



# Health Care Finance and Administration FY 2014 Budget Presentation

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# Continued Improvement



Because of TennCare's unique history, ability to stabilize a volatile Medicaid program, and status as being the first and only Medicaid program to enroll its entire population into managed care, more than half of the states have requested guidance from the Bureau over the past year. This includes information on a variety of topics including:

- Controlling medical trend
- Program integration
- Implementation of Medicaid managed care
- Integration of Long-Term Services and Supports into managed care

## HEDIS Scores 2012

- **Improvement in 88%** of measures tracked since 2006
- **Improvement in 31 of 41** measures introduced more recently  
Examples include:
  - ↑ Access and Availability of Care Measures – Adult and child access to primary care; prenatal and postpartum care
  - ↑ Prevention and Screening measures – Immunization rates; cervical cancer, breast cancer, and Chlamydia screening in women; weight assessment and counseling for nutrition and physical activity; lead screening in children
  - ↑ Disease specific measures – Treatment of respiratory conditions, cardiovascular conditions and diabetes
  - ↑ Effectiveness of care measures – Treatment of behavioral health conditions; medication management
- In addition, TennCare's health plans (MCOs) continue to be ranked **among the top 100 Medicaid health plans in the country**, with our highest ranking plan moving from 37<sup>th</sup> in 2011 to 30<sup>th</sup>.

## Recognition

- Innovation Award from SXC
- March of Dimes
- Mercy Award
- AARP

## Description

- Innovation in the enhanced Coordination of Benefits (COB) program
- Commitment to giving babies a healthy start
- Outstanding dedication to provide health care services to the underserved in Tennessee
- Recognized as one of the top Medicaid managed care LTSS programs in the nation

## 2012 TennCare Satisfaction Survey

93%



TennCare's continued goal is to keep member satisfaction above 90%

TennCare's member satisfaction has remained above 90% for the past 4 years



# Program Updates

## COVER+TENNESSEE

### AccessTN

- At the close of FY 2012, more than 3,000 Tennesseans were covered under this high-risk insurance program.
- AccessTN has had **no increase in member premiums for the past two years.**
- **AccessTN assessment on insurers was reduced by 21%** during FY 2012 based on improved trend.

### CoverTN

- While enrollment to new businesses remained closed in FY 2012, the 3,040 businesses currently participating in the program were allowed to enroll new employees bringing current enrollment to more than 17,000.
- CoverTN is a limited benefit program. In CY 2011, **less than 1% of members hit the annual \$25,000 coverage limit.**

### CoverRx

- Experienced a 15% increase in enrollment FY 2012 bringing total enrollment in the pharmacy assistance program to more than 54,000 Tennesseans.
- **High generic utilization of 91%** - compared to ~78% nationwide.\*

### CoverKids

- CoverKids continues to be in high demand as a result of the economic downturn. Enrollment increased by 16% in FY 2012 bringing total enrollment to approximately 56,871.
- CoverKids continues to improve quality of care. Overall, **the program improved in 57% of the quality measures** compared to last year.

## Tennesseehealth

### Electronic Health Record (EHR) Provider Incentive Program – 10/2012

	Providers	Amount	Hospitals	Amount
Year 1	2161	\$45,567,100	72	\$50,502,432
Year 2	118	\$1,000,167	7	\$1,820,287

- “Direct” – Health Information Exchange (HIE) through secure email.
- Continued support of RHIOs and more robust exchange functionality.
- Controlled Substance Monitoring Database (CSMD) enhancements.
  - Real-time reporting from pharmacies
  - “Provider friendly” interface/reports

## Insurance Exchange Planning Initiative



- Travelled across the state to meet with stakeholders on a 14-stop 2,000 mile “listening tour”.
- Released a white paper summarizing stakeholder input from that listening tour and met with stakeholders to help them understand what information has been released and what federal guidance is still outstanding.
- Evaluating models that could promote healthy behaviors and individual responsibility for health status.
- Taking the necessary steps to preserve the state’s options for either a state-run or federal-run Exchange.



# Top to Bottom Review Update



## Goals

## Update

Design Advanced  
Integrated and  
Coordinated  
Programs

### Integrate Health Care-Related Agencies into a Division of HCFA

- Incorporation of several agencies into one umbrella agency: TennCare, the Cover Tennessee Programs, the Insurance Exchange Planning Initiative, and eHealth.
- Review contracts and opportunities to align health care resources.

