Overview of Tennessee Medicaid Block Grant Draft Proposal

Full Proposal (link)

General Proposal: The State of Tennessee has submitted a preliminary draft waiver proposal to convert the financing of its TennCare Medicaid program into a block grant from the federal government. Under this approach, the federal government would pay Tennessee a lump sum each year while giving the State more administrative flexibility. Current eligibility levels for Medicaid services would not be reduced under this proposal.

Background: Medicaid is typically funded in each state via federal matching funds. Under this funding mechanism, the federal government pays states for a share of program expenditures and certain rules (i.e. who is covered and benefits provided) must be followed. The federal medical assistance percentage (FMAP) rate is determined by a standardized formula that takes into account each state's overall wealth.

Medicaid block grants were part of several alternative Republican healthcare plans proposed during the "repeal and replace" debate on the Affordable Care Act (ACA) in 2017. Since then, President Trump has been sympathetic to the idea, calling for Medicaid block grants in his budgets. Seema Verma, Administrator of the Centers for Medicare and Medicaid Services (CMS), has urged states to consider block grant and per capita cap approaches, and the White House's Office of Management and Budget is currently reviewing draft guidance that CMS has drafted for states on this subject.

Tennessee is the first state attempting to switch to the block grant funding model. The move already faces opposition from national and Tennessee-based patient advocacy organizations.

Timeline: This is a preliminary draft proposal open for public comment. The final version is expected to be submitted by late November and will then be subject to another formal comment period. After the submission of the proposal in November, the office of Governor Bill Lee expects it to take approximately six to nine months (or potentially longer) to negotiate a final waiver.

Key Financial Components:

- A request that the federal government replace most, but not all, of Tennessee's TennCare funding with approximately $8 billion in block grant funding (adjusted forward by inflation). The amount is determined by a calculation based on the average of three previous years' Medicaid spending on four specific eligibility groups – blind and disabled, aged, children, and adults-- and adjusting this amount to reflect the "without waiver" cost of overage under the state's current 1115 waiver. This increases the state's base allotment. The block grant would be adjusted yearly for inflation based on Congressional Budget Office (CBO) projections.
- A request that the Federal government approves per capita funding adjustments if enrollment increases in any category during a recession, natural disasters, or other economic dislocation.
- A shared savings plan which splits any money not spent from the initial annual block grant allotment 50-50 between the state and federal government.
- A state maintenance of effort requirement (MOE) based on FY2019 expenditures.

Excluded Services:

- The draft proposal **does not include** TennCare services currently carved out of the program, including outpatient prescription drugs, expenditures on behalf of individuals also eligible for Medicare, services for people with intellectual and developmental disabilities (I/DD), targeted case management services for children in state custody, uncompensated care payments to hospitals, and administrative costs. The cost of any new populations the state chooses to cover under TennCare will also be excluded until there is sufficient experience to update the block grant formula.

State Flexibilities:

- TennCare would have more flexibility under the waiver proposal to tailor coverage for different populations based on medical factors and other considerations rather than provide comparable benefits to all beneficiaries in broad ranges of eligibility. The state could change "amount, duration and scope" of coverage without having to submit such changes to CMS for review. TennCare could also add or cut optional benefits without seeking federal approval.
- TennCare MCO rates would be exempted from a range of federal Medicaid managed care requirements, including CMS certification of actuarially sound MCO payment rates.
- Instead of covering all drugs subject to Medicaid rebates, TennCare could create a closed formulary by negotiating exclusive agreements with drug manufacturers based on clinical efficacy and affordability.
- TennCare could also spend funds not otherwise eligible for Medicaid reimbursement if they benefit the health of members. Examples of such expenditures include services for members in Institutions for Mental Diseases (IMDs), services to address social factors with a direct impact on member health (e.g. nutritional assistance, housing supports, and transition assistance for individuals preparing to exit correctional facilities).
- TennCare could also spend block grant money to support rural health transformation, including telemedicine programs to increase access to specialists.
- TennCare would have greater flexibility to suspend eligibility for up to 12 months or stipulate requirements for continued eligibility in in cases where a beneficiary commits fraud.
- The State could make changes to its enrollment process, service delivery systems, and comparable program elements without further amendment.

What's Missing?

- Performance metrics tied to quality of care.
- Assurances related to enrollment and redetermination simplification.
- Commitment to use savings to expand coverage (e.g., childless adults).

Major Implications:

- More flexibility to tailor benefit packages, address social factors that impact health, and implement service delivery reforms.
- More flexibility to address pharmacy costs.
- Immediate windfall of federal dollars for state based on block grant calculation, but potential harm to beneficiaries if inflation factor is too small, or if per capita adjustments are insufficient to cover costs when enrollment increases during economic downturns.
- Potential reduction of federal consumer protections for Medicaid beneficiaries.
- Potential reduction of federal payment protections for managed care plans and providers.