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Tennessee Block Grant Proposal Threatens Care for Medicaid Beneficiaries

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Earlier this year, the Tennessee legislature enacted a bill requiring the governor to seek federal approval to convert federal funding for much of its Medicaid program (TennCare) to a block grant. On September 17, Governor Bill Lee released a Medicaid waiver proposal that would radically change TennCare.¹ If approved, it would threaten access to care for the 1.4 million vulnerable Tennesseans the program covers, especially children, low-income parents, and people with disabilities.

The proposal would give the state strong financial incentives to cut benefits and reduce enrollment, as well as new authority to do so. For example, Tennessee could restrict core services such as hospital and emergency care or cut services like physical therapy, hospice, and transplant coverage without normal federal oversight or public comment. The waiver's supposed protections for beneficiaries wouldn't prevent these and other cuts, because other provisions of the waiver effectively undo them.

In addition, aspects of Tennessee's waiver conflict directly with federal law. For example, the Secretary of Health and Human Services cannot approve waivers that alter Medicaid's basic financing structure, as Tennessee's proposal would do. The proposal also conflicts with Trump Administration policies on waivers and federal Medicaid costs by exposing the federal government to the risk of significant cost increases, with the extra federal dollars going to subsidize other parts of Tennessee's budget. If a version of the waiver is ultimately approved, it would likely leave Tennessee with *less* federal funding, and more financial risk, than the state's proposal.

What the Proposal Would Do

The state's proposal would alter TennCare in three major ways.

Funding structure. The proposal would cap Tennessee's federal Medicaid funding for children, low-income parents, and people with disabilities, based on the state's projected costs of serving

¹ TennCare II Demonstration, Amendment 42, Division of TennCare, September 2019, <https://www.tn.gov/content/dam/tn/tenncare/documents2/TennCareAmendment42.pdf>.

these populations without the waiver. The cap would be raised if enrollment rose above its 2016-2018 average, but would not be lowered if enrollment fell. If costs exceeded the state's calculations, Tennessee would be responsible for the full excess amount. If costs were less than these amounts, Tennessee would retain half of the unspent federal funds.²

Use of funds. Tennessee is seeking authority to spend Medicaid dollars on *anything* the state determines will improve beneficiaries' health, which could include social services or public health infrastructure that the state is already funding with state dollars.

Authorities to make cuts. The proposal requests authority to:

- **Change covered services without federal oversight.** The proposal would allow TennCare to limit the “amount, duration, and scope” of core benefits that TennCare is required to provide, and to limit or eliminate optional benefits, without requesting approval from the federal government or providing an opportunity for public comment.
- **Eliminate federal standards for Medicaid managed care plans.** The proposal seeks to exempt Tennessee from all federal regulations for managed care plans.³
- **Exclude coverage of prescription drugs.** The proposal requests authority to deny beneficiaries access to FDA-approved prescription drugs, an approach known as a closed formulary. The state would only be required to cover one drug per therapeutic drug class, and the proposal does not specify an appeals process for beneficiaries with a medical need for drugs that aren't covered.

Proposal Puts Beneficiaries' Coverage and Services at Risk

Tennessee's waiver proposal endangers beneficiaries in several ways.

New State Authority to Make Cuts

The elimination of federal oversight would enable Tennessee to restrict — or even end outright — services like physical therapy, occupational therapy, hospice, and transplant coverage, or to arbitrarily limit who gets those services. The state also could limit access to core health services like hospital care and emergency services (for example, capping the number of inpatient hospital days covered per year), again without federal oversight or public notice.

Perhaps even more important, exempting Tennessee from federal standards and oversight of its Medicaid managed care plans would give the state substantial ability to cut costs by limiting access to care for the 93 percent of TennCare beneficiaries covered through such plans.⁴ For example, Tennessee could let plans ration care or provide such limited networks that beneficiaries would have trouble accessing services.

² State spending on outpatient prescription drugs, beneficiaries who are dually eligible for Medicaid and Medicare, supplemental payments to hospitals, and all administrative costs would be excluded from the block grant calculation.

³ Kaiser Family Foundation, Total Medicaid MCO Enrollment, 2017, <https://www.kff.org/other/state-indicator/total-medicaid-mco-enrollment/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>.

