTMENT: In the context of Medicaid reform, a general term for a designated amount of federal funds available for state spending. For example, a federal allotment could take the form of a block grant or could be determined by multiplying a per capita cap by total enrollment.

AT-RISK: In the context of Medicaid managed care, also known as capitated or PMPM payments. The term refers to the risk that MCOs take on to keep enrollees' costs within the payment rates provided.

BLOCK GRANT: A lump sum of money provided by the federal government to state governments for a broad purpose. In the context of Medicaid reform, a block grant would provide a single federal grant for all Medicaid activities. Funding to Tennessee under a block grant would only change from year to year based on some growth factor and not based on changes in enrollment.

CAPPED ALLOTMENT: In the context of Medicaid reform, a capped allotment would be similar to a block grant in that the maximum allotment available to a state would change based on some growth factor and not based on changes in enrollment. However, the total amount a state could actually spend from the capped allotment could be based on enrollment or tied to some matching requirement.

CAP: Generally, a limit on federal funds available for state spending. The more specific per capita cap would apply a limit on federal funds available for state spending on a per enrollee basis.

CAPITATED PAYMENT: In the context of Medicaid managed care, also known as a PMPM or at-risk payment. Under a capitated payment, Medicaid MCOs receive a single lump-sum payment for each enrollee to cover all the health care needs of that enrollee. The payment is based on data of MCOs' actual health care costs in prior years for enrollees and is adjusted based on enrollee characteristics that would drive health care needs (e.g. age, gender, disability status). MCOs are responsible – or "at-risk" - for any differences between the payment and actual health care costs, whether they are profits or losses. This provides an incentive for MCOs to manage enrollees' costs.

CHILDREN'S HEALTH INSURANCE PROGRAM: Also known as CHIP. CHIP is a companion program to Medicaid (sometimes administered separately and sometimes integrated into Medicaid programs) which allows states to cover uninsured children with incomes too high for Medicaid eligibility. CHIP is administered to states as a capped allotment – with state matching requirements determined by an enhanced FMAP that is about 15 percentage points higher than under the normal Medicaid FMAP. The federal cap each year for overall CHIP spending is defined in law and not pegged to any specific growth factor. Because it is a capped allotment, CHIP is not considered an entitlement, and enrollment can be capped. CHIP also provides states with some design flexibilities related to benefits and cost-sharing that are not allowed under Medicaid.

CHIP: Also known as the Children's Health Insurance Program.

CMS: The federal Centers for Medicare and Medicaid Services within the U.S. Department of Health and Human Services (HHS), which administer both Medicare and Medicaid at the federal level.

CONSUMER-DIRECTED HEALTH CARE: A general term often used to refer to insurance plans or structures that may require enrollees to be more exposed to health care costs or to pay for many costs out of pocket (i.e. cost-sharing). Proponents of these structures argue that they create financial incentives for enrollees to be more thoughtful and invested in using health care and choosing health care providers.

COST-SHARING: Refers to an insurance enrollee's responsibilities to share the insurer's cost of providing health insurance. Cost-sharing usually takes the form of deductibles, co-pays, and/or coinsurance. In the context of Medicaid reform, cost-sharing requirements can be met with either an enrollees' own money or with subsidies.

Under a deductible, an enrollee is responsible for paying for a certain amount of care out of pocket before health insurance coverage kicks in. For example, if a plan has a $2,000 deductible, an enrollee would be required to pay for the first $2,000 worth of care and/or prescriptions they receive before the insurance plan would begin paying providers on the enrollee's behalf. Many refer to plans with a high deductible as a catastrophic plan, because an enrollee would be responsible for paying for most of their health care needs unless something catastrophic and costly happened.

Under co-pays, once any deductible have been met, enrollees are required to pay a set fee for the use of certain kinds of health care or for prescription drugs regardless of the underlying price. Continuing the example above, once an enrollee has paid for the first $2,000 worth of care they receive, they may then be required to pay $10 out of pocket for each visit to the doctor, $10 for each brand name drug, or $5 for each generic drug, and the insurance company will pick up the rest of the bill.

Coinsurance is similar to co-pays but vary based on the cost of the care or prescriptions received. For example, once the deductible is met, an enrollee may be required to pay 10% of the cost of any doctor's visit, and the insurance company will pay the remaining 90%.

