

## BREAKING DOWN TENNCARE'S BLOCK GRANT PROPOSAL

TennCare has released a draft of its opening bid in negotiations with federal regulators over a Medicaid block grant. (1) The proposal includes three key components:

1. A broad set of administrative and benefit design flexibilities that Tennessee could tap without prior federal approval or oversight.
2. An allotment to replace current federal funding for a portion of TennCare costs.
3. The opportunity to keep (without a state match requirement) half of any savings from spending less than the full allotment.

This brief asks (and attempts to answer) seven questions to help stakeholders understand the details of the proposal and what it could mean for TennCare enrollees and providers and the state's budget.

*Editor's Note: This post is based on our initial analysis of the draft as released on 9/17/2019. Should we receive clarifying information on any piece of our interpretation, we will update the post accordingly.*

### KEY TAKEAWAYS

- The plan would give Tennessee policymakers unprecedented control over changes to optional program benefits and provider payments without federal approval or oversight.
- The state would also shoulder some additional long-term financial risk under this plan, but overall the proposed funding changes are weighted heavily in Tennessee's favor.
- This broad shift in power from federal to state policymakers could have significant effects on TennCare spending, enrollees, and providers – either positive, negative, or mixed depending on if and how current or future state officials use that power.

### 1. Why is TennCare proposing this?

**Earlier this year, the General Assembly passed legislation requiring TennCare submit a request to the federal government to convert the state's Medicaid funding into a block grant.** It established a November deadline for submission to the federal Centers for Medicare and Medicaid Services (CMS) and included broad parameters for how the block grant should work. (2)

### 2. What flexibilities are in the proposal?

**The draft waiver proposes a broad set of benefit design and administrative flexibilities that Tennessee could tap without prior federal approval or oversight.** Federal approval processes are largely in place to ensure transparency, set goals and parameters, and evaluate and monitor the effects of changes on enrollees. (3) (4) (5) However, these processes can also be administratively burdensome for states. (4) Any use of the new flexibilities – either administratively or through legislation – would be defined exclusively by the state without having to conform to existing federal approval and reporting processes.

TennCare's proposed flexibilities fit into three buckets.

1. **The draft proposes to tap existing flexibilities to change benefits – but without the formal federal oversight and approval currently required.** For example, TennCare would like the ability to modify both the coverage of optional benefits and details of other covered benefits (e.g. how much is covered and for how long) without federal approval. Other examples include tailoring benefits to specific enrollee groups, offering non-health care benefits not traditionally covered by Medicaid (e.g. nutrition assistance), modifying enrollment processes, and changing the criteria for payments to hospitals for uncompensated care costs.
2. **The proposal includes new flexibilities not currently offered by federal law or regulation.** Examples include instituting a drug formulary, funding broad public health initiatives, supporting technology adoption in rural areas, and instituting lock-out periods or benefit sanctions for enrollees found guilty of defrauding the program. It also pitches the idea of allowing a longer or even permanent approval period for the TennCare waiver.
3. **The draft includes exemptions from federal oversight requirements.** TennCare is primarily asking to be exempt from federal regulations of Medicaid managed care programs. For example, these regulations require that states get federal approval of contracts and payment rates with managed care organizations (MCOs) ahead of time, maintain an MCO enrollee appeals process, and offer an MCO quality rating system.

**The proposal does not appear to include any changes that would affect eligibility.** TennCare would have to go through the normal CMS approval process to expand or shrink eligibility. If TennCare were to ask to add new populations in the future, they would be separate from the federal funding allotment until costs become predictable.

**The proposed changes could have significant effects on TennCare spending, enrollees, and providers – either positive, negative, or mixed depending on if and how current or future state officials use that power.** The proposal gives examples of how some of the flexibilities might be applied (e.g. to test pilot programs without federal approval), but it does not specify when or how state policymakers would use them. Without these details, there are few limits on the range of possible outcomes.

