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Fiscal Review Committee



STATE OF TENNESSEE
G-19 WAR MEMORIAL BUILDING
NASHVILLE, TENNESSEE 37243-0057
615-741-2564

Tom Nelson

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EXECUTIVE DIRECTOR
DONALD L. MORTON

MEMORANDUM

TO: Each Member of the TennCare Committee
FROM: Donald L. Morton, Executive Director *DM*
DATE: October 27, 1993
SUBJECT: TennCare Financing

You have requested my comments relative to TennCare financing.

Schedule 1 reflects the state's answer to HCFA regarding amounts and sources of state match relating to the TennCare Program. Beginning with the "Budget FY 1993-94" Column, the Total Column (\$3,596,811,400) is divided into the "Federal" entry of (\$2,267,074,100) to obtain the federal contribution percentage of 63.03%. Yet part of the TennCare revenue of \$563,125,000 is Other Health Appropriations (Federal) - TennCare. This means we are calling federal funds non-federal funds when computing the federal percentage contribution.

Our comments relating to the six sources of TennCare revenue - all of which are considered by the state as state match or share - are as follows:

1. Coinsurance, deductibles, and insurance premiums serve to reduce the program cost and are neither a state match or federal share.
2. Other state-federal programs were probably placed in the funding scheme because the state portion is high compared with related federal funds.
3. Local governments cannot be a source of funding because the state, under TennCare, has not imposed a matching requirement against local governments.
4. Charity care is not a source of funding but even if it were, why would it be 100% state funding and not 68% federal and 32% state.

Memorandum
page 2
October 27, 1993

The waiver requests an increase in federal funds of \$513,835,200 over the Governor's FY 1993-94 Proposed Medicaid Budget originally recommended to the 1993 General Assembly and an increase of \$361,856,400 over the 1992-93 approved Medicaid budget. State matching (share) funds on a continuing basis decrease by \$404,350,000 from the Governor's 1993-94 Proposed Medicaid Budget originally recommended to the 1993 General Assembly and by \$376,125,200 on a continuing basis from the 1992-93 approved Medicaid budget.

Schedule 2 reflects our analysis of federal and state funding for TennCare for the first full year.

Schedule 3 reflects our analysis of the estimated additional state funding needed (\$430 Million) to implement the TennCare Program for 1,775,000 eligibles, if the assumption is made that total funding of \$1,279.84 per eligible is adequate. (See Schedule 4)

Schedule 5 reflects our analysis of the estimated additional state funding needed (\$264 Million) to continue Medicaid under a managed care system, if the assumption is made that the total funding of \$1,279.84 per eligible is adequate. (See Schedule 4)

If you have any questions or need additional information, please let me know.

DLM:jmr

Amounts and Sources of State Match

Budget Total	Budget FY 1989/90	Budget FY 1990/91	Budget FY 1991/92	Budget FY 1992/93	Budget FY 1993/94	Budget FY 1994/95	Budget FY 1995/96	Budget FY 1996/97	Budget FY 1997/98
State Core	\$357,788,300	\$404,703,000	\$365,024,300	\$378,424,700	\$383,049,300	\$384,540,700	\$406,378,900	\$418,568,200	\$431,125,200
State - Other *	\$85,000,000	\$133,000,000	\$397,098,000	\$541,000,000	\$383,563,000	\$84,000,000	\$88,200,000	\$92,810,000	\$97,241,000
Federal	\$997,035,200	\$1,152,827,800	\$1,805,850,300	\$1,905,155,000	\$2,287,074,100	\$2,380,427,800	\$2,499,449,200	\$2,824,421,700	\$2,755,642,800
TennCare Revenue	\$0	\$0	\$0	\$0	\$583,125,000	\$1,184,987,500	\$1,250,195,300	\$1,320,117,500	\$1,394,686,200
TOTAL	\$1,439,821,500	\$1,690,530,800	\$2,357,872,600	\$2,824,579,700	\$3,996,811,400	\$4,043,958,000	\$4,244,221,400	\$4,455,717,400	\$4,978,675,200
Charity - TennCare					\$297,750,000	\$831,485,500	\$872,875,900	\$717,926,800	\$766,479,900
Coinsurance and Deductible - TennCare					\$42,898,600	\$89,987,000	\$94,150,400	\$98,857,900	\$103,800,300
Insurance Premiums - TennCare					\$71,219,400	\$149,581,000	\$157,039,000	\$184,891,000	\$173,136,000
Other Health Appropriations (State) - TennCare					\$94,132,100	\$193,912,000	\$199,729,000	\$205,721,000	\$211,883,000
Other Health Appropriations (Federal) - TennCare					\$22,324,900	\$57,542,000	\$71,278,000	\$74,840,000	\$78,582,000
Local Government - TennCare					\$25,000,000	\$52,500,000	\$55,125,000	\$57,881,000	\$60,775,000
TOTAL	\$0	\$0	\$0	\$0	\$583,125,000	\$1,184,987,500	\$1,250,195,300	\$1,320,117,500	\$1,394,686,200
Percent Federal Contribution	69.25%	68.19%	68.10%	67.45%	63.03%	68.86%	68.89%	68.90%	68.90%

* This includes: License Fee/Services Tax - Hospitals, License Fee - Nursing Homes, Donations - Hospitals, and CPE

STATE OF TENNESSEE
COMPARISON OF FEDERAL FUNDING AND STATE FUNDING FOR TENNCARE

	<u>FEDERAL</u>	<u>STATE</u>
TOTAL FUNDING	\$2,267,074,100	\$383,049,300
LESS: PROGRAMS OUTSIDE TENNCARE		
SKILLED NURSING	\$ 45,279,400	\$ 22,045,600
ICF REGULAR/MR	474,760,400	231,150,600
MEDICARE/ADM	<u>111,280,100</u>	<u>54,179,900</u>
TOTALS	\$631,319,900	\$307,376,100
LESS: NURSING HOME BED TAX	<u> -</u>	<u>80,300,000</u>
 TOTAL NET PROGRAMS OUTSIDE TENNCARE	 <u>631,319,900</u>	 <u>227,076,100</u>
 NET FUNDING FOR TENNCARE EXCLUDING FUNDING FOR PROGRAMS OUTSIDE TENNCARE	 <u>\$1,635,754,200</u>	 <u>\$155,973,200</u>
 PERCENTAGE FUNDING	 91.29%	 8.71%

COST PER ELIGIBLE EXCLUDING CO-PAY, DEDUCTIBLES AND PREMIUMS \$1,635,745,200 + \$155,973,200 = \$1,791,718,400 DIVIDED BY 1,775,000 = \$1,009
 COST PER ELIGIBLE INCLUDING CO-PAY, DEDUCTIBLES AND PREMIUMS \$1,635,745,200 + \$155,973,200 + \$227,836,000 = \$2,019,554,000 DIVIDED BY 1,775,000 = \$1,137

STATE OF TENNESSEE
ESTIMATED COST FOR TENNCARE UNDER A MANAGED CARE SYSTEM ASSUMPTION: THE COST PER ELIGIBLE WOULD BE THE SAME AS THE HARD DOLLAR FUNDING UNDER TENNCARE

TOTAL PROJECTED TENNCARE COST FOR 1,775,000 ELIGIBLES @ \$1,009 PER ELIGIBLE \$1,790,975,000

FUNDING BREAKDOWN:

FEDERAL 67.25% @ \$1,790,975,000 \$1,204,430,687
 STATE 32.75% @ \$1,790,975,000 586,544,313

TOTAL \$1,790,975,000

<u>TOTAL ESTIMATED TENNCARE PROGRAM COST</u>	<u>FEDERAL</u>	<u>STATE</u>
COST FOR TENNCARE ELIGIBLES	\$1,204,430,687	\$586,544,313
ADD: SKILLED NURSING	45,279,400	22,045,600
ICF REGULAR/MR	474,760,400	231,150,600
MEDICARE/ADM	<u>111,280,100</u>	<u>54,179,900</u>
ESTIMATED TENNCARE PROGRAM COST	\$1,835,750,587	\$893,920,413
TOTAL	<u>\$2,729,671,000</u>	

ADDITIONAL STATE FUNDING NEEDED

EST. STATE FUNDS NEEDED FOR TENNCARE \$893,920,413

LESS: FUNDS AVAILABLE FOR ELIGIBLES UNDER TENNCARE 155,973,200
 SKILLED NURSING 22,045,600
 ICF REGULAR/MR 231,150,600
 MEDICARE/ADM 54,179,900

TOTAL FUNDING PLANNED 463,349,300

ADDITIONAL STATE FUNDING NEEDED \$430,571,113

COMPARISON OF PER ELIGIBLE PAYMENT TO PROVIDERS UNDER THE
EXISTING SYSTEM WITH PER ELIGIBLE PAYMENT TO MANAGED CARE
ORGANIZATIONS UNDER THE TENNCARE PLAN

EXISTING PROGRAMS:

PROJECTED COST PER MEDICAID ELIGIBLE PER TENNCARE PLAN IF MEDICAID WERE CONTINUED	\$1,641.00
ADD: PER MEDICAID ELIGIBLE EQUIVALENT FOR OTHER STATE AND FEDERAL FUNDS (\$252,913,900 DIVIDED BY 1,128,399)	<u>224.13</u>
TOTAL FROM STATE UNDER CURRENT SYSTEM	<u>\$1,865.13</u>

 TENNCARE PROGRAM:

PROJECTED COST PER TENNCARE ELIGIBLE FROM STATE AND FEDERAL FUNDS	1,009.00
ADD: PER TENNCARE ELIGIBLE EQUIVALENT FOR OTHER STATE AND FEDERAL FUNDS (\$252,913,900 DIVIDED BY 1,775,000)	142.48
PROJECTED CO-PAY DEDUCTIBLES AND PREMIUMS TO BE PAID BY TENNCARE ELIGIBLES (\$227,836,000 DIVIDED BY 1,775,000)	<u>128.36</u>
TOTAL FROM STATE AND PERMITTED BY THE STATE TO BE COLLECTED	<u>1,279.84*</u>
DECREASE IN PER PAYMENT PER ELIGIBLE	<u>\$585.29</u>
PERCENTAGE DECREASE IN PER ELIGIBLE PAYMENT	31.38%

* APPROXIMATELY 10-20% OF THIS AMOUNT WILL NOT BE RECEIVED BY PROVIDERS
BUT WILL BE RETAINED BY MANAGED CARE ORGANIZATIONS FOR OPERATING
EXPENSES AND PROFITS. UNDER MEDICAID ALL AMOUNTS WOULD HAVE BEEN
RECEIVED BY PROVIDERS.

