



STATE OF TENNESSEE
DEPARTMENT OF FINANCE AND ADMINISTRATION
STATE CAPITOL
NASHVILLE, TENNESSEE 37243-0285

DAVID L. MANNING
COMMISSIONER

D R A F T 3-23-93

A PROPOSAL FOR
HEALTH CARE REFORM IN TENNESSEE

BENEFITS OF THIS PROPOSAL INCLUDE:

- . Comprehensive health insurance for every Tennessean;
- . Eliminates the "medicaid problem" in the state's budget by assuring that future growth will not exceed the rate of growth in state tax revenue;
- . Eliminates the need for the Hospital Services Tax;
- . Saves the federal government an estimated \$1.5 billion over the next five years;
- . Eliminates "cost shifting" to the paying patient and the business community of the cost of indigent health care;
- . Permits the market to limit total health care spending in Tennessee which would, if limited to the growth in our economy, save an estimated \$6.5 billion by the year 2000; and
- . Moves Tennessee in the direction of national health care reform.

Tennessee and the nation face critical decisions in health care reform. The President will make recommendations to the Congress in a few weeks which will result in a major national debate about how best to make and pay for the needed changes. The most optimistic time-frame for a decision by the Congress is late 1993 with a three to five year implementation period. Unfortunately, Tennessee does not have that much time. In fact, we must make critical decisions in the next thirty days.

If we make these decisions as they have been made in the past, we must either have a major tax increase or make major reductions in health care for the almost one million Tennesseans who are covered by the Medicaid program. In either case, the solution will be for one year with even greater tax increases and/or health care reductions required next year and in every

eding year until fundamental reform becomes a reality. President Clinton has indicated that he will give states the flexibility to design their own solutions through the waiver process. Obviously, any alternative approach that we pursue for Tennessee should move us toward reform, which is consistent with the objectives of national reform, including comprehensive universal coverage and cost control.

The most recent Congressional Budget Office study of health care and our own estimates of health care spending in Tennessee document an enormously inefficient health care system. The CBO study estimated that health care costs were over \$800 billion in 1992 or about 13.6 percent of Gross Domestic Product (GDP). This is more than double the share of GDP which health care consumed in 1965. The CBO also projects that if the current system is not changed it will consume about 18 percent of GDP, or about \$1.7 trillion, by the year 2000. In Tennessee, it is estimated that health care costs were approximately \$13 billion in 1992. If present trends continue, health care will cost almost \$27 billion in Tennessee by the year 2000 (Attachment A).

Using the State of Tennessee's Group Insurance Plan as an example of a comprehensive managed care plan, this problem can be clearly demonstrated. The state's group insurance plan is an aggressively negotiated Preferred Provider Organization covering in excess of 100,000 employees and dependents. The benefit structure compares very favorably with large, private sector plans. It's managed care provisions are primarily process oriented with preventive care and wellness programs in the mainstream of large, private sector plans. The average cost per covered person in FY 92 was \$1463 (\$1194.40 plan cost and \$268.86 out-of-pocket). If the same level of coverage were provided for all Tennesseans the cost would be approximately \$7.2 billion, in contrast to the \$13 billion actually spent on health care. Approximately \$1.4 billion of the difference is nursing home and dental expenditures, leaving an unexplained difference of \$4.4 billion after considering the full cost of universal coverage.

It is doubtful if a substantial portion of this difference is explained by extraordinarily high cost among a portion of the insured population for at least two reasons. First, a group of the size of the state group insurance program has a diversity of risk which should reasonably represent the entire population. Secondly, the medicaid population includes a large number of our most medically fragile citizens and its cost was only \$1,474 per eligible (excluding Nursing Home Care, Medicare Premiums and MDSA).

At the national level, the numbers are not significantly different. Adjusting the Tennessee costs to the national average (Attachment B), universal coverage would cost approximately \$409.5 billion, in contrast to the \$809 billion actually spent on health care. If you assume that the 37 million uninsured Americans pay no out-of-pocket costs (an unreasonable assumption

since the CBO study indicates that almost 40% of the uninsured have incomes above 200 percent of the poverty level) it would increase the cost by approximately \$10 billion, leaving enormous financial flexibility for an "efficiently" managed system.

The answer to paying for universal coverage is not to put even more money into such a massively inefficient system, but instead to redirect public and private resources into large Health Insurance Purchasing Cooperatives at the community level with a mandate to cover all citizens living in their respective communities. An alternative, and perhaps transitional approach, is to pool certain public resources to purchase care for the combined medicaid and uninsured populations. It is this concept that Tennessee should seriously consider to address our immediate health care problems.

FINANCING HEALTH CARE REFORM IN TENNESSEE

Universal coverage for all Tennesseans can be accomplished by pooling certain public financial resources without the need to continue the hospital services tax. The public resources which should be pooled, include state and federal medicaid funds, other state and federal health care funds, the cost of charity care (including bad debt) already provided to the uninsured by health care providers and existing local government subsidies for indigent care. These funds should be combined with premiums (20% of total premium), coinsurance, co-pays and deductibles of individuals covered under the new program with incomes above the poverty level. The total of these resources is estimated to be over \$3.8 billion (Attachment C), assuming the federal government contributes, for the first year of the plan, the same amount it would have contributed if the Medicaid program had continued without change. Total federal participation as a percentage of total funding, even without the hospital and nursing home taxes, would be less than the current federal participation level of 67%. These funds could provide for the cost of full coverage for almost 1,000,000 Tennesseans covered by the Medicaid Program and the uninsured population which is estimated to be between 14 and 16 percent of our population.

The plan, which would require a federal waiver, would work as follows:

- (1) Expand the Tennessee Comprehensive Health Insurance Program (TCHIP) to include all Tennessean's now covered under the state's Medicaid Program and the entire uninsured population. Require, on an annual basis and at time of enrollment, citizens to choose any TCHIP option which would include the present Blue Cross plan, the HMO's presently operating and planned for the Medicaid Program and other qualifying plans (see Attachment D for requirements to be a TCHIP Plan).

(2) All participants in the program with family incomes above the poverty level would be required to pay 20 percent of the premium cost and co-insurance in the same amounts as those required under the state group health insurance plan. Individuals under 200 percent of the poverty level paying on a sliding scale based on their ability to pay. TCHIP's benefit structure would be the same as the benefit structure of the state group insurance plan with the exception of the deductible which would be maintained at the current TCHIP level of \$1,000. No deductibles or co-pay would be required for preventive services. (Attachment E)

(3) All health care providers would be required to accept TCHIP as a condition of participation in any state or federal health care program.

(4) All employers would be encouraged to enroll and provide payroll deduction of premiums for all of their employees (full-time and part time) and employee dependents to the extent they are not eligible for coverage in an employer sponsored health plan under conditions existing on March 1, 1993.

(5) State government would enroll all citizens who are eligible for Medicaid, all recipients of unemployment compensation who are not covered under another health plan and all others, to the extent they qualify for coverage as described in Attachment F.

(6) Community Health Agencies (CHA's) would enroll all eligible citizens who were not enrolled by state agencies as described above. CHA's would also be responsible for: developing quality and cost information and making it available to the public, health care providers and employer health insurance sponsors. CHA's could also accept for enrollment referrals for TCHIP directly from health care providers.

(7) Health care providers would be required to track out of state patients separately and ensure, to the best of their ability, that profits at least covered any losses due to charity and bad debt.

(8) Each community would be separately rated and each plan within that community would be given a per capita spending target. Initial per capita spending targets and provider reimbursement would be based on the actual cost of hands-on care (i.e. the provider's marginal cost less charity care) plus the management fee, with the final spending target based on the final number of persons covered by each TCHIP plan. Final provider reimbursement would be based on a negotiated rate not to exceed their charge to their best customers, with the HMO or insurance company paid a management fee based upon the management fee paid under the

state employee group insurance plan. Each TCHIP plan within a community exceeding its target expenditure in total would be prorated back to the target, with any TCHIP plan producing a savings would be permitted to distribute the savings among its providers as long as final reimbursement does not exceed 105% of the provider's negotiated rate. Provider reimbursement, however, would never be less than the provider's marginal costs.

(9) The chronically mentally ill and children in state custody or at risk of state custody, would be enrolled in separate TCHIP plans which would continue to be administered by the state.

(10) The Nursing Home Program and services to mentally retarded citizens would continue under the present Medicaid Program.

(11) Public Health services would be continued and directed to assure services in areas which would otherwise be underserved and to assist all TCHIP Plans in providing preventive health services to help control long-term health care costs.

(12) State funding would be increased each year at a rate equal to the growth in state tax revenue, less any dedicated tax increase, not to exceed the rate of growth in the economy. Local government funds would be frozen at their current level. Federal and other funds would grow at the rate of growth in total plan expenditures, not to exceed the growth in the state's economy.

(13) All private health insurance plans (including deductibles and co-pay) would be encouraged to limit the amount their premiums could grow in future years to a rate not exceeding growth in the state's economy (Attachment G). The only exception would be private plans with benefits which are lower than the state group insurance plan, which would be encouraged to grow in excess of the rate of growth in the economy until their benefits are comparable.

HOW IS THIS POSSIBLE?

The obvious question is how can Tennessee finance universal converge without the hospital taxes, if we can't adequately finance Medicaid with those taxes? The answer lies in taking full advantage of all of the financial resources we have to serve the uninsured and placing them in an accountable, managed care system. Financial resources available for the uninsured include:

Medicaid Disproportionate Share Payments	\$431 million
Charity Care	595 million
Co-Pay and Deductible from those above the poverty level	228 million
Local Government Funds	<u>50 million</u>
	\$ 1,304 million

Based on the demographics of the uninsured and the cost of coverage under the Medicaid Program (using Medicaid actuarial tables adjusted to 1994 levels) this represents more than an adequate amount to insure the entire group. The enormous growth of the Medicaid Program has been driven, for the most part, by the steady movement of these uninsured Tennesseans into the Medicaid Program. They have come under Medicaid coverage as a result of rising medical costs which force people to "spend down" their assets making them "Medicaid eligible" and federal mandates requiring states to extend Medicaid coverage to more of the uninsured population. Extending coverage to the entire uninsured population will both bring management to this group's health care cost and eliminate this major source of the Medicaid cost explosion, as well as control cost shifting to the private sector.

The other major reason this reform is financially feasible is the opportunity to manage the health care of those who are Medicaid eligible in the same way we manage the health care of other large groups. The State Group Insurance Program has successfully used the buying power of a large group to purchase health care on the "margin". The combined Medicaid and uninsured populations are a group which is almost eight times larger than the combined state employee, teacher and local government plans. This should permit the purchase of quality health care at the best price available in the market place. This buying power should enable us to both insure the entire Medicaid and uninsured population and control future costs much more effectively than we have been able to control these costs in the Medicaid Program.

CONCLUSION

Tennessee has little choice but to actively pursue health care reform on a faster time-frame than national reform. Our reform should be aligned, to the maximum extent possible, with the direction of national reform, and should focus on better management of existing funds. This proposal meets these objectives and, with timely federal approvals, can be implemented by early 1994.

In addition, the proposal will virtually eliminate "cost shifting", thus removing one of the most serious barriers to true business negotiation in health care. It will also limit the growth in health care spending to the growth in our state's economy and thus encourage competitive forces to restructure both the existing financial resources and new financial resources into a market driven health care system which provides quality, accessible health care for all Tennesseans.

Attachment A
Projected Tennessee Health Tax Sources

Sources of Funds	Health Tax Sources*			
	Millions			
	CY1990	CY1992	CY1995	CY2000
Total	10,694	12,990	17,213	26,960
Offices and clinics of doctors of medicine	2,609	3,170	4,200	6,578
Offices and clinics of dentists	563	684	906	1,419
Offices and clinics of doctors of osteopathy	10	13	17	26
Offices and clinics of other health practitioners	208	253	335	525
Nursing and personal care facilities	593	721	955	1,496
Hospitals	5,927	7,199	9,540	14,941
Payments for medical services	5,116	6,214	8,234	12,896
Other amounts from providing services to patients	101	123	163	255
Governmental grants	22	26	35	54
Private grants	55	67	89	139
Investment income	67	81	107	168
Rents and commissions	4	5	7	11
Appropriations	540	656	870	1,362
All other sources	19	23	31	48
Contract research and rental of medical equipment	3	3	4	7
Other health services	783	951	1,261	1,974
Medical and dental laboratories	217	264	350	548
Home health care services	197	239	317	496
Kidney dialysis centers	16	20	26	41
Specialty outpatient facilities	214	260	345	540
Health and allied services	63	77	102	159
Other	76	91	121	190

* For 1992, 1995 and 2000 the national growth rate was assumed.

