



DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary

Washington, D.C. 20201

Facsimile Cover Sheet

To: Carol Rasco

Organization: WH

From: Pat Woods/John Monahan

Date: 11/22/93

Intergovernmental Affairs
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Recipient's Fax Number: (202)456-2878

Number of pages including this sheet: 4

Remarks:

IMPORTANT

November 22, 1993

NOTE TO: Carol Rasco
Kathi Way
Charlotte Hayes
John Hart

From : John Monahan
Director for IGA
Office of the Secretary

Subject: TennCare Waiver -- Qs & As

On Friday my office faxed you some questions & answers regarding TennCare. The copies which came to you may not have contained a transmittal sheet which stressed that these questions and answers are to be used for internal purposes only. They should not be disseminated to any external parties. If you have any questions about this, I will be pleased to talk with you about it.

Attached are revised answers to the questions which were on pages 10 and 26.

**TENNCARE
Health Care Reform
(revised)**

Q: Is TennCare a good example of the President's policy of providing the States flexibility to design health care delivery systems that best fit their specific circumstances?

- A:**
- TennCare is just one example of the Administration's commitment to give States the flexibility we know they need to fashion programs in ways that best meet the needs of their citizens.
 - In Medicaid demonstration waiver activity this year, we have now approved four statewide health care reform waivers for Oregon, Hawaii, Rhode Island, and Tennessee.
 - + Indeed, HCFA has approved virtually all statewide health reform waivers that are in its processing pipeline (the Kentucky waiver proposal is still under Department review; however, we hope to be able to approve it within the next several weeks).
 - We have approved 16 other State Medicaid demonstration waivers in more policy-focused areas (e.g., pregnant substance abusers, long-term care, and family planning).
 - HCFA is in the midst of discussions with 12 other States over health care reform initiatives.

**TENNCARE
Implementation
(revised)**

Q: Do you expect Tennessee to be able to implement this program on January 1, 1994? Since they do not currently have many health plans available to serve this population, are you satisfied that the plan can be implemented on the schedule proposed by the State?

- A:**
- HCFA has not required the State to meet a preset implementation date.
 - However, we believe that Tennessee will be able to enroll some persons in TennCare MCOs beginning on January 1, 1993.
 - The State will negotiate contracts with managed care organizations (MCOs) and HCFA must approve all contracts with MCOs prior to the start date of delivery of any services.
 - HCFA is requiring the State to provide assurances that plans would not enroll more beneficiaries than they can effectively serve.
 - + Before a plan begins to operate, HCFA will agree that it includes a sufficient number of providers to care for the potential population. For example, a plan might be approved to enroll 10,000 beneficiaries--no more.
 - In addition, the State has agreed to allow all Medicaid eligibles to make new plan selections, if they desire, after TennCare is approved by HCFA.



DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary

Washington, D.C. 20201

*Priority
attention*

Facsimile Cover Sheet

To: Carol Pasco

Organization: White House

From: John Monahan

Date: 11/18/93

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Number of pages including this sheet: 3

Remarks:

JYI - Press Release

Re TENNCARE!

HHS NEWS

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

FOR IMMEDIATE RELEASE
Thursday, Nov. 18, 1993

Contact: Anne Verano
(202) 690-6145

HHS Secretary Donna B. Shalala today announced approval of federal waivers that will enable Tennessee to reform its Medicaid program and extend coverage to many uninsured citizens.

"Approval of the TennCare plan is consistent with the administration's policy of encouraging states to develop alternative programs to serve the health care needs of their people," Secretary Shalala said.

The plan is a five-year demonstration project that will use managed care organizations to deliver care to a million Medicaid recipients. TennCare will cover an additional 300,000 currently uninsured in the first year. The number of uninsured enrolled in the program could reach 500,000 in the second year.

According to Bruce C. Vladeck, administrator of the Health Care Financing Administration, "The project is designed to expand health insurance coverage to many uninsured, low-income residents of Tennessee and to assure access of all enrollees to appropriate and high quality health care."

Enrollees with incomes above the federal poverty level will be required to share some of the costs by paying premiums, deductibles and copayments.

Tennessee will require managed care organizations to establish delivery systems that assure recipients of access

- More -

- 2 -

to primary and specialty care. The state is placing a high priority on the provision of preventive health care services.

Under the demonstration, Tennessee will remove some limitations on hospital and physician outpatient and inpatient care, prescription drugs and laboratory and X-ray services. Outpatient treatment for substance abuse is one of the new services to be covered.

"To help protect the right of recipients to choose their own health care providers, Tennessee will initiate a new enrollment process for the uninsured and a re-enrollment process for Medicaid recipients," Vladeck said.

Between now and the time that Medicaid recipients are enrolled in health plans, they will continue to have access to their regular providers under Tennessee's existing Medicaid program.

The Health Care Financing Administration is the federal agency which administers the Medicaid and Medicare programs.

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November 18, 1993

MEMORANDUM FOR: The Secretary
Thru: DS _____
CoS _____
OS/ES _____

FROM : John Monahan 
Director for
Intergovernmental Affairs
Office of the Secretary

SUBJECT : Briefing Materials for Your Call to
Governor Ned Ray McWherter of Tennessee
BRIEFING

Background

HCFA has approved TennCare, the State of Tennessee's 1115 waiver proposal. Under TennCare, the state plans to reform its Medicaid program and extend health care coverage to many of its uninsured citizens. Beneficiaries will be asked to select a managed care plan from among those contracting with the State. Individuals with incomes at and above the poverty level will be required to share some of the costs by paying premiums.