### Integration into Division of HCFA

Ongoing integration of HCFA agencies. Health planning transitioned to DOH. Multiple Cover Tennessee contracts consolidated with estimated savings of \$2.85 million for Jan-June 2012. RFP in process to integrate eligibility determination across multiple programs.

### Dual Integration/Coordination

- Integration/coordination of services for those with both Medicaid and Medicare.
- Improve quality of care and reduce cost of care through coordination of benefits, management of chronic conditions and care transitions.

### Dual Integration/Coordination

Submitted CMS proposal to implement a dual eligible demonstration project. Strengthened coordination requirements in contracts with existing D-SNPs.

Proper Alignment of  
Incentives

### Alternative Payment Methodologies

- Explore and develop new ways to pay TennCare providers to encourage high-quality cost-effective care including:
  - Bundled payments;
  - Quality incentives; and
  - Capitated arrangements.
- Increase member participation in patient-centered medical home and develop evaluation matrix for all medical home arrangements.

### Alternative Payment Methodologies

Joined Catalyst for Payment Reform initiative to drive toward value-based purchasing. Analysis in process to support development of methodology for non-recurring supplemental acuity-based payments to nursing facilities for FY 2013 and implementation of a new NF reimbursement methodology to better reflect acuity and incentivize quality.

Enhance Customer  
Experience

### Modernize Member Experience

- Simplify the member enrollment process and make certain member functions available online.
- Explore the possibility for members to opt to receive email communication to make it easier for the member and save state resources.

### Modernize Member Experience

Eligibility system RFP will allow applicants to file a single online application for multiple insurance products. IT changes in process to support member email communication options.

### Improve Provider Services

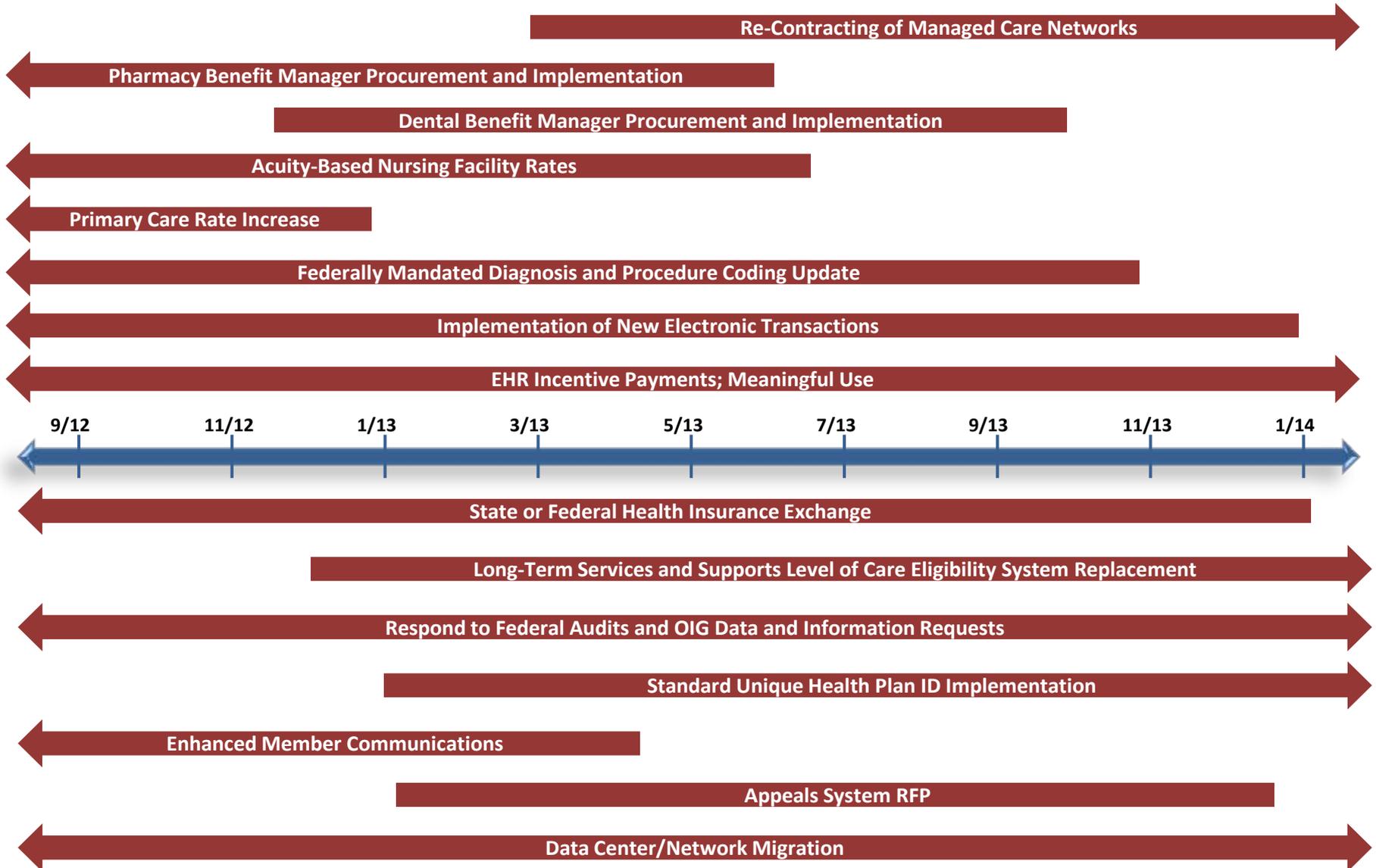
- Leverage web-based technologies to simplify and improve provider registration processes, conduct provider training, and support ongoing communication processes.