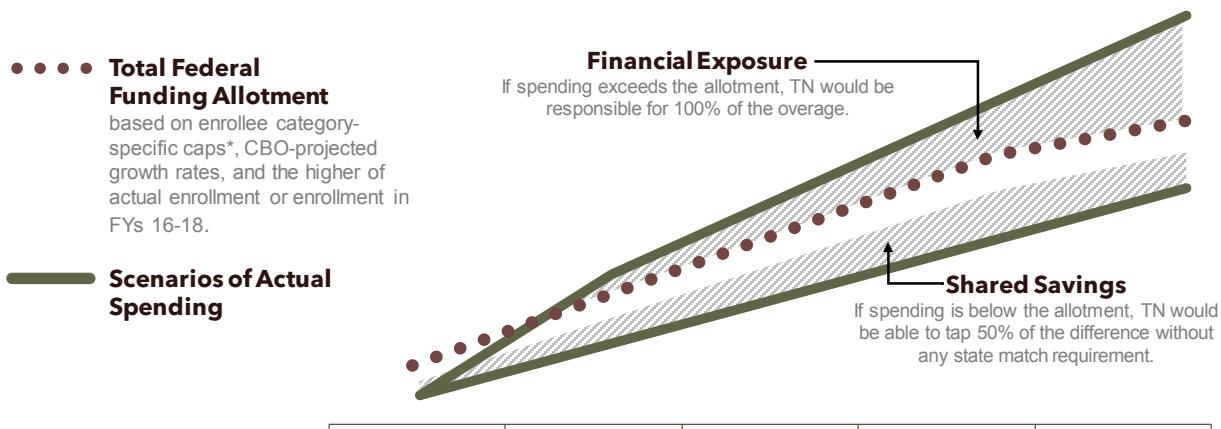
**The draft in its current form does not specify if and how the program might report on its use of these flexibilities and their impact.** There are no rules for how TennCare would notify CMS, affected stakeholders, or the public when state officials decide to use these new powers. While TennCare proposes tracking expenditures and measures around access to care and health outcomes for the entire waiver, the draft does not say how TennCare might monitor, evaluate, and share findings on the effects of using specific flexibilities.

**TennCare's recent record of instituting significant changes has had mixed results.** In some circumstances, TennCare has been cited as a national leader in innovative payment and benefit models (e.g. value-based purchasing for behavioral health). (6) (7) (8) (9) In other cases, it has been criticized for how it has handled the implementation of major administrative changes (e.g. eligibility redetermination) and the monitoring of new initiatives (e.g. episodes of care). (10) (11)

### 3. How does the proposal change federal funding?

**Under the proposal, federal funding for most TennCare enrollees' medical costs would be capped.** Today, [the federal government pays 65% of TennCare's costs](#), and the state pays the remaining 35% (subject to the limitations discussed in question four). This 65-35 arrangement would be replaced by a fixed federal funding allotment for the affected enrollees/spending. Under the proposal, Tennessee would be responsible for 100% of any spending above the new federal allotment but could use part of any savings from spending less than the allotment without a state match requirement (**Figure 1**).

**Figure 1. How Funding Would Work Under TennCare's Proposed Block Grant**



For illustrative purposes only.

\* TennCare's draft block grant waiver as released on 9/17/2019 would exclude administrative costs, supplemental payments to hospitals, and pharmaceutical costs and exclude dual eligibles and enrollees in programs outside the 1115 TennCare waiver (e.g. DIDD waivers).

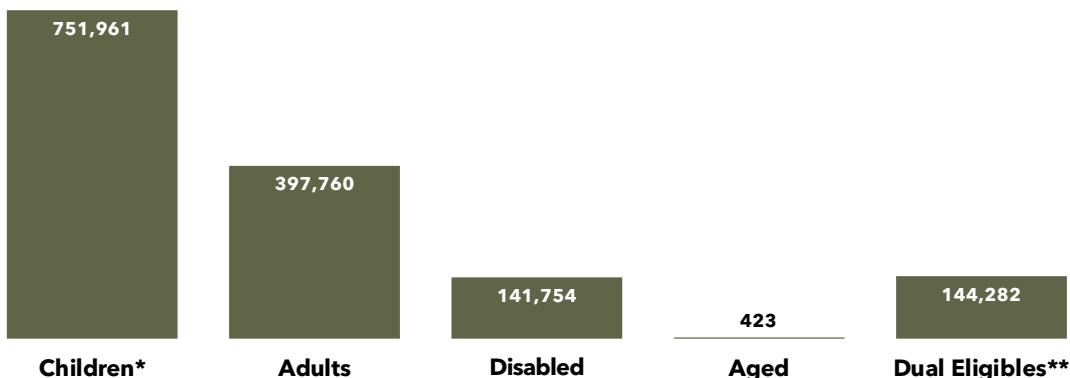
Key details of the federal funding allotment include:

- **Enrollee-Specific Per Capita Caps:** TennCare's federal funding allotment would be based on per capita amounts for four enrollee groups – children, adults, individuals with disabilities, and the elderly. **Figure 2** shows average monthly enrollment across all five TennCare waiver groups in FY 2018. (12) The allotment would not apply to individuals eligible for both Medicare and TennCare ("dual eligibles") or enrollees outside the main TennCare waiver (e.g. DIDD waivers).
- **Enrollee-Specific Cost Projections:** Each year, the per capita costs would grow by the Congressional Budget Office's (CBO) projected rates for each of the four enrollee groups (**Figure 3**). (13)
- **Enrollment:** The federal funding allotment would be based on the higher of two metrics, either actual enrollment or enrollment in FYs 2016-2018 (i.e. "the base period").

- **Exclusions:** Pharmaceutical costs, administrative costs, and supplemental payments for hospitals (e.g. for training physicians, uncompensated care) are all excluded from the allotment.
- **State Maintenance of Effort:** The state could use the allotment to reduce its share of costs for the affected enrollees/spending below the current 35% as long as state spending does not fall below a "maintenance of effort" (MOE) level. This state spending floor would be based on FY 2019 expenditures. The details of this calculation are not specified.

## Figure 2. TennCare Enrollment by Category in FY 2018

Avg. Monthly TennCare Waiver Enrollment by Enrollee Category (FY 2018)



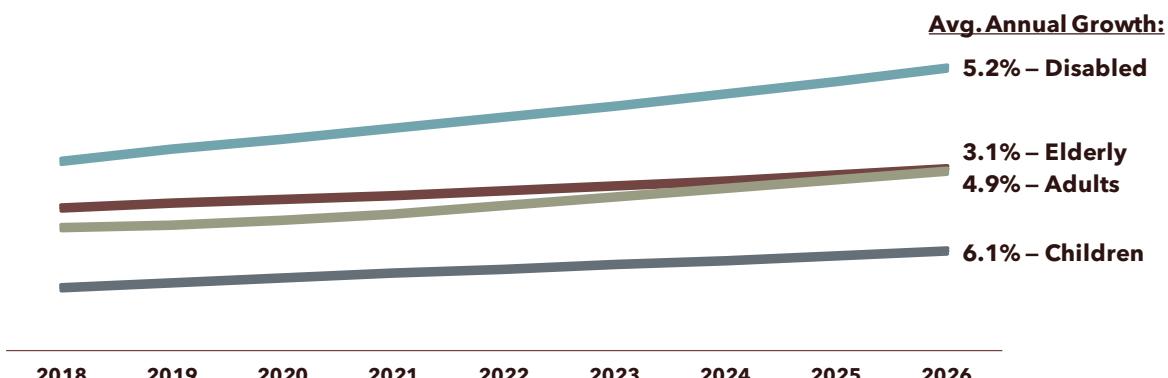
\*Children include individuals 18 and under. TennCare's draft block grant waiver as released on 9/17/2019 defines children as those under 21.

\*\*Dual eligibles are excluded from the federal funding allotment proposed in the draft waiver.