Calls to the Governor & The Hill

You promised Governor McWherter that you would call on Thursday, November 18 to advise him of the Department's decision regarding TennCare. ASL has recommended that you also call Senators Sasser (D-TN) and Mathews (D-TN), and Representatives Cooper (D-TN) and Ford (D-TN) to alert them of this waiver approval. We have scheduled those calls to begin at 3 p.m. Suggested talking points are attached.

Other "Roll Out" Actions

As you know, states, interest groups, advocacy groups, professional associations, and others have expressed considerable interest in our decision regarding TennCare. We have, therefore, prepared the attached comprehensive outreach strategy to alert interested parties of our decision and to brief them fully on all aspects of TennCare.

Immediately after your call to the governor we shall issue a press release. Attached is a fact sheet prepared by HCFA which we shall make available to the press and to those interested in having more information about TennCare.

HCFA has prepared the attached letter to the governor which officially notifies him of his waiver approval. Please sign this letter now.

Attachments

TALKING POINTS FOR YOUR CALL TO
GOVERNOR McWHERTER

(615) 741-2001

When you call, Mandy Johnson will receive the call and put you right through to the governor.

- o I am pleased to advise you that the Department has approved your TennCare waiver demonstration.
- o As you know, there were many issues to work out on this ambitious plan, and I am pleased that our staffs worked so diligently to reach resolution.
- o We wish you good luck in implementing TennCare, and hope that it will be as successful as you have envisioned.

TALKING POINTS FOR YOUR CALLS TO
SENATORS SASSER & MATHEWS
AND REPRESENTATIVES COOPER & FORD

Senator Jim Sasser	224-3344
Senator Harlan Mathews	224-4944
Representative Harold Ford	225-3265
Representative Jim Cooper	225-6831

- o I wanted to let you know that I have just advised Governor McWherter of the Department's approval of his 5-year, managed care demonstration project, TennCare.
- o Under TennCare, Tennessee will reform its Medicaid program and extend coverage for the first time to many in its uninsured and uninsurable population.
- o Undoubtedly you are aware that providers and constituents have expressed strong opposition to the governor's proposal. In view of that, we would like to assure you that:
 - o The benefits under TennCare are more generous than those offered under Medicaid.
 - o The plan provides incentives for the use of preventive care services.
 - o The State has estimated that TennCare will save the federal government \$3 billion over the life of the demonstration.
- o **Our approval of Tennessee's demonstration shows that the Clinton Administration is serious about providing states with the flexibility needed to test expansions of care to the uninsured.**

11/16/93

TENNCARE ROLLOUT

I. Legislative Consultation

OLP: Tom Gustafson, Meg Holland
ASL: Sharon Clarkin

- o Brief key members in advance
 - o Bruce met with Waxman Tuesday
 - o Bruce to meet with Dingell staff (Schriber and Murphy) on Thursday
 - o OLP to offer briefing for Senate Finance Staff for Thursday or at their convenience.
- o Secretary to make calls day of announcement to Sasser, Matthews, Cooper, and Ford. (ASL to prepare talking points or briefing.)
- o Other Courtesy Phone Calls, after announcement (ASL/OLP)
 - o Tennessee delegation
 - o Moynihan staff - Offner, Horvath
 - o Finance Committee minority - Roy R.
 - o Kennedy staff - David Nexon
- o Other Briefings
 - Upon request, more general briefings could be arranged for:
 - o Energy and Commerce
 - o Senate Finance Key Staff

II. Press Rollout

HCFA AAC: Faye Baggiano, Marty DeSario
OASPA: Melissa Skolfield

- o HCFA Press Office to circulate draft press release for everyone to clear on Wednesday
- o Marty has list of Tennessee press to be invited to conference call with Faye. If roll-out occurs on Thursday, Kathy Buto will do conference call.
- o If other reporters call in with questions, Faye will return their calls, even if roll-out is on Thursday.
- o Calls from senior Post and Times reporters will be handled by Bruce.

III. Q&As to Assist Press Shops in Answering Inquiries

MB/IGA: Richard Chambers
OLP: Meg Holland
ORD: Rhonda Rhodes
OA: Joanne Pokaski

- o List of Q's has been generated (see Richard for information)
- o Drafts of answers now being done by Richard Chambers, Meg Holland of OLP, and Rhonda Rhodes of ORD
- o Will be circulated to all for comment on Wednesday (both to staff for technical comments/accuracy, and to principals for overall approach (Bruce/Helen, Monahan, LaVelle, Klepner, others))

IV. Interest Group Process

IGA: Monahan
OA: Smits, Moore
AAC: Baggiano
MB: Richardson, Chambers
ORD: Buto, Rhodes

- o Prepare list of interest groups to touch base with (ORD, Richard Chambers, OA):
 - Providers
 - Consumer Groups
 - State Medicaid Directors/NGA
 - others?
- o Outline strategy for each: Helen Smits, Faye Baggiano/Judy Moore, Sally Richardson/Richard Chambers/John Monahan, Kathy Buto
- o Produce a fact sheet oriented toward each group (Chambers, Holland, Rhodes, DeSario)
- o Develop plan of contact for each group:

Providers (TMA, AMA, AHA, ACP, THA): Kathy Buto to meet with them.