STATE OF TENNESSEE

ESTIMATED COST TO CONTINUE MEDICAID BUT UNDER A MANAGED CARE SYSTEM
ASSUMPTION: THE COST PER ELIGIBLE WOULD BE THE SAME AS THE HARD DOLLAR
FUNDING UNDER TENNCARE

TOTAL PROJECTED MEDICAID COST FOR 1,128,399
 ELIGIBLES @ \$1,137 PER ELIGIBLE \$1,282,989,663

FUNDING BREAKDOWN:

FEDERAL 67.25% @ \$1,282,989,663	\$ 862,810,548
STATE 32.75% @ \$1,282,989,663	<u>420,179,115</u>

TOTAL	<u>\$1,282,989,663</u>
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<u>TOTAL ESTIMATED MEDICAID PROGRAM COST</u>	<u>FEDERAL</u>	<u>STATE</u>
COST FOR MEDICAID ELIGIBLES WHO WOULD HAVE BEEN COVERED UNDER TENNCARE	\$ 862,810,548	\$420,179,115
ADD: SKILLED NURSING	45,279,400	22,045,600
ICF REGULAR/MR	474,760,400	231,150,600
MEDICARE/ADM	<u>111,280,100</u>	<u>54,179,900</u>
ESTIMATED MEDICAID PROGRAM COST	\$1,494,130,448	\$727,555,215
TOTAL	<u>\$2,221,685,663</u>	

ADDITIONAL STATE FUNDING NEEDED

EST. STATE FUNDS NEEDED FOR MEDICAID \$727,555,215

LESS: FUNDS AVAILABLE FOR MEDICAID ELIGIBLES UNDER TENNCARE	155,973,200
SKILLED NURSING	22,045,600
ICF REGULAR/MR	231,150,600
MEDICARE/ADM	<u>54,179,900</u>

TOTAL FUNDING PLANNED 463,349,300

ADDITIONAL STATE FUNDING NEEDED \$264,205,915

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November 5, 1993

VIA FEDERAL EXPRESS

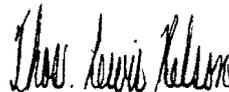
The Honorable Donna E. Shalala
Secretary of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Secretary Shalala:

Enclosed are two reports to the Tennessee General Assembly's TennCare Oversight Committee confirming our earlier conclusion that the State of Tennessee's demonstration project known as TennCare is actuarially unsound and woefully underfunded. The first report is from the Oversight Committee's outside consultants, Schubert Associates, Inc. and Milliman & Robertson. The second report is from the Executive Director of the General Assembly's Fiscal Review Committee, Tennessee's equivalent of the Congressional Budget Office.

We urge you will seriously consider the analysis of these disinterested consultants in deciding whether to grant the waiver that Tennessee's implementation of TennCare would require. Please let us know if you have any questions.

Very truly yours,



Thomas Lewis Nelson

c: The Honorable John D. Dingell → NOTE
The Honorable Carol Hampton Rasco
The Honorable Bruce C. Vladeck
Darrel J. Grinstead, Esq.

October 28, 1993

Senator Milton H. Hamilton, Jr.
Chairman, Oversight Committee on TennCare
13 Legislative Plaza
Nashville, TN 37243

Dear Senator Hamilton:

Since our retention as your consultants SCHUBERT ASSOCIATES INC. and Milliman & Robertson have performed an intense review of TennCare and its implementation to date.

We appreciate the excellent support provided to us by Mr. Douglas Wright and Mr. Ron Paolini as well as the Executive Assistant of the Comptroller of the Treasury, Mr. John Morgan.

We were able to meet on several occasions with Mr. Manny Martins and members of his staff. We appreciate their cooperation in our review process.

We also acknowledge the receptiveness of various health plans, individual physicians and other professionals, the various trade associations particularly the Tennessee Hospital Association and the Tennessee Medical Association.

A survey was sent under your auspices to each of the Managed Care Organizations (MCOs) that indicated a desire to contract with TennCare. This survey provided certain basic information and afforded respondents a vehicle for comments and suggestions.

A telephone survey of a limited number of randomly selected physician offices and clinics from existing health plan directories was conducted. Another telephone interview survey of high Medicaid volume physician offices was also carried out.

Through out the course of our review, we were supplied numerous documents and analyses that concerned TennCare and its implementation. These were furnished by the Bureau of Medicaid, The Comptroller's office, legislative offices, and many other interested parties.

We also obtained valuable input from our attendance at several of your committee's legislative hearings on the TennCare program.

In performing our review, we concentrated on answering several global questions that were raised by your committee as well as by other involved groups. These global questions contained ancillary questions which also were addressed.

This report is divided into an Executive Overview and Recommendations.

SCHUBERT ASSOCIATES INC. and Milliman & Robertson appreciate the opportunity to review the TennCare program for the committee. We hope our initial report will be useful both to the legislature and the administration. We look forward to continued participation with you in the implementation of this challenging and important project.

Sincerely,

A handwritten signature in cursive script that reads "James J. Schubert M.D.".

James J. Schubert, M.D.
President

Executive Overview

Our report concentrated on three global issues from which a series of additional issues and questions were developed. The following represents a synopsis of our findings.

Question 1. Was the determination of the capitation rates to be paid to the participating Managed Care Organizations (MCOs) based upon sound actuarial principles and methods?

Response:

1. The process used by the state to develop the gross capitation rates was not based on sound actuarial principles.

The state used calendar year 1992 Medicaid experience as the basis for its calculations.

The state effectively assumed all Medicaid beneficiaries were covered a full 12 months in 1992. In actuality, the average coverage period was 8.7 months, which causes a significant understatement in the capitation.

2. The state's underlying 1992 Medicaid utilization levels suggests there is significant potential for MCOs to reduce Medicaid utilization. The state did not make an explicit cost reduction assumption in developing its capitation rates. We believe such an adjustment is appropriate. However the adjustment should also recognize the administrative expenses that MCOs will incur in conjunction with this program.
3. The state's proposed gross capitation rates effectively equate to a 25% reduction in projected 1994 Medicaid costs per eligible month on average. Recognizing MCO administrative expenses, MCOs would have to achieve medical cost reductions of about 35% in order to operate within the capitation levels. Reductions of this magnitude will be extremely difficult for MCOs to achieve unless providers are willing to accept reimbursement levels significantly below the state's current fee levels.
4. We believe an explicit cost reduction assumption of 10% in 1994 would be more appropriate which, when recognizing MCO administrative expenses, would require MCOs to achieve medical cost reductions of about 20%.
5. The reductions to the gross capitation rates were not well documented. The source of these reductions should be reviewed and adjustments made if appropriate. The charity care reductions should be adjusted to reflect the actual number of uninsured enrolled.

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Question 2: Can TennCare be implemented by January 1, 1994?

Response:

Yes, TennCare can be implemented by January 1, 1994, provided the following issues are adequately addressed:

1. Federal Waiver

Until the federal waiver is approved providers and beneficiaries are unable to make key decisions, i.e. providers contracting with a MCO(s), beneficiaries selecting a primary care case manager. These decisions must be made prior to January 1 and are sequential decisions.

2. Provider Contracts

The MCOs develop contracts with providers that result in adequate network coverage and capacity.

3. MCO selection

The enrollees have sufficient opportunity to select MCOs after the networks are identified.

There is an MCO assignment default mechanism that allocates enrollees equitably among the MCOs.

Adequate provision exists to allow enrollees to change their MCOs after the initial enrollment process is completed.

4. Provider Support

The current provider resistance is overcome through equitable reimbursement and risk sharing arrangements with all MCOs. Provider exclusion from the TennCare development process and the lack of ongoing provider input into the program design has fostered an adversarial relationship with the provider community that will create substantial problems for a timely and successful TennCare implementation.

5. Enrollee Support

There has been significant chaos and confusion on the part of beneficiaries that will be disruptive to the plans, the state administration, physicians, hospitals, clinics and emergency rooms. These concerns can be alleviated through improved communication from the state and MCOs.

Question 3: Do the MCOs that have indicated their intent to contract possess the ability to provide TennCare program components for the Medicaid and uninsured population?

Response:

It was not possible, based on the information available, to evaluate each of the MCOs ability to provide the required program components of TennCare. These program elements include: 1. An adequate network of providers, including primary care, specialty care and hospitals willing to assume care of the enrollees; 2. Management staff experienced in utilization and quality management; 3. Operating systems sufficient to pay claims, track services and develop reports; 4. Adequate financial reserves to cover startup costs and unexpected administrative and/or health care costs.

1. The absence of a final MCO contract makes it difficult to evaluate each MCO's capability to implement and operate an effective managed health care delivery system by January 1, 1994.
 - Weakness in any one program component, particularly utilization management, could be a serious detriment to operating within the capitation budget for the MCOs. It may take several years for start up plans to obtain maximum efficiency.
2. Some MCOs will fail due to:
 - Lack of financial reserves, if capitation income is inadequate, to cover an MCO's administrative costs in addition to health care costs for their enrolled population.

Smaller MCOs will not have the reserves to carry unforeseen administrative and health care costs, while mature and larger MCOs will have reserves allowing them to cover costs for several years until the costs are stabilized. The TennCare program design favors larger statewide organizations or MCOs with capital, rather than local or regional MCOs.

- Inadequate or unstable provider networks.
One of the MCOs initially has proposed very low reimbursement rates to certain providers. Providers feel that they are being forced to contract and accept the proposed rates or lose other patients.

Many primary care providers are not certain they will accept these rates and may choose not to contract. This would leave a large primary care void in their county, particularly, in rural areas.

- Management staff and plan inexperience in managed care.
- Adverse selection.

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Many primary care providers are not certain they will accept these rates and may choose not to contract. This would leave a large primary care void in their county, particularly, in rural areas.
- Management staff and plan inexperience in managed care.
- Adverse selection.

Adverse selection could be an problem for smaller MCOs that are attractive to the uninsured, and could seriously impact the MCOs financial results. Specifically, safety net provider MCOs have voiced concern that they could be selected by a disproportionate number of the sicker beneficiaries with a history of care at their facility, or that the state could assign these beneficiaries disproportionately. Safety net sponsored health plans have the potential to suffer more financially because of adverse selection.

3. Primary Care Case Management (PCCM) phase-in

- Currently, the MCO contract does not require implementation of PCCM programs for 3 years. PCCM programs are an integral component of managed care programs and are necessary for utilization management, quality, continuity and appropriateness of referral services.

4. PPO Standards

- PPOs should have a portion of their administrative fees placed at risk in order to provide incentives to meet certain utilization and cost targets. The amount of risk that the PPOs administrative fee is placed should be equal to the risk they have asked their participating providers to accept. As an example, if primary care physicians have a 20% risk withhold, then the PPO's fee should have a similar withhold.

5. Network Adequacy

- The current MCO contract with the state does not require the MCOs to identify how many beneficiaries a provider agrees to accept. Without this information, network adequacy and access cannot be accurately assessed.

