TennCare Presentation on the Governor's FY 2012 Recommended Budget

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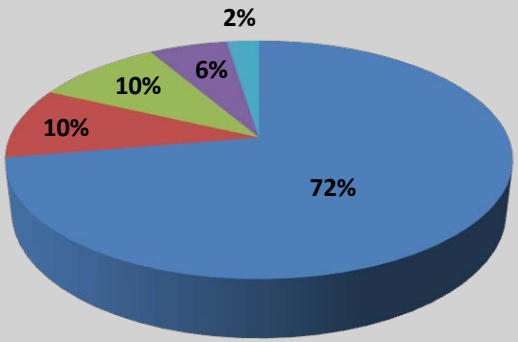
Presentation Overview

- Over the past five years, the TennCare program has been successful in reducing escalating costs, improving quality of care, and increasing care options for the state's most vulnerable populations.
- Difficult decisions positioned the program to weather recent nation-wide economic difficulties.
- In addition to a solid fiscal and programmatic foundation, an influx of non-recurring funds has postponed the implementation of reductions included in the past two budgets.
- Some or all of these one-time funds will not be available to offset reductions in the upcoming fiscal year.
- This recommended budget puts forth a plan that will allow the Bureau to continue providing quality health care to approximately 20 percent of Tennesseans despite current budgetary restrictions.

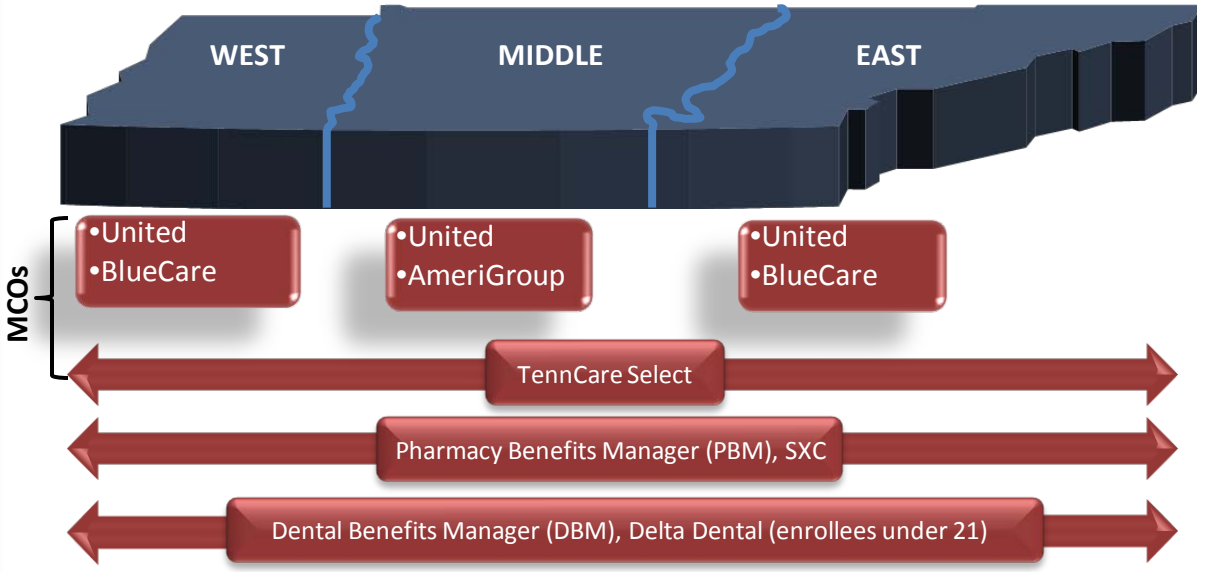
TennCare Overview

Percentage Breakdown of the TennCare Budget



*Percentage includes: funding for DHS county offices and outreach at health departments.

TennCare Statewide Managed Care Delivery System



- TennCare is 100 percent Managed Care – meaning all 1.2 million TennCare enrollees receive coordinated health services through a Managed Care Organization (MCO).
- TennCare uses an integrated approach which means all physical, behavioral and LTC needs are taken care of by one of four MCOs.
- This helps reduce costs because of better coordination of care and increases the quality of care for enrollees by ensuring appropriate care and preventative care.
- TennCare uses a "Medical Home" model where all enrollees are matched with a primary care provider to deliver patient-centered care and ensure the appropriate care is provided at each step.