Consumer groups: ? ORD -

State Medicaid Directors: Richardson/Abato

NGA: Monahan

Others?
- o Calls made on Thursday to set up briefing for Friday or

Monday.

V. Detailed Timetable

OA: Pokaski, Fortuna
IGA: Monahan
MB/IGA: Chambers

Is attached.

ORD to prepare fact sheet. Chambers to prepare talking points for Secretary.

11/16/93

DRAFT

TIMETABLE FOR TENNCARE ROLLOUT

After Decision is Reached and Prior to Announcement:

- o Monahan to coordinate announcement/process with Governor's office, including agreement that announcement will not be made early by Tennessee
- o OS/Monahan to confirm plan with White House
- o IGA determines time of call from Secretary to Governor (confirms timing with White House?) and informs HCFA/Pokaski, ASL, OASPA
- o OASPA/HCFA AAC determine timing of press release and inform HCFA/Pokaski and IGA (& others?)
- o IGA, HCFA/Pokaski, press (OASPA/AAC), and legislative (ASL/OLP) confer to ensure that timing decided upon will work in practice
- o Pokaski informs HCFA bureaus (ORD, MB) of timing decisions

*Press release, press Q&As, fact sheets, and talking points for Secretary's calls should be cleared and ready. Copies of terms and conditions to be given to OLP, ASL.

On Day Announcement is Made:

- o IGA/OS confirms timing with White House (if necessary)
- o Secretary/IGA informs Governor of final decision
- o Secretary calls Sasser, Matthews, Cooper and Ford

Immediately Following:

- o Press release is released
 - o ORD informs State Medicaid Director and Regional Office
 - o ASL/OLP make calls to less critical Members of Congress
 - o AAC/DeSario calls members of Tennessee press to tell them of conference call to take place two hours later.
 - o Calls to interest groups (Buto to providers, Richardson to State Medicaid Directors, Monahan to NGA, etc.) to invite to briefings to be held Friday or Monday.
-
- o Two hours later, HCFA spokesperson holds conference call with TN press.
 - o Calls from other reporters to be returned by Faye Baggiano, Bruce to return calls from Post or Times senior reporters ASAP, but no later than mid-day Friday.
 - o Letter from Secretary to Governor and letter from Bruce to Medicaid Director sent.

FACT SHEET TENNESSEE TENNCARE DEMONSTRATION

Tennessee submitted a proposal for a five-year managed care demonstration project requiring several waivers of Medicaid program requirements.

TennCare is a statewide program to provide health care benefits to Medicaid beneficiaries, uninsured State residents and those whose medical conditions make them uninsurable. Enrollment will be capped at 1,500,000. If the cap is reached, those in mandatory Medicaid coverage groups and the uninsurables will continue to be enrolled, but enrollment of the currently uninsured group will be limited. All enrollees will be served in capitated managed care plans that are either health maintenance organizations (HMOs) or preferred provider organizations (PPOs).

Significant features of the TennCare program are as follows:

Managed Care Plans

- Initially, the State will develop a community capitation rate to pay plans; thereafter, annual capitation rates will be developed based on the cost experience of the lowest cost managed care organization meeting TennCare quality standards within each community.
- Managed care organizations will be required to provide detailed information on provider and recipient activity, including encounter data, types of care provided, levels of care provided and outcomes of care. These health care plans will compete for enrollment based on quality of service.
- The State will contract with managed health care organizations that are either PPOs or HMOs. Each managed care organization will offer a standard benefit package.
- Each managed care plan within a community will be given a spending target based on number of enrollees. If the spending target is exceeded, plans would be required to pro rate provider reimbursement back to the target.
- Community Health Agencies (CHAs) will be the geographic unit of delivery. The 12 CHAs in the State are governed by a community-based board.
- Existing services for two special populations, Children's Plan enrollees (children in State custody or at risk of custody) and persons with chronic mental illness will be provided through special TennCare plans making use of the existing State delivery system.
- Long term care is not included in the managed care plan.

Eligibility

Three distinct groups will be offered coverage:

- All persons meeting the eligibility requirements of the Medicaid program as it currently exists in fiscal year 1993. The State's current estimate of this group is one million.
- Persons with an existing or prior health condition causing them to be uninsurable, estimated to be about 4,000.
- Persons who are not eligible, either directly or as a dependent, for an employer-sponsored or government-sponsored health plan as of March 1, 1993.

The State is planning to cap enrollment at 1,500,000. While enrollment will not be restricted for those currently eligible for Medicaid or the uninsurables, the cap on total enrollment may limit the number of uninsured served.

Cost-sharing

TennCare requires cost-sharing in the form of premiums, deductibles, and co-payments based on income. All adults and children with incomes above 100 percent of the Federal poverty level (FPL) would be required to pay, except those in mandatory Medicaid eligibility groups. Cost sharing expenditures will be limited by annual out-of-pocket maximums, excluding premium payments. To encourage use of preventive services, no deductible or copayment will be required for such services.