Recommendations: TennCare

It would be customary for us, as your consultants, to propose numerous specific recommendations that could have been adopted by the state. However, in this particular instance, we are faced with a certain set of circumstances which dictate a more reserved response.

Those circumstances are as follows:

- a. The state's ability to fund the Medicaid program in 1994 at its current level is restricted.
- b. In an attempt to live within its fiscal constraints, the state has devised a plan which through federal funds and the use of state credits and discounts provides managed care to both the Medicaid and uninsured populations.
- c. Because of the critical need for fiscal relief, the state, simultaneous with its federal waiver application, has pushed forward with its implementation plan by proposing contracts with multiple managed care organizations.
- d. Currently the state is simultaneously enrolling beneficiaries, negotiating contracts and carrying out other needed implementation functions while awaiting federal approval.
- e. Assuming some form of federal approval, our recommendations must be crafted so as not to unduly disrupt or impede but rather facilitate and enhance a successful start up.

Recommendations:

1. The gross capitation rates should be redetermined, with adjustments to reflect both the average Medicaid coverage period per beneficiary and an explicit cost reduction assumption. We believe a cost reduction assumption of 10% in 1994 would be appropriate.
2. The source of the reductions to the gross capitation rates should be made available and reviewed, and adjustments made if appropriate. The charity care reduction should be adjusted to reflect the actual number of uninsured enrolled.
3. Gross capitation rates and capitation rate reductions should vary by geographical area.
4. A relief mechanism should be established for MCOs who enroll a disproportionate number of high cost, high risk uninsured enrollees.
5. The providers must be reassured that they are not the fiscal underwriters or the payors of last resort for TennCare. There should be specific limits on the total

risk that any provider should be asked to accept. Provider risk and surplus sharing should be equitable between the plans and the providers. PPOs should have a portion of their administrative fees placed at risk in order to provide incentives to meet certain utilization and cost targets. PPOs should place their administrative fee at risk in proportion to the risk assumed by their participating providers. As an example, if PPO primary care physicians have a 20% risk withhold, then 20% or more of the PPO's fee should be placed in the risk pool.

6. A primary care case manager (gatekeeper) system should be required in each MCO within 6 months of the start work date for at least 50% of enrollees; 100% at 12 months.
7. A meaningful, consistent communications program should be developed by the state to directly communicate with physicians, hospitals and other providers. The objective of this program is to encourage and develop the provider support essential for the success of TennCare.
8. Primary care physician and clinic contracts with MCOs should clearly state the number of TennCare patients targeted for enrollment in each practice.
9. A short term extension of the enrollment process would provide the state and enrollees a more reasonable amount of time to resolve MCO selection issues.

CHARITY CARE

QUESTION:

HCFA staff has admitted that it would accept my argument that charity care could receive Federal match if I were to tax providers for the value of charity care and cycle this money through the State treasury. Why are you making us jump through burcaucratic hoops?

ANSWER:

- ▶ **Provider taxes are more than just "bureaucratic hoops."** Taxes are fundamentally different than directly matching charity care. To be permissible, provider taxes must meet certain requirements imposed by the 1991 donations and taxes law. These requirements are intended to make the burden more equitable, but also make the taxes less popular with providers. If a permissible tax were created, the revenues could be used to pay for charity care in a State and matched with Federal dollars.
- ▶ **We are willing to match charity care under certain conditions.** If the care is provided to a TennCare enrollee by a public facility and the uncompensated amount is identified as a certified public expenditure, Federal matching funds are available. This amount is less than the full amount of charity care for which Tennessee requested Federal match.
- ▶ **However, we are not willing to recognize all charity care as a matchable expense.** Since charity care is often difficult to define and account for, an open-ended recognition of charity care could have a large effect on the Federal treasury, up to \$13 billion annually. We do not want to set a precedent that would result in full Federal reimbursement of hospitals' uncompensated costs.

KEY INFORMATION:

- ▶ The provider taxes and donations regulations were developed to place a firm limit on State methods of revenue raising for the purpose of Medicaid matching. State abuses have received considerable press and Congressional attention, and lead to a statutory restriction on provider taxes. If we open the door to charity care here, other States will ask for the same relief through the waiver process.

BLOCK GRANT APPROACH

QUESTION:

Why do you object to a block grant approach when it not only holds the federal government fiscally harmless from cost increases, but reduces the growth in Tennessee's Medicaid program?

ANSWER:

Although a block grant is no longer being considered, let me outline our concerns with Tennessee's original proposal.

- ▶ **The State could drastically reduce its Medicaid spending.** As originally proposed, the block grant approach was unacceptable because the Federal government would have been required to maintain its prior level of Medicaid spending but the State would not have been subject to the same requirement. This would have significantly altered the Medicaid matching percentages in Tennessee and severed the basic federal-state financing relationship.
- ▶ **Approval of a block grant could undermine the Health Security Act.** Key members of Congress, including Representatives Dingell and Waxman, essential to passing health care reform, would strongly object to a block grant approach and may respond by threatening to curtail the Secretary's waiver authority.
- ▶ **Growth in Tennessee's Medicaid program is likely to slow anyway.** The State had expanded its program over the last several years by using donations and taxes funding. The new donations and taxes law has substantially reduced the ease with which such funds can be raised.
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 - + Other States have successfully reduced the rate of growth in their Medicaid programs while maintaining a matching arrangement.

KEY INFORMATION:

- ▶ **Arizona.** Tennessee's request for a block grant is fundamentally different from the funding approach taken at the outset of Arizona's Health Care Cost Containment System (AHCCSS) program. For Arizona a fixed Federal payment was established based on per capita data from other States with comparable populations and services. At the time, Arizona did not have an operational Medicaid program and this approach allowed the State to quickly build its program from scratch. Arizona has since gradually moved toward a matching arrangement. Tennessee planned to use a block grant to radically restructure its Medicaid program and reduce its State Medicaid expenditures.

PRESERVING FEDERAL/STATE MATCHING IN MEDICAID**QUESTION:**

What is so important about preserving Federal/State matching of Medicaid costs?

ANSWER:

Tennessee has agreed to follow the Medicaid matching policies for TennCare. The matching relationship provides an essential tool for ensuring that States manage their Medicaid programs effectively.

- ▶ Medicaid is jointly funded by both Federal and State governments, yet it is administered by the States.
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HEALTH CARE REFORM

QUESTION:

Our program is just like your proposal for national health care reform: Tennessee will cover many of the uninsured, enroll them in managed care, and bargain down provider rates to obtain the efficiency that is now missing in the system. How can you turn down in Tennessee what you are trying to do nationally?

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QUESTION:

The Health Care Financing Administration (HCFA) has acted like an "over-ruled, over-regulated, over-governed" bureaucracy throughout the TennCare waiver review process. How can such an agency effectively help States implement health care reform?

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11/8/93

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I appreciate the fact that you are having difficulties with the financing of your Medicaid program, because of the repeal of your provider tax and the high growth rate of your program.

However, your TennCare proposal presents a number of difficulties for the Federal government, as well as for beneficiaries and providers in Tennessee:

- o The State is sharply reducing its "real" contribution to the Medicaid program, while expecting the Federal government to maintain and increase its contribution. This puts us in an awkward position immediately prior to health reform, which assumes state maintenance of effort.
- o You have asked us to approve a number of unorthodox financing arrangements that other states will quickly imitate, at a cost to the Federal budget. Your plan has also caught the attention of Congressional oversight committees.
- o Your planned implementation date of January 1 has been difficult for beneficiaries. You have required beneficiaries to select health care plans before they know which one their doctor has signed up for. This has been especially difficult for those with special needs and multiple providers.
- o Physicians are up in arms over the 25-35 percent cuts in reimbursement they anticipate under TennCare; we have concerns that many critical providers may not participate.

The Department of Health and Human Services has worked with you in good faith over the past two months in an effort to develop a compromise that both sides could live with. Both Secretary Shalala and HCFA Administrator Bruce Vladeck have had substantial personal involvement. It appears that considerable progress has been made toward that goal.

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It is in Tennessee's best interest to continue working with HCFA and to make the necessary compromises that will allow a TennCare program to emerge under the circumstances they have laid out.

- o If we push too much further on several of these issues, the entire program will be in jeopardy. Inquiries and pressure from the Congress are increasing. Given the criticism that TennCare is facing on so many fronts, it will be difficult or impossible for us to go further than we already have.
- o I am sympathetic to the financing dilemma that the State faces. We need a comprehensive approach to health reform so that the states and Federal government through the Medicaid program do not have to continue to bear so much of the burden of covering the uninsured.
- o We have the ingredients for an agreement, if you can make some progress in identifying real dollars to fill the State's shortfall in the project's financing. We are prepared to work with you to put together a viable TennCare program that both of us can be proud of.

CHARITY CARE

QUESTION:

HCFA staff has admitted that it would accept my argument that charity care could receive Federal match if I were to tax providers for the value of charity care and cycle this money through the State treasury. Why are you making us jump through bureaucratic hoops?

ANSWER:

- ▶ **Provider taxes are more than just "bureaucratic hoops."** Taxes are fundamentally different than directly matching charity care. To be permissible, provider taxes must meet certain requirements imposed by the 1991 donations and taxes law. These requirements are intended to make the burden more equitable, but also make the taxes less popular with providers. If a permissible tax were created, the revenues could be used to pay for charity care in a State and matched with Federal dollars.
- ▶ **We are willing to match charity care under certain conditions.** If the care is provided to a TennCare enrollee by a public facility and the uncompensated amount is identified as a certified public expenditure, Federal matching funds are available. This amount is less than the full amount of charity care for which Tennessee requested Federal match.
- ▶ **However, we are not willing to recognize all charity care as a matchable expense.** Since charity care is often difficult to define and account for, an open-ended recognition of charity care could have a large effect on the Federal treasury, up to \$13 billion annually. We do not want to set a precedent that would result in full Federal reimbursement of hospitals' uncompensated costs.

KEY INFORMATION:

- ▶ **The provider taxes and donations regulations were developed to place a firm limit on State methods of revenue raising for the purpose of Medicaid matching.** State abuses have received considerable press and Congressional attention, and lead to a statutory restriction on provider taxes. If we open the door to charity care here, other States will ask for the same relief through the waiver process.

BLOCK GRANT APPROACH

QUESTION:

Why do you object to a block grant approach when it not only holds the federal government fiscally harmless from cost increases, but reduces the growth in Tennessee's Medicaid program?

ANSWER:

Although a block grant is no longer being considered, let me outline our concerns with Tennessee's original proposal.