ELIGIBILITY: In the context of Medicaid, eligibility refers to the criteria that determines whether someone may receive health insurance coverage under Medicaid. Although people will often refer to Medicaid as a health insurance program for low-income individuals, eligibility is far more complicated than that. For that reason, people often refer to Medicaid eligibility based on various categories (or "eligibility categories"), but the categorizations that people use may change based on the context of the discussion.

For example, people may distinguish between mandatory and optional eligibility categories, which refers to whether or not eligibility is required under federal rules or whether it is optional for states. Because some categories are mandatory and some optional, eligibility for Medicaid varies greatly by state. Some of the federal mandatory and optional eligibility categories are outlined below.

Mandatory eligibility for:

- Children up to age 19 and pregnant women with family incomes at or below 133% of the federal poverty limit (FPL)
- Infants born to pregnant women eligible for Medicaid
- Children and certain adults who would be eligible for cash assistance under the welfare rules that were in effect in July 1996
- Children and certain adults with incomes below 185% of FPL in families that are leaving welfare for work
- Children in foster care or an adoption assistance programs
- Elderly individuals and individuals with disabilities that receive cash benefits under Supplemental Security Income (SSI) (The income limit for SSI is around 75% of FPL.)

Optional eligibility for:

- Children, families, and pregnant women with incomes higher than the limits above
- Elderly individuals and individuals with disabilities whose incomes are less than the FPL but who do not receive SSI
- Certain severely impaired individuals who are working but make too much for SSI
- Individuals with disabilities whose incomes are under 250% FPL and are working
- All individuals under 65 with incomes under 138% of FPL not otherwise eligible

The various groups eligible for Medicaid are also sometimes divvied up by the federal government between "categorically needy" and "medically needy." Categorically needy refers to classes of individuals who are categorically eligible because they are eligible for and/or enrolled in some other program (e.g. welfare or SSI). Medically needy refers to individuals who may be eligible based on a combination of their income and some health need (e.g. low-income pregnant women).

Many refer to the optional eligibility category added by the ACA for all individuals under 65 with incomes under 138% of FPL as the "expansion population."

Finally, per capita cap proposals often refer to 4 categories: aged, disabled, adults, and children. Although these loosely align with eligibility criteria, these 4 categories also align with different cost profiles. That is, disabled enrollees often cost Medicaid programs the most, with elderly individuals next, then adults, and then children.

ENHANCED FMAP: An enhanced FMAP provides additional federal funds to states above what would normally be provided under a state's FMAP. Enhanced FMAPs have taken the form of a percentage add-on for all Medicaid costs or as a special FMAP for specific eligibility categories or kinds of spending. Enhanced FMAPs can be used as a tool by the federal government to encourage certain types of spending or eligibility expansions by states or to help defray state costs during economic downturns. For example, during the Great Recession (2007-2009), Congress added a temporary 6.2 percentage point increase onto each state's FMAP – allowing the federal government to pick up a larger share of the tab of Medicaid costs during this period when Medicaid enrollment was up and state revenue collections were down. The ACA also included an enhanced FMAP for the Medicaid expansion population – limiting any state's share of costs for this population to 10% beginning in 2017.

ENTITLEMENT PROGRAM: Refers to federal programs that guarantee benefits to a certain group based on eligibility criteria. Medicaid is an entitlement program because all who meet mandatory eligibility criteria are eligible to enroll and receive all covered benefits. As a result, spending on the program – by both the federal and state governments – is tied to enrollment and the utilization of health care by all who are enrolled. As such, entitlements are not subject to spending caps, and enrollment in entitlement programs is not limited.

FEE-FOR-SERVICE MEDICAID: Also known as traditional Medicaid.

FLEXIBILITIES: In the context of Medicaid reform, refers to giving states *new* legal authority to determine their own eligibility categories, benefit structures, and enrollee requirements for their Medicaid programs. This could include allowing states to apply limits or restrictions on eligibility and/or benefits or placing new requirements on enrollees not currently allowed under current federal law. For example, a design flexibility could be used to allow states to eliminate eligibility for a population currently required to be covered by federal law or to allow states to require cost-sharing from some or all enrollees for accessing certain benefits.