⁴ Kaiser Family Foundation, Total Medicaid MCO Enrollment, *op. cit.*

As noted, the proposal would also give Tennessee unprecedented authority to limit access to FDA-approved prescription drugs, without any defined criteria for which drugs would be covered or an appeals process for individuals with a medical need for an excluded drug. This would likely lead the state to exclude or restrict access to high-cost drugs, preventing some people with serious health conditions from accessing needed medications.

Stronger Financial Incentives for Cuts

By changing Medicaid's funding structure and what Medicaid dollars could pay for, the proposal would give Tennessee strong financial incentives to use new and existing authorities to cut services and shrink enrollment.

Under Medicaid's current financing structure, established by federal law, Tennessee receives 65 cents in federal reimbursement for every dollar it spends on allowable services for Medicaid enrollees. As a result, for every dollar the state reduces total Medicaid spending, it saves 35 cents, while the federal government saves 65 cents. Under the proposal, Tennessee would receive 50 percent of the unspent federal funds for every dollar it cuts from the TennCare program. This change would nearly double the state's financial reward for cutting Medicaid spending on children, low-income parents, and people with disabilities, whether by shrinking enrollment or by cutting services.

Moreover, under the proposal, Tennessee could use federal matching funds, up to the caps, for a wide range of other state expenditures, such as costs it *already incurs* for social services or anything else it might deem health related. That means Tennessee could cut its spending on health care for low-income people, diverting those dollars to other areas of its budget or tax cuts, without giving up any federal funds.

Reduced Federal Funding if Per-Person Costs Increase Sharply

By capping federal Medicaid funding, the proposal could leave Tennessee with unanticipated financial costs above those it faces today, further increasing the demand for TennCare cuts.

As discussed below, Tennessee is proposing to set federal funding caps well above its likely spending levels in order to minimize its financial risk and maximize its potential gains from the waiver. And, as noted, it proposes to adjust those caps upward if enrollment grows. But even so, the proposal leaves Tennessee exposed if *per-person* TennCare costs grow substantially faster than expected, as could occur in a public health crisis (such as the opioid crisis) or due to innovations in medical treatment.⁵ Because it would squeeze federal funding exactly when per-person costs are highest, the waiver could put coverage at risk even for groups excluded from the block grant itself, such as seniors and some children with disabilities.

⁵ Kristi L. Nelson, "TennCare Shifts to Coverage of Longer-Term Opioids Addiction Treatment," *Knoxville News Sentinel*, April 3, 2019, <https://www.knoxnews.com/story/news/health/2019/04/03/opioid-addiction-tenncare-medication-assisted-therapy-suboxone-methadone/3288432002/>.

Waiver's Protections for Beneficiaries Are Illusory

While the waiver claims to protect beneficiaries, the supposed protections wouldn't prevent the state from cutting coverage or services.

The proposal's most concrete guardrail is a "maintenance of effort" requirement, which would prevent Tennessee from reducing state Medicaid spending relative to its 2019 levels. But because Tennessee also requests authority to spend Medicaid dollars on anything the state decides will promote beneficiaries' health, it could easily meet this requirement without actually maintaining current spending on health care for beneficiaries. For example, the state could substantially cut TennCare services but meet the requirement by counting the amount it already spends on social services that primarily serve low-income people *outside* TennCare.

Similarly, while the waiver states that Tennessee's proposal doesn't cut eligibility or benefits, it would give the state unfettered authority to make these cuts later. Moreover, even taken at face value, the waiver wouldn't preclude changes to state procedures that make it harder for people to get and keep coverage. Experience from other states shows that such changes, like requiring beneficiaries to complete additional paperwork or renew their coverage more frequently, can lead to large drops in enrollment even without changes in eligibility rules.⁶

The best indicator of what Tennessee would do under its waiver is likely what it has done in the past, and Tennessee has a long track record of harmful Medicaid cuts. During the 1990s, the state froze TennCare enrollment, cutting off access to health coverage for many low-income adults and children.⁷ In 2005, the state dropped 170,000 people from TennCare due to budget pressures.⁸ And even in the past two years, when the state has not faced exceptional budget pressures, TennCare enrollment has dropped sharply, including for children, likely due in part to new state procedures that make it hard for people to stay enrolled.⁹ The proposed waiver would likely make matters worse by increasing the state's authority and financial incentive to make cuts.

