Summary of TennCare III Aggregate Cap Demonstration

Overview

On January 8, 2021, the Centers for Medicaid and Medicare Services (CMS) approved Tennessee's request for a Section 1115 waiver demonstration project titled "TennCare III," which will convert the financing mechanism for the state's Medicaid program to an aggregate cap. Under this aggregate cap approach, the state of Tennessee agrees to a fixed budget target — essentially a lump sum maximum for most state Medicaid spending — and in return is granted more flexibility from the federal government in how to use those funds as well as the opportunity to earn federal savings that can be reinvested in improving state health programs. The TennCare III demonstration leverages many of the flexibilities outlined in the Healthy Adult Opportunity (HAO) guidance CMS released in early 2020. CMS and the State believe this approach will allow Tennessee to more efficiently utilize federal Medicaid dollars by aligning incentives across the state and federal government to shift the focus of Medicaid care from volume of care to value of care. Tennessee's full approved TennCare III demonstration can be found here.

Background

Medicaid is typically funded in each state via federal matching funds. Under this funding mechanism, the federal government pays states for a set percentage 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 proposed as an alternative funding mechanism for Medicaid during the "repeal and replace" debate on the Affordable Care Act (ACA) in 2017. The Trump administration has been sympathetic to the idea and CMS Administrator Seema Verma urged states to consider block grant and per capita cap approaches. The TennCare III demonstration submission predates the announcement of the HAO initiative, which was focused on the Medicaid expansion population.

Key Features

Tennessee's 1115 waiver uses a budget neutrality structure bound by an aggregate cap on demonstration funding based on established recent historical state costs and enrollment for most populations covered under the demonstration. This aggregate cap takes into account both cost and population growth in future years and includes a two-sided risk corridor of +/- 1% change in enrollment between the demonstration's base year enrollment and actual enrollment. The state would be held harmless for any increase in enrollment above 1%, and the federal government would be held harmless for any decrease in enrollment of more than 1%.

Under this agreement, Tennessee will be eligible to receive and reinvest up to 55% of any savings achieved from the annual aggregate budget caps established under the demonstration. These additional matching federal funds can be used for state health programs that fall within the "Designated Savings Investment Programs" described in the waiver. CMS's approval letter state that the intent is to include programs that address social determinants of health for vulnerable populations.

CMS is approving the TennCare III waiver for a period of 10 years. The aggregate budget cap will be rebased to actual expenditures after the first five years.

Flexibilities

The state will have the flexibility to make additive changes in coverage and benefits for existing populations without seeking prior approval from CMS; however, any reductions to current coverage or benefits would require an amendment, and could also trigger a change to the calculation of the aggregate cap. It will also have more flexibility to tailor benefits for newly covered populations.

Tennessee is also granted new flexibilities to help control drug costs. The state will be able to collect statutory section 1927 manufacturer drug rebates and negotiate for other supplemental rebates directly with drug manufacturers. The state is also granted the authority to implement a "commercial-style" closed drug formulary while continuing to receive statutory drug rebates for covered drugs, except for drugs for individuals eligible for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit.

Additionally, TennCare III will allow the state to control the amount of uncompensated care funding for hospitals and develop a new distribution methodology for its virtual disproportionate share hospital and uncompensated charity care pools without prior approval from CMS. This is intended to allow the state to move towards a value-based model to promote value over volume of services.

As noted previously, the state will be eligible to earn shared savings, capped at 55 percent of total savings under the aggregate cap, on an annual basis, when it underspends the aggregate cap and meets quality targets. The state will establish these quality targets through the *Shared Savings Quality Measures Protocol,* and submit to CMS for approval of at least 10 quality measures in line with this protocol. These measures will establish the complete quality targets for the state, called the "shared savings metric set." Any shared savings earned can be spent immediately or in any future year through December 31, 2030.

Finally, this approved demonstration also grants the state authority to implement new fraud penalties, allowing Tennessee to suspend Medicaid eligibility for individuals who have been convicted of Medicaid fraud in state or local courts for a period of up to 12 months, with beneficiaries given the right to appeal or seek reinstatement of eligibility on a separate basis.

Changes from Tennessee's Initial Demonstration Request

While CMS approved much of Tennessee's demonstration request, some provisions were not approved constituting notable changes from Tennessee's initial plan. CMS denied the state's request to be exempted from future federal mandates regarding eligibility or benefits without an agreement to add federal funding to the budget neutrality calculation. CMS also denied the state's request to permanently approve this demonstration, instead approving it for 10 years (note: Section 1115 waivers are normally approved for 3-5 years).

Tennessee also withdrew its requests for flexibility to receive Federal Financial Participation (FFP) for services provided in Institutions for Mental Diseases (IMDs) and to be exempted from some regulatory requirements related to managed care, including federal oversight of actuarial soundness of payment rates.

Legislative Approval and Potential Challenges

Now that CMS has approved the TennCare III demonstration request, the waiver will be presented to Tennessee's legislature. Although the state legislature is expected to quickly approve it, legal challenges are expected. CMS acknowledged in its approval that the vast majority of public comments regarding the demonstration opposed its approval, but CMS countered by noting that the final approved demonstration is different from the initial "block grant" financing approach described by the state in its initial application.

Summary of Implications

- The amount of total Medicaid dollars the Tennessee can receive is subject to an aggregate cap adjusted for cost and enrollment growth, although the demonstration does not change the way the federal government provides matching funds for state expenditures.

- The state can reinvest shared savings below the annual aggregate cap in state health programs, including those that address social determinants of health.

- New flexibilities allow the state to more easily tailor coverage and benefits for new populations added to the program and expand the use of value-based purchasing and incentive, but no commitment was made by the state to expand coverage to single adults as allowed under the Affordable Care Act.

- Tennessee now has new flexibilities to administer pharmacy benefits, uncompensated care, and beneficiary fraud.

- Tennessee could be fiscally vulnerable if program costs rise faster than the growth of its aggregate cap.