- Premiums will be based on the capitation rates paid to health care plans. Participants with incomes over 100 percent of the FPL will pay some portion of their premiums on a graduated fee schedule so that payments will increase as income increases. There will be individual and family premiums.
- Deductibles will not be required for mandatory Medicaid eligibles. Deductibles will be \$250 for an individual and \$500 for a family with incomes between 101 and 199 percent of the FPL. Enrollees at or above 200 percent FPL may choose to pay a higher deductible (\$1000 for individuals and \$2000 for a family) with a lower premium or a lower deductible (\$250 for an individual and \$500 for a family) with a higher premium. The high deductible plan premium will be about half of the low deductible plan premium.
- Copayments will be up to 10 percent of costs, based on a graduated scale for enrollees with incomes between 101 and 199 percent of the FPL (other than mandatory Medicaid eligibles) and would be 10 percent of the cost of a service for those at or above 200 percent of the FPL. There will be a \$25 fee for non-emergency use of a hospital emergency room.

Benefit package

The TennCare benefits are more generous than those offered under Medicaid for acute care, primarily in that most limits on services are eliminated. The plan emphasizes preventive care by providing all preventive care to adults and children without copayments or deductibles.

Cost

If current rates of State expenditures were to continue, the State has estimated that the Federal share of Tennessee's Medicaid program would be \$11.6 billion under the five-year demonstration, and \$14.8 billion without the demonstration.



THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

The Honorable Ned McWherter
Governor of Tennessee
State Capitol
Nashville, Tennessee 37243

Dear Governor McWherter:

I am pleased to inform you that the Department of Health and Human Services has approved Tennessee's request for Medicaid waivers to implement the TennCare demonstration.

The formal award letter, which is being sent under separate cover, includes the special terms and conditions for conducting this demonstration. These terms are designed to ensure that the demonstration provides high quality health care services to eligible Medicaid recipients, and maintains Federal cost neutrality.

I look forward to following the progress of the demonstration.

Sincerely,

Donna E. Shalala



DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary

Washington, D.C. 20201

Facsimile Cover Sheet

To: Carol Rasco

Organization: WH

From: Pat Woods/John Monahan

Date: 11/19/93

Intergovernmental Affairs
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REMARKS:

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- 1 What were the main issues of negotiation between the State and the Department? What was the resolution of these issues?
- 2 Tennessee's current/final proposal is different from the proposal originally submitted to HCFA. What changes has the State made to the plan to make it more acceptable and ultimately approvable?
- 3 Why did it take so long to approve this plan?

Beneficiaries

- 4 How will current Medicaid beneficiaries be advantaged under Tennessee's proposal?
- 5 Some Medicaid beneficiaries, such as pregnant women and individuals with special needs, have continuing health care needs. Does the plan contain any protections to ensure that enrollees will be allowed to keep the same doctors they have now?
- 6 Are Tennessee and the Federal government financing health care for the uninsured at the expense of current Tennessee Medicaid beneficiaries?

Providers

- 7 Many provider groups wrote to HCFA expressing concerns about the low payment rates and the implementation date. How were those issues addressed in the proposal approved by the Department?

Access/Quality

- 8 How comfortable is HCFA that Tennessee will be able to purchase high quality care given that the proposed managed care premiums will be 75 percent of the Medicaid fee-for-service rates? Are you satisfied that providers will be paid enough to participate in the program?
- 9 How will you ensure that TennCare enrollees will have sufficient access to quality care? What access standards will you use?

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- 10 Do you expect Tennessee to be able to implement this program on January 1, 1994? Since they do not currently have many health plans available to serve this population, are you satisfied that the plan can be implemented on the schedule proposed by the State?
- 11 Why was the enrollment system changed and how will re-enrollment work? Will it provide recipients the necessary time and education to make informed decisions in selecting providers?
- 12 How will the transition to TennCare affect providers, current Medicaid beneficiaries, and the uninsured?

Costs

- 13 How much will this plan cost the Federal government compared to Tennessee's Medicaid program absent a waiver? Is it budget neutral? Are you confident that the Federal treasury will be adequately protected?
- 14 Will the plan save Tennessee money in its Medicaid costs? If so, how much and where will the savings be realized?

Financing

- 15 Tennessee's financing arrangement for TennCare has been criticized as being "actuarially unsound and woefully underfunded." What is the current financing proposal and are these criticisms accurate?
- 16 Can you explain how Tennessee will be able to expand eligibility to 500,000 new eligibles while eliminating a major source of State funding, its hospital provider tax. Does the Federal government have to increase its contribution to make up for the State reduction?
- 17 Does the new waiver give Tennessee a higher nominal Federal matching rate than it had under its old Medicaid program?
- 18 Did the Department accept the State's proposal for matching charity care? If not, why not?
- 19 What is HCFA's definition of Certified Public Expenditures (CPE) for the Tennessee waiver? Will other States be able to utilize this definition, either with or without a waiver?
- 20 The original proposal called for a block grant from the Federal government. Was the block grant concept approved and if not, why not?

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- 21 Tennessee's hospital services tax is scheduled to expire in early 1994 and the State will be losing a significant funding source for its Medicaid program. How will the State be able to maintain the same level of funding for TennCare in the absence of a provider tax?