⁶ Michael Perry *et al.*, "Overcoming Barriers to Enrollment: Findings from a National Survey," Kaiser Family Foundation, January 2000, <https://www.kff.org/medicaid/report/medicaid-and-children-overcoming-barriers-to-enrollment/>.

⁷ Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, "Issues in Developing Programs for Uninsured Children: A Resource Book for States. TennCare," March 2, 1998, <https://aspe.hhs.gov/report/issues-developing-programs-uninsured-children-resource-book-states/tenncare>.

⁸ Emily Siner, "TennCare's Big Cuts in 2005 May Have Delayed Breast Cancer Diagnoses, Study Suggests," Nashville Public Radio, June 27, 2017, <https://www.nashvillepublicradio.org/post/tenncare-s-big-cuts-2005-may-have-delayed-breast-cancer-diagnoses-study-suggests#stream/0>.

⁹ Matt Broaddus, "Research Note: Medicaid Enrollment Decline Among Adults and Children Too Large to Be Explained by Falling Unemployment," Center on Budget and Policy Priorities, July 17, 2019, <https://www.cbpp.org/research/health/medicaid-enrollment-decline-among-adults-and-children-too-large-to-be-explained-by>. See also Brett Kelman, "Tennessee Erased Insurance for at Least 128,000 Kids. Many Parents Don't Know." *Nashville Tennessean*, April 4, 2019, <https://www.tennessean.com/story/news/health/2019/04/02/tennessee-tenncare-coverkids-medicaid-erased-health-care-coverage-for-children/3245116002/>.

Proposed Provisions Likely Conflict With Federal Law and Policy

Under federal law, Medicaid waivers are required to promote the program’s objectives. It is unclear how any part of Tennessee’s waiver proposal advances Medicaid’s central goal of providing health coverage to low-income people, so the waiver would likely be subject to legal challenge on that basis alone.

But beyond that, specific features of Tennessee’s proposal conflict with federal law and policy. Even Governor Lee has acknowledged that the waiver pushes the bounds of federal requirements, stating, “this is not one of those arrangements that we are fully expecting the federal government to do.”¹⁰ A version of the proposal omitting these features would likely provide Tennessee with less federal funding than the current proposal.

Proposed Financing Structure

Tennessee’s waiver proposes to change Medicaid’s matching structure. As explained above, it would enable Tennessee to reduce its spending on Medicaid relative to the state’s calculations in the waiver while forfeiting only half the federal matching funds for those unspent dollars. In effect, Tennessee could obtain some federal funding without providing a state match. Tennessee’s waiver application emphasizes that this provision “is a key feature and a necessary component of the state’s proposal.”¹¹

That proposal is not approvable under federal law.¹² Medicaid waiver authority under section 1115 of the Social Security Act only authorizes the Secretary of Health and Human Services to waive provisions in section 1902 of the Social Security Act, which defines whom states must (and can opt to) cover, what benefits they must (and can opt to) provide, the processes for determining eligibility, various beneficiary protections, and various requirements and options for delivering health care services.

To alter Medicaid’s financing structure as TennCare proposes — including the formula that sets out how states draw down federal Medicaid funds — the Secretary would have to waive a provision in section 1903 of the Social Security Act, which governs how Medicaid is financed and requires the federal government to pay states a fixed percentage of the amount the state spends to provide health care services to eligible beneficiaries. *The Secretary cannot grant waivers of section 1903 and hence can’t approve waivers that alter Medicaid’s basic financing structure.*

¹⁰ Natalie Allison, “Exclusive First Look at Gov. Bill Lee’s Plan to Seek Block Grants for TennCare, Changing How State Receives Medicaid Dollars,” *Nashville Tennessean*, September 2, 2019, <https://www.tennessean.com/story/news/politics/2019/09/03/bill-lee-block-grant-tennessee-medicaid-tenncare/2165394001/>.