ATTACHMENT B-1

The cost per person should be adequate based on the average cost per employee of \$1,194.40 for the State of Tennessee's Group Insurance Plan plus \$268.86 out-of-pocket cost, adjusted to the national average of other large insured plans documented in the "Foster Higgins 1991 Health Care Benefits Survey". The adjustment is made by inflating the state plan's cost by the difference between the South Central region's cost and the average cost for all employers (i.e. $\$3,605 - \$3,256 = 110.72$).

The State of Tennessee's Group Insurance Plan is an aggressively discounted Preferred Provider Organization which should better reflect managed care cost than typical plans.



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MEMORANDUM

TO: Commissioner Manning
FROM: Richard Chapman *RLC*
SUBJECT: State Plan Costs
DATE: December 22, 1992

You asked me to determine the per plan participant cost of the State Plan for FY 1991-92. This figure had not been calculated previously because the State has not maintained a count of participants (employees, spouses and dependent children) covered by the plan only monthly contracts.

To determine the average number of plan participants the November 1992 eligibility file was examined. During that month 135,074 lives were covered by 60,931 contracts, about 2.216 individuals per contract. During FY 1991-92 we averaged 59,845 contracts per month or about 132,667 individuals based upon the November 1992 ratio.

Blue Cross reported providing \$158,457,300 in benefits during the period. Treasury cleared \$162,423,788 in checks. The Treasury figure needs to be adjusted by about 3% which has been the normal value of workers compensation adjustments and refunds from Blue Cross which are accounted for separately. Based upon that fact, the adjusted Treasury figure would be \$157,551,075.

Using what Blue Cross reported the benefit cost for 1991-92 was \$1,194.40 per State Plan participant. The Treasury figure, when adjusted, was \$1,187.57.

Should you have any questions or require additional information, please let me know.

RLC:ce

Comparison of Health Care Benefit Cost

Region	1991	% chg	1990	%chg	1989	%chg	1988	%chg
Pacific	\$3,659	12.24%	\$3,260	10.77%	\$2,943	21.31%	\$2,426	8.01%
Mountain	3,262	8.81%	2,998	10.91%	2,703	16.01%	2,330	21.99%
N Central	3,546	9.65%	3,234	14.60%	2,822	9.81%	2,570	24.46%
S Central	3,256	9.15%	2,983	18.80%	2,511	9.03%	2,303	20.39%
New England	3,918	16.57%	3,361	16.06%	2,896	30.69%	2,216	7.42%
Mid- Atlantic	4,066	14.44%	3,553	19.55%	2,972	28.83%	2,307	16.87%
S Atlantic	3,412	15.47%	2,955	22.72%	2,408	14.23%	2,108	18.29%
ALL EMPLOYERS	3,605	12.06%	3,217	17.07%	2,748	16.74%	2,354	18.59%

RGMDCST8
12-21-92

Tennessee is in South Central Region
Source: Foster-Higgins 1991 Health Care Benefits Survey

Attachment C
Funding Available for Health Care Reform in Tennessee

FUNDS AVAILABLE:

\$2,261,484,226	Federal Funds ¹
\$383,049,300	State funds ²
✓ \$188,264,100	Other Health Appropriations (State)
\$64,649,800	Other Health Appropriations (Federal)
✓ \$50,000,000	Local Government Funds
✓ \$80,000,000	Nursing Home Tax ³
\$358,050,000	Hospital Charity Care ⁴
\$182,650,000	Physician Charity Care ⁵
\$54,800,000	Other Charity Care ⁶
\$85,356,160	Full co-pay and deductibles ⁷
\$94,560,000	Full 20 percent co-insurance ⁸
\$22,734,202	Sliding scale co-pay and deductibles ⁹
\$25,185,600	Sliding scale 20 percent co-insurance ¹⁰
<hr/>	
\$3,850,783,388	Total Funds Available

LESS:

\$67,325,000	Skilled Nursing Care
\$548,935,000	ICF - Regular
\$156,976,000	ICF-MR
\$31,520,000	Medicare-Institutional
\$41,883,000	Medicare-Professional
\$92,057,000	Medicare-Premiums
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\$938,696,000	Total Deductions
<hr/>	
\$2,912,087,388	Available for medical coverage for 1.775 million citizens ¹¹
\$1,641	Amount per capita available for medical coverage

¹Federal Funds based on \$3.4 billion total budget based on .6681% federal match

²State funds (excluding the Hospital Services Tax and the Nursing Home Tax) based on FY 94 Budget

³Nursing Home Tax is based on the existing provider tax for nursing homes.

⁴Hospital charity care based on 5% of gross revenue.

⁵Physician charity care based on 5% of gross revenue.

⁶Other charity care based on 5% of gross revenue.

⁷Full co-pay and deductibles for those above 200% poverty assuming 39.4% of the 800,000 uninsured are above 200% of the federal poverty level (based on March 1990 Current Population Survey) and the actual average co-pay and deductible for FY92 State Group Insurance Program of \$268.86.

⁸Full 20 percent co-insurance(based on \$1500 premium) for those above 200% of the poverty level.

⁹Sliding scale co-pay and deductibles for those between 100 and 199% of the poverty assuming 31.85 of the 800,000 uninsured are between 100% and 199% of the federal poverty level (based on the March 1990 Current Population Survey) and that they average 33% of the full-cost of co-pays and deductibles.

¹⁰Sliding scale 20 percent co-insurance(based on \$1500 premium) for those between 100 and 200% of the poverty level.

¹¹Assume 25,000 are covered by Medicare.

Attachment D

Requirements for TCHIP Plans

To become an eligible TCHIP health plan the following minimum requirements must be met:

- (1) Demonstrate the existence of a network of health care providers capable of providing comprehensive health care services throughout the community where it is offered, including preventive health services, primary care services, home health care services, pharmacy service, physician services and hospital services including comprehensive emergency services. Services shall, to the extent practical considering quality, accessibility and cost, be provided within the community served.
- (2) Demonstrate the capability to provide case management services and, within three years, to establish primary care physicians as gate-keepers for all health care services provided to enrollees and as the case managers for all cases warranting intensive case management;
- (3) Agree to provide such preventive health services are required by the TCHIP Board;
- (4) Agree to such other requirements as the TCHIP Board may reasonably establish; and
- (5) Demonstrate sufficient financial capital to ensure delivery of health care on a reimbursement basis.

STATE PLAN BENEFITS

	NETWORK	NON NETWORK
Deductible per calendar year	\$200 per individual \$500 per family	
per emergency room use	\$25	\$25
Co - Payment how covered expenses are shared	Plan pays 90%	Plan pays 80%
Out of Pocket Maximum using eligible expenses except for treatment of behavior disorders	\$1,000 per individual \$2,000 per family	
Lifetime Maximum Benefit	\$1,000,000 per individual	
Benefits For Behavior Disorders		
Mental Illness Inpatient	Plan pays 90%	Plan pays 80%
	Up to 45 days a year	
Outpatient	Plan pays a percentage of allowable expenses for 45 sessions per year conducted by a psychiatrist, licensed psychologist, or LCSW	
	75% of UC for first 15 sessions 50% of UC for next 15 sessions 25% of UC for final 15 sessions	
Lifetime Maximum	\$100,000 per individual	
Substance Abuse Inpatient	Plan pays 90%	Plan pays 80%
	Limited to two treatment programs no longer than 28 days each plus two 5-day detox stays in a lifetime	
Outpatient	Limited to two treatment programs of not more than \$3,000 each in a lifetime	
Lifetime Maximum	\$30,000 per individual	

Comparison of Medicaid and State Plan Benefits

SERVICE	MEDICAID BENEFIT	STATE PLAN BENEFIT
Hospital inpatient	Payment reduced to 60% of per diem after 20 days per FY Preadmission required Concurrent review	No limitation on days Preadmission required Concurrent review
outpatient	30 visits per FY	No limitation
Psychiatric Facility under 21	Preadmission required Concurrent review	Benefit limitation of 45 days per CY Preadmission required Concurrent review
21 to 65		Benefit limitation of 45 days per CY Preadmission required Concurrent review
Nursing Facility NF ICF SNF	Preadmission required	Generally not covered Generally not covered Up to 100 days following inpatient hospitalization
Physician Services outpatient	24 visits per FY	No limitation
inpatient services	20 visits per FY with transplant exceptions	No limitation
psychiatric inpatient	Corresponds to approved days	No limitation
psychiatric outpatient	Primarily through mental health centers	Reducing Benefit for up to 45 sessions
Lab & X-Ray (independent)	30 occasions per FY	No limitation
Hospice	210 days within 6 months of death	No limitation
Dental	Limitations depend on age	Generally not covered
Vision	Coverage for children	Generally not covered (limited follow-up after surgery)
Home Health Agency	60 visits per FY	No limitation

Comparison of Medicaid and State Plan Benefits

Pharmacy	7 prescriptions or refills per month	No limitation
Durable Equipment	Some require prior approval	No limitation
Medical Supplies	Covered for home use Some require prior approval	No limitation
Ambulance	Covered by court order	No limitation

Attachment F

Eligibility shall be limited to citizens who are not covered through any employer or other government sponsored health plan (either directly or through a family member) under terms and conditions existing on March 1, 1993 and those citizens meeting one of the following criteria:

1. Would have been Medicaid eligible under the Medicaid Program as it was administered during FY 92-93;
2. Eligible for unemployment compensation, without respect to weather benefits have been exhausted. ~~X~~

Eligibility shall cease when the person becomes eligible for participation in an employer sponsored plan, either directly or indirectly through a family member, or when eligibility for Medicare or other government health plan begins. However, in the event that such an individual had not enrolled in TCHIP within 90 days of initial eligibility, they would be responsible for the full amount of any premium for which they would have been responsible, for the lesser of the preceding year or back to their initial eligibility date.

Attachment G
Projected Cost of the Current Tennessee Health Care System
(Selected Calendar Years)*

Sources of Funds	Calendar Year			
	1990	1992	1995	2000
Private	\$6,166	\$7,081	\$9,217	\$13,954
Public:				
Federal	3,131	4,062	5,508	9,088
State and Local	1,397	1,847	2,489	3,918
Total, Tennessee	\$10,694	\$12,990	\$17,214	\$26,960

Projected Cost of Reformed Tennessee Health Care System
(Selected Calendar Years)**

Private	\$6,166	\$7,081	\$8,477	\$11,121
Public:				
Federal	3,131	4,062	4,864	6,386
State and Local	1,397	1,847	2,216	2,907
Total, Tennessee	\$10,694	\$12,990	\$15,557	\$20,414

Projected Savings
(Selected Calendar Years)***

Private	\$0	\$0	(\$740)	(\$2,833)
Public:				
Federal	0	0	(644)	(2,702)
State and Local	0	0	(273)	(1,011)
Total, Tennessee	\$0	\$0	(\$1,657)	(\$6,546)

NOTE: All dollar values are reported in millions.

* Source: U.T. Center for Business and Economic Research

** The rate of growth in GDP (Gross Domestic Product) is taken from the Congressional Budget Office study and applied to health costs in 1995 and 2000.

*** This is calculated as the projected cost of the current system less the projected cost of the reformed system.

TENNESSEE MEDICAID PROGRAM (TENNCARE)

Under TennCare, approximately 400,000 Tennesseans who had previously been uninsured are now covered. The managed care industry, which prior to TennCare had enrolled only about 140,000 people in Tennessee, has now grown to cover nearly all 1.2 million TennCare enrollees. These are considerable accomplishments in the space of 15 months.

QUESTION:

Does the Tennessee waiver experience confirm that states can increase their enrollments by as much as 50% within current Medicaid budget ceiling?

SUMMARY:

No. Program information to date is ambiguous and often contradictory. A federal evaluation contract will begin systematic data collection this month. But, there are strong indicators that:

- program accomplishments to date reflect Tennessee-specific and first-year effects; and
- continued operation is probably unsustainable without supplemental federal financial concessions or a paring back of the program.

Thus, it would be premature to label TennCare a success or a program worth promoting.

BACKGROUND:

First Year of TennCare

1. **Base year for the federal expenditure cap was set too high.**

Growth rate between actual data (1992) and first year of the program was over 16%. This was much higher than the national average growth between these years (approximately 9%), and was higher than the actual rates for 1993 and 1994 (prior to the demonstration).

Disproportionate share payments--over 15% of total Tennessee Medicaid payments in 1993 -- are included in the federal cap, although Tennessee repealed the hospital tax that funded its share of the program. Tennessee's DSH expenditures increased by over 200% in both 1991 and 1992.

2. **Capitation rates were set low.**

Tennessee set its capitation rates to managed care plans much lower than historical Medicaid per-beneficiary expenditures, and did not use actuarial estimates. While in most markets, providers would reject exceptionally low rates, Tennessee providers who were caring for state employees were required to accept TennCare enrollees at these low rates -- known as the "cram down".