Waiver Authority/ Impact on Other States

- 22 Will other States be able to replicate the TennCare proposal?
- 23 Tennessee's plan contains some innovative ideas and financing arrangements. Will other States be able to adopt these concepts either with or without a waiver?
- 24 Tennessee used donations and taxes arrangements to finance much of its Medicaid program in the late 1980s. Now that those programs are more difficult to establish, the State is seeking new sources of funding to maintain. Is it equitable to State that never used donations and taxes to approve Tennessee's new financing "scheme"?

Health Care Reform/Big Picture

- 25 How is TennCare different from the President's proposal for health care reform?
- 26 Is TennCare a good example of the President's policy of providing the States flexibility to design health care delivery systems that best fit their specific circumstances?

**TENNCARE
General**

**Q: What were the main issues of negotiation between the State and the Department?
What was the resolution of these issues?**

- A:**
- There was no disagreement about the major goals and objectives of TennCare: expanding coverage for the uninsured and controlling costs. The major disputes evolved around the precise method for achieving those goals.
 - The main issues of negotiation with the State were:
 - block grant approach;
 - preserving Federal/State match;
 - matching charity care;
 - adequacy of State funding;
 - matching of services provided to eligibles (in addition to enrollees);
 - matching of premiums; and
 - implementation date

The issues were resolved as follows:

1. HCFA did not accept the block grant approach, and required that the regular Federal/State matching be continued.
2. HCFA required that the Federal/State match of 67/33 be maintained.
3. To the extent that charity care provided by public hospitals satisfies the Medicaid regulations for Certified Public Expenditures, HCFA agreed to recognize these expenditures for State match.
4. HCFA is assured that the State will have sufficient revenues to meet its matching requirements. If the State does not have sufficient revenues, the State may be required to revise its eligibility income criteria for the uninsured (which currently is unlimited).
5. HCFA agreed to match the cost of services provided to TennCare eligibles who are not enrolled in managed care organizations.
6. HCFA agreed to recognize premium revenues collected by the State as matching funds, subject to a limitation for higher income individuals.
7. The State agreed to reopen the enrollment process and allow beneficiaries additional time for enrollment and plan selection.

**TENNCARE
General**

Q: Tennessee's current/final proposal is different from the proposal originally submitted to HCFA. What changes has the State made to the plan to make it more acceptable and ultimately approvable?

- A:**
- The major changes from the approved proposal and the original proposal are related to the financing for the TennCare demonstration. The original State proposal called for a block grant and would have effectively reduced the State matching from 33 percent to approximately 15 percent.
 - HCFA did not accept the block grant approach and required that the matching rates remained unchanged.
 - In the approved proposal, the State has identified State sources of matching which are acceptable to HCFA. The total budget for the project was smaller when the State reduced the number of uninsured served under TennCare, from 750,000 to 500,000.
 - The State will reopen its enrollment process to allow beneficiaries additional time for plan selection.

**TENNCARE
General**

Q: Why did it take so long to approve this plan?

- A:**
- The proposal was originally submitted on June 16, and the Department committed to making a decision by September 16. On September 16, it was clear to both the State and the Department that there were significant issues to be resolved, and both parties agreed to an extension.
 - The Department and the State have been involved in extensive negotiations on complex issues involving financing for the TennCare proposal.
 - Because both the Department and the State shared the goals of expanding eligibility for the uninsured and improving access through managed care, they continued discussions until all issues were resolved to their mutual satisfaction.

**TENNCARE
Beneficiaries**

Q: How will current Medicaid beneficiaries be advantaged under Tennessee's proposal?

A: Current Medicaid beneficiaries will gain the following advantages under TennCare:

1. The TennCare benefits are somewhat more generous than those offered under the current Medicaid program. While services covered under the current program are retained, limits on many of the services are abolished.
2. There will be a reduced risk of losing Medicaid benefits if income increases. Individuals may remain eligible for TennCare services even though they are no longer eligible for AFDC or the current State medically needy program.
3. Provision of services through managed care organizations should improve access and continuity of care. Use of emergency rooms and public clinics should be reduced.
4. There will be an increased emphasis on providing preventive services for infants and prenatal care for pregnant women. Also, there are no copayments for preventive and prenatal services.

**TENNCARE
Beneficiaries**

- Q:** Some Medicaid beneficiaries, such as pregnant women and individuals with special needs, have continuing health care needs. Does the plan contain any protections to ensure that enrollees will be allowed to keep the same doctors they have now?
- A:**
- The State will ensure that patients in active care at the time of transition will have a reasonable opportunity to complete their treatment or care without the need immediately to change providers.
 - In addition, existing services for two special populations, Children's Plan enrollees and persons with chronic mental illness, will be continued through special TennCare plans making use of the existing State delivery system.

**TENNCARE
Beneficiaries**

Q: Are Tennessee and the Federal government financing health care for the uninsured at the expense of current Tennessee Medicaid beneficiaries?

- A:**
- No. The TennCare demonstration will offer improved benefits to current eligibles, and reduce their risks of losing eligibility if their income increases.
 - In addition, we anticipate that managed care plans will provide improved access and continuity of care compared to the current fee-for-service system.