### Improve Provider Services

Implemented Online Provider Registration Portal for individual providers (in process for provider groups). Web-based training initiated for LTSS providers.



# Sample of Other Significant HCFA Implementations\*

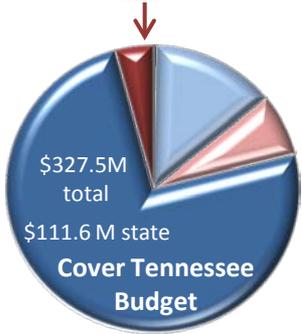
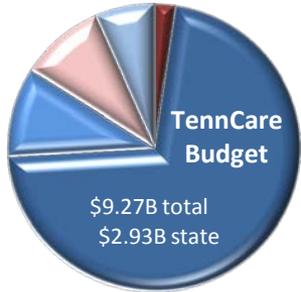




# Current HCFA Budget and 5% Reduction Plan

## FY 2014 Recommended Reduction Items

- TennCare Administration
- TennCare Medical Services
- Supplemental Payments
- Intellectual Disabilities Services
- Medicare Services



- Cover Tennessee Administration
- CoverTN
- AccessTN
- CoverKids
- CoverRx

### Other HCFA Agencies

Budget Item	State	Total
Administrative reduction in CoverTN program	\$897,000	\$897,000