3. **Supplemental hospital funding pools eased the transition, but have recently dried up.**

In the first year of the demonstration, Tennessee received federal matching funds for special funding pools to pay hospitals for medical education, indigent care, high-cost

cases and other expenses. In December, the state ended pool payments, explaining that it no longer had funds to sustain them. These funds served two purposes. First, they provided hospitals payments for applicants for whom capitation payments had not yet been paid. If these hospital payments were less than the capitation payments, then the state paid less than it would under a fully implemented system. Second, hospitals contend that these payments compensated for a capitation rate that are too low. These payments limited adverse effects in the first year. It is unclear what will happen with the end of these pools.

4. **Reports of access are poor.**

Implementation of the system occurred rapidly and created transitional problems for enrollees. About 45% of Tennessee's Medicaid-eligible enrollees were dissatisfied with the program.

Future of TennCare

1. **Funding problems threaten TennCare's future viability.**

Tennessee officials have indicated that there is difficulty in securing the state's share of the expenditures. Tennessee could not draw down the full amount of the federal expenditure cap in its first year of TennCare. Officials have approached DHHS suggesting that Tennessee's problem in finding the state's share of Medicaid will continue. They have asked for a block grant, in which the state would receive the full amount of federal expenditures without the obligation of matching those funds.

The state also faces federal Medicaid recoveries associated with non-compliant financing through provider donations and taxes. Both issues suggest that TennCare is underfunded, and cannot support its increased enrollment within its current budget.

A third issue is the adequacy of the capitation and their growth rates. Tennessee's budget neutrality agreement locked in high base year but low growth rates. For this reason, the GAO found in a recently released report that TennCare appeared budget neutral. The GAO assessed budget neutrality through a simple comparison to national growth rates, and did not examine state-specific trends or the size of the base year expenditures. Thus, the "front-end" adequacy of funding for TennCare may evaporate over time.

CONCLUSION:

The unique combination of a high federal expenditure cap, low capitation rates, and transitional pools allowed Tennessee to increase its enrollment dramatically in the first year of TennCare. However, these circumstances are not replicable.

- **Federal expenditure cap:** Growth rates have moderated since 1992. Consequently, the high pre-waiver growth rate in Tennessee will not be permitted in any current waiver application. Also, since the regulations controlling state funding for DSH have been implemented, no state will be able to include high federal DSH payments in its waiver baseline.

- **Capitation rates:** Greater attention is being paid to actuarial soundness of capitation and health care provider payment rates. In addition, states must show evidence of a dialogue with providers, which was missing in Tennessee. This makes it unlikely that another waiver can be approved with questionable capitation rates.

Additionally, it is uncertain whether the TennCare program is sustainable after its first year. The end of the transitional pool plus the signals from state officials that they are experiencing financing problems indicate that TennCare may not in fact be a viable program.

Given the unique circumstances of the first year of TennCare and its questionable future, it cannot be concluded from Tennessee that states can significantly increase their enrollment within their current budget ceiling.

A Medicaid Miracle?

Tennessee is drawing national attention for an overhaul of its Medicaid program that greatly expanded coverage while putting a lid on state spending. But the reforms have sparked plenty of controversy at home.

BY STUART SCHEAR

NASHVILLE—While the debate over comprehensive health care reform lumbered on in the nation's capital last year, Tennessee finance and administration commissioner David L. Manning gambled with his state's health care system and his career. Manning set up TennCare, a program with two seemingly contradictory goals: expanding Medicaid coverage for the poor and disabled while capping state spending on the program.

In some respects, the gamble paid off. Within a year, Manning extended coverage to an additional 418,000 Tennesseans, channeled recipients into cost-conscious "managed care" plans run by private companies and established a firm limit on Medicaid spending.

But Manning's policies and tactics—particularly an alliance that he forged with consumer activists and the state's largest insurer—so rankled Tennessee's doctors that Republican Don Sundquist, who was elected governor on Nov. 8, made a campaign pledge to replace him. TennCare will survive his departure, though, and its track record has already become the subject of a debate among would-be reformers from other states.

As the prospect of comprehensive national health care reform fades, the focus has shifted to the states. And for many states, fixing Medicaid is a top fiscal priority. The joint federal-state health insurance program is breaking state budgets across the nation. Costs skyrocketed during the late 1980s and early 1990s; in 1993, the federal and state governments spent \$131.8 billion on Medicaid, up from \$54.3 billion only five years earlier. In Tennessee, the annual increases topped 20 per cent. Although the increases have moderated somewhat, cash-strapped governors are still demanding savings.

Reforming Medicaid has bipartisan appeal; Republican governors have placed it close to the top of their post-election wish list. And Medicaid reform is one of the few arenas in which the White House still wields power to reshape the health care system: states wishing to overhaul their Medicaid programs must ob-

tain waivers from the federal Health Care Financing Administration (HCFA). (For details, see box, p. 298.)

Increasingly, would-be Medicaid reformers are turning to the managed care models now dominating the private sector. These range from preferred provider organizations (PPOs)—networks of doctors and hospitals working for discounted fees—to traditional health maintenance organizations (HMOs) that use "gatekeeper" physicians to direct patients' care.

Dozens of states have introduced managed care into their Medicaid programs; according to the Health and Human Services Department, 23 per cent of the nation's 34 million Medicaid beneficiaries were enrolled in some kind of managed care plan in 1994, up from 14 per cent the year before. But Tennessee, which received a five-year waiver from HCFA to operate TennCare as a demonstration project, has the nation's most aggressive and farthest-reaching program.

After months of negotiations, HCFA gave Tennessee the go-ahead in November 1993. On Jan. 1, 1994, the state began moving its nearly 900,000 Medicaid enrollees from the old fee-for-service program into managed care plans and started expanding coverage to the previously uninsured. A year later, all former Medicaid enrollees and another 418,000 people—the vast majority of all Tennesseans who lacked health coverage a year earlier—were covered by TennCare plans. The program grew so rapidly that the state froze open enrollment of the uninsured working poor in January 1995 to ensure adequate funds to cover those already enrolled.

Everyone agrees that the pace has been breathtaking. "You can probably implement programs like this faster than we had thought possible, but not as fast as Tennessee decided to do it," without encountering serious disruption, HCFA administrator Bruce C. Vladeck said in an interview.

Tennessee "created a number of enemies" by moving so quickly, said Sara Rosenbaum, co-director of the George Washington University Center for Health

"We're in for a battle," Rep. Jim Ramstad, R-Minn., a former Judiciary Committee member who helped to draft the language in the GOP contract, said. "The trial lawyers will pull out all the stops to protect the status quo."

But trial lawyers and consumer groups may not be the main reason the legal reform plan faces trouble. The business coalitions created to lobby for various parts of the package are split over strategy and tactics. The Product Liability Coordinating Committee, a business coalition, favors a bipartisan bill that can pass Congress and be signed by Clinton. An overly broad bill could kill the best chance for product liability reform in years, the group argues.

But other business lobbyists maintain that the Republican sweep in November has created a mandate for broad-scale legal reforms that could never have passed a Democratic-controlled Congress.

The provision that would require the losers in some federal lawsuits to pay the winners' legal costs—a rule that is followed in English courts—already appears to be dead. "It's probably the most highly controversial part of the bill," Ramstad said. "A lot of us won't fall on our swords over that."

CONSERVATIVE AGENDA

The Contract With America will keep the Judiciary Committee busy at least through March. But Hyde and his subcommittee chairmen intend to pursue an aggressive conservative agenda once they finish work on the contract.

Justice Department oversight is a certainty. The hearings, Hyde said, "will be thorough."

Clinton Administration officials can expect to be grilled about the war on drugs, which, McCollum complained, "is not going the way it should."

Moreover, the Republicans will challenge the Administration's strong support of affirmative action. A major target will be the Justice Department's recent efforts to counter bank redlining and its reversal of the Bush Administration's policy in a controversial reverse-discrimination case involving a white schoolteacher in Piscataway, N.J. (See *NJ*, 12/3/94, p. 2830.)

"These are just two examples of the way the current Administration is reaching to the outermost points of the galaxy on making quotas the operative principle of civil rights enforcement," Hyde thundered at Jan. 20 briefing on affirmative action. And during an interview, he asked, "How long are we going to labor under the notion that because of what happened in the 1800s, before the Civil

A FLY IN THE OINTMENT?

During his 20-year career on Capitol Hill, Rep. Henry J. Hyde, R-Ill., has had a well-earned reputation for probity. But Hyde is also the only Member of Congress who's been sued by the Resolution Trust Corp. (RTC).

In 1993, the RTC accused Hyde of breach of fiduciary duty, gross negligence and mismanagement for his role in a \$17.2 million loss at the Clyde Federal Savings and Loan Association in North Riverside, Ill., which failed in 1990. Hyde was a director of the thrift from 1981-84, collecting a fee of \$300 a month during at least part of that period.

Hyde has repeatedly denied any wrongdoing. David H. Baris, the executive director of the American Association of Bank Directors, said that the RTC's complaint against Hyde is based on a single loan approved by an advisory committee at the thrift.

The RTC's suit generated little adverse publicity for Hyde until he was thrust into prominence when he became the new chairman of the Judiciary Committee following the GOP's takeover of Congress. Accounts of Hyde's legal trouble have appeared recently in several magazines, including the *American Banker*, *Crain's Chicago Business*, *In These Times* (a Chicago-based liberal weekly) and *The New Republic*.

Democrats on Capitol Hill have said little about the suit against Hyde. According to congressional sources, Democrats and Republicans remain reluctant to bash one another over an S&L crisis that tarred lawmakers in both parties. But some Democratic aides cautioned that Hyde's role in the collapse of Clyde Federal Savings, which cost taxpayers \$67 million, could become an issue once Republicans start hearings on President Clinton's involvement in the collapse of an Arkansas thrift that is at the center of the Whitewater investigation.

Settlement discussions between the RTC and lawyers for the 11 defendants in the case have stalled. Hyde's attorney has asked the U.S. District Court for the Northern District of Illinois to dismiss the case. Recent appeals court decisions have made it harder for the RTC to win cases against outside directors.

An unanswered question is how Hyde intends to pay his lawyers. House rules preclude Hyde's lawyers from offering their legal services as a gift. In a recent interview, Hyde said that he doesn't even know the amount of his legal fees. "How would I have any idea what they are?" he asked. The lawyers "are going to submit a bill when the case is over."

Hyde has obtained the permission of the House Standards of Official Conduct (Ethics) Committee to set up a legal defense fund. Under House rules, lawmakers can use campaign contributions to pay legal bills. Hyde's campaign disclosure forms show that he had \$140,000 left over from his 1994 reelection campaign.

Hyde said that he's put \$10,000 in an escrow account as a retainer to pay his lawyers. "Hopefully," he said, "I will get some of it back."

War, my children and my grandchildren must continue to pay for it because they are white?"

The Legal Services Corp., which liberal lawmakers have long defended from conservative attacks, can also expect some rough sledding before the Judiciary Committee. "I don't see the federal nexus between some woman with four kids being evicted from her apartment who is unable to pay for a lawyer," Hyde said. Local governments, bar associations, public defenders and lawyers doing pro bono work should handle these types of cases, Hyde suggested.

Despite his reputation as a fierce opponent of abortion rights, Hyde said that he's been too busy so far to meet with anti-abortion groups, mainly because of the pressures created by the GOP contract.

Once the committee finishes "the big-ticket items" in the contract, Hyde said, he will study what can be done "to save unborn children."

High on his list are limits on fetal experimentation and restoration of the "gag rule"—imposed by the Reagan Administration, maintained by the Bush Administration and lifted by the Clinton Administration—that barred doctors at clinics getting federal aid from providing abortion counseling.

But even the abortion issue must wait. His first commitment is helping the Republicans get the contract to the House floor. Hyde's allies predict victory. Hyde got this job, Rep. Coble emphasized, "because nobody is going to push him around."

More than 50 years ago, Hyde proved it. Jusk ask George Mikan. ■

Policy. Doctors complain that they have been coerced into treating TennCare patients; hospitals and community health centers say that the program has placed them in a dangerous financial squeeze. These groups have filed a flurry of lawsuits against TennCare and are lobbying hard in the state capital to revamp the program. Sundquist appears receptive to many of their arguments.

And TennCare will be under growing pressure to rein in costs. Under its agreement with HCFA, the state got a hefty increase in federal medicaid funds during TennCare's first year. But increases in federal spending are to be sharply restricted during the next four years of the program. And if TennCare's total costs exceed \$12.16 billion over five years, HCFA will not help pay for the excess. (Now, federal funds cover about two-thirds of TennCare costs, and the state picks up the rest.)

There are signs of trouble already: On Jan. 30, the Sundquist administration announced that TennCare ran a \$99 million deficit during its first year.

TURKEYS AND LIFE INSURANCE

To get TennCare up and running, state officials pooled their medicaid funds—including special payments to hospitals serving the poor—with other state and federal funds dedicated to public health services. The consolidated \$3 billion budget was used to pay for expanded coverage and to gain enough leverage in the market to wring out deep discounts in the fees charged by providers.