FMAP: Also known as the federal medical assistance percentage. The FMAP varies based on state and determines the percentage of a state's Medicaid costs that will be covered by the federal government. The remaining portion is the state's matching requirement. The FMAP for each state is calculated each year based on the state's per capita personal income compared to the national per capita income average. No state's FMAP can be less than 50%. Tennessee's is usually around 65% - leaving 35% as the state's matching requirement.

The FMAP is also used to determine matching requirements for other non-Medicaid programs – including federal funding for certain child care programs, foster care, and adoption assistance.

FPL: Also known as the federal poverty limit. In 2016, the FPL for an individual was $11,880 per year. For a family of 2, $16,020. For a family of 3, $20,160. For a family of 4, $24,300.

GROWTH FACTOR: In the context of Medicaid reform, growth factor refers to the rate at which the cap on federal funds for a state's Medicaid costs would grow from year to year. The growth factor could apply to a block grant, a per capita cap, or a capped allotment. Some potential growth factors that have been discussed include inflation (i.e. the growth in prices), the gross domestic product (GDP) (i.e. the growth in the U.S. economy), or per capita GDP (i.e. the growth in the U.S. economy and population).

HMO: Also known as a Health Maintenance Organization. HMOs are a certain type of private health insurance company – including MCOs – that use a managed care approach.

MANAGED CARE: Generally, managed care is an approach used by private health insurance companies to manage the costs of their enrollees. For example, an insurance company may limit enrollees to use only "in-network" providers with which insurers have negotiated a discounted payment rate. In the context of Medicaid, managed care is an approach used by many states, including Tennessee, in which the state Medicaid program contracts with MCOs to administer benefits to enrollees in exchange for an at-risk capitated payment. Many Medicaid managed care programs need a waiver to operate.

MANAGED CARE ORGANIZATION: Also known as an MCO. In the context of Medicaid managed care, MCOs are private health insurance companies that administer and manage the benefits of Medicaid enrollees in exchange for an at-risk capitated payment. TennCare uses MCOs to administer Medicaid benefits -- including BlueCross BlueShield of Tennessee, Amerigroup, and UnitedHealthcare.

MCO: Also known as Managed Care Organizations.

MATCHING REQUIREMENT: Requirement for states to contribute a certain amount of funding for federally funded activities. For example, states may be required to contribute $0.50 for every $1 provided by the federal government. In the context of Medicaid, the FMAP determines the state Medicaid matching requirement under which Tennessee is required to cover about 35% of most costs related to TennCare.

MAINTENANCE OF EFFORT REQUIREMENT: Requirement for states to maintain either a certain level of funding or certain eligibility or benefits criteria in exchange for federal funding. For example, under certain programs,

states cannot reduce their spending on a federally-funded activity below their spending in a certain year even if the lower level of state spending meets a matching requirement.

MEDICAID: First established in 1965, Medicaid is a health insurance program largely targeted at certain low-income individuals who are over age 65, have a disability, are mothers, are pregnant, or are children. The program is jointly funded by federal and state governments (as determined by the FMAP) and is administered by states within certain federal parameters for eligibility and benefits. Because eligibility, benefits, and requirements vary by all 50 states, references to Medicaid includes terms like "state Medicaid programs" or state-specific program names. Tennessee's Medicaid program is TennCare.

MEDICAID EXPANSION: Refers to the optional Medicaid eligibility expansion in the ACA – allowing states to receive an enhanced FMAP for providing Medicaid coverage to individuals under 65 with incomes under 138% of the federal poverty limit (FPL) not otherwise eligible for Medicaid.

MEDICARE: Established in 1965, Medicare is a health insurance program for all individuals over age 65, certain younger individuals with disabilities, and individuals with permanent kidney failure. Medicare is administered by and exclusively funded by the federal government. If a Medicare enrollee has a low income, they may also be eligible for Medicaid. These individuals are known as "dual eligible" (or simply "duals"), and both states and the federal government share the costs of covering the cost-sharing requirements of Medicare and any benefits covered by Medicaid but not Medicare.

OBAMACARE: Also known as the ACA or the Affordable Care Act.

PER CAPITA CAP: In the context of Medicaid reform, per capita caps would provide a capped payment to state Medicaid programs for each Medicaid enrollee. The caps could vary based on eligibility categories, but each state's overall allotment under a per capita cap would change year to year based on some growth factor and enrollment.