Source: TennCare's Quarterly Reports to CMS (12)

## Figure 3. TennCare's Proposed Block Grant Would Grow Based on Federal Projections For Each Enrollee Group

Congressional Budget Office Medicaid Per Capita Cost Projections by Enrollee Category (FFYs 2018-2026)



FFY = federal fiscal year

Source: CBO's May 2019 Baseline Projections (13)

- **Shared Savings:** If TennCare does not spend the full federal allotment, Tennessee would be able to use 50% of those savings without any state match requirement. The waiver is not specific on how the funds could be used, but the supporting documents suggest they would be spent on "health-related services."
- **Time-Limited (or Permanent?):** The proposal amends the current TennCare waiver. Waivers typically last for three to five years, which would allow the state and federal government to periodically revisit the proposal. Waivers can be extended many times. In fact, the current waiver (which expires on June 30, 2021) is an extension of the "TennCare II" waiver that was first approved by the federal government in 2002. However, the draft also proposes that the federal government consider making Tennessee's waiver permanent or extending the period beyond the typical five years.

## 4. How does TennCare's funding work now?

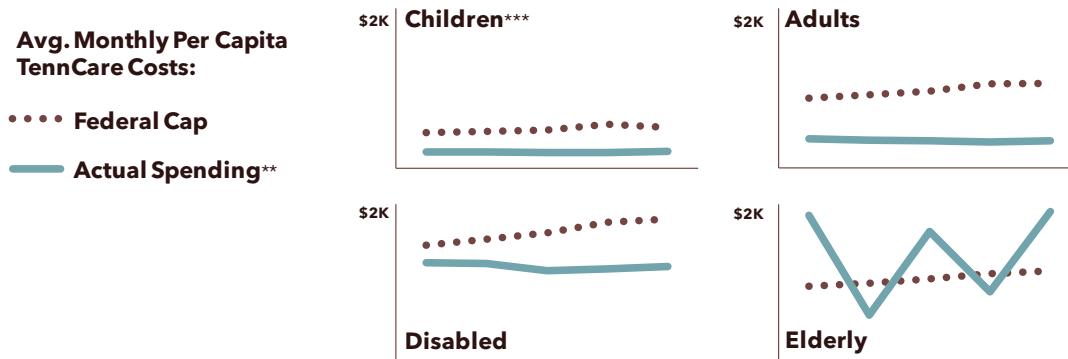
**The proposal builds on some of the financial concepts already at work in TennCare.** Because TennCare operates under a waiver, it must meet federal "budget neutrality" requirements. In other words, a state waiver cannot cost the federal government any more than it would be expected to spend in the absence of the waiver.

**Similar to this proposal, the current budget neutrality requirement creates a federal funding ceiling based on enrollee-specific per capita caps, cost projections, and actual enrollment.** (14)

The existing base per capita caps were established under the initial TennCare II waiver in 2002. Since then, the caps have increased in line with federal projections for Medicaid growth nationwide. CMS has also allowed savings (i.e. the difference between actual spending and the budget neutrality cap) from one waiver period to roll-over into subsequent extension periods. If a state exceeds its total budget neutrality ceiling after accounting for any rollover savings, it must repay the excess amount to the federal government. (15)

### Figure 4. TennCare's Actual Costs for Most Enrollees Are Usually Below Current Federal Caps

The TennCare Waiver's Budget Neutrality Caps by Enrollee Category\* vs. Actual Spending (FY 2014-FY 2018)



\*Current federal budget neutrality requirements use a formula that includes avg. monthly per capita cost estimates to cap total program spending under 1115 waivers. \*\*Includes pharmaceutical costs, which are excluded from the federal allotment proposed in TennCare's draft block grant waiver as released on 9/17/2019.  
\*\*\*Children include individuals 18 and under. TennCare's draft block grant waiver defines children as those under 21. Source: TennCare's Quarterly Reports to CMS (12)

**TennCare has consistently remained below its total budget neutrality ceiling.** Between 2003 and 2021, TennCare predicts the program will cumulatively spend \$31 billion less than the federal budget neutrality caps. (16) **Figure 4** shows TennCare's average annual per capita costs for each enrollee category since FY 2014 alongside the federal caps. (12)