TennCare expanded coverage to include low and moderate-income people who previously were uninsured, as well as "uninsurable" people with preexisting medical conditions. And by all accounts, it drove down the price of care.

At the center of TennCare's structure are 12 managed care organizations, known as MCOs, that provide care to all enrollees. The MCOs, which vary in size and structure, have established networks of participating health professionals, hospitals and clinics. Two operate statewide; the others serve regional markets. Each must provide a standard package of benefits mandated by the state, including prescription drugs, in exchange for a fixed annual payment from the state for each enrollee.

TennCare's goal is to "empower consumers," Manning said, by letting them choose an MCO. Once a year, there is an open-enrollment period during which they may switch plans. That, Vladeck said, is consistent with the principle of "managed competition," allowing consumers to vote with their feet if they are dissatisfied with the care they are getting.



Stuart Scheer

David L. Manning, Tennessee's finance and administration commissioner, so rankled the state's doctors in setting up the program that the new governor made a campaign promise to fire him. Manning is unapologetic. "I plead guilty to managing costs," he said.

During the initial sign-up period last year, MCOs offered potential enrollees incentives ranging from fresh turkeys to \$10,000 life insurance policies. Dr. Russell Adcock, a family physician in the small town of South Pittsburgh who sees many TennCare enrollees, said that these goodies enticed many of his patients to sign up for plans that didn't serve them very well. State authorities responded by issuing rules to limit such incentives.

How well is TennCare working for patients? Trips to doctor's offices, clinics and hospitals serving low-income patients turn up contradictory information.

Jeremy Nance, a quadriplegic 16-year-old from rural central Tennessee, has been a winner. Jeremy, who is confined to

a wheelchair and breathes with the aid of a respirator, was disabled in a car accident nearly seven years ago. His private insurance ran out; his multiple surgeries and ongoing rehabilitation cost far more than the \$1 million limit under his family's policy. TennCare now covers all his care.

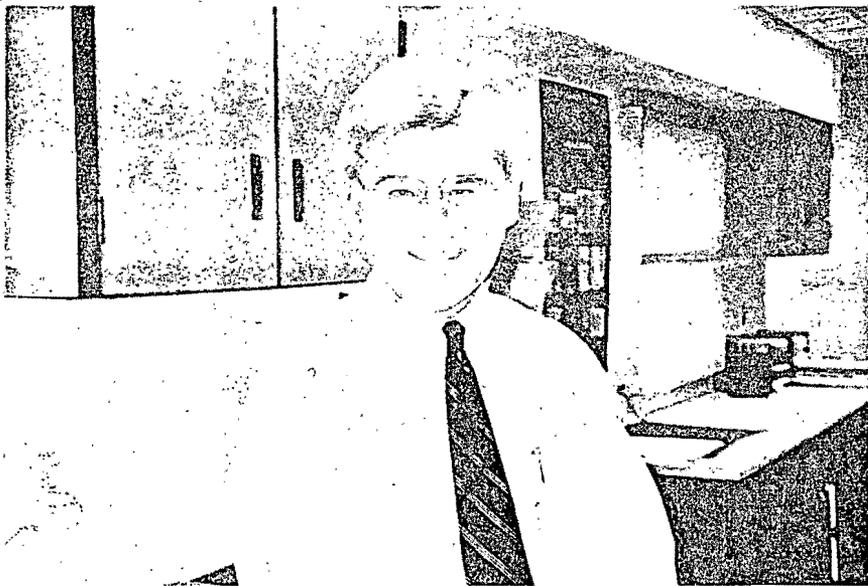
But the program's cost-consciousness proved nearly fatal for Mary Milburn, an elderly woman in Nashville. Milburn, who had been successfully treated for high blood pressure under medicaid, discovered that her MCO would not pay for her expensive medicine and was forced to take another medication. Her blood pressure shot up and down, causing several visits to the local hospital and a couple of close calls with death.

Despite TennCare's promise that every MCO provides essentially the same care, clear disparities exist. In the waiting room of a Memphis clinic for people infected with the AIDS virus, a young man reports that his MCO consistently provides him with everything his doctor has ordered, including 10 prescription medications. But a man sitting next to him complains that his MCO won't approve the only drug he needs at the moment: a new antidepressant.

The greatest gap between TennCare's

legal aid lawyer in Nashville who has sued the state dozens of times over expanding access to health care for the poor, said that fixing TennCare's problems is "simply a function of time and political will."

And the Tennessee Health Care Campaign, a coalition of advocacy groups that operates a state-financed telephone hotline to help Tennesseans navigate the new system, reports that the volume of calls has dropped markedly in recent months and that many callers' problems are easily resolved.



Stuart Scheier

Tennessee Medical Association vice president Warren McPherson: TennCare's policies are so coercive that doctors have become "state employees."

promise and its performance results from the unpreparedness of its provider networks. In the intensive care unit of the Regional Medical Center in Memphis, a man tells how his son was injured in a car accident. The son, in his mid-30s, was already disabled from severe diabetes and was covered by an MCO. But when he was taken from the scene of the accident to a nearby hospital, it would not admit him because no doctor affiliated with his MCO was on staff. The operator on the MCO's toll-free line told the father to transport his son to a hospital 100 miles away.

There have been administrative snafus, too. Annie Watkins, a longtime employee of a Memphis hospital, enrolled her grandparents in an MCO formed by the hospital. But her grandparents received a letter of acceptance from another MCO that they hadn't applied to join. And they were sent membership and billing cards by yet another MCO. Now Watkins is not certain where they should seek care.

Despite such complaints, Tennessee officials say that TennCare's framework is sound and that its problems can be resolved. Gordon Bonnyman, a veteran

"If enrollees call MCOs, they often don't know the buzzwords and what will work," said Patricia Whitewell, a patient advocate who works with the hotline. "You have to know how to cut through." Patient advocates often speak directly with the MCO staff and sometimes file appeals with MCO medical directors. If they aren't satisfied with the response, they can file a complaint with the medical director of the state's TennCare bureau, the final arbiter of disputes. Only 26 such cases arose during TennCare's first year.

MCOs are budget-driven. The state pays a flat fee, averaging \$1,507 annually, for each enrollee. The MCO is expected to economize by negotiating discounted fees with doctors and hospitals and squeezing out unnecessary care. If an MCO fails to live within its budget, the doctors and hospitals affiliated with it must accept reduced payments. State officials say that under TennCare, non-emergency visits to emergency rooms by poor people have dropped by close to 40 per cent, and that the amount of inpatient care has declined.

The state recognizes that some plans may attract an unusually large number of

high-cost enrollees, such as patients with cancer or the AIDS virus. The state has set up a \$40 million account that can be drawn upon to ease the burden on any MCO that has enrolled a disproportionately large number of patients requiring unusually expensive care. No payments are to be made from the account until HCFA approves the state's method for deciding which plans deserve aid.

A BOON FOR THE BLUES

Some MCOs operate as HMOs, requiring their members to select a primary care physician who oversees their care. Others function as PPOs, looser networks of health professionals who are willing to accept discounted payments in exchange for a guaranteed flow of patients.

The quality of the MCOs is uneven. One of the two statewide plans, Access Med Plus, is notorious for requiring patients to travel long distances to see physicians and for being slow in making payments to physicians and hospitals. While some MCOs seem to function well in regional markets, TennCare's anchor has been Tennessee Preferred, a statewide PPO put together by Blue Cross and Blue Shield of Tennessee.

Finance commissioner Manning knew that a statewide network was essential to TennCare's success. Realizing that starting from scratch would be impossible, he turned to Blue Cross, the state's largest insurer. Several years earlier, Manning and Blue Cross officials had worked together to build the Tennessee Provider Network, a PPO for state employees.

But, in a move that still angers many Tennessee doctors, Blue Cross told doctors in the Tennessee Provider Network that if they wished to continue participating in that plan, they would have to take TennCare patients.

Doctors quickly dubbed that requirement the "cram-down" rule. Some doctors feared that the presence of medicaid patients in their waiting rooms would scare away private patients. Many, including Tennessee Medical Association vice president Warren McPherson, argued that the policy was so coercive that it made doctors into "state employees."

Rather than accept TennCare patients, nearly half of the 7,000 providers in Blue Cross's private network (which serves 220,000 state employees and one million other customers) dropped out of both plans. Mayhem ensued; many of Blue Cross's TennCare patients, as well as middle-class patients in its private plan, had trouble finding doctors.

But Blue Cross stuck to its guns, and in time, providers began to make their way back into both networks. Doctors discov-

ered that they could not maintain their practices without conducting business with the state's largest insurer. By August, Blue Cross had regained virtually all of its original network.

Blue Cross's steadfastness was hailed by consumer activists who wanted equal treatment for the poor. But Blue Cross senior vice president Glen Watson said that although the company believes in taking all comers, the decision was based on business considerations. According to Watson, Blue Cross determined that it could deliver care and thrive financially within TennCare.

Some observers conjecture that Manning played hardball, telling Blue Cross that its continued participation in the state employee plan might hinge on its cooperation in TennCare. Others argue that Blue Cross needed no prodding because it viewed TennCare as an opportunity to increase its market share. Blue Cross has captured 50.6 per cent of the TennCare market. A Nashville health lobbyist, who didn't want his name used, said that providers fear Blue Cross's growing power, viewing it as tantamount to that of a state single-payer system.

The most rancorous opposition to Blue Cross's role has come from the Tennessee Medical Association. In sharp contrast with the American Medical Association, which initially was receptive to comprehensive national health reform, the state association immediately took a firm stand against TennCare. The doctors' group used a lawsuit, intense lobbying, political campaigning and a public relations drive to try to weaken, delay or stop TennCare.

Although its lawsuit stalled in the state courts, the association's political strategy was more successful. Its political action committee and an overwhelming majority of its members contributed heavily to the campaign of Gov. Sundquist, who is establishing a committee to review TennCare. According to an aide, Sundquist has no plan to scrap TennCare but wants to "fix" it. He has promised to end the cram-down rule and "wants to bring providers to the table," the aide said.

PUSHING FOR CHANGES

Even TennCare's sharpest critics concede that it is here to stay. The action now centers on reengineering the program. Some of the same health care interest groups that lobbied heavily in Washington last year are now at work in Nashville, pressuring Sundquist's administration to change TennCare according to their specifications.

The insurance and hospital lobbies, often at odds with physicians, have found common ground with the Tennessee

Medical Association. All three groups complain that the state's annual payments to MCOs are too low.

Sundquist has promised a review of the rates, but if he decides to increase them, he would probably have to slow down enrollment in TennCare or reduce the services that enrollees receive. (He has ruled out any tax increase to raise revenues for the program.)

Manning, a budget hawk, forged an unlikely alliance between consumer advocacy groups and the administration of

Under TennCare, the payments ended; instead, the funds were used to pay MCOs to provide coverage to the uninsured.

Manning reasoned that hospitals would benefit because patients who enrolled in MCOs would be less likely to visit hospital emergency rooms for routine care. He and other state officials also set \$100 million aside in a transition fund that could continue to make some payments to hospitals to cover their care of the uninsured.

But the situation for some hospitals is more complicated. Consider the Regional



Legal aid lawyer Gordon Bonnyman
TennCare has hurt some hospitals and clinics. But more people are getting care.

Sundquist's predecessor, moderate Democrat Ned R. McWherter, whose top priority was avoiding a looming state budget shortfall. Tony Garr, executive director of the Tennessee Health Care Campaign, said that McWherter helped keep opposition in the legislature at bay. Twenty bills were introduced to break up Blue Cross's network, Garr said, but McWherter made sure they never got out of committee.

Now, consumer advocates are worried. Garr said he fears that the state will no longer support the advocacy phone line. As for the new governor's commitment to end the cram-down rule, Garr said, "Sundquist made a promise to the [Tennessee Medical Association] that he would break up the network, but one of the admirable things about TennCare was that the poor could see the same doctors" who cared for middle-class patients.

Hospitals and community health centers that have traditionally provided care to the poor are also pushing for changes. Until last year, 126 Tennessee hospitals received special payments from HCFA to help compensate them for treating a disproportionate share of uninsured patients.

Medical Center in Memphis, known locally as the Med. Until recently, virtually all of the area's poor came to the Med, which has a policy of accepting all comers. Although many of the Med's patients are now covered by TennCare, their MCOs pay the hospital far less than it received for treating Medicaid patients in the past. MCOs also refuse to cover some services that Medicaid once paid for routinely.

What's more, hospitals complain of patient dumping by MCOs. For example, officials at the Med say that Access Med Plus has directed its patients to the Med even though the hospital is not part of the MCO's network.

Charlotte Collins, the Med's senior vice president for policy and chief legal counsel, said that the hospital has been forced to eliminate 250 of 2,800 staff positions, primarily because of TennCare. She bristles at Manning's argument that hospitals such as the Med must learn to compete in the market. Nonetheless, Collins has helped the Med form its own MCO.