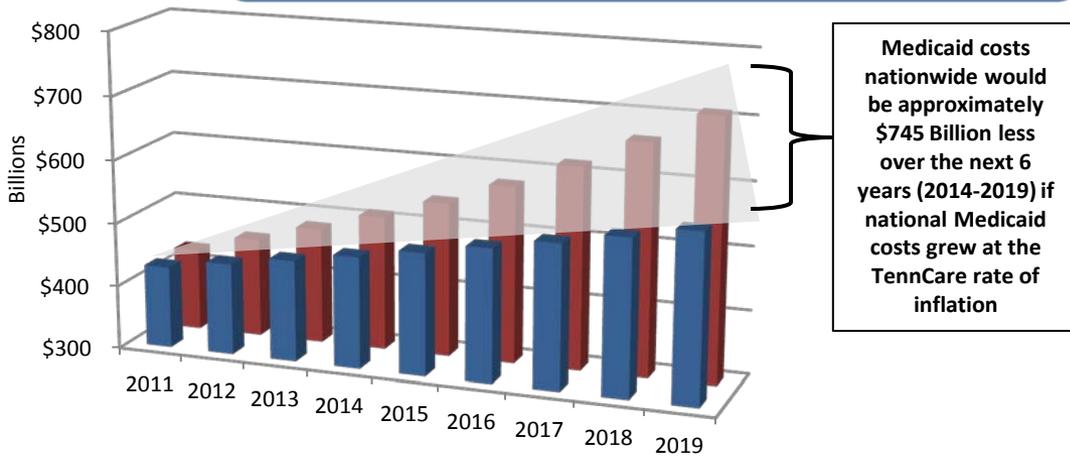
### TennCare

Budget Item	State	Total
Transition to 100% electronic claims submission	\$175,000	\$700,000
Non-coverage of allergy medications for adults	864,600	2,506,100
\$1.50 copayments for generic prescriptions for adults	2,112,300	6,122,600
Pharmacy integration (increased federal revenue)	29,544,300	
Establish chronic pain management benefit protocols	4,241,300	12,293,500
Back brace pricing parity	1,345,500	3,900,000
Establish drug testing frequency protocol	1,725,000	5,000,000
Transition of CHIP program to TennCare	9,540,000	39,750,000
Delivery reimbursement adjustment	1,688,200	4,893,300
Early elective delivery reduction initiative	1,897,500	5,500,000
Perinatal grants	2,272,800	4,545,600
Elimination of hospice support services	5,925,400	17,175,000
2.4% provider rate reductions	39,376,100	114,133,600
<b>TOTAL</b>	<b>\$100,708,000</b>	<b>\$216,519,700</b>

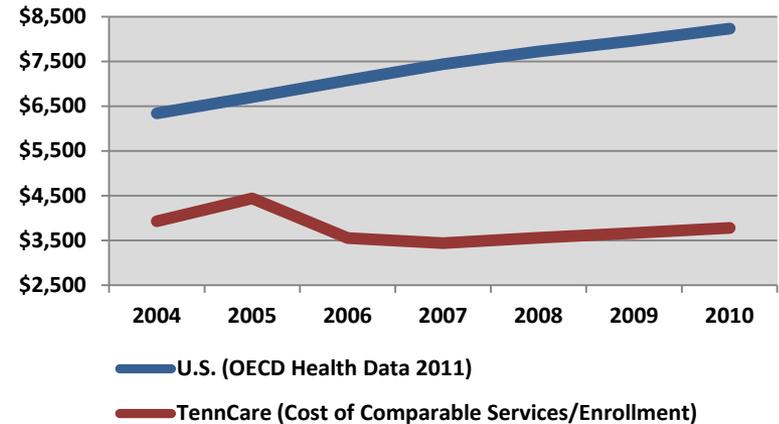


# Non-Health Reform Related Base Cost Increases

National Medicaid Expenditures at the Current National Rate and What the Expenditures Would be if at the TennCare Rate



U.S. Expenditure on Health Care Per Capita Vs. Comparable TennCare Per Member Cost



- Total National Medicaid Spend Projected at TennCare Medical Inflation Rate
- Total National Medicaid Spend Projected at Current National Average Medical Inflation Rate

HCFA has been able to keep medical inflation well below the national Medicaid and commercial averages. PriceWaterhouseCooper projected an average of 7.5% medical inflation for commercial insurance. TennCare's trend is projected to be 3.5% for FY 2014. Even with a low rate of inflation, some cost increases are expected due to rising health care costs and enrollment.

FY 2014 Est. Cost Increases

Budget Item	State	Total
TennCare funding request for medical inflation/enrollment growth	\$93,950,000	\$272,318,900
CoverKids funding request for medical inflation/enrollment growth	8,168,400	29,197,100
Replace use of one-time funds for pharmacy and Medicare expenditures with recurring	51,585,600	182,291,200
Continuation of funding for existing Standard Spend Down Program (FY 2013 funded with non-recurring funds)	11,121,800	32,237,100



# National Health Reform Overview

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- We do not believe the health reform plan passed into law is the best solution to address problems within the current health care delivery and payment system. However, states must make the changes mandated by the law unless or until the law is amended or repealed.
- The law requires some of the more significant changes to be made by Jan. 1, 2014. Many of the programmatic changes will take months of preparation in order to meet the current aggressive federal timeline.
- We estimate the net cost of health reform to the state could be as much as \$1.4 billion over the first five and a half years (Jan 1, 2014 – June 30, 2019).
- The majority of that cost is unavoidable and will be incurred by the state regardless of its decisions on Medicaid expansion and the administration of the Exchange.



