THE SYCAMORE INSTITUTE

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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