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BACKGROUND ON TENNCARE WAIVER**Original TennCare Waiver Proposal**

Tennessee's Medicaid program came under great pressure because of its extremely high growth rate and a politically unpopular tax on hospitals. Providers recently pressured the State legislature to repeal the \$500 million tax, which had supported a large portion of the State share of the Medicaid program. However, the Governor wants to salvage the situation with the unorthodox TennCare plan. The original TennCare proposal would:

- o Enroll the State's one million Medicaid recipients in "managed care" as of January 1, 1994;
- o Add most of the uninsured in the State to the program (800,000 people);
- o Put Federal Medicaid funds in a block grant, locking in a growth rate below the historical average; and
- o Pay for this ambitious program by:
 - (1) cutting provider rates by 25-35 percent;
 - (2) keeping the Federal contribution high while cutting State share (or, viewed another way, by asking the Federal government to match "charity care" contributed by private and public providers in the State); and
 - (3) asking the Federal government to match a number of other unusual and precedent-setting items, including premiums paid by beneficiaries and the cost of services provided to residents of institutions for mental diseases (IMDs).

HCEA's Objections to the Proposal

- o **Financial:** We feared the many precedents that approval of the TennCare waiver would set:
 - (1) The State wants to extend coverage to more individuals, even as it eliminates its provider tax and cuts State contributions by over \$500 million. It proposes to do this through a block grant, that is, by reducing State funding but keeping Federal funding at current levels. This would increase the Federal share from 67% to about 85%. Key members of Congress such as Mr. Dingell and Mr. Waxman would strongly object to a block grant approach and might respond by curtailing the Secretary's waiver authority. Finally, the legal authority to block grant the Medicaid program even under our demonstration authority is dubious at best.

- (2) Allowing Tennessee to reduce its "real" financial effort, especially just prior to health reform, would allow it to decrease state maintenance of effort in advance of passing the Health Security Act. If the base period for maintenance of effort is changed by Congress and other states emulate this approach, a larger shortfall in Federal financing for the Act would result.
- (2) Charity care funds are not State revenue, and matching them would set a precedent that would cost the Federal government an estimated \$13 billion per year if other states were to follow.

Other states have shown intense interest in our decision on TennCare, suggesting privately they will follow Tennessee's lead if the waiver is approved.

- o Implementation Date: HCFA believes that Tennessee's insistence on full implementation of TennCare by January 1 has been confusing and unfair to beneficiaries. Already the State has "cut corners" in the enrollment process. For example, the State has not yet completed contracts with managed care plans, nor have plans signed contracts with providers. Nevertheless, Medicaid recipients were told that, if they did not select a managed care plan by November 1, the State would arbitrarily assign them to a plan. Many beneficiaries seeking to ensure a continued relationship with physicians found that their doctors had not yet joined plans and were uncertain if they would ever do so. This has been especially difficult for those with special needs and multiple providers.

Although the State's eagerness to enroll its beneficiaries in managed care is admirable, only about 4 percent of its population is now enrolled in managed care, making it very difficult to create the needed infrastructure in such a short time.

Tennessee responds to this point by arguing that the confusion of the enrollment process is less painful than the dislocation of major program cutbacks that might ensue if the waiver were disapproved.

- o Provider Participation: In order to finance TennCare with limited dollars, Tennessee has proposed capitation rates to managed care organizations that would cut provider reimbursement by 25-35 percent. Little savings from managed care can be expected during the first year of the program. The State argues that there are sufficient funds in the system, including charity care, to justify cuts of this magnitude. We remain concerned that there may not be enough providers participating to ensure access.

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Governor McWherter is under increasing pressure in the local media to resolve this issue. The State legislature has generally supported the Governor, but some legislators are beginning to voice concerns.

Beneficiaries: Consumer groups are generally supportive of the plan because they believe the alternative to TennCare (sharp reductions in optional services) will be worse. There have been a number of press stories about beneficiary confusion, particularly as the November 1 enrollment deadline approached. One lawsuit has been filed to date.

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Congressional Interest: Sen. Sasser has expressed support for the proposal. Rep. Dingell has sent a staffer to Tennessee to investigate the program, and his staff believes that TennCare's financing is designed to shift costs to the Federal government.

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Overview: The Governor will argue that HCFA is blocking innovation and being regulatory and bureaucratic. However, HCFA's position is that the State can configure its program as it wishes, as long as the State meets certain basic conditions:

- o It assures access to quality care for enrollees. That is, there have to be adequate provider and managed care plan agreements in place to make the program viable. Enrollees need to be able to make a choice once these arrangements have been completed.
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THE WHITE HOUSE

WASHINGTON

November 8, 1993

MEETING WITH GOVERNOR MCWHERTER

DATE: November 8, 1993
LOCATION: Oval Office
TIME: 4:20
FROM: Carol H. Rasco

I. PURPOSE

You will meet with Governor McWherter at his insistence to discuss his pending Medicaid waiver, TennCare. He does not want HHS or HCFA individuals present and has stated repeatedly to me that if the President tells him he has to do what HCFA has directed in order to have the waiver approved - more money and a delayed timeline - then he will accept those facts. We have delayed this meeting as long as we possibly could.

II. BACKGROUND

TennCare was submitted to HHS on June 16, 1993. This proposal to cover Medicaid clients as well as the uninsured up to a certain percentage of poverty was designed by Tennessee as they began to face the sunset date of April 1, 1994 of their provider tax which has allowed them to create one of the most generous Medicaid programs in the country. Without the provider tax they face serious cutbacks in the program.

Late in the summer HHS told Tennessee they would meet a self-imposed September 17 decision date. That date passed but work continued between HCFA and Tennessee officials. Governor McWherter came to see Secretary Shalala and myself individually about three weeks ago. Work has continued in good faith between Tennessee and HCFA since that time. Attached is the latest status report from HCFA. Late Friday evening the chief financial officer in Tennessee, Mr. Manning, with whom we have all been working CONFIDENTIALLY told Kathi Way of my staff that he wanted us to be aware that Bruce Vladeck of HCFA has been working in total good faith the last three weeks and that Vladeck/Manning are in agreement on the financing, but the Governor will still seek to have you as President intervene.

A set of the most expected questions/requests from Governor McWherter will be prepared by the time of the meeting based on the latest negotiations.

The most critical point to keep in mind is that this meeting must not be seen by the Governor as one in which he came in and got the final approval and/or changes in the conditions; that is the job of HHS. If he does see it as a meeting in which he gets you to make changes, you are opening the door for other states to stop their work with HHS/HCFA and come directly to you.

Senators Sasser and Mathews have both expressed interest in the waiver to HHS, and I had a lengthy conversation with Mathews by phone recently. He reminded me of his support and that of the Governor for you. I have also had a call from Congressman Dingell who reminded me of his sub-committee's watchful eye on this waiver as well as other Medicaid plans used by states and the fact that approval of the TennCare waiver will prompt an immediate investigation into the approval; he indicated he understood the Secretary of HHS was being pressured by the White House to approve the waiver. I assured him the White House expected HHS with whom the authority rests to grant waivers to review the applicable laws and regulations in evaluating any waiver.

III. PARTICIPANTS

President Clinton
Possibly Vice-President Gore
Governor McWherter: We have not been notified by his office as to anyone accompanying him.
Carol Rasco

IV. PRESS PLAN

No press coverage.

V. SEQUENCE OF EVENTS

Governor McWherter will want to present his case refuting the HCFA demands on cash and redoing the enrollment of clients. He should be allowed to talk and then you will need to firmly tell him that in order to carry out the federal responsibility to cover the clients and preserve the integrity of health care reform overall he must meet the necessary match requirements as well as provide an orderly move into the program.

VI. REMARKS

None required.



DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

The Administrator
Washington, D.C. 20201

November 4, 1993

NOTE TO CAROL RASCO

CONFIDENTIALFROM: Bruce C. Vladeck
Administrator, Health Care Financing Administration

SUBJECT: TennCare Waiver Proposal -- Status

As you know, HCFA has been reviewing a proposal from the State of Tennessee that would waive Federal Medicaid requirements in order to provide coverage to Medicaid eligibles and uninsured in the State. While we are making every effort to provide maximum flexibility to states as they redesign their health care delivery systems, we have been concerned about the financing approach, beneficiary confusion, and the implementation schedule that the State has promoted. The State has provided responses to a number of our questions about TennCare, most recently on October 29. The Governor is pressing for a positive decision right away.

Last night we laid out for Tennessee the conditions under which we would approve a waiver. (Attached is the material we faxed to them.) The following are the key features of our offer, along with the reactions I expect from the State:

- o HCFA Offer: Our approach reflects significant movement on our part in three areas since the state's original proposal. We have agreed to (1) provide limited Federal matching funds for a new form of Certified Public Expenditures (CPE); (2) provide limited Federal matching funds for services provided to residents of institutions for mental diseases (IMDs), consistent with the Health Security Act, and (3) allow certain premium payments by patients who would not otherwise be eligible for Medicaid to count as the State's share of Medicaid costs. We have endeavored to limit the precedent these three developments might set in other states, although it is probably not possible to eliminate it.

Expected Reaction: The State should regard the first item as a positive development, and will perceive some improvement on the second item. On the third item, we had previously communicated our position to them, but they had argued against the very reasonable limitation we had placed on them. Our most recent response reiterates our position, which they will not regard as progress.

- o HCFA Offer: We clarified to the State that we will not provide Federal match for capitation payments for individuals who are eligible for TennCare but not enrolled in the program. However, I should note that we are prepared to match the costs of uncompensated care (similar to disproportionate share payments) to the extent that these are actual State cash expenditures that account for costs borne by participating providers.

CONFIDENTIAL

2

Expected Reaction: As we discussed in our meeting the other day, the State's latest proposal suggests that they may regard this a new and significant restriction, even though it should have been obvious to them based on all our previous statements. Tennessee may be interested in our alternative, but may have difficulty raising the State resources to support this approach.

- o HCFA Offer: Rather than dictating an implementation date to the State, we outlined for them the process we would require prior to implementation. In addition, we will require them to repeat the enrollment/plan selection process after contracts with providers have been signed and approved by HCFA.

Expected Reaction: We are mildly optimistic that the State will react positively to this approach.

- o HCFA Offer: We had previously argued that Tennessee must increase the capitation rate to providers because it is not adequate to ensure access and quality of care. (This is the core issue that has prompted 100-200 letters to us per day from Tennessee physicians.) In our new approach, we agree that HCFA should not be in the position of dictating Medicaid rates to states (a position with which we were never entirely comfortable), but we require that the State be able to assure access and monitor quality in the TennCare program.

Expected Reaction: Should be positive.

Finally, it is important to note that, even if Tennessee concurs with all of our conditions, the State still has a shortfall of funds for the program. Estimates of the magnitude of the shortfall can vary widely depending upon assumptions about the number of enrollees, treatment of CPE, capitation rates, and the need for any supplemental pools, but it is in the range of \$100-\$350 million per year.