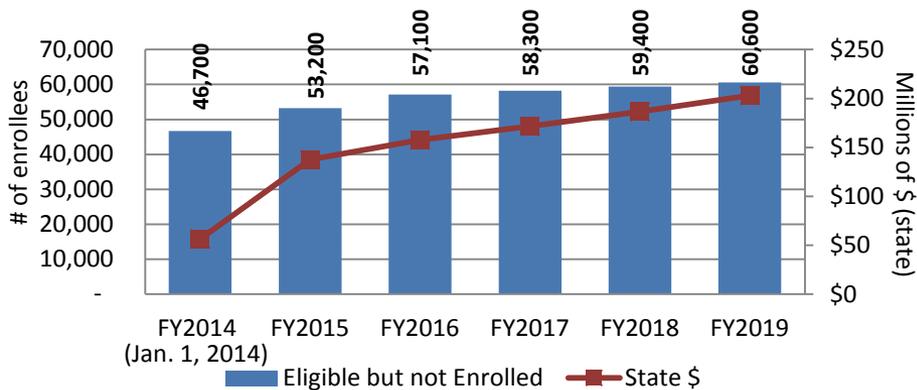
# Unavoidable Cost Increases Due to Health Reform

The majority of costs associated with health reform will be experienced by the state regardless of its decisions on Medicaid expansion and the Insurance Exchange.

## Eligible but not Enrolled Population (EBNE)

These are individuals who come on to Medicaid after Jan. 1, 2014 and would have been eligible under current eligibility guidelines. This population will draw down the current match rate of 65% not the enhanced match rate of 100%. Experts believe this will be due to the federal mandate that most people carry insurance, the requirement that individuals must be screened for Medicaid before purchasing insurance in the Exchange and the increased publicity and outreach on health insurance leading up to Jan. 1, 2014.

Est. Unavoidable Cost of Medicaid Enrollment due to Health Reform



Year	FY2014*	FY2015	FY2016	FY2017	FY2018	FY2019
EBNE (in millions)	46,700	53,200	57,100	58,300	59,400	60,600
State Cost (in millions)	\$56.5	\$137.5	\$157.6	\$171.5	\$186.6	\$203.1

Estimated EBNE State Cost:

FY 2014 \$56.5 Million

5.5 year \$912.8 Million

## Excise Tax on Health Plans

This is a federally-mandated broad-based tax imposed on health insurance companies including Medicaid managed care companies. This tax will be reflected as a cost to the state for states utilizing Medicaid managed care.

Estimated Excise Tax State Cost:

FY 2014 \$55.9 Million

5.5 year \$335.3 Million

## Other Costs

There are other state costs associated with the law including:

- the requirement that Medicaid agencies cover benzodiazepines and barbiturates – drugs that TennCare does not currently cover
- the reduction in the state share of pharmacy rebates
- the continued increase in pharmacy costs due to pharmaceutical companies reacting to the impacts of health reform on their industry
- initial personnel costs due to required changes to Medicaid and CHIP eligibility processes
- the requirement that Medicaid agencies cover foster children up to age 26

**At this time our estimates show costs related to the items immediately above may be offset by other programmatic changes.**

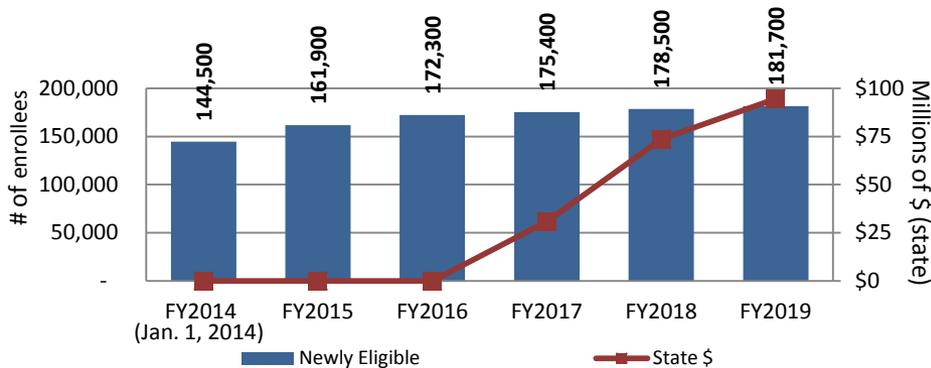


# Potential Medicaid Expansion Costs

Although much of the cost increases to Medicaid are unavoidable, there is still a very real cost impact associated with the potential Medicaid expansion. Expansion could cost the state approximately \$200 million over the first 5.5 years of implementation and \$100 million or more annually after FY 2019. This cost estimate assumes the federal government continues a match rate of 90% for the Newly Eligible population. Due to federal budget pressures, the match rate could be reduced in future years.