**TENNCARE
Providers**

Q: Many provider groups wrote to HCFA expressing concerns about the low payment rates and the implementation date. How were those issues addressed in the proposal approved by the Department?

- A:**
- HCFA did receive many letters of concern from provider groups concerning the payment rates and the implementation date.
 - Since providers make their own decisions on whether to participate in a managed care organization, HCFA believed it was inappropriate to endorse or reject individual payment rates between MCOs and providers. We did, however, include assurances that plans would not enroll more beneficiaries than they can effectively serve.
 - + Before a plan begins to operate, HCFA will agree that it includes a sufficient number of providers to care for the potential population. For example, a plan might be approved to enroll 10,000 beneficiaries--no more.
 - HCFA has required the State to reopen the enrollment process to assure that beneficiaries can make informed choices concerning their health plans.

**TENNCARE
Access/Quality**

Q: How comfortable is HCFA that Tennessee will be able to purchase high quality care given that the proposed managed care premiums will be 75 percent of the Medicaid fee-for-service rates? Are you satisfied that providers will be paid enough to participate in the program?

- A:**
- Each provider will make his/her own decision about whether to join a managed care organization. Clearly a key component of that decision will be the payment rates offered by the managed care organization.
 - HCFA traditionally does not examine payment rates between managed care organizations and providers since these are contracts freely entered into between two parties.
 - HCFA will review and ensure that there is sufficient provider capacity before it permits enrollment to proceed in any given plan.

**TENNCARE
Access/Quality**

Q: How will you ensure that TennCare enrollees will have sufficient access to quality care? What access standards will you use?

- A:**
- **HCFA and the State have agreed on guidelines for assuring that managed care organizations have available, accessible, and adequate numbers of providers and service sites for the provision of covered services, including all emergency services, on a 24-hour -a-day, 7-day-a-week basis.**
 - **These guidelines include patient loads, distance/time from providers, and appointment/waiting times. We can make available our specific term and condition for access if requested.**
 - **In addition, the State will require all managed care organizations to implement a quality assurance system, and the State will do its own independent review of quality of care in the plans.**
 - **The State will also conduct a sample survey of all TennCare enrollees each year to determine beneficiary satisfaction.**

**TENNCARE
Implementation**

- Q:** Do you expect Tennessee to be able to implement this program on January 1, 1994? Since they do not currently have many health plans available to serve this population, are you satisfied that the plan can be implemented on the schedule proposed by the State?
- A:**
- HCFA has not required the State to meet a preset implementation date.
 - However, we believe that Tennessee will be able to enroll some persons in TennCare MCOs beginning on January 1, 1993.
 - The State will negotiate contracts with managed care organizations (MCOs) and HCFA must approve all contracts with MCOs prior to the start date of delivery of any services.
 - HCFA is requiring the State to provide assurances that plans would not enroll more beneficiaries than they can effectively serve.
 - + Before a plan begins to operate, HCFA will agree that it includes a sufficient number of providers to care for the potential population. For example, a plan might be approved to enroll 10,000 beneficiaries--no more.
 - In addition, the State has agreed to allow all Medicaid eligibles to make new plan selections, if they desire, after TennCare is approved by HCFA.
 - Because of these requirements under the terms of the new waiver, it is unlikely that Tennessee will be able to enroll all eligible persons in TennCare by January 1.

**TENNCARE
Implementation**

Q: Why was the enrollment system changed and how will re-enrollment work? Will it provide recipients the necessary time and education to make informed decisions in selecting providers?

- A:**
- The State implemented an initial enrollment process for current Medicaid eligibles in October, prior to signing contracts with managed care organizations (MCOs).
 - In order to avoid an potential or actual confusion among beneficiaries, HCFA and the State have agreed that all Medicaid beneficiaries will have an opportunity to make a new selection of a managed care organization after the demonstration is approved by HCFA and after contracts are signed with MCOs.
 - In addition, the State will ensure that patients in active care at the time of transition will have a reasonable opportunity to complete their treatment or care without the need immediately to change providers.

**TENNCARE
Implementation**

Q: How will the transition to TennCare affect providers, current Medicaid beneficiaries, and the uninsured?

- A:**
- The TennCare program will require all Medicaid beneficiaries to receive acute care services through managed care organizations. The current fee-for-service delivery system will be replaced by a delivery system in which Medicaid beneficiaries will select a managed care organization (MCO) to provide their services. All Medicaid providers must affiliate with a MCO in order to provide services to Medicaid eligibles. The State will pay each MCO a monthly capitation rate for each Medicaid beneficiary.
 - HCFA believes that this managed care delivery system should improve access for Medicaid eligibles, who often use emergency rooms of hospitals because they do not have ready access to primary care physicians. The State is placing an emphasis on preventive and prenatal services to reduce development of severe and costly medical problems.
 - For the uninsured in Tennessee, the TennCare program will provide access to an organized delivery system at reasonable premiums. It will provide access to services for up to 500,000 currently uninsured individuals and families who have not been able to afford private health care.

**TENNCARE
Costs**

Q: How much will this plan cost the Federal government, compared to Tennessee's Medicaid program absent a waiver. Is it budget neutral? Are you confident that the Federal treasury will be adequately protected?