Taking Control of Rising Costs

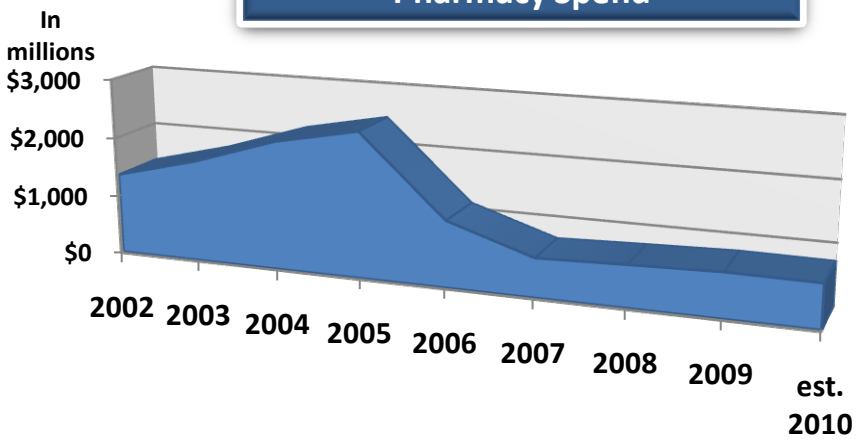
Actual Expenditures vs. McKinsey and Co.'s Best Case Scenario Estimates

In Billions	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Expenditures	$4.5	$5.4	$6.1	$6.9	$7.6	$8.6	$6.9	$7.1	$7.5	$7.7	$8.2
McKinsey Est.							$9.5	$10.6	$11.8	$13.1	$14.6*

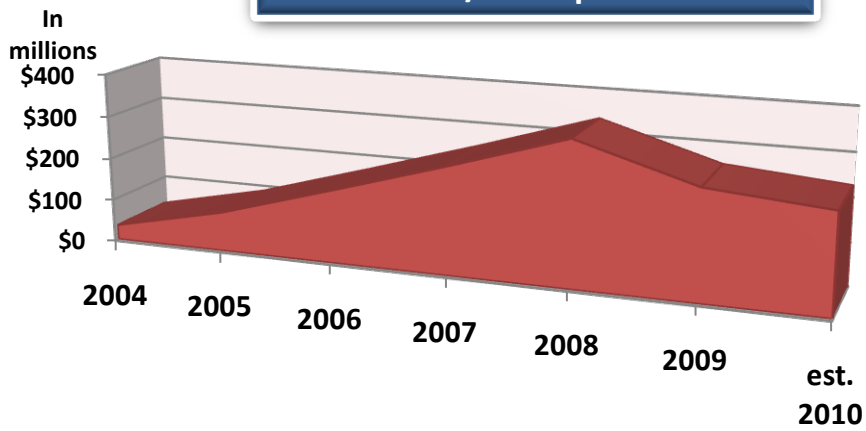
* The 2009 and 2010 figures were calculated by continuing the 2006-2008 trend.

- Costs under control – McKinsey and Co.'s best case scenario estimated the TennCare budget at more than $4 billion over actual expenditures in 2008.
- Requested no new state dollars two years in a row due to aggressive program management.
- Reserves built up to record highs and available to help the state through recent tough economic times.
- Effective monitoring and management of cost-drivers - soaring pharmacy and Home Health/Private Duty Nursing costs contained.