## Expand Medicaid up to 138% of Poverty Option

The law, as originally written, required state Medicaid agencies to expand Medicaid eligibility to 133% of poverty. This coupled with a 5% income disregard makes the true level of qualification 138% of poverty. However, the Supreme Court ruled the mandatory Medicaid expansion unconstitutional, making this optional for states. This population is referred to as "Newly Eligible" or NE.



Year	FY2014	FY2015	FY2016	FY2017	FY2018	FY2019
Match Rate	100%	100%	100%	95%	94%	93%
NE (in millions)*	\$0	\$0	\$0	\$30.8	\$73.7	\$94.6

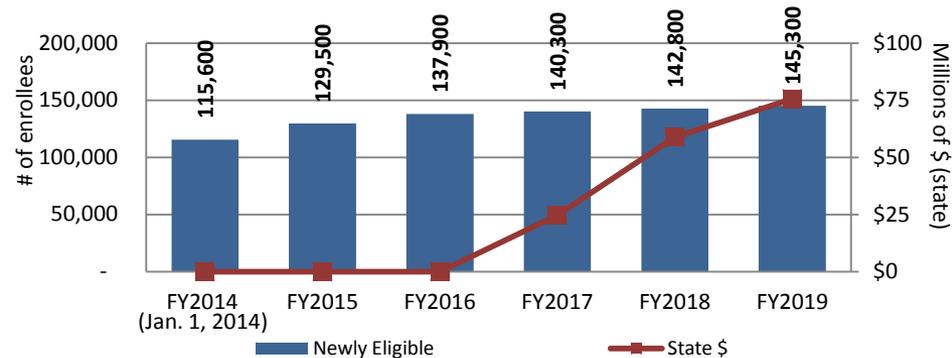
**Estimated NE up to 138% State Cost:**

**FY 2014 \$0**

**5.5 year \$199.1 Million**

## Expand Medicaid up to 100% of Poverty Option

While the law originally intended to make individuals with household incomes below 133% of poverty eligible for Medicaid, the law only allowed Insurance Exchange subsidies for households between 100% and 400% of poverty. Without the Medicaid expansion, this creates a coverage "doughnut hole" (see app.). Those below 100% of poverty who do not qualify for Medicaid today would not qualify for Medicaid nor would they receive federal subsidies to purchase insurance through the Exchange. Due to this "doughnut hole" we have modeled the estimated state cost impact should Medicaid only be expanded up to 100% of poverty.



Year	FY2014	FY2015	FY2016	FY2017	FY2018	FY2019
Match Rate	100%	100%	100%	95%	94%	93%
NE (in millions)*	\$0	\$0	\$0	\$24.7	\$58.9	\$75.6

**Estimated NE up to 100% State Cost:**

**FY 2014 \$0**

**5.5 year \$159.2 Million**

\*These Medicaid expansion cost estimates do not include the EBNE costs which will be incurred regardless of the state's expansion decision