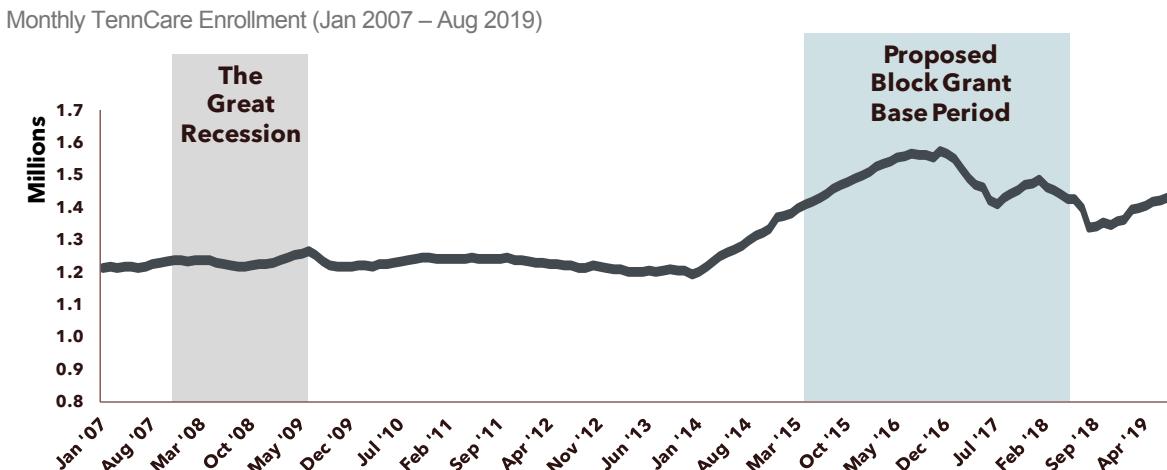
## 5. What is Tennessee's financial risk under the proposal?

**By design, any fixed federal funding allotment comes with financial risk that could present trade-offs for state policymakers.** Any downward pressure on federal TennCare funding might require state policymakers to balance the budget by making changes to TennCare, shifting money from other priorities, and/or raising taxes. All of these decisions would pose trade-offs.

**The formula that would set the allotment, as currently proposed, is heavily weighted in Tennessee's favor** – at least in the short-term. Both the details of each variable and how those details interact matter. Below, we outline how the proposal deals with some of the critical details that determine the state's financial risk.

- **Base Amount:** TennCare proposes an FY 2018 base of \$7.9 billion, which would be adjusted each year based on the parameters discussed above and below. For context, Tennessee received \$7.0 billion in total federal funding in FY 2018 for all TennCare expenses, not just those proposed for inclusion in the allotment.
- **Adjustments for Enrollment:** TennCare enrollment during FYs 2016-2018 would be used to set a floor for the federal funding allotment. Enrollment during this base period was historically high (**Figure 5**) – even compared to the last recession. The allotment could be adjusted upward for changes in both overall enrollment and the mix of enrollee types. For example, the allotment would grow if a recession increased enrollment over the base period. It would also account for changes in the number of enrollees across each category even if overall enrollment remained stable.

### Figure 5. TennCare Enrollment Was Historically High During the Proposed Base Period for the Block Grant Waiver



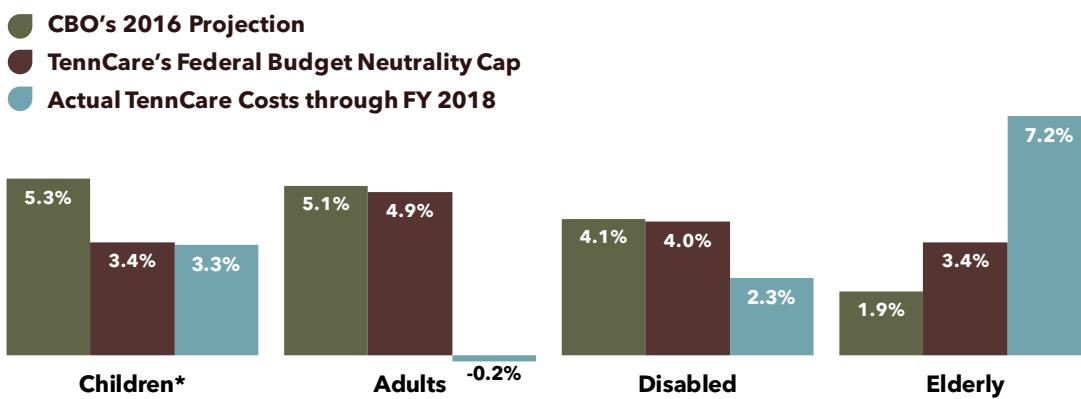
The base period would be used for calculating the minimum federal funding allotment in TennCare's draft block grant waiver as released on 9/17/2019.