TennCare has also placed competitive pressures on Tennessee's federally financed community health centers. They complain that MCOs pay them far too lit-

Stuart Scheer

USHERING IN REFORM THROUGH THE BACK DOOR?

Tennessee is far from alone in its endeavor to revamp Medicaid. Six other states—Florida, Hawaii, Kentucky, Ohio, Oregon and Rhode Island—have won waivers from the Health Care Financing Administration (HCFA) to enlarge their Medicaid programs and in many cases to steer participants into managed care systems. HCFA recently gave South Carolina a tentative approval, and nine more applications are pending.

With at least a dozen other states contemplating similar requests, policy makers are beginning to wonder whether the waivers, which are supposed to let states operate short-term demonstration projects to test theories about Medicaid efficiency, aren't bringing about a fundamental restructuring of the program that merits a closer look in Washington.

"When you have a million and one demo projects, they're no longer demo projects," said Rep. Michael Bilirakis, R-Fla., who chairs the Commerce Subcommittee on Health and the Environment, which has jurisdiction over Medicaid. Congress will have to make a broader policy decision about the future of Medicaid, Bilirakis said.

Should Medicaid be expanded—and if so, how? Can the costs to the federal and state governments be controlled? Should states be allowed to force recipients to enroll in managed care plans?

With congressional Republicans eyeing Medicaid cuts to help finance deficit reduction, those questions may have to be addressed soon. The Senate Finance Committee has already begun discussions about reforming Medicaid in the context of welfare reform, a top priority for the GOP.

For now, many in the Administration and Congress want to continue granting waivers to states to encourage them to experiment. Judith Feder, the principal Health and Human Services deputy assistant secretary for planning and evaluation, said it doesn't matter whether the state programs are real demonstration projects, as long as the results are positive. "States are making use of the process for a wide array of activities," she said. The Administration is considering restructuring the waiver process, though.

But Bilirakis questioned why states should have to obtain federal waivers if they want to expand coverage and save money at the same time. He favors giv-

ing states Medicaid block grants to use as they wish.

Gov. Howard Dean, D-Vt., the National Governors' Association chairman, said that he and other governors are talking with the House Republican leadership about legislation that would do away with the waiver process.

The waivers now are granted for five years, during which HCFA may pay a state more for Medicaid than it paid previously. But at the end of five years, HCFA will stop paying for recipients who were added to the rolls during the demonstration project. The question is whether states by then will have realized enough savings from managed care to pay for the expanded coverage.

Members of the Physician Payment Review Commission, which advises Congress on physician reimbursement under Medicaid, have suggested that Congress should examine the issue more closely. "This one here is a large political question," said Princeton University professor Uwe E. Reinhardt, a commission member. "If we expand the waiver authority beyond research, is this a backhand way of reforming Medicaid?"

—Marilyn Werber Serafini

tle for their services. Alarmed that other states will follow Tennessee's example, the National Association of Community Health Centers is suing the federal government to halt the Medicaid waiver program under which TennCare and six other state programs are operating.

James Feldesman, the association's counsel in Washington, said that community health centers are trying to form a national network that could compete effectively with commercial insurers in caring for Medicaid patients. Building such a network will take time and capital, though, and the centers need federal aid to survive the newly competitive market engendered by Medicaid reform, he said.

Feldesman noted that President Clinton's proposed Health Security Act would have furnished community health centers and other "essential community providers" with the kind of protection that HCFA has refused to grant them in Medicaid reform: a five-year transition period. When it comes to health care reform, he said, Medicaid waivers are now "the only game in town, and . . . we would like to be given a chance to win."

Legal aid lawyer Bonnyman, who has filed an amicus brief opposing the com-

munity health centers' lawsuit, acknowledges that TennCare has hurt some institutions that traditionally cared for the poor. But, he said, a more important point is that TennCare is covering hundreds of thousands of previously uninsured people.

Still, the reaction of health care providers remains a big stumbling block for TennCare, and their political influence appears to be growing. The Tennessee Medical Association's McPherson denounced TennCare as "managed costs and not managed care;" Collins of the Med. ordinarily no friend of the doctors' group, called TennCare "fiscal reform and not health reform."

"I plead guilty to managing costs," finance commissioner Manning responded. "I don't mean to be critical of health care providers. They just responded to the bad incentives that were out there. . . . We believe that the health care system has far too long been organized and judged by the levels of satisfaction providers have had with the system as opposed to consumers. . . . We want to make sure that consumers are served by the system."

James Blumstein, a Vanderbilt Univer-

sity law professor who has been a leading advocate of health care market reforms, contends that providers' complaints are proof that TennCare has brought real reform. "The old view was that there was a single right way to deliver care, and that was an old-fashioned and very paternalistic view," he said. "The bottom line on TennCare is that it is changing the way services are delivered."

Rosenbaum of George Washington University takes a more critical view. "It is never possible to make change without making a lot of people angry," she said, but "it is my sense from some of the architects of TennCare that they hate health care providers."

Bonnyman remains optimistic about TennCare, although he warns that the state's "political will" is essential to its continued success. "Squirreled away in Dogpatch, U.S.A., this state has covered 400,000 people," he said. "Now, one state in the country has the possibility of tying its spending to the health needs of the public—what a radical concept!" ■

Stuart Schear is a media fellow of the Henry J. Kaiser Family Foundation, which financed his travel for this article.

June 12, 1995

TO: Carol Rasco
FR: Diana Fortuna
CC: Jeremy Ben-Ami
Chris Jennings
Jennifer Klein



Attached FYI is a summary on the status of TennCare that HHS did
at our request.

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DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

The Administrator
Washington, D.C. 20201

To: Carol Rasco

From: Bruce Vladeck

through Chief of Staff KJ

Date: June 5, 1995

Re: TennCare

Following is an update on Tennessee's Section 1115 Medicaid demonstration, TennCare. Please do not hesitate to call me if you have any questions or if you would like additional information.

THE TENNESSEE EXPERIENCE

Purpose

At a recent meeting, you asked for an update on Tennessee's approach to health care reform under the section 1115 Medicaid demonstration, known as TennCare. Under TennCare, the State has expanded coverage to about 400,000 formerly uninsured individuals, replaced a fee-for-service Medicaid program with Statewide managed care, and it appears to have done so by spending less than was allowed under the budget neutrality limits established under the demonstration.

Background

On November 18, 1993, HCFA approved Tennessee's health care reform demonstration project, TennCare, and implementation began on January 1, 1994. The program provides health care benefits to Medicaid beneficiaries, uninsured State residents, and those whose medical conditions make them uninsurable. Enrollment is capped at 1.4 million. All enrollees are served in capitated managed care plans that are either HMOs or PPOs.

The demonstration proposal was an ambitious plan to increase coverage to about 500,000 new individuals, reduce payments to providers, provide managed care plan choices to beneficiaries, and use State employees' networks of providers to serve these low income individuals. Under the five-year demonstration, the State agreed to limit the aggregate expenditure growth in its Medicaid program to percentages ranging from 8.3 percent in the first year to 5.1 percent in the last year. Prior to the demonstration, the State's annual rate of growth in Medicaid expenditures was averaging close to 24 percent.

Expansion of Coverage

In the first year of implementation, Tennessee has provided coverage for about 400,000 formerly uninsured individuals. Former Governor McWherter and State staff had as a goal increasing total insurance coverage in the State to over 95 percent. Implementing TennCare has put coverage in that range. One year after implementation, a survey of TennCare enrollees indicates that 80 percent are satisfied or highly satisfied with TennCare. Further, 92 percent of formerly uninsured TennCare enrollees rated their care under the TennCare program as the same or better, compared to only 55 percent of former Medicaid beneficiaries.

We cannot assess at this time whether access and quality have improved or worsened for low income individuals under TennCare. The State has been slow to provide person-level encounter data, making it impossible to evaluate the performance of individual plans or TennCare as a whole. Advocacy groups, which supported implementing TennCare, have expressed concerns about a failure on the part of many managed care organizations (MCOs) to provide adequate appeals mechanisms and to allow plan

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changes for good cause. Early in TennCare, some MCOs had difficulty recruiting adequate numbers of physicians, and problems remain with some categories of providers and in some areas of the State. Because the State has had difficulty with financing services, it froze new enrollments at the end of calendar year 1994, below its demonstration enrollment cap of 1.4 million.

Because of the short timetable for implementation, beneficiaries had to make plan selections before many physicians had made firm commitments to individual plans. Beneficiaries, providers, and health plans have been confused about enrollment procedures and payment of premiums. The State has recently informed HCFA that it has disenrolled more than 11,000 families from TennCare for non-payment of premiums.

Expenditure Levels

o *Budget Neutrality Limits*

State spending under TennCare appears to be lower than anticipated and below the budget neutrality limit, although we do not have reliable expenditure data at this point. While this apparently lower spending is due in part to a 25 percent reduction in provider payments, it also reflects the fact that the base year is probably higher than it would have been had we been able to account fully for legislative changes limiting disproportionate share hospital (DSH) payments. These changes were enacted after Tennessee's proposal was submitted to the Department. At the time we approved the TennCare demonstration, we were not able to compute the impact of the changes on the baseline and allowed Tennessee to include high DSH expenditures in its base year when determining budget neutrality limits. The State's DSH payments before provider taxes were \$70 million, but rose to about \$440 million in the years just prior to TennCare.

HCFA did not make two adjustments in DSH expenditure projections that would have had an impact on the TennCare baseline:

First, HCFA did not reduce the base year to account for potentially impermissible provider taxes. At the time, HCFA could not determine whether Tennessee's provider taxes would continue to be permissible under the law prohibiting certain tax schemes. Also, if the taxes were found illegal, it would have been difficult to estimate what the effect of the loss of provider tax revenues would be on Medicaid spending. Tennessee has since eliminated one provider tax and HCFA is in the process of making a final determination on a second tax.

Second, HCFA did not adjust the base year to reflect impermissible DSH payments resulting from provisions limiting DSH payments resulting from provisions in the Omnibus Budget Reconciliation Act of 1993 (OBRA 93). The OBRA 93 provisions limiting DSH payments to hospitals to the amount of uncompensated care incurred by each hospital had not yet gone into effect.

o *Financing Difficulties*

As part of TennCare, the State discontinued its DSH program and used those funds to make capitation payments for new eligibles and set up a fund for supplemental payments to providers. However, as under regular Medicaid, a State's ability to draw down federal matching funds is dependent on its being able to come up with its State share. So even though the base year spending for TennCare was high, the elimination of provider tax schemes and DSH payments affected Tennessee's ability to maintain this level of financing.

Tennessee still has difficulty coming up with the State share for program expenditures and has made several requests for HCFA to approve mechanisms that would generate federal matching funds by substituting other sources of funds for the State share. In its original demonstration proposal, Tennessee requested a block grant at an amount that would have continued to provide federal funds at the rate they flowed to Tennessee when provider taxes were used to effectively lower the State share. When the block grant approach was denied, the State proposed using as State share a combination of State appropriations and other innovative sources of State matching funds, such as certified public expenditures (CPE), TennCare premiums, and local government funds. HCFA agreed to match CPE and capitation payments, while allowing the State to retain the premiums it collected.

The State has also had difficulty collecting premiums from enrollees. Initially, the lack of an enrollment system prevented collections for the first six months of the program, then an oversight by a contractor resulted in failure to send 80,000 premium notices. The lower level of premium collections has further exacerbated the State's difficulties in financing TennCare.

o *Request to Reinstate its DSH Program*

Since the CPE methodology and premium collections have not yielded the expected level of federal matching funds, the State has recently indicated that it would like to reinstate a DSH program to take advantage of the OBRA 93 provision that permits DSH payments up to 200 percent of a public hospital's uncompensated care costs, until June 30, 1995. Tennessee would use an intergovernmental transfer from two counties to provide the State share of the DSH payment and therefore be able to obtain additional federal dollars without using new State funds. After July 1, 1995, OBRA 93 rules will restrict the amount of DSH payments to 100 percent of uncompensated care costs, thus limiting the continued use of this mechanism.

Implementation Issues

The State moved quickly to secure demonstration approval and to implement TennCare. Tennessee did not, however, provide an opportunity for broad public participation in the

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development of the demonstration proposal. Advocacy and provider groups supported the plan, but many say that they did so out of concern that the alternative would be reductions in the benefits package and in provider payments. Prior to implementing the demonstration, the State's Medicaid program had almost no managed care experience. The State moved aggressively to qualify plans and to run the enrollment process for beneficiaries. To ensure that a sufficient number of physicians would participate, the State persuaded Blue Cross/Blue Shield (BCBST) of Tennessee to modify existing contracts with its preferred providers to require participation in TennCare. The State's power to do that resided in its State employee contract with BCBST. Providers are infuriated with this requirement, referring to it as the "cram down provision." Although some physicians and hospitals initially refused to join, many have now signed contracts with TennCare.