Pharmacy Spend



HH/PDN Spend



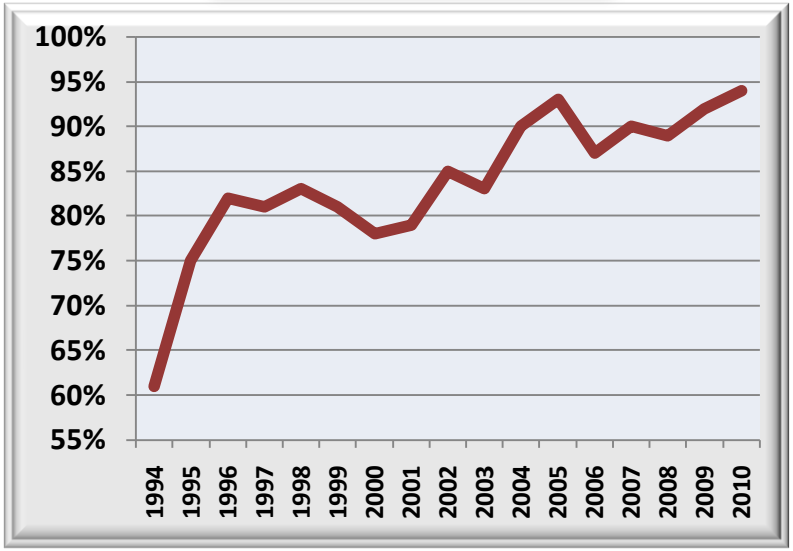
TENNCARE

Increased Focus on Quality

Background on TennCare Quality

- In 2006, TennCare became the first state in the country to require NCQA accreditation across its Medicaid managed care network.
- NCQA is an independent, nonprofit organization that assesses and scores managed care organization performance in the areas of quality improvement, utilization management, provider credentialing and member rights and responsibilities.
- TennCare MCOs are also required to report HEDIS measures. HEDIS is a set of standardized performance measures that makes it possible to track and compare MCO performance over time.

UT Study on TennCare Enrollee Satisfaction



UT surveys random sampling of TennCare households for annual satisfaction report.

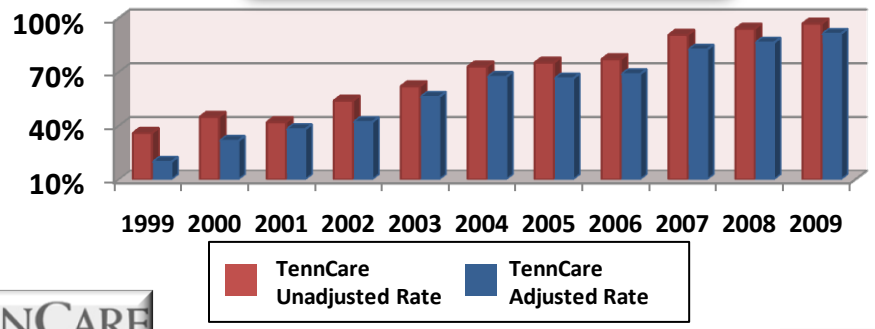
Quality Results

The 2010 HEDIS results showed:

- Improvement in 6 of 8 adult diabetes measures from 2006 to 2010.
- Improvement in 5 of 6 women's health measures from 2006 to 2010.
- Improvement in 12 of 12 child health measures from 2006 to 2010.
- 10 of 12 child health measures exceed national Medicaid average in 2010.

80% TennCare's child dental screening rates reached 80 % in 2009 - up from 59% in 2003.

Well-Child Screening Rates



TENNCARE

TennCare CHOICES in Long Term Care Rebalances Long-Term Care Enrollment and Funding

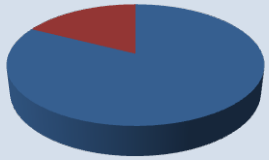
TennCare CHOICES in Long-Term Care (LTC) allows the state to use existing dollars to offer more options to those in need of LTC .

How?

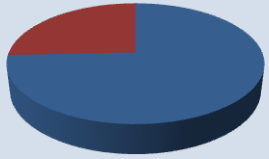
- Often times the home is the most appropriate and cost effective setting to receive LTC services.
- The CHOICES program design allows more people to be served with existing funding so long as it can be done safely and cost effectively.
  - **$19,000** (average annual cost HCBS)
  - **vs.**
  - **$55,000** (average annual cost level 1 NF)

- TennCare CHOICES in Long-Term Care integrates TennCare nursing facility (NF) services and Home and Community Based Services (HCBS) for the elderly and adults with physical disabilities into the existing managed care system offering more options for individuals in need of LTC.
- This better prepares the program to adapt to the state's growing aging population in the years to come.
- CHOICES was implemented in Middle TN in March of 2010 and statewide in August of 2010.