PMPM: In the context of Medicaid managed care, also known as at-risk or capitated payments. PMPM stands for "per member per month," because payments to MCOs are made on a monthly basis for each enrollee.

SUBSIDIES: In the context of Medicaid reform, subsidies refer to financial assistance provided to enrollees to help defray cost-sharing requirements or requirements to pay premiums for Medicaid coverage. The amount of subsidy can vary based on enrollee characteristics like income or age and can be structured to create incentives for certain behaviors or choices – for example, providing bigger subsidies for enrollees that participate in a wellness program or choose a certain kind of health plan.

TENNCARE: TennCare is Tennessee's Medicaid program. It operates under a waiver as a Medicaid managed care program, under which all TennCare enrollees receive care from MCOs. As a result, TennCare is sometimes referred to as "Tennessee's waiver program." TennCare is managed by the Division of Health Care Finance & Administration within the Tennessee Department of Finance & Administration - sometimes referred to as the TennCare Bureau.

TRADITIONAL MEDICAID: Also known as fee-for-service Medicaid. Under traditional Medicaid, benefits are administered by the state, and payments are made directly by the state to any health care providers wishing to participate in the program based on a fee schedule. This is in contrast to managed care, under which private health insurance companies receive capitated payments from the state to manage the costs of enrollees through cost-savings practices like limited provider networks. In most cases, waivers are not necessary to operate traditional Medicaid programs.

WAIVER: The law establishing Medicaid – the Social Security Act – provides opportunities for CMS to waive certain federal rules if states have ideas for better managing their programs. When states seek to waive these rules, they do so through a waiver. For example, a state may want a waiver from rules that bar all enrollees from being automatically enrolled in an MCO. Or a state may have an idea for waiving certain benefit rules that might generate enough savings to expand eligibility to new populations within existing funding levels.

Waivers, however, are time-limited and must be reapproved periodically by CMS – usually about every 5 years. The waiver approval process isn't laid out in law and isn't always transparent. The waiver authority is also still relatively narrow – meaning that it does not provide unlimited flexibility to states to change eligibility, benefits, and enrollee requirements. TennCare is operated through a waiver.