The State will probably view the limitations that we have listed as significant. Nevertheless, these limitations are essential to assure that we maintain the current percentage shares of financing borne by the Federal and State governments and to protect beneficiaries during the transition.

We are preparing additional background documents and talking points on these issues for you to share with your colleagues.

cc: Kevin Thurn

HCEA POSITION ON TENNCARE ISSUES

The following provides details of our position on TennCare financing. These details reflect our longstanding view that we may only match allowable costs, rather than the originally-proposed block grant approach. We also provide further specification of our matching policy for certified public expenditures. In addition, we provide additional clarification on several non-financing issues.

Financing Issues

- o We will provide Federal Financial Participation (FFP) at the applicable Federal medical assistance percentage (FMAP) for the actual capitation payments made by the State to the Managed Care Organizations (MCOs) for each TennCare enrollee.
- o We will provide FFP at the applicable FMAP for actual expenditures certified by public hospitals for TennCare enrollees only to the extent that the public hospital is able to document that it has an actual expenditure for providing services to a TennCare enrollee which exceeds the amount paid to that hospital from the MCO for the cost of providing the service to that TennCare enrollee.
- o These public hospital expenditures will be matched on an as-incurred basis, not paid as an add-on to the capitation rates.
- o We will provide FFP at the applicable FMAP for actual expenditures for providing services to a TennCare enrollee residing in an IMD for the first 90 days of an inpatient episode, subject to an aggregate annual limit of 60 days.
- o We will provide FFP at the applicable matching rates (FMAP and administrative rates) for the actual ongoing non-TennCare costs (i.e. long-term care, HCBS waivers, Medicare cost sharing, administration) of the Medicaid program.
- o We will provide FFP for supplemental pools only to the extent that FFP matches actual State cash expenditures to account for costs borne by participating providers.
- o Premium revenues must be offset on an individual by individual basis, not in the aggregate, as the State has proposed. Any premium payments paid by an individual TennCare enrollee in excess of the State share of the State's capitation payment made to the MCO on behalf of that individual TennCare enrollee must be offset in full against the otherwise allowable Federal share of the State's capitation payment made to the MCO for that individual TennCare enrollee.

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2

Non-financing Issues

- o We are prepared to accept the State's assurances as to the adequacy of its capitation rates. At the same time, we will require close monitoring of access, patient satisfaction, and quality of care. In order to verify that there is sufficient access to care throughout the State, we must have sufficient time for HCFA review and approval of MCO contracts, as appropriate, after approval of the waiver but prior to the implementation of the TennCare program. In addition, the State will provide copies of subcontracts between the MCOs and providers if required by HCFA for its review.
- o Substantial changes have been made in the TennCare project, from agreements reached in our discussions and actions taken by the State. To confirm our mutual understanding of the actual program for which waivers may be granted, an updated description of the TennCare program is necessary. In addition to covering eligibility, benefits, and service delivery provisions, a revised financing proposal must clearly delineate the sources and sufficiency of State funding to support TennCare. Prior to implementation, the State must provide satisfactory assurance to HCFA that it has adequate State resources to support the program as revised.
- o Once the final configuration of the proposal is clear, we will develop the budget cap that is customary in demonstration projects to address the growth rate in Federal spending related to TennCare.
- o The State will establish an implementation date that provides sufficient time for the State to arrange MCO contracts, assure the adequacy of MCO-provider networks, set up systems, and complete administrative provisions. It must allow time for HCFA to conduct appropriate pre-implementation review, and for corrective actions by the State if appropriate.
- o The State will repeat the enrollment/plan selection process after contracts with MCOs and providers have been signed.

MEMORANDUM ON TENNCARE FINANCING PROPOSAL

The initial TennCare proposal contained the following elements:

- The State would cover its current Medicaid population of roughly 1 million plus an additional estimated 775,000 currently uninsured and uninsurable individuals in the State.
- The State proposed to provide care to these individuals using managed care plans with an average capitation rate of \$ 1,641 per enrollee of which approximately \$ 335.00 represented the value of charity care contributed by providers. The State was asking the federal government to match the value of that charity care.
- The State proposed to use its own estimate of Medicaid expenditures as the baseline for projecting the federal contribution. It proposed to cap the federal government's annual increases at 8.3% which is the inflation rate the State has experienced in Medicaid without counting population growth.

The current TennCare proposal contains the following changes:

- The State will still cover its current Medicaid population but has reduced the additional number of individuals to be served in the program to 500,000. The new entrants will be limited to 300,000 in the first year and move to 500,000 in the years thereafter.
- While the proposed capitation rate remains the same, the State is no longer asking the federal government to match the value of charity care. It should be noted that the State has provided HCFA with letters from numerous plans who have agreed to participate in the program at the stated capitation rate.
- The State has agreed to use HCFA's estimate of a baseline for the project and has proposed limiting the federal government's exposure to an annual increase of 8.3% or the figures estimated for Medicaid growth in the President's health care reform plan, whichever is lower.

The current financing proposal:

- HCFA has repeatedly rejected the State's proposal to block grant the federal contribution to TennCare notwithstanding the showing of savings to the federal

government over the life of the project of between 11 and 15 percent or \$1.5 to \$2 billion dollars over five years.

- HCFA has insisted that the State demonstrate compliance with the match rate requirement. The State's revised proposal does so using the concept of Certified Public Expenditures that is contained in existing regulations.
- The State's share is made up of the following elements:
 - State appropriations for Medicaid;
 - Other State and Local grant funds which have been used to support care for the indigent. This does not include any funds currently receiving a federal match;
 - Patient premiums that the State will guarantee to the health plans and pay directly to them; and
 - Certified Public Expenditures of public hospitals.

Here is how Certified Public Expenditures work:

- The State will identify the revenues of these public hospitals which are in excess of the costs incurred in providing services to insured patients. Hospitals have historically used these funds to cover the cost of care for the uninsured. This constitutes a public expenditure and it is these funds that the State has identified as available for the care of TennCare patients.
- Other States have certified these types of funds as the State match for Medicaid and have received federal matching funds for these certified public expenditures.
- While HCFA may contend that Certified Public Expenditures can only be based upon state and/or local tax revenues, the regulations at 42 CFR 433.55 are not so limited and other states are receiving federal matching funds based on Certified Public Expenditures derived from hospital revenues.
- HCFA may further contend that the Certified Public Expenditures do not represent real state dollars because HCFA cannot point to any money changing hands. This objection fails to acknowledge that in today's health care system, the costs of caring for the uninsured are shifted to paying patients and facilities are expected to use these cost shifted revenues to pay for the cost of serving the uninsured. When the provider is a public entity the cost shifted revenues become public funds and eligible for certification as state match.

Further, with respect to the financing proposal:

- HCFA has criticized the State for not continuing to impose the services tax which

currently exists on hospitals. (The State is continuing its provider tax on nursing homes). However, the State has identified other sources of State match that have not previously been used to draw federal Medicaid matching funds. These new funds combined with the Certified Public Expenditures more than offset the revenues which had been raised by the services tax on hospitals.

- HCFA has also continuously expressed the fear that if they approve TennCare, other states will rush to do the same thing. The answer to this is that HCFA should be pleased to approve any States' waiver that embodies all of TennCare's features i.e. expanded access, improved service efficiency, lower per capita costs, and savings to the federal government.

In conclusion, Tennessee's proposal:

- Assures substantial savings to the federal government in federal Medicaid expenditures of at least \$1.5 and perhaps as much as \$2.1 billion dollars over five years.
- While achieving these savings, the State will provide the security of health care protection for 1.5 million citizens including 500,000 who are currently uninsured.
- Numerous well-established providers in the State have agreed to participate in the plan at the State's proposed capitation rate with the understanding that they must meet stringent quality assurance standards which were developed by HCFA.
- Is consistent with the President's proposal and will provide an excellent demonstration of many of its key components including:
 - The effect of pooling the purchasing power of 1.5 million people;
 - Using managed care to promote efficient and effective service delivery; and
 - An emphasis on preventive and primary care, particularly for children;

SAUCON 21/11/11
MOT/11/11/11

Providers agreed to
discount 25% the cap rate
thus 1100 to 1300

38% is Gen. share of Cix
State \$'s

IG transfer (certy.
public exp. money)

Pub. hosp.
will transfer
to state CPE

Not char. care

THE WHITE HOUSE
WASHINGTON

JENN

① match

② ship date

③ Cap. rate

11,500 (discount)

cc

THE WHITE HOUSE

WASHINGTON

TO: Mack McLarty
Roy Neel
Jack Quinn
Marcia Hale
Joan Baggett
Ira Magaziner

FROM: Carol H. Rasco

SUBJ: Tennessee waiver for Medicaid

DATE: September 16, 1993

Lest anyone think the Tennessee waiver is just an issue between Tennessee and HHS, please see the attached. This letter arrived at HHS less than twenty minutes after Dingell's staff attended a briefing done for them by HHS late yesterday. Dingell has told the HHS Secretary he was first alerted by a Tennessee provider to watch this situation. He also stressed to her he is trying to be helpful and provide help to the Administration.

I will include this letter in my briefing with the President on the issue this afternoon.

Thank you.

JOHN D. BUNTING (MEMBER, CHAIRMAN)

SHERRILL BROWN, OHIO
MARJORIE MANDUCAS-DEWINSKY,
PENNSYLVANIA
HENRY A. WATSON, CALIFORNIA
DARRIN COLLINS, ALABAMA
BOB WYDEN, OREGON
JOHN BRYANT, TEXAS

DAN BONASER, COLORADO
CARLOS J. MOOREHEAD, CALIFORNIA
FRED LUTON, MICHIGAN
PAUL E. BELLER, OHIO

NEED P.F. STULTZ (STAFF) DIRECTOR/CHIEF COUNSEL

U.S. House of Representatives
Subcommittee on Oversight and Investigations
of the
Committee on Energy and Commerce
Washington, DC 20515-6116

September 15, 1993

VIA FACSIMILE

The Honorable Donna E. Shalala
Secretary
Department of Health and Human
Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Secretary Shalala:

Pursuant to Rules X and XI of the Rules of the U.S. House of Representatives, the Subcommittee on Oversight and Investigations of the Committee on Energy and Commerce is continuing its investigation of accounting gimmicks and other financing mechanisms employed by states to maximize federal Medicaid matching dollars.

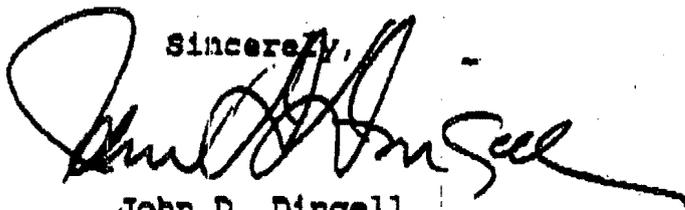
In this regard, the Subcommittee understands that the Department of Health and Human Services (HHS) is reviewing a waiver request by the State of Tennessee for its Medicaid program. We further understand that this request would result in fundamental changes in the state's Medicaid program and could dramatically alter the federal financial obligations to that state.