MCOs have begun to complain about losses in TennCare. Both of the Statewide plans, which together cover 73 percent of the population, have experienced financial difficulties. BCBST, a PPO, recently announced to the Governor's TennCare Roundtable that it lost \$8 million during the first year, and hinted that its continued participation is in jeopardy. Public hospitals have been deeply affected by TennCare's termination of both medical education and DSH payments. The Regional Medical Center in Memphis, for example, may face a loss of up to half the \$50 million it received in TennCare supplemental pool payments for the first State fiscal year of operation. Meharry-Hubbard hospital is also experiencing financial strain due to TennCare. Public employees' unions are concerned about possible layoffs of hospital employees unless more funding can be provided to the hospitals. Although the focus is on payments under TennCare, the implications for the State's larger health care system are significant. Problems faced by Blue Cross/Blue Shield of Tennessee and the public hospitals will affect access to care in Tennessee beyond the TennCare population.

Federal Stewardship

The Federal government has played an active role in overseeing and monitoring TennCare, as it does with all 1115 demonstrations, and has let a contract to evaluate TennCare and all other operational demonstrations. We are currently awaiting expenditure data from the State to be able to evaluate the budget neutrality of the demonstration to date. HCFA continues to work with the State to improve its encounter data reporting system in order to better monitor quality and access of care provided by the MCOs. HCFA also has delayed approval of the State's request to expand its managed care delivery system to cover special populations, such as the severely and persistently mentally ill and the mentally retarded/developmentally disabled. These populations will remain in the State's fee for service Medicaid program until HCFA is assured that the State has the provider capacity to serve them through managed care and has addressed some of the operational problems in TennCare. Finally, HCFA has committed itself to working with the State on the long term financing of the program to ensure that TennCare remains a viable program in the future.

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Implications for Other States

Tennessee has achieved some of its initial goals to enroll large numbers of uninsured in its demonstration and in having a broad spectrum of plans and providers participating, despite funding constraints. Both federal and State governments have learned a great deal about enrollment processes, beneficiary information, and the steps needed to implement a change of the magnitude Tennessee has pursued. Tennessee also has involved advocacy organizations in monitoring access in TennCare in a way that has helped the program through its disruptive first 18 months.

We believe that some important elements of the TennCare demonstration approval are unique and would be difficult for other States to implement. Tennessee agreed to an aggregate, fixed budget over the five years, with lower than nationally projected growth rates, something that few States are willing to risk. The demonstration also has an unusually high reliance on non-appropriated sources of funds to make up the State share. In addition, Tennessee is unique in that budget neutrality for the five year demonstration was computed before adjustments could be made to account for OBRA 93 changes that affected use of DSH in Medicaid programs.

Since TennCare was implemented, HHS has adopted public notice guidelines that would have States make available waiver proposals before they are submitted for approval. This broader public participation pre-submission makes it unlikely that other States could replicate the "cram down provision," to coerce providers' participation.

While the Tennessee Medicaid program has been dramatically altered under the 1115 demonstration, it is still in transition. Governor Sundquist supports TennCare and has taken some action to strengthen it. A new oversight position has been created in the State to oversee the financial stability of all types of MCOs, rather than the limited oversight of HMOs that existed previously. The State continues to have difficulties assuring the long term financial viability of TennCare, although the new Governor plans to request some additional funding to address shortfalls. Because of the uncertainty of its financing structure and our lack of more definitive information on access, quality, and costs, we believe it is too early to tell whether Tennessee has successfully covered more people, reduced program costs, and maintained or enhanced quality of care.

June 5, 1995

H. Alexander
Tennessee Medicaid File

DRAFT

THE TENNESSEE MEDICAID WAIVER (TENNCARE)
A Background Paper

Out of page

SUMMARY

On the face of it, the idea of (a) increasing enrollment by 50%, (b) contracting with managed care plans with their associated administrative and profit margin costs, and (c) capping Federal contributions at the before-waiver level is counter-intuitive provided that some reasonable assumptions are made about savings under managed care (conventionally thought to be 3-8%).

In summary,

- o Tennessee repealed a hospital tax, and under-funded TennCare at the outset. Combined with a 50% increase in participants, apparently serious financing stresses remain unresolved.
- o To hold onto the approximately \$750 million in Federal funds that had been matching those hospital tax-financed State Medicaid expenditures, the State proposed and DHHS agreed it would recognize other "contributions" as State share of Medicaid costs. But none represented new cash investments.
- o Low capitation and provider payment rates, and loss of long-standing indigent care and other payments to hospitals are some of the financing results that continue to retard maturation of the program and create political stresses. Early start-up chaos has subsided, and about 400,000 formerly uninsured Tennesseans have received insurance coverage through TennCare.
- o The State has been to HCFA looking for additional financial help. It is considering some combination of seeking a Federal block grant at 1993 levels (including illegal tax income), reinterpreting the waiver agreement in order to claim additional Federal funding, and finding non-tax means of bringing additional state funds into TennCare.

TENNESSEE BEFORE THE WAIVER --BACKGROUND

Tennessee is a relatively poor state:

- o their Federal Medicaid matching rate, based on a measure of poverty, has ranged from 69.64 in 1989 to 66.52 in 1994 (in the latter year, 14 states had higher Federal match rates -- i.e., are, by this standard, poorer);

- o in 1991, 15.5 percent of the population had family incomes below the poverty level; by 1993, this had increased to 19.6 percent (7 states have higher percentages);
- o in terms of total taxable resources, Tennessee in 1993 was ranked 36th among states (it had experienced a 9.6% growth over 1991).

✓ During the early late 1980s and early 1990s, Tennessee, like other states, experienced a significant growth in Medicaid enrollment. This was due in part to the recession and in part to requirements to enroll more pregnant women and children.

- o During the period 1988-93, the number of beneficiaries in Tennessee grew by about 89% (an average annual rate of 13.6%) compared to a nationwide increase of 47% (8.1% per year).
- o In 1993, Tennessee had a rate of beneficiaries per 1,000 state residents that was 5th highest in the nation.

Their Medicaid provider payment levels have been similar to Medicare levels, and were only slightly below the national average for all state Medicaid programs.

During this same period, average annual growth in Medicaid expenditures per beneficiary (excluding disproportionate share payments) was 3.3% in Tennessee compared to a national average growth of 7.6%.

Legislation in 1986 and 1987 gave states additional flexibility in raising funds to finance their Medicaid programs. States exploited that mechanism by levying taxes on and accepting donations from hospitals and nursing homes; the States then returned those funds to the institutions in the form of "disproportionate share" (DSH) Medicaid "expenditures" and claimed Federal matching funds. This effectively increased the Federal matching rate.

In 1989-90, Tennessee raised \$85 million of the State share of Medicaid program funding through taxes, fees and donations; by the 1992-93 program year, those special funds had increased to \$541 million. By including these DSH funds, Tennessee's average annual expenditure per beneficiary in the period 1988-93 grew at 6.4% (national 10.6%), nearly twice Tennessee's without-DSH expenditure increase of 3.3%.

The centerpiece of Tennessee's special funding was a hospital tax which, in the 18 months between July 1, 1992 and its repeal on December 31, 1993, yielded

\$565 million. When the State returned those tax proceeds to the hospitals under the heading of Medicaid "disproportionate share" payments, this generated 67% Federal matching funds of approximately \$376 million. This effectively raised the Federal matching percentage. Both this tax and a nursing home tax (which generates about \$85 million in annual revenues and about \$57 million in Federal matching funds) have now been challenged by HCFA to have been unlawful.

With the special hospital tax scheduled to "sunset" in June of 1994, and little political likelihood of extension, Tennessee was faced with the annual loss of about \$376 million in Federal matching funds.

FINANCING THE TENNESSEE WAIVER -- AS PROPOSED, AS APPROVED

Initially, Tennessee proposed that the Federal Government approve an 1115 waiver that amounted to a block grant: even though Tennessee would withdraw \$376 million (the repealed tax), the Federal Government would pay at previous levels, and the effective Federal matching rate would be increased from the statutory 67% to over 80%. This was rejected. The State then began a search for any spending that the Federal Government could be persuaded to recognize as "State share" and to match with Federal funds.

Perhaps the most creative state share "contribution," was a projected \$572 million (over 5 years) in "certified public expenditures." Public hospitals would serve TennCare beneficiaries, managed care plans would be permitted to underpay hospitals' costs by an estimated \$326 per eligible, and that amount would be termed a "public expenditure" eligible for Federal matching. Furthermore, although the State would be making some payments from special pools to the hospitals to meet some of their uncompensated care costs (e.g., for persons considered "TennCare-eligible but not enrolled", the State argued that the Federal Government should disregard those State payments and match hospitals' gross uncompensated care rather than net. When HCFA insisted on matching only net uncompensated care, the State told hospitals that Washington had "changed the rules" necessitating a halt to State payments from special pools.

Other State-share contributions approved for Federal matching were

- o some \$457 million (over 5 years) in "patient revenues" of which the majority would be premium payments by some TennCare enrollees; instead of flowing directly to the managed care plans in which they were enrolled, these premiums would be captured by the State and then dispensed to the plans so Washington would recognize the payments as State expenditures, hence federally matchable;

- o certain payments for TennCare enrollees in Institutions for Mental Diseases (mainly State mental hospitals) not generally matchable; (these were to include persons already residing in IMDs when the waiver began, not only persons admitted during the period of the waiver);
- o about \$251 million (5 years) in local government indigent health services expenditures for TennCare eligibles and enrollees (including payments to private hospitals in Knox and Davidson Counties).

The State also proposed that HCFA match \$188 million in State payments for public health and mental health services (including State funds required to match certain PHS grants); this was later withdrawn.

FINANCING IN TENNESSEE TODAY -- FACTS AND EFFECTS

Under TennCare, approximately 400,000 Tennesseans who had previously been uninsured are now covered. The managed care industry, which prior to TennCare had enrolled only about 140,000 people in Tennessee, has now grown to cover nearly all 1.2 million TennCare enrollees. These are considerable accomplishments in the space of 15 months.

However, three factors -- two financial and the one political -- combine to produce a tense and unstable condition for TennCare today.

The first was the State's method of calculating the capitation rate that Managed Care Plans would be paid for each enrollee. The basic capitation rate was set by calculating a Medicaid historical fee-for-service per-capita equivalent amount -- \$1,641. From this was deducted \$335 in expected charity care from providers (in effect, holding onto hospitals' cost shift to private payers); \$28 in local indigent care funds the plans were expected to benefit from; and \$48 in patient coinsurance and deductible payments. This left a net capitation to plans of \$1,230 (raised last July to \$1,275). The low MCO capitation has resulted in low payments to physicians who contract with managed care plans, and to other providers participating in the MCOs' provider networks.

The second was the December 31 discontinuation by the State of payments to hospitals from an "unallocated funds pool." HCFA agreed to recognize State expenditures up to the Federal cap. Amounts in the pool represented the difference between the Federal funding cap for the year and aggregate amounts the State was paying to managed care plans as capitation. For the first six months between January 1 and June 30, 1994, these unallocated funds were estimated at

\$175 million, and were paid for medical education, uncompensated care payments to essential providers, extra payments to high-Medicaid caseload hospitals, and extra payments to MCOs for the first 30 days of care to TennCare beneficiaries (pent-up demand).

As enrollment increased, and as the State had to send increasing amounts of funds to managed care plans as capitation payments, the State had decreasing amounts available for these pool payments. In late December, when enrollments reached about 1.2 million and the State realized it could afford to enroll no more people and closed enrollments, the State informed the hospitals that no more pool payments were available. At least one hospital, the Regional Medical Center in Memphis ("The Med") is going through rapid and sharp cutbacks.

The third was the political arm-twisting by the State to force physicians to participate in TennCare. To avoid contention and compromise, the State did not engage Tennessee physicians in a dialogue over this plan. Blue Cross/Blue Shield (which has about 40% of TennCare enrollees) told the physicians participating in its managed care plan for State employees that if they wanted to continue in the state employees program, they would have to agree to participate in the TennCare program at TennCare payment rates. Without this requirement (called the "cram down" in Tennessee), the program would have been unlikely to be able to attract enough physicians at low payment levels to operate the program. (In fact, Governor Sundquist, who campaigned on a promise to eliminate this "cram down" requirement, has had to renege on that promise.) The Tennessee Medical Association sued the State (unsuccessfully) over this issue. This participation requirement, and the Governor's failure to eliminate it, have left a reservoir of ill-will in the physician community and, despite assurances to the contrary by TennCare officials, it is apparently difficult to obtain TennCare services in some specialties. There are said to be significant pressures from hospital and physician organizations to pare back eligibility and/or benefits to free up more funding for higher per-service payment levels to health care providers.

CURRENT TENNCARE FINANCING PROBLEMS

Tennessee was supposed to collect \$98 million in premiums from upper-income enrollees last year; instead, it collected \$12 million. In order to finance program costs to have been covered by the \$86 million in missing premiums, and to earn the approximately \$57 million in Federal matching funds, the State must make up the loss.