- A:**
- HCFA has imposed expenditure caps on Federal expenditures under the demonstration to assure that TennCare will be budget neutral. We believe that the savings from the TennCare demonstration will be between \$1 and \$3 billion, depending on the actual State expenditures.
 - The State has provided savings estimates under a number of scenarios.
 - + If current rates of State expenditures would continue, the State has estimated that the Federal share of Tennessee's Medicaid program would be \$14.8 billion over five years without the demonstration, and \$11.6 billion during the five-year demonstration .
 - + Under the State's most conservative savings estimate, the Federal costs without the demonstration (assuming Health Care Reform is enacted) would be \$13.1 billion over five years, and the Federal costs under the demonstration would be \$12.2 billion.

**TENNCARE
Costs**

Q: Will the plan save Tennessee money in its Medicaid costs? If so, how much and where will the savings be realized?

- A:**
- **Questioners/callers asking about Tennessee's estimates of cost savings should be referred to the State for response.**
 - The State has made estimates of State savings under a number of scenarios. The State's estimate of State savings over the 5 years of the demonstration range between \$ 0.4 and \$1.6 billion. These savings are attained through savings from capitation payments to managed care organizations, which are lower than fee-for-service costs, and through lower rates of growth in health care costs under the demonstration.

**TENNCARE
Financing**

Q: Tennessee's financing arrangements for TennCare have been criticized as being "actuarially unsound and woefully underfunded." What is the current financing proposal and are these criticisms accurate?

- A:**
- HCFA has worked closely with the State to assure that there is adequate financing by the State for the proposal. The current State match of approximately 33 percent will be maintained.
 - The State is assuming that significant savings will accrue by substituting a managed care delivery system for the current inefficient fee-for-service (FFS) system.
 - The State will negotiate contracts with managed care organizations (MCOs) based on current Medicaid fee for service costs. HCFA must approve all contracts with MCOs prior to the start date of delivery of any services.
 - + HCFA will have 30 days to review and approve the contracts.
 - + No Federal funds will be available for contracts not approved by HCFA in advance of their effective date.
 - If there are sufficient MCOs which are willing to accept the State's capitation payment, then Tennessee providers will have, in effect, determined that the State's capitation rates are adequate.
 - HCFA will monitor the adequacy of the managed care delivery system to assure that there is sufficient capacity to provide services to all eligibles.

**TENNCARE
Financing**

Q: Can you explain how Tennessee will be able to expand eligibility to 500,000 new eligibles while eliminating a major source of State funding, its hospital provider tax? Does the Federal government have to increase its contribution to make up for the State reduction?

- A:**
- The State will be able to expand eligibility by implementing a more efficient managed care delivery system. Through this delivery system, the State will reduce the rate of growth of Medicaid costs. These savings will permit covering the additional eligibles.
 - The State has substituted other existing State funding sources to partially replace the hospital provider tax.
 - In addition, the State will also obtain new State revenues from patient premiums.
 - HCFA has required that the current State match of 33 percent be maintained during the demonstration. The Federal government will not increase its contribution to make up for the State reduction.

**TENNCARE
Financing**

Q: Does the new waiver give Tennessee a higher nominal Federal matching rate than it had under its old Medicaid program?

- A:**
- HCFA has required that the current Federal matching rate of 67 percent be maintained during the demonstration.
 - We have not modified the matching rate.

**TENNCARE
Financing**

Q: Did the Department accept the State's proposal for matching charity care? If not, why not?

- A:**
- **HCFA did not agree to match \$600 million of charity care because it did not satisfy the current criteria for Medicaid expenditures that are matchable.**
 - **Charity care does not represent an expenditure by the State Medicaid program, as required for matching. Instead, charity care represents the amount of revenue that hospitals would have received had patients paid their bills.**
 - **To the extent that charity care provided by public hospitals qualifies as Certified Public Expenditures (CPE) under current Medicaid regulations, HCFA will recognize such expenditures.**

**TENNCARE
Finaneing**

- Q:** What is HCFA's definition of Certified Public Expenditures (CPEs) for the Tennessee waiver? Will other States be able to utilize this definition, either with or without a waiver?
- A:**
- Current Medicaid regulations (42 CFR 433.51) state that public funds may be considered as the State's share in claiming Federal Financial Participation (FFP) if they satisfy the following conditions:
 - (1) the public funds are appropriated directly to the State or local Medicaid agency, or transferred from other public agencies to the State or local agency, or certified by the contributing public agency as representing expenditures eligible for FFP; and
 - (2) the public funds are not Federal funds, or are Federal Funds authorized by Federal law to be used to match other Federal funds. Funds meeting these conditions are recognized as CPE.
 - Other States are currently claiming CPE using this definition for expenditures under the regular Medicaid program.
 - For the TennCare demonstration, HCFA agreed to CPE to the extent that a public hospital is able to document that it has an actual unreimbursed expenditure for providing TennCare services to a TennCare enrollee or eligible. This is permissible under the current regulation.
 - No waiver was required to recognize this CPE. However, the TennCare waiver to expand eligibility provides for coverage of services to individuals at these hospitals who were not previously eligible for Medicaid.