Please arrange a briefing on this matter for the Subcommittee staff by close of business Friday, September 17, 1993. To arrange for the briefing and to answer any questions you or your staff may have, please contact D. Ann Murphy of the Subcommittee staff at 202-225-4441.

The Honorable Donna E. Shalala
Page 2

Thank you for your cooperation with the work of the
Subcommittee.

Sincerely,

A handwritten signature in black ink, appearing to read "John D. Dingell", written in a cursive style.

John D. Dingell
Chairman
Subcommittee on Oversight
and Investigations

cc: The Honorable Dan Schaefer, Ranking Republican Member
Subcommittee on Oversight and Investigations

TennCare Waiver
September 21, 1993

I. Overview of Recent Events

II. Major Outstanding Issues

- | | | |
|---|------------------------------|-------|
| o | Financing | Tab A |
| o | Implementation Schedule | Tab B |
| o | Adequacy of Provider Payment | Tab B |

III. Next Steps

How to use these separators

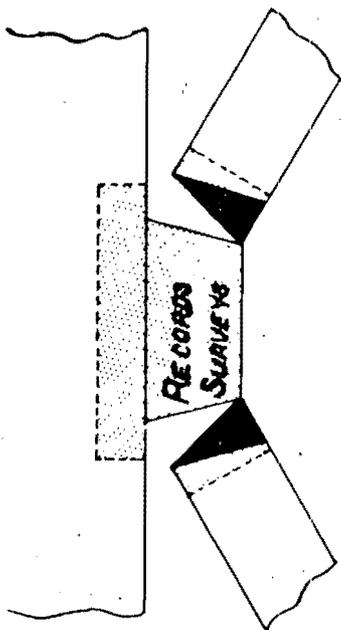
Look for your reference letter. The far left column designated "TAB" will indicate proper tab position for that number or letter. Cut off and discard all tabs except the one you wish to retain. Example: Position number "10" would be found behind the fourth tab. Position letter "C" would be found behind the third tab.

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FOURTH		94	87	80	73	66	59	52	45	38	31	24	17	10	3
FIFTH		95	88	81	74	67	60	53	46	39	32	25	18	11	4
SIXTH		96	89	82	75	68	61	54	47	40	33	26	19	12	5
SEVENTH		97	90	83	76	69	62	55	48	41	34	27	20	13	6



9/21/93

TENNESSEE WAIVER REQUEST

Problem Tennessee is reducing its matching contribution to the Medicaid program but wants to avoid losing over \$1 billion in Federal Medicaid matching funds as a result.

Background Tennessee enacted a provider tax to take advantage of the "taxes and donation" loophole. That tax generates an estimated \$600M in State revenue, drawing down a Federal match of \$1.2B.

Providers succeeded in pressuring the State legislature to repeal the tax early next year, and they will strongly resist any renewal.

The State wants to drop the tax, but to continue to receive Federal matching funds at the same level without putting up any new State funds to replace the lost tax.

This questionable financing plan is at the center of the State's ambitious "TennCare" proposal to expand coverage to the uninsured and immediately enroll all Medicaid eligibles in managed care.

Disapproval of the waiver may trigger a State financing crisis. The State is laying the groundwork to blame such a crisis on the Federal government. For example, brochures were recently mailed to potential enrollees announcing that TennCare will be in place on January 1.

Tennessee Proposal The State has modified the specifics of their proposal in an effort to justify their approach, but our basic objection has not changed:
Original: Furnish Federal Medicaid funds as a block grant, drop the matching concept, and disregard how the State raises the additional funds it needs.

Sept. 10: Retain the matching system, but ask us to match the value of a 5% charity care effort by providers; attempt to build in conditions that would prevent other states from copying.

Sept. 13: Health care plans "donate" \$400 per enrollee into a "pool" which is made available to the State; State then raises its capitation payments to plans by that same amount.

Effect

- o would create precedent for potentially massive cost shift by other states
- o would raise the effective Federal Medicaid match rate for Tennessee from 67% to 86%
- o would lower the State maintenance of effort for health reform

Current
Status

We have made it clear that we are ready to discuss any new proposals from the State that could make it possible for us to approve a waiver, but they must present legitimate State matching funds sufficient to justify their request for federal funds. We sent them our position on the major outstanding issues on Friday, and we expect them to respond today or tomorrow to that document.

Tennessee's
Arguments

Question: Providing a Federal match for charity care would simply short-circuit what is a circular flow of funds. That is, why bother to tax providers and then give the funds back to them in payments for service? Why not instead count the value of charity care as though it were a contribution and match it?

Response: Either course would set back our efforts to ensure that states meet their Medicaid matching requirements by providing legitimate sources of state revenue, rather than by shifting costs onto the Federal government. Charity care funds are not State revenue, and matching them would set a precedent that would cost the Federal government an estimated \$13 billion per year if other states were to follow. Donation and tax strategies that tax a group of providers only in order to gain a Federal match, and then return the funds to the very same providers violate our requirement that any taxes be broad-based.

Question: Why should the Federal government care how Tennessee raises its matching funds if TennCare saves the Federal government \$3.5 billion over four years and provides coverage for 700,000 additional citizens?

Response: Tennessee estimates a savings for the Federal government based on extremely unrealistic and optimistic assumptions about the level of Federal funds the State could draw down in the absence of a waiver. It is more reasonable to argue that, because of the repeal of State's hospital provider tax, the waiver would cost the Federal government \$3 billion.

Extending coverage to the uninsured is an admirable step, but it should be done in a prudently phased-in manner, supported by adequate and legitimate sources of funding.



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

DAVID L. MANNING
COMMISSIONER

September 14, 1993

Mr. Bruce Vladeck
Administrator
Health Care Financing Administration
200 Independence Avenue, S.W.
Room 314G
Washington, DC 20201

Dear Mr. Vladeck:

As you are aware, Tennessee has submitted the TennCare application for a Section 1115 Demonstration Waiver for review and approval by the Secretary and the Health Care Financing Administration. We appreciate your meeting with us last week and assuring us that HCFA is eager to see TennCare approved and implemented. We also appreciate your continuing commitment that a decision will be made by September 17, 1993.

Subsequent to our meeting with you, and at your request, we met with your staff and discussed the TennCare program at length. As a result of that meeting, we proposed an approach to deal with what we understand to be HCFA's major concern regarding the TennCare program. The concern appears to be the policy issue of whether a financial proposal involving a "fixed" federal commitment would be an acceptable arrangement. Included in Tennessee's proposal is the use of charity care as a matching fund, which we also understand raises concerns with HCFA. Tennessee subsequently submitted an approach (attached) which we feel limits HCFA's exposure to other such proposals. In an effort to continue to resolve this outstanding issue, Tennessee is proposing these additional options for HCFA's consideration:

Option 1 The State of Tennessee will contract with the Community Health Agencies (CHAs) in each of the twelve regions to assist in the administration of the TennCare program. The State will pay the CHAs an average annual capitation rate for each enrollee in the region (less discounts for local government contributions and coinsurance and deductibles) of \$1,549. The

CHAs will capitate Managed Care Organizations (MCOs) in the region at a rate of an average annual capitation rate of \$1,213 per enrollee. The CHAs will retain an amount not to exceed 20% of the total annual capitation rate (\$1,641) for every enrollee to fund the administrative functions performed for TennCare. These functions will include but not be limited to:

1. Coordinate indigent care activities in the region.
2. Provide for enrollment of TennCare eligibles.
3. Perform quality assurance monitoring.
4. Work with employers to implement programs to enroll uninsured in TennCare and process premiums through payroll deductions.
5. Assure appropriate provider enrollment in MCOs.
6. Provide for TennCare "trouble-shooting" in the field.
7. Administer the distribution of funds available for the uninsured that do not enroll in TennCare (see description provided in "Distribution of Unallocated TennCare Funds").
8. Other administrative functions as required.

Each year, as required by state statute, the CHAs must develop and submit a Plan of Operation to the State for approval. Effective January 1, 1994, each Plan will contain a component to ensure that charity amounts equal to 5% of all health related charges in the community will be provided. Each CHA will remit these funds to the State of Tennessee in order to maximize federal funding in delivering a basic set of health care services, as described in the TennCare waiver, to the indigent population, including the uninsured, in Tennessee.

Option 2. Each month TennCare will pay each managed care organization (MCO), for each enrollee, the monthly cap rate (by enrollee category) less any discounts for local government contributions and applicable coinsurance and deductibles. (To the extent that an enrollee is only eligible for a partial month, the appropriate reduction would be made.)

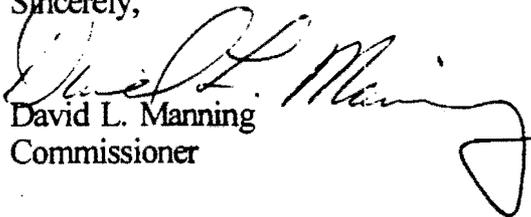
TennCare will assess each MCO \$33 per month for each enrollee. In addition, MCOs will be assessed \$33 per month per unenrolled individual whose unpaid medical bills are reimbursed through the MCO from the TennCare unexpended pool. These assessments will be made in accordance with the contracts between TennCare and the managed care organizations.

Option 3 - Further Limitation on Charity Care. To further confine the precedential effect of charity care, Tennessee proposes that it be limited to the amount that would have been raised from health care providers had a repealed tax of general applicability been maintained.

Tennessee stresses that the essence of its financing proposal is that the federal contribution for an expanded program will be substantially lower than its projected contribution to the Medicaid program. The most direct way to facilitate this is through a capped federal commitment without regard to the federal match rate requirement. However, should the federal government insist that this proposal be packaged in a traditional match rate context then we believe the most appropriate way to achieve this is through recognition of charity care as an element of the state's contribution and we are willing to do so under the conditions specified in Attachment I, with the modification described in proposal three above. This approach is much preferable to a tax or pooling arrangement, which achieve the same end result but with more complexity and less certain consequences.

We continue to be available to discuss these and any other issues at your convenience.

Sincerely,


David L. Manning
Commissioner

cc: Secretary Shalala

Attachment I

TennCare Financing Proposal

Since HCFA has expressed concern about the precedent set by approving TennCare's financing proposal, the State suggests a series of conditions for limiting the application of Tennessee's proposal to include charity care as a part of the State's match to support the TennCare program.