Statewide LTC Enrollment Before CHOICES 3/1/10

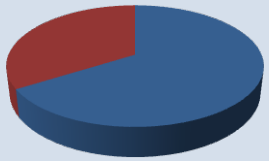


Statewide LTC Enrollment as of 4/1/11



Since the statewide launch of CHOICES, total enrollment has shifted from 17.5% to 25.7% HCBS in just one year.

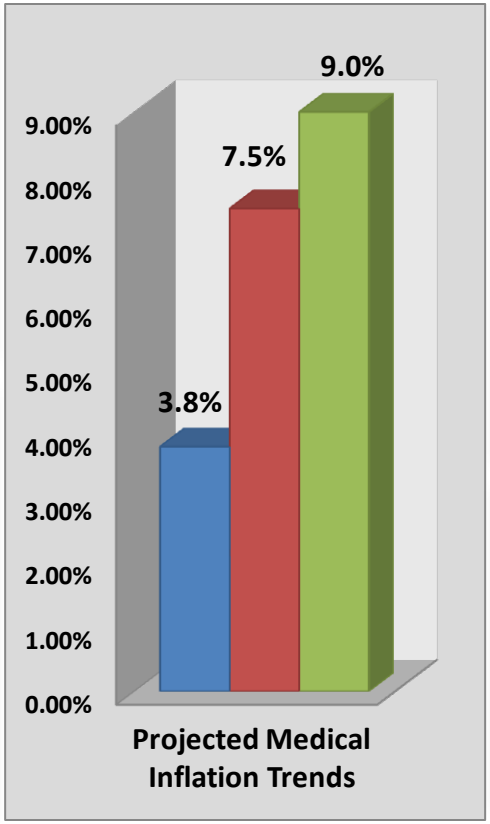
Statewide LTC CHOICES *New* Enrollment



Beating National Medicaid Inflation Trends

- TennCare projected Medical Inflation SFY 2012
- National Medicaid projected Medical Inflation FFY 2011 (Source: OMB)
- Commercial Plans projected Medical Inflation CY 2011 (Source: PricewaterhouseCoopers)

Nationally Medicaid Programs project an inflation rate of approximately 7.5 percent and commercial plans a rate of 9.0 percent. TennCare projects an inflation rate of approximately 3.8 percent.



Projected Medical Inflation Trends

How does TennCare control trend?

MCOs and PBM provide Coordination of Care and Medical Management:

Pharmacy
- Point of Sale Edits
- Preferred Drug List/Drug Rebates/Generics
- Prescription Limits