MEDICAID REFORM 101: MORE THAN JUST BLOCK GRANTS

APPENDIX B – LOOKBACK ANALYSIS DATA

THE SYCAMORE INSTITUTE

RESULTS FROM ANALYSIS 1 – AN ILLUSTRATIVE BLOCK GRANT

	Estimate of ACTUAL Federal Funding		Estimate of Federal Funding under a BLOCK GRANT w/ CPI-U GROWTH			Estimate of Federal Funding under a BLOCK GRANT w/ PER CAPITA GDP GROWTH			Estimate of Federal Funding under a BLOCK GRANT w/ GDP GROWTH		
	Total Federal Funding *(in millions of dollars)*	Total Federal Funding (without ARRA) *(in millions of dollars)*	CPI-U	Federal Block Grant *(in millions of dollars)*	+/- Actual Federal Funding (without ARRA) *(in millions of dollars)*	Nominal Per Capita GDP Growth	Federal Block Grant *(in millions of dollars)*	+/- Actual Federal Funding (without ARRA) *(in millions of dollars)*	Nominal GDP Growth	Federal Block Grant *(in millions of dollars)*	+/- Actual Federal Funding (without ARRA) *(in millions of dollars)*
FY 2009-2010 (base year)	6,227	5,417	1.6%	*5,417*		2.9%	*5,417*		3.8%	*5,417*	
FY 2010-2011	6,391	5,565	3.2%	5,504	-$61	2.9%	5,576	$10	3.7%	5,623	$58
FY 2011-2012	6,007	6,007	2.1%	5,680	-$326	3.3%	5,738	-$269	4.1%	5,831	-$175
FY 2012-2013	6,121	6,121	1.5%	5,800	-$321	2.6%	5,928	-$193	3.3%	6,070	-$51
FY 2013-2014	5,869	5,869	1.6%	5,887	$18	3.4%	6,080	$211	4.2%	6,271	$402
FY 2014-2015	6,099	6,099		5,981	-$118		6,286	$187		6,534	$435
Subtotal, FY 2010-2011 - FY 2014-2015...					**-$809**			**-$52**			**$670**
Difference as a Percent of Actual.....					***-3%***			***0%***			***2%***
FY 2005-2006 (base year)	4,460	4,460	3.2%	*4,460*		4.8%	*4,460*		5.8%	*4,460*	
FY 2006-2007	4,567	4,567	2.8%	4,602	$36	3.5%	4,674	$107	4.5%	4,718	$152
FY 2007-2008	4,675	4,675	3.8%	4,731	$56	0.7%	4,837	$162	1.7%	4,931	$255
FY 2008-2009	5,349	4,694	-0.4%	4,911	$217	-2.9%	4,872	$178	-2.0%	5,014	$320
FY 2009-2010	6,227	5,417	1.6%	4,891	-$526	2.9%	4,731	-$687	3.8%	4,914	-$503
FY 2010-2011	6,391	5,565	3.2%	4,970	-$596	2.9%	4,869	-$696	3.7%	5,101	-$464
FY 2011-2012	6,007	6,007	2.1%	5,129	-$878	3.3%	5,011	-$996	4.1%	5,290	-$717
FY 2012-2013	6,121	6,121	1.5%	5,236	-$885	2.6%	5,177	-$944	3.3%	5,507	-$614
FY 2013-2014	5,869	5,869	1.6%	5,315	-$554	3.4%	5,309	-$559	4.2%	5,688	-$180
FY 2014-2015	6,099	6,099		5,400	-$699		5,490	-$609		5,927	-$172
Subtotal, FY 2006-2007 - FY 2014-2015...					**-$3,828**			**-$4,045**			**-$1,924**
Difference as a Percent of Actual.....					***-8%***			***-8%***			***-4%***
FY 2004-2005 (base year)	5,196	5,196	3.4%	*5,196*		5.7%	*5,196*		6.7%	*5,196*	
FY 2005-2006	4,460	4,460	3.2%	5,373	$913	4.8%	5,492	$1,032	5.8%	5,544	$1,084
FY 2006-2007	4,567	4,567	2.8%	5,544	$978	3.5%	5,755	$1,189	4.5%	5,866	$1,299
FY 2007-2008	4,675	4,675	3.8%	5,700	$1,024	0.7%	5,957	$1,281	1.7%	6,129	$1,454
FY 2008-2009	5,349	4,694	-0.4%	5,916	$1,222	-2.9%	5,999	$1,305	-2.0%	6,234	$1,540
FY 2009-2010	6,227	5,417	1.6%	5,893	$475	2.9%	5,825	$408	3.8%	6,109	$692
FY 2010-2011	6,391	5,565	3.2%	5,987	$422	2.9%	5,996	$430	3.7%	6,341	$776
FY 2011-2012	6,007	6,007	2.1%	6,178	$172	3.3%	6,170	$163	4.1%	6,576	$569
FY 2012-2013	6,121	6,121	1.5%	6,308	$187	2.6%	6,375	$254	3.3%	6,845	$724
FY 2013-2014	5,869	5,869	1.6%	6,403	$534	3.4%	6,538	$669	4.2%	7,071	$1,203
FY 2014-2015	6,099	6,099		6,505	$406		6,760	$661		7,368	$1,269
Subtotal, FY 2005-2006 - FY 2014-2015...					**$6,333**			**$7,393**			**$10,610**
Difference as a Percent of Actual.....					***12%***			***14%***			***20%***