¹¹ TennCare II Demonstration, *op. cit.*

¹² Nicholas Bagley, “Tennessee Wants to Block Grant Medicaid. Is That Legal?” *Incidental Economist*, September 17, 2019, <https://theincidentaleconomist.com/wordpress/tennessee-wants-to-block-grant-medicaid-is-that-legal/>. See also Judith Solomon and Jessica Schubel, “‘Block Grant’ Guidance Will Likely Invite Medicaid Waivers That Pose Serious Risks to Beneficiaries, Providers, and States,” *Center on Budget and Policy Priorities*, June 27, 2019, <https://www.cbpp.org/research/health/block-grant-guidance-will-likely-invite-medicaid-waivers-that-pose-serious-risks-to>.

The Centers for Medicare & Medicaid Services (CMS) recently acknowledged that it lacks the legal authority to change the federal Medicaid matching rate in a letter to North Carolina, stating:

Section 1115(a)(i) waiver authority extends only to provisions of section 1902 of the Act, and does not extend to provisions of section 1905 of the Act, such as section 1905(b). Nor is CMS able to grant the state's request by providing expenditure authority under section 1115(a)(2)(A) of the Act. Section 1115(a)(2)(A) only permits state expenditures to be regarded as federally matchable. It does not allow applicable federal match rates to be altered.¹³

Prescription Drug Proposals

Tennessee's proposal to arbitrarily exclude coverage of some prescription drugs also conflicts with federal law. A separate section of Medicaid law requires states that include prescription drug coverage in their Medicaid programs — which all states do — to cover all FDA-approved drugs with very limited exceptions, which the law explicitly defines. In return for covering all prescription drugs, Medicaid requires drug companies to provide substantial rebates, giving states a much lower price than typically offered to commercial health plans. These provisions reflect a carefully negotiated legislative compromise that has allowed the federal government and the states to achieve savings of about 50 percent, according to the HHS Office of Inspector General.¹⁴ Tennessee's proposal closely resembles a 2017 Massachusetts proposal to establish a closed formulary in its Medicaid program, which CMS rejected in 2018.¹⁵

Federal Costs

As discussed above, Tennessee's proposal puts the state at risk if per-person Medicaid costs rise substantially faster than expected. But the proposal also exposes the federal government to the risk of significant cost increases, with the extra federal dollars going to subsidize other parts of Tennessee's budget.

Tennessee's proposed federal funding caps are based on higher-than-current enrollment levels and outdated per-person spending projections that exceed the state's current spending on health care services to TennCare beneficiaries, so they are well above what the state would likely spend absent the waiver.¹⁶ And, because the proposal would enable Tennessee to spend Medicaid funding on anything it determines will improve beneficiaries' health, Tennessee could use additional federal funding up to the inflated caps to *replace existing state spending* in areas tangentially connected to TennCare beneficiary health, without spending any additional state dollars — or even while cutting state spending on health care.

¹³ Centers for Medicare & Medicaid Services, North Carolina Medicaid Reform Demonstration Approval, October 19, 2018, <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/nc/Medicaid-Reform/nc-medicaid-reform-demo-demo-appvl-20181019.pdf>.

¹⁴ Office of Inspector General, Department of Health and Human Services, "Medicaid Rebates for Brand-Name Drugs Exceeded Part D Rebates by a Substantial Margin," April 2015, <https://oig.hhs.gov/oei/reports/oei-03-13-00650.pdf>.

¹⁵ Centers for Medicare & Medicaid Services, MassHealth Demonstration Amendment Approval, June 27, 2018, <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ma/MassHealth/ma-masshealth-demo-amndmnt-appvl-jun-2018.pdf>.

¹⁶ Mandy Pellegrin, "Breaking Down TennCare's Block Grant Proposal," Sycamore Institute, September 19, 2019, <https://www.sycamoreinstitute.org/breaking-down-tenncares-block-grant-proposal/>.

Approving such a waiver also would conflict with the Administration’s stated goals and written policies related to waivers and federal Medicaid costs, in two areas.

First, the Administration recently issued guidance aiming to tighten “budget neutrality” standards for Medicaid waivers. Longstanding federal policy requires that Medicaid waivers be budget neutral to the federal government: they cannot cost the federal government more than it would have spent without the waiver. However, recent CMS guidance argues that past practices for assessing budget neutrality led “to increased federal Medicaid spending and [put] the fiscal integrity of the program at risk.” The new guidance commits to “strengthen[ing] accountability and prevent[ing] the federal government’s exposure to excessive expenditures under [waivers].”¹⁷ The TennCare proposal violates this principle.