# Health Reform Update

## Examples of Medicaid Expansion Options

Option	Pros	Cons
<p>No Medicaid Expansion</p>	<ul style="list-style-type: none"> <li>No future state financial liability for the expansion</li> <li>Operational clarity</li> <li>Reduced entitlement exposure</li> <li>100% and above will be eligible for tax subsidies in the Exchange</li> </ul>	<ul style="list-style-type: none"> <li>Income ‘doughnut hole’ coverage gap – see appendix</li> <li>Continued dependence on state-only funded coverage programs</li> <li>Possible DSH reduction for hospitals, without offset</li> <li>Potential increased exposure to employer tax penalties</li> <li>May impact Exchange risk pool</li> </ul>
<p>Temporary Medicaid Expansion until 100% FMAP expires</p>	<ul style="list-style-type: none"> <li>Temporarily eliminates ‘doughnut hole’ coverage gap</li> <li>Limited future state financial liability</li> <li>Delays DSH implications</li> </ul>	<ul style="list-style-type: none"> <li>Will have to remove covered population when 100% FMAP expires</li> <li>CMS may impose an MoE requirement preventing or limiting disenrollment</li> <li>Temporary increased entitlement exposure</li> <li>Provider concerns over continuity of care</li> </ul>
<p>Expand Medicaid as ACA originally contemplated (i.e., 138% FPL)</p>	<ul style="list-style-type: none"> <li>Increased % of population with insurance options</li> <li>Additional financial support for providers</li> </ul>	<ul style="list-style-type: none"> <li>Future state financial liability</li> <li>Increased dependence on federal entitlement program</li> <li>Covering a portion of the population eligible for tax credits with state funding</li> <li>Larger portion of the expansion covered at Medicaid provider reimbursement levels</li> </ul>
<p>Partial Medicaid Expansion (i.e., 100% FPL)</p>	<ul style="list-style-type: none"> <li>Eliminates ‘doughnut hole’ coverage gap</li> <li>Limits future state financial liability</li> <li>Increased portion of expansion covered at Exchange provider reimbursement levels</li> <li>Limits entitlement exposure</li> <li>Mitigates DSH implications</li> </ul>	<ul style="list-style-type: none"> <li>Unclear if enhanced FMAP will be available</li> <li>May impact Exchange risk pool</li> <li>Possible increased exposure to employer tax penalties</li> </ul>



# Health Reform Update

## Insurance Exchange Options

Option	Pros	Cons
Federally-Run Exchange	<ul style="list-style-type: none"> <li>Limited implementation risk with respect to aggressive federally-imposed deadlines</li> <li>Reduced implementation risk due to lack of complete federal guidance</li> </ul>	<ul style="list-style-type: none"> <li>Federal control of Medicaid and CHIP eligibility procedures with substantial risk for increased state expenditures</li> <li>Federal design of Qualified Health Plan (QHP) criteria without local involvement or insight</li> <li>Federal cost structure, which will presumably be higher</li> <li>State may have to pay costs of assuming Exchange if it decides to do so post 2015</li> </ul>
State/Federal Partnership	<ul style="list-style-type: none"> <li>While the federal government would control the tax credit eligibility, there is potential limited state involvement with Medicaid and CHIP eligibility determinations</li> <li>State has some control over QHP criteria and plan management</li> </ul>	<ul style="list-style-type: none"> <li>Significant IT coordination w/federal govt.</li> <li>Disjointed/fragmented eligibility determinations (particularly related to appeals)</li> <li>Federal cost structure, which is expected to be higher than state-based option – costs would be born by Tennesseans</li> <li>State may have to pay costs of assuming Exchange if it decides to do so post 2015</li> </ul>
State-Based Exchange	<ul style="list-style-type: none"> <li>State retains control of Medicaid and CHIP eligibility determinations</li> <li>State sets QHP criteria and has full control over plan management</li> <li>Streamlined administrative processes</li> <li>Better able to control administrative costs</li> </ul>	<ul style="list-style-type: none"> <li>Aggressive federal implementation timelines</li> <li>Uncertainty about context and requirements</li> </ul>

### Potential State Costs Associated with the Insurance Exchange

- If the state decides to create a state-based Exchange prior to Jan.1, 2014, the administrative cost of implementing the Exchange would be 100% federally funded. If the state elects to let the federal government run the Exchange and then later decides to move forward with a state-based Exchange, the cost of implementation would be born entirely by the state.
- There would likely be additional state costs associated with a federally-run Exchange in the form of potential increased TennCare enrollment.
- If new insurance benefit mandates are passed into state law, the costs associated with those mandates would be born by the state in either a state-run or federal-run Exchange.



# Summary

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- Over the past several years we have received recognition from across the country for our expertise, dedication and innovation in the design and implementation of creative health care solutions.
- We have managed HCFA programs in a manner that continues to beat national health care inflation trends while simultaneously improving quality. Keeping costs down has better prepared us to address the upcoming financial burden we will face due to health reform.
- We have many decisions before us related to health reform. Regardless of those decisions, there are unavoidable costs the state will bear as a consequence of health reform.
- The two most significant reform related decisions before us are whether to expand Medicaid and whether the state or the federal government should administer the Insurance Exchange. These are complicated issues with major financial implications for the state which affect many different stakeholders – providers, insurers, consumers and business owners.



# Appendix

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# Post SCOTUS ACA Eligibility Expansion