HCFA is seeking to recover Federal payments made in 1993 related to the now-unacceptable hospital tax (\$381 million). And an illegal nursing home tax of \$2,600 per bed (which the state repays to the institutions) has led to steps by HCFA to recover \$120 million for the 1993 year, with the expectation of similar recoveries for 1994.

The State has now approached HCFA for extra matching for local government payments to their public hospitals. Although HCFA already matches the value of charity care discounts below costs for care which public hospitals give to TennCare eligibles and enrollees (considered a "certified public expenditure"), Tennessee now wants to claim local appropriations of about \$43 million which counties pay to those same hospitals (a public hospital revenue, not an expenditure) to offset the costs of such uncompensated care.

Former and current State officials recently visited Washington to press for a block grant (in part, they said, so they "wouldn't have to keep jumping through hoops to come up with the State share.") Discouraged over the level of funding likely to be available to them under a block grant, however, they appear to have fallen back on trying to squeeze more Federal funds out of the current arrangement (see preceding paragraph) while conceding that there is probably a need for a 5-10% hike in capitation rates this year.

PROGRAM UNCERTAINTIES

Departmental officials who recently visited Tennessee were left with a number of uncertainties. They could not determine

- (1) whether there is beneficiary underutilization of the system; if so, what the volume and its trends might be, and whether it is purposeful as consequence of State and/or MCO plan-erected barriers (due to underfinancing) or incidental and a natural -- and temporary -- consequence of shifting a population into an unfamiliar arrangement;
- (2) how much real care management is occurring and how much is simply discounted fee-for-service (five of the 12 plans are PPOs which will not be required to have gatekeepers until year 3);
- (3) the financial stability of managed care plans - whether capitation payments are sufficient to permit profits by MCOs and to underwrite plan-to-provider contract rates adequate to keep providers in the program (State-sponsored audits are under way);

- (4) whether payment delays are about what would be considered normal, or might be indicators that some MCOs are performing poorly, purposefully delaying payments for cash flow reasons, or this is evidence of underlying problems in the overall levels or structure of financing;
- (5) the ratio of operational problems to total plan performance; whether early performance complaints (access, enrollment, referrals, information) are largely behind the plans, or there continue to be significant design errors and implementation problems that are not being recognized or overcome.

HYPOTHESES: HOW DID THEY MAKE IT WORK?

Program impact and performance data is not yet available. Assertions and anecdotes are inconsistent and ambiguous. But the essential conundrum remains: on the face of it, the idea of (a) increasing enrollment by 50% and (b) capping Federal contributions at the before-waiver level is counter-intuitive providing that reasonable assumptions are made about savings under managed care.

The following hypotheses suggest a framework within which to consider what may be happening.

Hypotheses #1: Tennessee's Medicaid program was so financially robust before the waiver that the program can now be adequately financed on a tight per capita fiscal diet.

The evidence to support this hypothesis might include pre-waiver per capita costs well above what would be expected (embodying some mix of high utilization and high prices). In fact, per beneficiary costs in Tennessee in 1993, were below the national average (\$2,946 vs. \$3,895), and slightly above the average for the states in their east south central region (\$2,892). Tennessee's Medicaid payment rates in 1993 were calculated by PhysPRC in 1993 to be at 1.05 - 1.17 of national fees; for example, their fee for total obstetrical care and vaginal delivery was \$1,100 compared to a national Medicaid median of \$1,051; and an office visit for a new patient was \$40 compared to the national Medicaid median of \$36.

When considered by class of service, Tennessee's acute care expenditures per beneficiary were \$1,683 compared to \$1,637 in their region and \$1,993 nationally. In long-term care spending per elderly beneficiary, Tennessee spent \$4,244 compared to \$3,878 by states in their region and \$6,907 nationally.

The foregoing does not suggest that, when compared to other states, Tennessee's Medicaid program was fat going into the demonstration.

Hypothesis #2: Tennessee's program is working and sustainable, but for reasons we don't understand.

The least visible funding in the Tennessee system is amounts hospitals garner from surcharging private payors and cost-shifting to subsidize TennCare eligibles and enrollees. Part of such funds (the gap between costs and payments they receive from health plans) is visible because hospitals account for it in order that the state might claim the Federal match for that difference as "certified public expenditures." But the Federal 2/3 match leaves 1/3 unfunded. In fact, it may be that the hospitals are raising greater amounts for cross-subsidies than is apparent, and these will be able to compensate for low TennCare hospital rates for an extended period. (Since public hospitals have less of a privately insured client base, they have greater difficulty obtaining funds for cross-subsidies.)

In addition, it is possible that new enrollees under TennCare may, on average, be healthier than the average Medicaid population; many appear to be in low-wage working families. Conceptually, persons with chronic medical problems that left them unable to work, and children with ongoing problems are likely to have been enrolled under Medicaid prior to TennCare. If this turns out, upon empirical analysis, to be correct, their average costs would be lower than those of categorically eligible Medicaid population upon whose costs capitation rates were established.

There have been anecdotal reports that hospitalization rates per 1000 program beneficiaries are down significantly which could save substantial amounts if true. On the other hand, it could represent lack of access; a visiting Federal group heard reports that the second-largest HMO has been unable to conclude a contract with hospitals in one region of the state (including a large city), and the inconvenience faced by going outside of the region could dampen utilization temporarily.

Hypothesis #3: That TennCare is unsustainable without infusion of additional funding.

Empirical information on program effects is not yet available, and qualitative reports are ambiguous. Some hospitals and other providers are declining to continue to participate, but it is not known how generalizable that is. Discussions with a very few beneficiaries indicated some continued mechanical problems (like being

switched from plan to plan with no notice or reason), and difficulties with referrals and drug formularies.

A number of program elements may have, in the first year, masked the tenuousness of the program's financing foundation. First, the Federal payment cap did not take into account the phase-in of new beneficiaries through the first year. Given the early start-up confusion and the time it would take to enroll people and for them to begin to use health services, it is more likely that an appropriate capitation estimate for the first year would be about one-half the annual rate for the first year. In the second year, the average costs are more likely to nearly approximate ongoing costs.

Second, managed care organizations were frantically busy in the first year building their referral networks -- primary care physicians, referral specialists, hospital, etc. The very incompleteness of those networks probably held down costs, a factor much less likely to have effect in the next (and first full) year of operation.

Third, beneficiary sign-up with managed care plans, linkage with a primary care provider, transportation arrangements and other problems is likely to have had two effects: first, some -- perhaps many -- may have under-used needed services because they couldn't find access or gave up in frustration. Second, many went to their former care providers at least some of which went ahead and provided a service anyway, hoping that reimbursements could later somehow be obtained from one of the managed care plans; some of those reimbursements probably did not happen. This chaos (and any savings that may have accrued to the State and the plans) is not likely to be repeated.

Fourth, plan payments to providers are widely reported to have been slow. There may even be some significant backlog of physician and hospital payments by some of the managed care plans which matured State monitoring will cause to be paid; this will increase retroactive first-year costs, and (unless repeated) will not mask second year costs.

Perhaps the strongest indication of the precariousness of current TennCare funding comes from Washington visits by former-Governor McWherter and the former director of Finance and Administration Manning seeking additional funding. Their concerns are outlined by Tennessee press reports in which Robert Corker, current Director of Finance and Administration, testifying before the legislature's TennCare Oversight Committee, is reported as indicating a TennCare financing shortage in the area of \$200 million.

The outlook for TennCare is ambiguous. On one hand, the managed care delivery

networks should begin to mature during the coming year, with real case management beginning to replace what, in many cases now, is reported to be essentially discounted fee-for-service care. Quality oversight by the State will begin to reinforce expectations that preventive and primary services in doctors' offices will replace episodic acute care in hospital emergency rooms. An increase in capitation payments should ease financing pressures, perhaps drawing additional specialist physicians into the program easing access pressures.

On the other hand, serious risks remain. Provider disenchantment could continue to build into further litigation, and more physicians could leave the program as well as some hospitals that are least dependent on Medicaid funding. There continues to be talk that at least one of the managed care plans may not be able to continue (although Blue Cross/Blue Shield may offer replacement coverage). The Tennessee legislature may continue to under-fund the program in which case the State will continue to have difficulty making enough qualifying Medicaid expenditures to attract Federal matching funds.

Chris -
still checking some facts - I
think this is right - Please don't
pass on -

used shift to MCOs to justify lower payments - somewhere include that they took the managed care reduction but gave three year waiver for real management.

THE TENNESSEE MEDICAID WAIVER (TennCare)

ISSUES:

- (1) How did the TennCare waiver enable Tennessee to cover more people within its current budget?
- (2) To what extent are the experiences from Tennessee applicable to other states?

BRIEF RESPONSES:

- (1) Tennessee's waiver had two primary components that enabled the state to expand coverage.
 - ▶ First, the federal government agreed to match state, local and private sources of spending that are not ordinarily matched under state Medicaid programs. The federal payments that result from matching these sources of spending replaced the federal matching payments the state had received under an expiring hospital tax, permitting the state to maintain its existing level of federal payments.
 - ▶ Second, the state was permitted to enroll Medicaid enrollees in managed care organizations ("MCOs") and pay capitation payments to MCOs that were significantly below its prior payment levels under Medicaid. The state used the savings from the reductions in provider payments to expand coverage.

It is as yet unclear whether total state and federal spending under TennCare will be more or less than it would have been under the former Medicaid program. There are unresolved issues between the state and HCFA regarding which categories of state and local spending are eligible for federal matching payments. There also are indications that the state may be unable to fund its share of program costs; the state has requested additional federal funds to balance the program. More complete results of the financial status of the program will not be available until the end of the state's fiscal year in July.¹

- (2) Tennessee's program is too new to draw definitive conclusions about its success. However, there are several reasons to question whether other states could apply Tennessee's strategy for expanding coverage.

¹In addition, HCFA has challenged the legitimacy of the former hospital tax and requested return of federal matching payments based on the tax made prior to the waiver. The baseline for federal payments to the program includes amount associated with the challenged tax.

- ▶ The state financed the coverage expansions through deep reductions in provider payments. In order to get a sufficient number of providers in TennCare at the low payment rates being offered, Blue Cross and Blue Shield of Tennessee (the largest carrier in the state) required providers to participate in the TennCare MCOs a condition of being participating providers in the state employee health plan. This provision, called the "cram down" in Tennessee, was and remains extremely controversial with physicians.

It does not appear that TennCare would have been able to attract a sufficient number of providers to the program at the low payment rates that were offered without some form of coercion. Whether this level of reduction would be politically tenable in many other states (and whether it is sustainable in Tennessee) is open to question.

- ▶ In addition, the future viability of TennCare without either new federal funds or cutbacks in eligibility or services is questionable. There is a major shortfall in the program's financing for this fiscal year, and the state has requested additional funds or changes in the waiver that would maintain federal funding at current levels but permit the state to reduce its share of program costs. HCFA has recently indicated its attention to recognize a change to the state program that would result in approximately \$100 million in federal payments to the state in the current fiscal year.

DESCRIPTION OF PROGRAM

TennCare was implemented on January 1, 1994. It is a state program that combines Medicaid with a state-run program to purchase health insurance for the uninsured. Almost 1.2 million people were enrolled in TennCare in 1994, including about 800,000 persons eligible for Medicaid and an additional 400,000 Tennesseans who had previously been uninsured. Due to funding constraints, the state closed enrollment for the uninsured (except those with pre-existing conditions) as of January 1995.

TennCare enrollees receive a fairly comprehensive benefit package. TennCare enrollees who are eligible for Medicaid do not have to pay premiums or cost sharing. TennCare participants with incomes over poverty pay premiums and cost-sharing that vary with their income.

TennCare enrollees receive primary and acute care through twelve managed care organizations (MCOs), which receive an annual capitated payment of around \$1,270 for each TennCare enrollee. Medicaid-eligible enrollees continue to receive long-term care services as under traditional Medicaid (outside of MCOs).

The financing for TennCare comes from a variety of state sources and from federal matching payments. The state's contributions include state general revenues, a nursing home tax, and premiums collected from enrollees with incomes over poverty. The federal government matches these state contributions; it also agreed to match other state and local expenses, including unreimbursed costs for TennCare enrollees at public and certain private hospitals (called "certified public expenditures") and payments for TennCare enrollees in state Institutions for Mental Diseases. Total federal matching payments are capped at the estimated amount of

federal Medicaid payments the state would have received absent the waiver.

The state makes capitation payment to MCOs to cover acute care services for TennCare enrollees. The capitation rates were calculated as follows:

- ▶ First, a 1993-94 gross capitation rate was calculated, based on experience from the state's Medicaid program and state employee health plan. The gross capitation was calculated to be \$1641. ~~This does not include the amount for managed care.~~
- ▶ Second, a series of discounts were taken. The \$1,641 was reduced by \$335 in expected charity care from providers (in effect, holding onto hospitals' cost shift to private payers); \$28 in local indigent care funds the plans were expected to benefit from; and \$48 in patient coinsurance and deductible payments. This left an initial net capitation to plans of \$1,230 (raised last July to \$1,275).²

Two pools were created to supplement payments to providers.