**TENNCARE
Financing**

- Q:** The original proposal called for a block grant from the Federal government. Was the block grant concept approved and if not, why not?
- A:**
- HCFA did not approve the block grant concept. The primary reason the block grant was not approved was that it would have changed the Federal matching rate from 67 percent to approximately 85 percent.
 - This would have significantly shifted costs from the State to the Federal government. HCFA required that the matching rate not be modified.

**TENNCARE
Financing**

- Q:** Tennessee's hospital service tax is scheduled to expire in early 1994 and the State will be losing a significant funding source for its Medicaid program. How will the State be able to maintain the same level of funding for TennCare in the absence of a provider tax?
- A:**
- Although the State will lose the revenues from the hospital service tax (approximately \$600 million), the State has indicated it will be able maintain its level of funding.
 - In fact, the State estimates that its funding in SFY 93-94 will increase to \$1,036 million, up from the estimated SFY 92-93 expenditures of \$877.7 million.
 - The State will obtain additional State Medicaid funding from local government contributions, patient premiums, and other State revenues.

**TENNCARE
Impact on Other States**

Q: Will other States be able to replicate the TennCare proposal?

A:

- HCFA reviews each State health care reform proposal on its own merits.

- + Section 1115 is a demonstration authority.

- + We could have other similar demonstrations.

- + Simple replication is not the way we would proceed.

- + Each application would have to be separately—and carefully—evaluated.

- We have been encouraging States to submit proposals that are consistent with the President's health care reform initiatives, but thus far, each State's waiver has had its own unique features.

- We have previously awarded statewide health care reform waivers to the States of Oregon, Hawaii, and Rhode Island.

- + The Kentucky waiver has been approved but we are awaiting a decision by the Governor as to when the announcement will be made within the next week.

TENNCARE
Impact on Other States

Q: Tennessee's plan contains some innovative ideas and financing arrangements. Will other States be able to adopt these concepts either with or without a waiver?

- A:**
- The fundamental concept that Tennessee is implementing is to finance the expansion of Medicaid eligibility to the uninsured through the savings from managed care delivery systems. This is not a unique concept, and is being tested in other State health care reform demonstrations approved by the Department.
 - To the extent that Tennessee's financing concepts are being implemented without waivers, they are available for all States to consider. If demonstration waivers are required, the State would have to submit a formal application for HCFA review since a prime consideration is that the proposal must be budget neutral.

**TENNCARE
Impact on Other States**

- Q:** Tennessee used donations and taxes arrangements to finance much of its Medicaid program in the late 1980s. Now that those programs are more difficult to establish, the State is seeking new sources of funding to maintain its program. Is it equitable to States that never used donations and taxes to approve Tennessee's new financing "scheme?"
- A:**
- The primary waivers approved for Tennessee permit the State to expand eligibility and to require beneficiaries to enroll in managed care delivery systems.
 - We have required the State to maintain its 33 percent matching rate. It should be recognized that Tennessee has significantly reduced its dependency on donations and taxes arrangement under TennCare by eliminating its hospital service tax.

**TENNCARE
Health Care Reform**

Q: How is TennCare different from the President's proposal for health care reform?

A: TennCare is different in many key respects from the Health Security Act.

- **Financing. State financing is not assured.** Under health care reform, States will be required to make maintenance of effort payments to the alliance on behalf of Medicaid eligibles. Under TennCare, the State would not be obligated to maintain its previous level of Medicaid spending. Of course, since this is still a matching program, if the State contribution is reduced, the Federal share will be reduced accordingly.
- **Managed Care. Program participants will not have a fee-for service option.** Under health care reform, individuals will have a choice between managed care and fee for service health plans. In TennCare, Medicaid and uninsured individuals can only choose among managed care organizations.
- **Access. Universal access will not be assured.** Under health care reform, everyone will be guaranteed access to alliance coverage. With its capped enrollment and proposed phase-in, some individuals will remain uninsured under TennCare.
- **Cost Shifting. Rate reductions are likely to lead to cost shifting.** Under health care reform, balanced reductions in the public and private sectors will prevent further cost shifting. Under TennCare, further shifting is likely -- provider payments will be reduced only for those serving TennCare enrollees.
- **Mainstreaming. Distinctions of poor and rich will remain.** Under health care reform, the poor will be mainstreamed and discrimination reduced. Under TennCare, a separate program and continued payment differentials will keep care for the poor out of the mainstream.

**TENNCARE
Health Care Reform**

Q: Is TennCare a good example of the President's policy of providing the States flexibility to design health care delivery systems that best fit their specific circumstances?

- A:**
- TennCare is just one example of the Administration's commitment to give States the flexibility we know they need to fashion programs in ways that best meet the needs of their citizens.
 - In Medicaid demonstration waiver activity this year, we have now approved four statewide health care reform waivers for Oregon, Hawaii, Rhode Island, and Tennessee.
 - + Indeed, HCFA has approved virtually all statewide health reform waivers that are in its processing pipeline (the Kentucky waiver has been approved but we are awaiting a decision by the Governor as to when the announcement will be made within the next week).
 - We have approved 16 other State Medicaid demonstration waivers in more policy-focused areas (e.g., pregnant substance abusers, long-term care, and family planning).
 - HCFA is in the midst of discussions with 12 other States over health care reform initiatives.