Source: TennCare's Monthly Enrollment Data (17)

- **Accounting for Enrollee Differences:** The proposed allotment accounts for nominal differences in spending patterns across the four different enrollee groups and differences in projected cost trends (**Figure 3**).
- **Per Capita Caps:** The proposed allotment base uses the FY 2018 per capita caps from TennCare's existing budget neutrality ceiling. TennCare's average costs for most enrollees was well below these caps (**Figure 4**), which largely reflect estimates of national enrollee costs in the absence of a waiver. Beginning in 2021, however, CMS plans to "rebase" states' caps according to each state's recent experience, instead of national trends. (15) This is expected to reduce Tennessee's per capita caps under budget neutrality. It is unclear how CMS might weigh its new policy against TennCare's proposal.
- **National Medicaid Growth Trends:** The draft proposal would grow each per capita cap using CBO trend projections. In recent history, TennCare's actual costs and existing caps have grown slower than CBO projected for children, adults, and individuals with disabilities (**Figure 6**).

## Figure 6. TennCare's Actual Costs and Existing Caps Have Grown Slower for Most Enrollees than CBO Projected

Avg. Annual Per Capita Cost Growth by Enrollee Category During Current TennCare Waiver Period (2017-2021)



The current TennCare waiver spans December 2016-June 2021.

\*\*\*Includes pharmaceutical costs, which are excluded from the federal allotment proposed in TennCare's draft block grant waiver as released on 9/17/2019.

\*Children include individuals 18 and under. TennCare's draft block grant waiver defines children as those under 21.

Sources: CBO's 2016 Baseline Projections (18), TennCare's Quarterly Reports to CMS (12)

## 6. What happens next?

**The public will have two chances to comment on this proposal before a decision by federal regulators, and the General Assembly must approve any final agreement before it takes effect.**

- TennCare's release of its draft waiver kicks off a 30-day public comment period that will end on October 18, 2019. During this time, TennCare will also hold three public forums across the state.
- Under the 2019 law, TennCare must submit a revised draft to CMS by November 20, 2019. CMS will publish the submission and hold its own 30-day public comment period. Federal rules require

CMS to wait at least 45 days total after publishing the waiver before it can be approved. Most state-federal negotiations over Medicaid waivers take much longer than that. (19)

- Tennessee's General Assembly must approve any final agreement between the Lee administration and federal regulators before it could be implemented. (2)

## 7. What are the chances federal regulators approve this?

These are relatively uncharted waters, so it is impossible to say. Here's what we do know...

**The Trump administration appears motivated to approve an ambitious state Medicaid reform with broader state flexibilities.** (20) However, there is little precedent for the kinds of changes in the current proposal, and some less ambitious proposals by states like Kansas and Massachusetts have been rejected recently. (21)

**Even if CMS and state lawmakers approve something along these lines, it is likely to face legal challenges that may ultimately halt implementation.** The proposal would require significant deviations from previous interpretations of federal law and regulation, which will likely invite lawsuits. For example, many experts believe federal law does not allow the use of the waiver process to override the matching system that dictates Tennessee's 65-35 split. (21) (22) (3) However, it is possible that the proposal is or could be structured to meet the technical funding requirements of federal law.

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\*Updated on 9/23/2019 to correct a typo in Figure 2. The "disabled" category was incorrectly labeled as "aged."

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