With the inclusion of charity care, TennCare's financing proposal maintains the integrity of an FMAP based grant. In addition:

- Charity care can only be used as a state match, in the context of a Section 1115 waiver, for federal financial participation to the extent that the amount of charity care included does not exceed the amount of money that represents proceeds from a valid tax on health care providers which the State was collecting for a least a year prior to the proposed use of charity care. The charity care used as state match can not grow at a rate in excess of the rate at which the tax it replaces would reasonably have been expected to grow.
- The State would be required to maintain, at a minimum, the State's financial contribution that was in place to support the Medicaid program prior to the implementation of the valid tax on health care providers which is being replaced by charity care, and at the level of State effort in place at the commencement of the project.
- The State agrees to extend coverage for health care to a significant percentage of its currently uninsured population who have been the beneficiaries of charity care.
- The State agrees to an absolute ceiling on the amount at which the federal contribution to the program could grow each year over the life of the project.
- Charity care included in the proposal shall be based on documented charity care provided in the State in the base year.

How to use these separators

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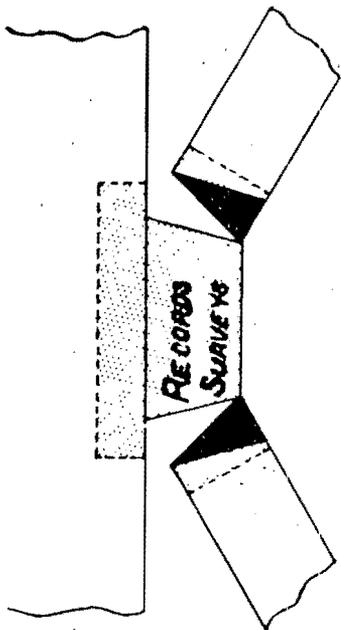
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FIRST	98	91	84	77	70	63	56	49	42	35	28	21	14	7	0
SECOND	99	92	85	78	71	64	57	50	43	36	29	22	15	8	1
THIRD	100	93	86	79	72	65	58	51	44	37	30	23	16	9	2
FOURTH		94	87	80	73	66	59	52	45	38	31	24	17	10	3
FIFTH		95	88	81	74	67	60	53	46	39	32	25	18	11	4
SIXTH		96	89	82	75	68	61	54	47	40	33	26	19	12	5
SEVENTH		97	90	83	76	69	62	55	48	41	34	27	20	13	6



One of the key health care reform elements is maintenance of effort. The current Tennessee proposal does not provide satisfactory evidence that the State would be able to sustain the necessary level of State expenditures. This also raises serious questions about the ability of the State to insure adequate quality and access. Assuming satisfactory resolution of this State maintenance of effort issue, the following additional considerations would apply to the demonstration:

- o There is a concern that payment rates are not adequate to insure access to care for Tennessee beneficiaries. Normally, Medicaid managed care programs pay providers at 95 percent of fee-for-service costs. We are willing to explore other States' experience, and evaluate whether a somewhat larger discount from fee-for-service rates would be appropriate for TennCare.

- o TennCare changes the service delivery system for a million current Medicaid beneficiaries, and adds up to three-quarter of a million additional people to the program. Such system-wide changes require sufficient time for preparation and initial implementation. A reasonable phase-in would add six months to the current implementation schedule, with TennCare services starting on July 1, 1994. Phase-in activities would include full testing of systems modifications and conducting beneficiary and provider education programs.

- o An effect of capping enrollment in TennCare could be to deny program participation to people who meet all eligibility criteria. As we agreed, the State shall propose an approach to program eligibility that will avoid this undesirable outcome.

- o Protection for Federally Qualified Health Centers will be provided using language approved for the Hawaii health reform demonstration. The specific term and condition is as follows:

The State shall require health plans to contract with Federally Qualified Health Centers (FQHCs). If a managed care plan can demonstrate to the U. S. Department of Health and Human Services and to the Tennessee Department of Human Services that both adequate capacity and an appropriate range of services for vulnerable populations exists to serve the expected enrollment in a service area without contracting with FQHCs, the plan can be relieved of this requirement. Health plans shall be required to address cost issues related to the scope of services provided by FQHCs and shall reimburse FQHCs either on a capitated (risk) basis considering adverse selections factors or reimburse FQHCs on a cost-related basis.

- o The use of funds from any grant from a PHS program would be subject to all of the appropriate terms and conditions under the relevant PHS statutes and regulations.

- o State funds used as matching for PHS grant funds will not be entitled to Medicaid matching funds.

THE WHITE HOUSE
WASHINGTON

DATE: 9/20

NOTE FOR:

Carol Rasco

The President has reviewed the attached, and it is forwarded to you for your:

Information

Action

Thank you.

JOHN D. PODESTA
Assistant to the President
and Staff Secretary
(x2702)

cc: *MARCIA HAIL*

THE WHITE HOUSE

WASHINGTON

TO: President Clinton
FROM: Carol H. Rasco *CHR*
SUBJ: Tennessee Medicaid Waiver
DATE: September 15, 1993

*I understand problems
but try to work something
out of them —
Thank you*

Per my phone conversation with Bruce this morning, here is the memo I received yesterday about the Tennessee waiver. I at that time did a memo to several divisions within the White House on the matter and because I did not have a briefing scheduled with you yesterday, I asked Mack to relay the message to you.

Obviously today in a meeting HHS had with Tennessee officials, Tennessee got the message they needed to negotiate in good faith. In a conversation with Roy Neel earlier this afternoon, McWherter's chief aide indicated they were quite willing to extend the date...the aide said they never imposed the date, HHS did...not true but that is beside the point somewhat in that the date is extended. HHS is now in the process of calling the aide to confirm the extension and negotiations will continue.

As you read this I would ask that if you wish to discuss it you do so with me before trying to call departmental officials or even more importantly, please do not try to talk with the Governor yet. I have a regular briefing time scheduled tomorrow with you in the afternoon and we can discuss it then.

As to Wisconsin, I had a long meeting with HHS officials on it this afternoon and will bring those issues to you directly in my briefing tomorrow.

Thank you.



SEP 10 1993

SEP 13 1993

MEMORANDUM FOR CAROL RASCO AND MARCIA HALE

This memorandum will describe our current position with respect to the State of Tennessee's TennCare proposal as well as possible next steps. The Department has promised the State a decision on the waiver request by September 17th.

The proposal cannot be approved without major revisions. The State has only recently shown any willingness to compromise. Tennessee officials have presented TennCare as a statewide reform plan consistent with national health reform. It includes cost containment through managed competition and significant expansion in coverage of the uninsured. It also includes major cost shifting to the Federal government caused by a significant decrease in legitimate State matching funds. The Department's general counsel has concluded that central elements of the proposal's financing arrangements could not legally be approved. Even if the financing were to be restructured to our satisfaction, the plan raises additional concerns about potential problems in quality and access to care.

Given the complexities of the Tennessee proposal and the financial and programmatic deficiencies, a compromise would be difficult to fashion. However, the Department remains committed to work with the State to help it amend the proposal to meet our concerns. If we are able to compromise, it would probably be necessary for the State to agree to an extension of the September 17th deadline. A description of the background and Qs & As are attached.

ISSUES

The following issues will require major adjustments in the plan:

1. Cost Shifting from the State to the Federal Government

Tennessee's severe fiscal problems figure prominently in this proposal, which effectively increases the Federal match from 67 percent to over 85 percent. The State accomplishes this in two steps. First, it takes an aggressive approach to defining the baseline for Federal Medicaid funding and then converts these funds into a block grant that inflates by up to 8.3 percent per year. Next, Tennessee will cut its actual contribution from tax dollars in half in the first year, from \$920 million to \$480 million. The

State makes up for this reduction by labeling existing charity care, anticipated beneficiary coinsurance and deductibles, and local government subsidies as State share which should be matched.

However, charity care does not qualify legally as a source of matching funds, and the Secretary does not have the legal authority to waive the statutory matching rate through a Section 1115 waiver. Moreover, if this approach were approved, it would set a precedent that other States would rapidly emulate, and the cost to the Federal budget would be many billions of dollars (and, given the entitlement caps, potentially quite dangerous).

The State misses the point by arguing that it would hold the Federal government harmless for the cost of its reform proposal. TennCare will simply increase the Federal share of a less expensive Medicaid program, achieved through overly optimistic assumptions about managed care savings and reliance upon various unacceptable non-State revenue sources.

2. Block Granting Medicaid is Incompatible With Health Reform

in summary
Major goals of reform include moving all persons (not just Medicaid beneficiaries) into a universal system of financing, cost containment, and service delivery. But a block grant, by definition, confers on the State broad flexibility to alter eligibility and benefits, reconfigure service delivery, and to identify, raise, and distribute non-Federal funding. This flexibility could produce differential treatment that works against the principles of health reform.

Tennessee proposes to use this flexibility to cap participation in a manner that could deny certain otherwise eligible persons the right to participate; to provide differing benefits to different beneficiary groups; and to redefine State financial effort to include beneficiary copayments that may not be received and charity care from all providers. This latter effort by the State to substantially reduce its real contribution to health care undercuts the state maintenance of effort requirement under health reform. Other states could exercise the flexibilities inherent in a block grant approach with similar sorts of results.

The statement of Section 1115 waiver principles sent to the National Governors' Association stated in part that "the Department ... reserves the right to disapprove or limit proposals on policy grounds;" we believe that a block grant approach should be ruled inappropriate on this basis. If, to overcome these problems and to protect beneficiaries, we were to agree to block grant Medicaid with numerous and detailed restrictions, we would probably not achieve what is the principal goal of 1115 demonstrations -- that is, to draw significant and policy-valuable lessons about the block grant approach per se.

Tennessee has indicated that they may be willing to drop the block grant approach if we are able to identify satisfactory state matching funds.

3. Questionable Federal Baseline Costs

The level of baseline Federal funding in the plan assumes existing provider taxes on nursing homes and hospitals will be found acceptable under the recently issued "Donations and Taxes" regulations. These two taxes alone generate over \$1 billion in Tennessee's current Federal match.

Preliminary determinations are that the hospital tax may be problematical and that the nursing home tax appears to be unacceptable. The State may litigate this matter once we have made a determination on these taxes, which means that essential elements of our baseline contribution could remain unresolved for well over a year. This is obviously not a reasonable basis from which to begin exploring the possibility of block grant funding.

The following concerns, while serious, could very likely be dealt with through mechanisms such as phased implementation after more extensive State consultation with consumers and existing providers:

4. Reduced Payments to Health Plans and Providers are Likely to Adversely Affect Access and Quality

Under TennCare, the State plans to reduce payment to providers by about 25 percent. This "discount" reflects the State's assumption that other resources "in the system" can subsidize State payments (e.g., charity care, local government funding, and patient cost-sharing revenues). Most State managed care programs set capitation rates at 90-95 percent of Medicaid fee-for-service (FFS) levels. Medicaid is often criticized for setting FFS payment levels so low that access to care is restricted and providers are forced to rely on other resources to supplement Medicaid rates. It seems unlikely that expanded services can be provided at 75 percent of Medicaid FFS levels.