Second, CMS recently proposed to change federal policy on Medicaid waivers to prevent states from drawing down federal Medicaid funds for state spending on non-Medicaid programs, known as “designated state health programs,” or DSHP. Prior to 2017, states could sometimes claim federal Medicaid funds to offset costs on programs that offered some benefit to Medicaid enrollees, such as breast and cervical cancer screening for low-income women (including, but not exclusively for, Medicaid enrollees). In 2017, CMS released guidance changing this practice, noting that “...federal DSHP funding frees up state dollars that the state can expend to obtain additional federal match. This, in effect, results in increased federal expenditures without a comparable increase in the state’s investment in its demonstration.”¹⁸ Tennessee’s proposal to use Medicaid funds on anything that the state deems is health related not only conflicts directly with the current Administration’s policy on DSHP but would constitute a dramatic expansion of any prior allowance of the practice.

The Administration could choose to disregard its own policies on these matters, although doing so would fly in the face of its stated concerns about federal Medicaid costs.¹⁹ But Tennessee policymakers should be wary of relying on verbal commitments from CMS regarding their waiver. Having reportedly assured Utah lawmakers that CMS would approve the state’s proposal for a partial Medicaid expansion, CMS recently announced that it will reject it²⁰ — “in large part because of estimates showing that this partial expansion would significantly increase ACA spending,” according to a former Administration official.²¹

¹⁷ Centers for Medicare & Medicaid Services, Budget Neutrality Policies for Section 1115(a) Medicaid Demonstration Projects, August 22, 2018, <https://www.medicare.gov/federal-policy-guidance/downloads/smd18009.pdf>.

¹⁸ Centers for Medicare & Medicaid Services, Phase-out of expenditure authority for Designated State Health Programs (DSHP) in Section 1115 Demonstrations, December 15, 2017, <https://www.medicare.gov/federal-policy-guidance/downloads/smd17005.pdf>.

¹⁹ Centers for Medicare & Medicaid Services, Remarks by Administrator Seema Verma at the American Hospital Association Regional Policy Board Meeting, September 10, 2019, <https://www.cms.gov/newsroom/press-releases/remarks-administrator-seema-verma-american-hospital-association-regional-policy-board-meeting>.

²⁰ Benjamin Wood, “‘We Probably Have to Implement the Thing’: Failure of Utah Legislature’s Medicaid Plan Tees Up Full Expansion — Again,” *Salt Lake Tribune*, July 28, 2019, <https://www.sltrib.com/news/politics/2019/07/27/we-probably-have/>.

²¹ Brian Blase, “Health Reform Progress: Beyond Repeal and Replace,” Galen Institute, September 2019, <https://galen.org/assets/Health-Reform-Progress-Brian-Blase.pdf>.

Proposal Would Not Address State’s Coverage Gap

Contrary to some supporters’ suggestions, the proposal would do nothing to address Tennessee’s coverage gap and isn’t an alternative to Medicaid expansion. More than 200,000 low-income adults in Tennessee are uninsured because of Tennessee’s failure to expand Medicaid: their incomes are too high for Medicaid but too low to qualify for tax credits to buy marketplace coverage.²²

While supporters have said that a block grant could provide an alternative way to address this coverage gap, the waiver proposal does not expand TennCare eligibility to *any* uninsured low-income adults.²³ Adopting Medicaid expansion would cover this group and avoid the waiver’s many pitfalls and dangers.

²² Matthew Buettgens, “The Implications of Medicaid Expansion in the Remaining States: 2018 Update,” Urban Institute, May 2018, https://www.urban.org/sites/default/files/publication/98467/the_implications_of_medicaid_expansion_2001838_2.pdf.

²³ Blake Farmer, “TennCare Designs Block Grant Proposal With Expansion of Services in Mind,” Nashville Public Radio, September 11, 2019, <https://www.nashvillepublicradio.org/post/tenncare-designs-block-grant-proposal-expansion-services-mind>.