~~These pools are:~~

- ▶ A Reserve Fund Pool pays plans for adverse selection, assists primary care physicians and offsets malpractice costs associated with TennCare enrollees. Additionally, special payments are made on behalf of children who are/will be incarcerated and the severely and persistently mentally ill.
- ▶ An Unallocated Fund Pool provided payments to compensate provider for medical education, uncompensated care by essential providers, high-Medicaid hospital caseloads, and the pent-up medical demand of TennCare enrollees (during their first 30 days of care). The amount in this pool was determined by the difference between the actual and budgeted enrollment: the monthly pool balance is the monthly capitation times the difference between actual and budgeted enrollment. When the enrollment reached its cap at the end of 1994, this pool ended.

The capitation rates appear to be resulting in much lower payments to health care providers. The Tennessee Hospital Association reports that hospitals are being paid 65 cents for every Medicaid dollar that they used to receive. Similarly, physicians assert that TennCare pays about 25 cents on the dollar compared to the 50 cents paid under the former Medicaid program (Derks, 1995).

There is not yet sufficient data to describe the effects of TennCare on quality and access. At the end of 1994, three Plans were not submitting useable data, and the other 9 have submitted data that the state has not yet validated. However, anecdotes suggest that there have been some

²Several actuarial firms have stated that the methodology used is not based on actuarial principals, and may be inadequate. For example, the Medicaid per capita payment was not adjusted to reflect the expanded services offered under TennCare (TennCare does not limit inpatient hospitalization, while the former Medicaid program had a 14-day limit).

problems, particularly during the initial implementation of the program. A visiting federal group heard reports that the second-largest HMO has been unable to conclude a contract with hospitals in one region of the state (including a large city). In early 1994, a mother had trouble finding participating provider for her sick infant, who subsequently died. This highly publicized case drew attention to the difficulty of TennCare enrollees of identifying and accessing health care providers.

Appendix 1. Tennessee's Previous Reliance on Provider Taxes, Donations, and the Disproportionate Share Program

In the late 1980s and early 1990s, some states took advantage of loopholes in Medicaid to increase the Federal funds flowing to those states. These loopholes allowed states to use taxes and donations from health care providers to draw greater federal matching payments. The providers were then compensated for the taxes and donations through either adjusted payment rates or "Disproportionate Share" (DSH) payments.

Unlike all other Medicaid provider payments, DSH payments are not restricted to Medicare payment rates. This allows states to offer hospitals large, supplemental payments. For example, a state levies a large hospital tax. It then offsets this tax with a DSH payment equal to or larger than the tax. This DSH payment is subject to federal financial participation, so at least half of the DSH payment is federally funded. Thus, the state gains the difference between the total tax revenue and the share of the DSH payment that it owes the hospitals (Ku & Coughlin, 1994). As a consequence of this loophole, DSH payments grew from \$1.4 billion in 1990 to \$17.5 billion in 1992. DSH funding leveled off in 1993 and 1994 due to the implementation of "The Medicaid Voluntary Contribution and Provider Specific Tax Amendments of 1991", which placed restrictions on such practices.

Tennessee relied heavily on provider taxes to fund its Medicaid program. In 1993, approximately 120 Tennessee hospitals received a total of \$430 million in Medicaid DSH payments, which on a per-uninsured basis is 30% higher than the national average.

Tennessee used two major provider taxes to finance Medicaid: a hospital tax and a nursing home tax. Beginning in 1987, Tennessee used special licensing fees and a hospital tax targeted toward hospitals with high Medicaid utilization. These hospitals would pay the tax -- all of which would be put into state general funds for use as state Medicaid share-- and then receive in return a DSH payment which would offset the tax. In 1992, the state replaced this targeted tax with a broader, 6.75% "service tax" on hospitals which, in the 18 months between July 1, 1992 and its repeal on December 31, 1993, yielded \$565 million. This substitution was intended to create a provider tax which complied with the new regulations that restrict the use of targeted provider taxes.

A second tax, effective on July 1, 1992 and ongoing today, is a nursing home tax of \$2,600 per bed per year, which has generated approximately \$85 million in revenue per year. This is repaid to nursing homes in two ways. For nursing facilities with Medicaid recipients, the amount of the tax is considered reimbursable by Medicaid.

Thus, the federal government contributes over two-thirds of the nursing facilities' cost of the tax. Is the whole tax a reimbursable expense, or just in proportion to Medicaid census in the facility? And, presumably the state contributes the other of the tax. Second, for facilities with private pay patients, it is assumed that the nursing facilities to pass along the tax cost to the private patients. A "Granny Grant" program was implemented simultaneously in which Tennessee pays low-income nursing home residents a grant that is roughly equivalent to the

nursing home tax (GAO, 1994). Thus the tax, which is shifted to the patients, is then offset by the Granny Grant to the patient.

It appears that the state used the revenue from the federal matching payments generated by the DSH program for two purposes. First, these revenues lowered the amount needed from state general funds for the Medicaid program. One report suggested that provider taxes in 1993 accounted for two-thirds of the state's share of Medicaid (Dabbs, 1993). In 1987, \$262 million of own-source revenues from state's general fund. By FY 1992, \$398 from general funds, and \$354 from provider taxes and donations. Thus, the effective state share of Medicaid expenditures in 1992 was 16.9% of total Medicaid (Dabbs, 1993).

Second, the state appears to have increased its provider payment rates (Dabbs, 1993). For example, in 1992, the obstetrical global fee in Tennessee was \$750. The state raised the fee to \$1,100 in 1993, but reduced it to \$800 under TennCare. Tennessee's Medicaid payment rates in 1993 were generally higher than the national averages. The Physician Payment Review Commission in 1993 to be at 1.05 to 1.17 of national fees. Its fee for total obstetrical care and vaginal delivery was \$1,100 compared to a national Medicaid median of \$1,051; and an office visit for a new patient was \$40 compared to the national Medicaid median of \$36. In early 1993, Tennessee was faced with severe financial problems as its major sources of state funding for Medicaid were threatened. The hospital tax was scheduled to "sunset" in 1994 and had little political likelihood of extension. Additionally, questions about the legitimacy of the nursing home tax were surfacing. The state claimed that its loss of these sources of state share were an estimated \$800 million for FY 1994.

Three options were considered by state officials: raising general taxes, making large cuts in Medicaid eligibility and benefits, or restructuring the system. The state publicly said that it would either need to increase its sales tax by over half of one percent, or cut the medically needy program, eliminate all optional programs and services, and cut reimbursement rates. These two options were unpopular in the state. The third option -- "restructuring Medicaid" -- was developed by a few senior state officials in a very short period of time.

To July / Gary

NEW DPC / State-based Medicaid
Options

EXPANDING COVERAGE THROUGH STATE FLEXIBILITY: MEDICAID OPTIONS

OVERVIEW

In the absence of significant coverage expansions at the federal level, one option for expanding coverage is to provide states with greater flexibility and resources to pursue health care reform.

The federal government has two levers to encourage state coverage expansions:

1. Providing greater flexibility to states in administering health care programs (e.g., Medicaid).
2. Providing additional funding to states to help pay for new coverage.

ADMINISTRATIVE FLEXIBILITY

There are several areas in which providing flexibility to states could produce savings that could be channeled into expanded coverage:

- Encouraging or requiring greater use of managed care organizations;
- Permitting benefit reductions; and
- Reducing administrative complexity (which can reduce administrative costs).

ADDITIONAL FINANCING

The Federal government could encourage states to expand coverage by extending additional financial resources to states, either as matching funds or as a direct grant program.

To protect the federal budget, caps on new federal spending for the program may be necessary.

GENERAL CONSIDERATIONS

- States will want greater administrative flexibility under Medicaid program without expanding coverage to new populations.
- States are unlikely to make new money available for coverage expansions, so any additional financing will probably come from redirecting existing state resources or from the federal government.

- States may be more interested in fiscal relief than coverage expansion. If new federal financing is made available, the challenge will be to assure that it is used to expand coverage rather than to substitute for existing state or private spending.
- Increasing state flexibility reduces the ability of the federal government to influence health care policy and decisions. The ability to protect consumers would necessarily be diminished.

OPTIONS

Option 1 Streamlining Medicaid Waivers for States that Expand Coverage

Key Considerations:

- Budget neutrality is difficult to achieve.
- Retains some of the federal guarantees and consumer protections.
- Loosening Medicaid requirements without prior review of state programs may lead to problems with access and quality.

Option 2 Providing Additional Funds to States for Expanding Coverage

Key Considerations:

- If funds are provided on a matching basis, the States most likely to participate are these that already cover a significant portion of the poor through Medicaid or state-financed programs. Poorer states with the most needy populations may be financially unable to participate in the program.

Option 3 Maximum State Flexibility/Medicaid Block Grant

Key Considerations:

- A block grant program would cap federal spending on Medicaid. If the Federal grant is insufficient, states would need to either expand state funding or cut services or eligible populations.
- Uncertainty for future program growth would be borne by the states and program recipients.
- States may reduce eligibility or benefits for groups now covered under the program.

DRAFT November 21, 1994

EXPANDING COVERAGE THROUGH STATE FLEXIBILITY

OVERVIEW

In the absence of significant coverage expansions at the federal level, one option for expanding coverage is to provide states with greater flexibility and resources to pursue health care reform.

The federal government has two levers to encourage state coverage expansions:

- Providing greater flexibility to states in administering health care programs (e.g., Medicaid).

- Providing additional funding to states to help pay for new coverage.

Providing flexibility to states can lead to some expansions of coverage. However, there are limits to how far existing resources can be extended, and expanding coverage is not necessarily the primary state interest in pursuing flexibility or additional funding.

- Many states are interested in pursuing flexibility as a way to reduce costs -- not expand coverage.

ADMINISTRATIVE FLEXIBILITY

There are several areas in which providing flexibility to states could produce savings that could be channeled into expanded coverage:

- Encouraging or requiring greater use of managed care organizations;

- Permitting benefit reductions; and

- Reducing administrative complexity (which can reduce administrative costs).

There are limits, however, on how far existing resources can be extended to provide new coverage. Medicaid is not a generous payer, so there are limits to amount of savings that managed care can achieve (estimates from 0 to 10%). In addition, reductions in the projected Medicaid baseline will make it harder for states to produce "savings" through state health care reform initiatives.

ADDITIONAL FINANCING

The Federal government could encourage states to expand coverage by extending additional financial resources to states, either as matching funds or as a direct grant program.

To protect the federal budget, caps on new federal spending for the program may be necessary.

GENERAL CONSIDERATIONS

- States will want greater administrative flexibility under Medicaid program without expanding coverage to new populations.
- States are unlikely to make new money available for coverage expansions, so any additional financing will probably come from redirecting existing state resources or from the federal government.
- States may be more interested in fiscal relief than coverage expansion. If new federal financing is made available, the challenge will be to assure that it is used to expand coverage rather than to substitute for existing state or private spending.
- Increasing state flexibility reduces the ability of the federal government to influence health care policy and decisions. The ability to protect consumers would necessarily be diminished.

OPTIONS

Option 1 Streamlining Medicaid Waivers for States that Expand Coverage

Provide presumptive waivers for specified Medicaid requirements (e.g., managed care flexibility) to states that propose significant coverage expansions. States would be able to modify their Medicaid programs within bounds without prior federal approval. However, the federal government would have authority to verify that states meet waiver requirements.

Key Considerations:

- Budget neutrality is difficult to achieve.
- Retains some of the federal guarantees and consumer protections.
- Loosening Medicaid requirements without prior review of state programs may lead to problems with access and quality.

Option 2 Providing Additional Funds to States for Expanding Coverage

Additional Federal funds would be provided to States that expand coverage of the uninsured. States could be provided with substantial flexibility under this new program, but Medicaid would remain as under current law.

Funds could be provided to states on a matching basis or as a direct grant. The Federal contribution to the program would be capped.

Key Considerations:

If funds are provided on a matching basis, the States most likely to participate are those that already cover a significant portion of the poor through Medicaid or state-financed programs. Poorer states with the most needy populations may be financially unable to participate in the program.

Option 3 Maximum State Flexibility/Medicaid Block Grant

The current Medicaid financing arrangements would be replaced with Federal block grant payments to States. Payments would include the Federal share of the Medicaid program and any new Federal funding. States would be given substantial flexibility in using these Federal payments -- and any required or optional State contributions -- to finance health services for low-income residents.

Key Considerations:

A block grant program would cap federal spending on Medicaid. If the Federal grant is insufficient, states would need to either expand state funding or cut services or eligible populations.

Uncertainty for future program growth would be borne by the states and program recipients.

States may reduce eligibility or benefits for groups now covered under the program.