RESULTS FROM ANALYSIS 2 – AN ILLUSTRATIVE CATEGORICAL PER CAPITA CAP

	Data from TennCare Actuarial Reports			Estimate of ACTUAL Federal Funding				Estimate of Federal Funding under a PER CAPITA CAP w/ CPI-U GROWTH				Estimate of Federal Funding under a PER CAPITA CAP w/ PER CAPITA GDP GROWTH				Estimate of Federal Funding under a PER CAPITA CAP w/ GDP GROWTH			
	Average Monthly Enrollment	PMPM Cost (in dollars)	PMPM Cost Annualized (in dollars)	FMAP	FMAP without ARRA	Federal Share of Annual PMPM Cost (without ARRA) (in dollars)	Total Federal Funding (without ARRA) (in millions of dollars)	CPI-U	Federal Per Capita Cap (in dollars)	Total Federal Funding (in millions of dollars)	+/- Actual Federal Funding (without ARRA) (in millions of dollars)	Nominal Per Capita GDP Growth	Federal Per Capita Cap (in dollars)	Total Federal Funding (in millions of dollars)	+/- Actual Federal Funding (without ARRA) (in millions of dollars)	Nominal GDP Growth	Federal Per Capita Cap (in dollars)	Total Federal Funding (in millions of dollars)	+/- Actual Federal Funding (without ARRA) (in millions of dollars)
Population: MEDICAID (TANF & RELATED)																			
FY 2009-2010 (base year)	892,694	226	2,707	75.4%	65.6%	*1,775*		1.6%	*1,775*			2.9%	*1,775*			3.8%	*1,775*		
FY 2010-2011	929,529	238	2,852	65.9%	65.9%	1,878	1,745	3.2%	1,804	1,677	-$69	2.9%	1,827	1,698	-$47	3.7%	1,843	1,713	-$33
FY 2011-2012	932,680	241	2,888	66.4%	66.4%	1,917	1,787	2.1%	1,861	1,736	-$51	3.3%	1,880	1,754	-$34	4.1%	1,911	1,782	-$5
FY 2012-2013	925,317	243	2,916	66.1%	66.1%	1,929	1,785	1.5%	1,900	1,759	-$26	2.6%	1,943	1,798	$13	3.3%	1,989	1,841	$56
FY 2013-2014	935,918	249	2,993	65.3%	65.3%	1,954	1,829	1.6%	1,929	1,805	-$24	3.4%	1,992	1,865	$36	4.2%	2,055	1,923	$94
FY 2014-2015	1,060,206	258	3,101	65.0%	65.0%	2,015	2,136		1,960	2,078	-$59		2,060	2,184	$48		2,141	2,270	$134
Subtotal, FY 2010-2011 - FY 2014-2015											**-$229**				**$15**				**$246**
Difference as a Percent of Actual											***-2%***				***0%***				***3%***
Population: DISABLED																			
FY 2009-2010 (base year)	132,124	956	11,475	75.4%	65.6%	*7,524*		1.6%	*7,524*			2.9%	*7,524*			3.8%	*7,524*		
FY 2010-2011	126,386	1,122	13,458	65.9%	65.9%	8,862	1,120	3.2%	7,645	966	-$154	2.9%	7,744	979	-$141	3.7%	7,810	987	-$133
FY 2011-2012	127,594	1,134	13,610	66.4%	66.4%	9,032	1,152	2.1%	7,889	1,007	-$146	3.3%	7,969	1,017	-$136	4.1%	8,099	1,033	-$119
FY 2012-2013	129,436	1,142	13,707	66.1%	66.1%	9,064	1,173	1.5%	8,055	1,043	-$131	2.6%	8,234	1,066	-$108	3.3%	8,431	1,091	-$82
FY 2013-2014	129,438	1,176	14,112	65.3%	65.3%	9,214	1,193	1.6%	8,176	1,058	-$134	3.4%	8,445	1,093	-$100	4.2%	8,710	1,127	-$65
FY 2014-2015	129,079	1,166	13,986	65.0%	65.0%	9,090	1,173		8,307	1,072	-$101		8,731	1,127	-$46		9,075	1,171	-$2
Subtotal, FY 2010-2011 - FY 2014-2015											**-$666**				**-$530**				**-$401**
Difference as a Percent of Actual											***-11%***				***-9%***				***-7%***
Population: COMBINED MEDICAID (TANF & RELATED) AND DISABLED																			
FY 2009-2010 (base year)																			
FY 2010-2011							2,866			2,643	-$223			2,677	-$188			2,700	-$166
FY 2011-2012							2,940			2,743	-$197			2,771	-$169			2,816	-$124
FY 2012-2013							2,958			2,801	-$157			2,863	-$95			2,932	-$26
FY 2013-2014							3,022			2,864	-$158			2,958	-$64			3,051	$29
FY 2014-2015							3,310			3,150	-$160			3,311	$1			3,442	$132
Subtotal, FY 2010-2011 - FY 2014-2015											**-$894**				**-$515**				**-$155**
Difference as a Percent of Actual											***-6%***				***-3%***				***-1%***