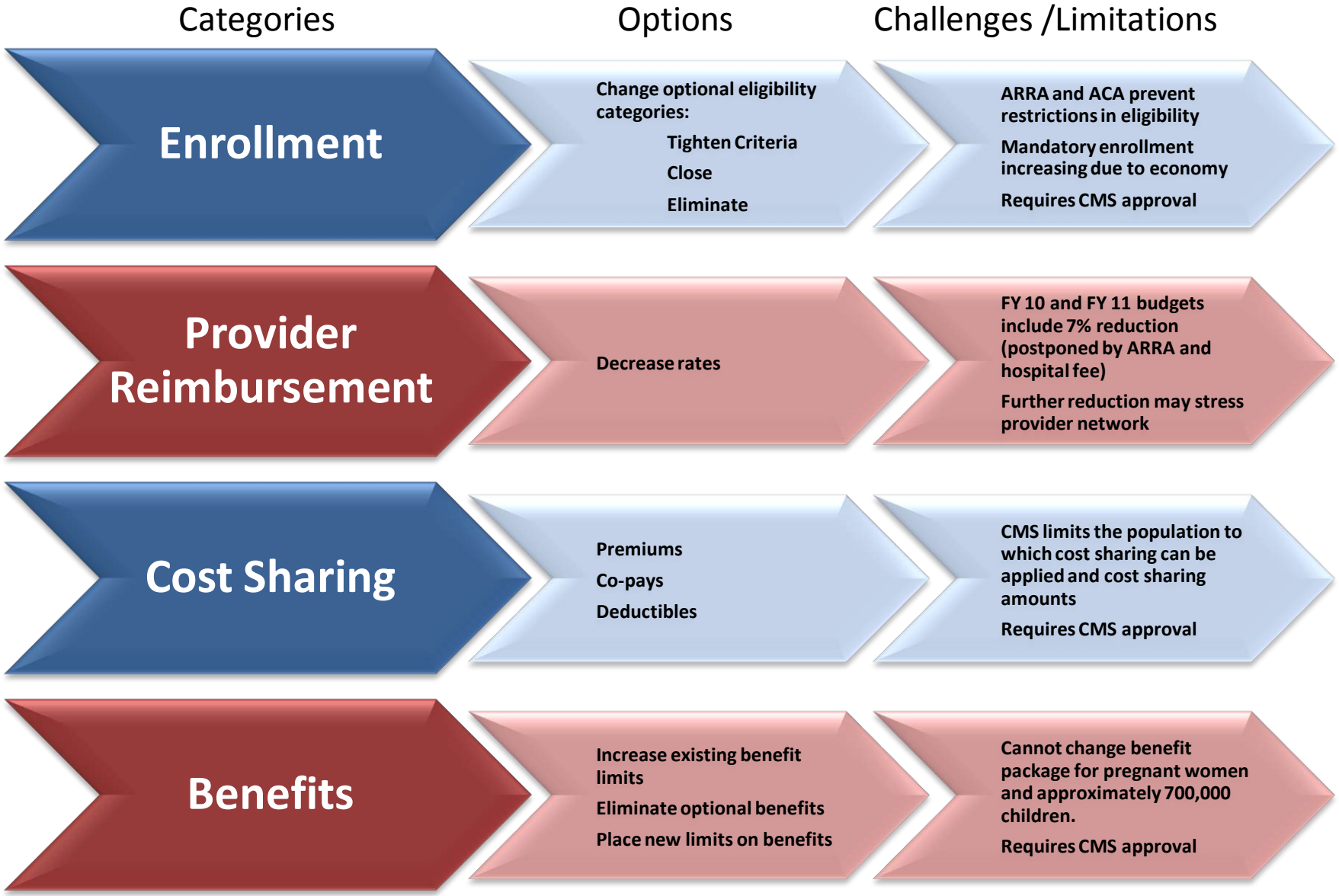
Medical
- Prior authorization
- Medical Home
- Network Consolidation
- Disease Management
- Case Management

Fraud and Abuse
- Narcotic Controls
- Pharmacy Lock-In
- Outlier Monitoring

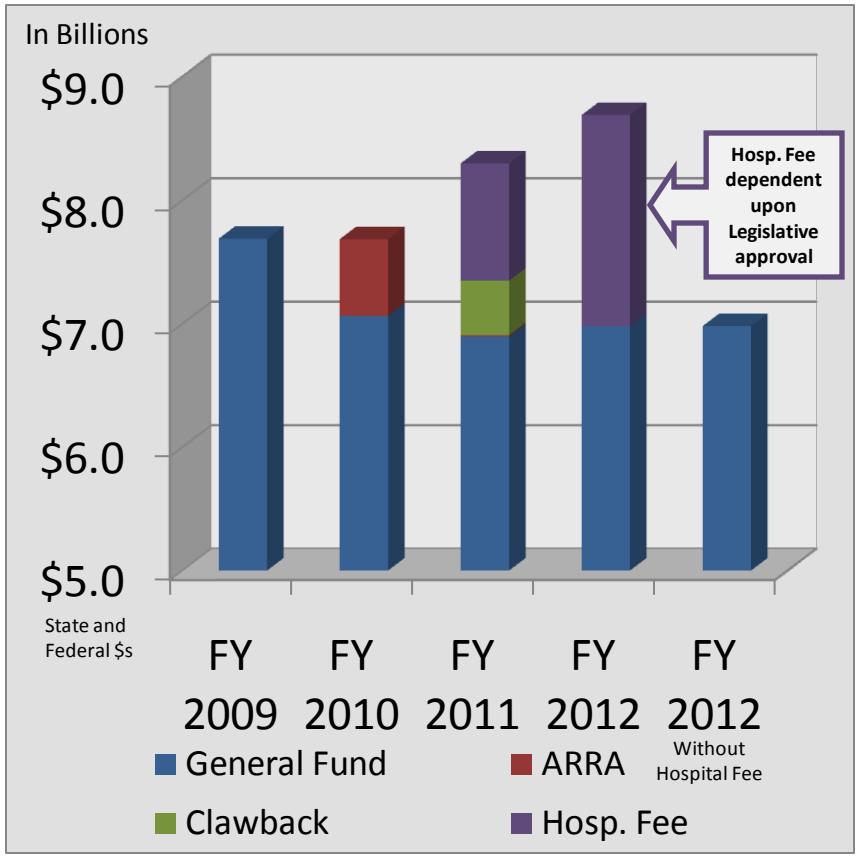
How do Commercial Plans Control Trend?
- Shifting from co-payments to cost sharing and raising deductibles - requiring more out-of pocket payment from members
- Shifting to Generics
- Assuming savings from return to pre-ARRA COBRA requirements