The problems with the 25 percent discount are compounded by the State's faulty financial assumptions. The plan assumes full payment of premiums, coinsurance, and deductibles by beneficiaries. To the extent there are shortfalls in these collections, providers will receive even less payment than the 75 percent FFS, and may reduce services to beneficiaries.

The State has not made provisions for the protection of essential primary care providers, such as public hospitals and Federally Qualified Health Centers. The proposal does not address how its managed care delivery system will assure continued access to these providers.

The State has not adequately considered the impact of the proposal on its medical schools which include East Tennessee State, one of the country's leaders in producing primary care physicians, and Meharry, one of the nation's major black medical schools (although Meharry does not oppose TennCare). We believe some adjustment, similar to that made in Health Reform, should be established to provide for educational costs.

5. Insufficient Managed Care Infrastructure and Experience

Only 5.5 percent of Tennessee's insured population was in HMOs in 1992, and the Medicaid program currently has only one contract with an HMO, which enrolls about 4 percent of the Medicaid population. In December 1992, Tennessee was denied a renewal of its Medicaid primary care case management waiver because of poor performance. The State does not have the necessary experience or health care infrastructure to implement such an ambitious program without some kind of phased implementation.

OUTSIDE INTEREST IN TENNCARE

The State initially produced statements of support for TennCare from a number of organizations, including the Tennessee Hospital Association, the Tennessee Health Care Campaign (a consumer advocacy group), Blue Cross/Blue Shield of Tennessee, and several hospitals that want to participate as providers. However, since then we have received over 300 letters either in opposition to the plan, or expressing serious reservations notably from the Tennessee Medical Association, the American College of Physicians, East Tennessee State University, and the Tennessee Academy of Family Physicians. The State's hospital association and primary care association have urged that stringent conditions be imposed on the proposal, including a less aggressive phase-in, and the Association of Academic Health Centers has also expressed concern.

Senator Sasser, Chairman of the Budget Committee, sent the only Congressional letter in support of the waiver application. Signs of strong Congressional opposition have come from staff of both the full Energy and Commerce Committee and the Subcommittee on Health. In addition, Congressman Dingell's staff indicated that the Chairman is considering holding an oversight hearing on the matter.

Other states are closely following TennCare's progress. Some states have informally told Department staff that, while they recognize that Tennessee's waiver request is essentially a new approach to shifting costs to the Federal government, they would apply for a similar waiver were we to approve it.

NEXT STEPS

We are eager to work with Tennessee to develop a revised proposal that would be acceptable to both parties. The fiscal consequences of not approving the application would be severe for the State. The provider tax on hospitals is scheduled to expire shortly, and the State faces a major fiscal crisis without the Federal funding levels proposed here. Approximately \$1 billion in Federal funds are at stake. The State might respond to a denial by raising new revenues (including possibly reinstating their hospital tax), cutting back on Medicaid eligibility, coverage or provider payments, reducing other State expenditures, or some combination of the above.

In meetings to date, State officials have recently expressed a willingness to compromise. However, State officials have stated that they will explore all political channels in their effort to gain approval of the waiver. Nevertheless, if the Department and the White House speak with one voice, it is still possible that the State will engage in substantive negotiations with us.

Although a compromise would be difficult to design, the best possible outcome would be an agreement on significant changes that would still preserve a TennCare program in some less expansive form but meet our objections. If we are to develop a compromise, it would probably be necessary for the State to agree to an extension of the September 17 deadline. We will keep you informed of our progress.



Kevin Thurm

Attachments

Background on TennCare Proposal

On June 17, 1993, Tennessee submitted a proposal for a 5-year managed care demonstration project requiring several waivers to Medicaid program requirements. The Department has committed to make a decision on Tennessee's request by September 17, 1993. The State intends to implement the new program on January 1, 1994.

- o TennCare's intent is to provide health care benefits statewide to Medicaid beneficiaries, uninsured State residents and those whose medical conditions make them uninsurable. Enrollment will be capped at 1,775,000, one million of whom are current Medicaid eligibles. If the cap is reached, those in mandatory Medicaid coverage groups and the uninsurables will continue to be enrolled, while the currently uninsured group enrollment will be limited.
- o Managed Competition/Managed Care Features: Although Tennessee does not have a track record of enrolling vulnerable populations in managed care, all enrollees will be immediately enrolled in capitated managed care plans that are either health maintenance organizations (HMO) or preferred provider organizations (PPO). Initially, Tennessee intends to develop a community capitation rate to pay plans; thereafter, the State will develop annual capitation rates based on the lowest cost managed care organization meeting its 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. Health care plans will compete for enrollment based on quality of service.

A standard benefit package will be provided by managed care organizations. Long term care is not included in the managed care plan.

Each managed care plan within a community will be given a spending target based on number of enrollees. Plans may elect not to be at full risk, in which case they may retain 5 percent of savings achieved. If the spending target is exceeded, plans would be required to pro rate provider reimbursement back to the target.

Community Health Agencies (CHA) will be the geographic unit of delivery. The 12 CHAs in the State are governed by a community-based board.

- o 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 would be required to pay, except those in mandatory Medicaid eligibility groups. To encourage their use, no deductible or copayment will be required for preventive services.

- o Budget: Rather than requesting the regular Federal match for Title XIX costs incurred by the State, Tennessee is asking for a commitment from the Federal government to contribute in the first year of the demonstration what the State estimates the Federal share would have been under the current system (\$2.267 billion). The Federal contribution in future years would be increased by the minimum of: (1) actual increase in costs; or (2) 8.3 percent (the historical per capita cost trend). Federal funding would essentially be a modified block grant.

QUESTIONS AND ANSWERS ON TENNCARE

Q. The TennCare proposal will save the Federal Government money. Isn't it irresponsible to turn it down?

A. Whether or not there are savings in Tennessee depends on how you count and where you start counting from. The State's estimates are all for future years and are based on assumptions that TennCare will increase more slowly than its conventional Medicaid program. In addition, the Federal "savings" assume very high Federal payments to start with; we disagree with the State's assumptions about appropriate Federal payments for 1994, and believe they will be lower.

The State also does not mention that in the past 2 years Tennessee's Medicaid costs have been escalating faster than those of almost every other state in the union -- 26 percent between 1992 and 1993 and 24 percent between 1993 and 1994. Only Florida and Louisiana have had similar increases in this period. With such a high base rate of inflation, it is not hard to show out-year savings from cost controls.

Many states have already achieved much greater control over their costs and ours than Tennessee proposes to accomplish in this demonstration. If you exclude the twelve fastest growing states from the analysis, the average increase in Federal share between 1993 and 1994 for the 38 states that remain is only 7.1 percent, considerably lower than the 3.3 percent cap TennCare promises.

The real Federal fiscal impact of this waiver, however, would not be in Tennessee but in the demands from other states that they be treated equally. The Federal budget impact of only one of the controversial financial arrangements -- the request that existing "charity care" be used in lieu of tax dollars as a State contribution -- would be somewhere in the vicinity of \$13 billion, or an overall increase in Federal Medicaid costs of 14 percent.

We certainly agree with Tennessee that their costs need to be brought under control and have a number of successful demonstrations and waivers underway which they can use as models.

Q: Why can't Tennessee claim the value of charity care as part of the State match under TennCare?

A: In 1993, the State is using revenue from a tax on hospitals to fund its State share of Medicaid expenditures. The tax will expire in December 1993 if TennCare is approved. As a substitute for the lost revenue, the State asserts that charity care valued at almost \$300 million will be provided in 1994, and that this amount is available to the State as its match.

However, charity care is not State revenue, or even arguably revenue that could be available to the State. Rather charity care represents the amount of revenue that hospitals would have received had patients paid their bills. It is not cash, but rather an accounting device used to portray the amount to be deducted from gross hospital charges to calculate net revenue.

The State may be asserting that charity care is a donation rather than a cash payment, but this argument does not withstand scrutiny. Under certain circumstances, donated services can be counted as part of the non-Federal share for matching purposes. However, the difference between last year's Medicaid rate for a service and this year's 25 percent lower rate is not a "donation" by the provider. Indeed, such a mandatory reduction seems the antithesis of a donation.

Q: If TennCare is rejected, the State faces a serious fiscal crisis. Shouldn't this make you more willing to accept the proposal?

A: The State's fiscal crisis comes as a result of rapid increases in Medicaid costs coupled with the repeal of the hospital tax. We are prepared to work with the State to address their problems, but Federal taxpayers should not be held responsible for this crisis.

Q: You have promised us State flexibility under Health Care Reform; why aren't you living up to the promise?

A: We have promised State flexibility within established guidelines, not unlimited ability to do whatever States want. We have approved innovative waiver proposals in Hawaii, Oregon, and other states, and want to foster more such experimentation in the future. However, flexibility to decrease State payments by shifting costs to the Federal government is not on the list of acceptable actions.

Q: Our proposal moves towards managed competition and resembles national health reform. Why aren't you more supportive?

A: The proposal differs from health reform in some very critical ways. For example, under national health reform states will have to meet maintenance of effort requirements. In addition, health reform acknowledges the responsibility of all payors to support the costs of graduate medical education. We plan to link that support to the production of more primary care physicians. Tennessee has not adequately protected the teaching programs of its medical schools; we are particularly concerned about potential harm to Meharry Medical College, a leading Black

school, and to East Tennessee State, one of the national leaders in the production of primary care physicians.

In addition, we do not believe that the "managed competition" proposed in this plan could be implemented immediately on a statewide basis given the low penetration of HMOs in Tennessee and the lack of previous Medicaid HMO experience. A phase-in period would be much more consistent with our intent nationally.

Q: Why are you forcing Tennessee to cut benefits and drop beneficiaries?

A: In recent years, Tennessee has greatly expanded its Medicaid coverage. The primary source of funds for this expanded coverage has come from the unpopular hospital tax and the resulting Federal match dollars. The Tennessee legislature has now repealed this tax, and is responsible for developing feasible fiscal solutions. We are prepared to work with the State to develop appropriate and innovative approaches to preserve essential health coverage.

Q: It doesn't sound like you want Tennessee to do anything in this plan. Is that true?

A: No. We believe that better control over Medicaid costs is an essential element in the long term solution to the State's fiscal problems. We would like to work closely with you to develop a Medicaid managed care proposal which could be approved and which will control your costs and ours in future years. At present, Tennessee is tied for second place nationally in terms of the inflation rate in the Federal costs of its Medicaid program. We are just as eager as you are to get those costs under control. Many of the elements of this plan could be incorporated in a new proposal based on different financial and timing assumptions.