Although TennCare is beating national Medicaid inflation trends - as well as most commercial insurance medical inflation trends - some medical inflation will always exist. For FY 2012, we project a trend of approximately 3.8 percent at an estimated cost of $90 million (state dollars). This increase in cost is due to medical inflation, enrollment, and shifts in population within TennCare eligibility categories. Also, a cost increase of $16 million is expected because provisions of the Affordable Care Act prevent the Bureau from implementing more stringent requirements for nursing home placements as contemplated under the Long Term Care Community Choices Act of 2008.

Ways to Significantly Reduce Expenditures



Recommended FY 2012 Budget and Proposed Hospital Fee



- **The reductions identified to be funded with the proposed FY 2012 Hospital Fee are required to be implemented 7/1/2011 if the fee is not ultimately approved.**
- **As a result, notices informing enrollees about the benefit changes would have to be drafted and ready to print by 5/1/2011.**

FY 2012 Hospital Fee Proposal*	Total	State
8 day In- Patient Hosp. benefit limit	$135,441,500	$45,734,531
Hospital Rate Reduction	109,830,500	37,086,465
Essential Access Hosp. Payment	100,000,000	33,767,000
DSH MATCH	81,023,000	27,306,600
8 Lab/Xray benefit Limit	80,772,800	27,274,551
Professional Rate Reduction**	76,292,600	25,761,722
Hospital Ceiling @100% Medicare	66,565,700	22,477,240
GME (Graduate Medical Education)	50,000,000	16,883,500
8 Office Visit benefit limit	42,496,100	14,349,658
Medicare Part A	35,550,400	12,004,304
Standard Spend Down up to 7,000 enrollees	32,727,300	11,051,027
8 Outpatient benefit limit	30,566,900	10,321,525
Elimination of PT/OT/ST benefit limit	13,277,600	4,483,447
Critical Access Hosp. Payment	10,000,000	3,376,700
Critical Access State-Only Payment	6,000,000	6,000,000
TOTAL	$870,544,400	$297,878,271

FY 2011 Budget	FY 2012 Base Budget without Hosp. Fee	FY 2012 Budget with Hosp. Fee
$8.29 Billion	$6.98 Billion	$8.69 Billion

•Approximately $455 million total ($154m state) of Hosp. Fee funds are used as a pool payment to hospitals and not reflected in these budget figures.
** Certain provider types are not included in the rate reduction buy-back: Nursing Homes, MCO Admin. Rates, Transportation, Mental Health Services, Lab and Xray Services, Dental Services, ICF-MR, PACE, Home Health Providers (excludes HCBS Services).

Reductions to be Implemented 7/1/2011

Postponed FY 2010 and FY 2011 reductions and FY 2012 reductions and are scheduled to be implemented 7/1/2011.

FY 2010 and FY 2011 Reductions Previously Postponed with Non-Recurring Funds

Reductions	Total	State
7% Rate Reduction		
A. Nursing Homes	$76,673,400	$25,890,300
B. MCO Administrative rates	23,348,300	7,884,000
C. Transportation providers	5,470,400	1,847,200
D. Mental Health Services	19,847,600	6,701,900
E. Lab and Xray services	16,322,200	5,511,500
F. Dental Services	11,403,000	3,850,500
G. ICF-MR providers	7,000,000	2,363,700
H. PACE program	876,100	295,800
I. Home Health providers (excludes HCBS services)	16,821,600	5,680,100
Meharry Grant eligible for federal matching funds	10,000,000	3,376,700
Meharry Grant not eligible for federal matching funds	3,000,000	3,000,000
Pharmacy Reimbursement - $4 for drugs that are widely accessible for $4 on commercial formularies	16,502,100	5,572,300
More aggressive MAC pricing for generic drugs	12,000,000	4,052,000
$2 Co-pay for Non-Emergency Transportation Services	3,829,300	1,293,000
Grant to the Regional Med, Metro General, and Jellico Hospitals for charity care	10,000,000	10,000,000
Perinatal Grants	4,545,600	2,272,800
TOTAL	$237,639,600	$89,591,800

FY 2012 Reduction Plan

Reductions*	Total	State
1.5% rate reduction		
A. Nursing Homes	$16,430,000	$5,547,900
B. MCO Administrative rates	5,003,200	1,689,400
C. Transportation providers	1,172,200	395,800
D. Mental Health Services	5,430,500	1,833,700
E. Lab and Xray services	3,534,500	1,193,500
F. Dental Services	1,036,600	350,000
G. ICF-MR providers	1,500,000	506,500
H. PACE program	79,600	26,900
I. Home Health providers (excludes HCBS services)	3,351,000	1,131,500
Change payment rates for C-section and vaginal deliveries	44,221,900	14,932,400
↓ payment rate to ER physicians for non-emergency services	24,998,200	8,441,100
Dosage limit on Opioid detox drugs for adults	5,561,800	1,314,600
Quantity limit on Sedative Hypnotics for adults	1,721,500	406,900
Implement new Hemophilia management program	1,200,000	283,600
Exclude acne products for adults	634,600	150,000
TNAAP Grant	468,200	234,100
TOTAL	$116,343,800	$38,437,900

*Excludes interdepartmental reductions

Special Disability Workload Dispute

Background

- The Social Security Administration (SSA) determines who receives disability benefits.
- Over the past 35 years, the SSA made a systematic error in the handling of about 300,000 cases of people who applied for disability.
- This resulted in some individuals receiving Supplemental Security Income (SSI) when they should have been receiving Social Security Disability Insurance (SSDI).
- SSA refers to the effort to correct this problem as the Special Disability Workload or SDW.

Financial Burden to States

- The SSA error has a cost impact to states because states were required to provide a portion of the funding for **Medicaid** benefits to individuals who should have qualified for federally-funded **Medicare** benefits.
  - Individuals receiving SSI automatically receive **Medicaid** benefits. **Medicaid** is funded by the state and the federal government.
  - Individuals receiving SSDI are eligible to receive **Medicare** benefits after receiving SSDI for two years. **Medicare** is primarily funded by the federal government.
- This resulted in states being owed approximately $4.2 billion* for services provided to SDW cases that Medicare should have covered.

Potential Credit to States

- The federal government is in discussions on how to credit the amount owed to states for providing Medicaid services to those wrongfully identified as SSIs.
- If the federal government agrees to credit states, Tennessee could receive an estimated one-time payment of approximately $82 million.*

*Center for Health Care Financing at the Univ. of Mass. Med. School estimate.

Current Status

- Though the federal government is looking at the issue, there is no guarantee they will credit states.
- If the federal government does credit states, there is no certainty states will receive the funds during the 2012 fiscal year.

Conclusion

- The Bureau has been successful in the past solving difficult budget situations.
  - TennCare has been able to reduce spending while improving program quality.
  - Previously TennCare was part of the budget problem. In recent years, TennCare has been part of the budget solution to help the state through the recent economic downturn.
- We must make difficult decisions in order to continue to live within our means during these trying economic times.
- This recommended budget accounts for the loss of one-time funding and provides further reduction options that are needed given projected revenues.
  - We are prepared to implement these changes while continuing to provide quality health care to 1.2 million Tennesseans.