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## An Analysis of Tennessee's New Medicaid Waiver: TennCare III

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# **An Analysis of Tennessee's New Medicaid Waiver: TennCare III**

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Spring 2021

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## Introduction

### **Background on Medicaid in Tennessee**

Medicaid is a federal-state partnership to provide health coverage benefits to certain vulnerable groups. Each state is responsible for administering its own Medicaid program in accordance with certain federal rules which include mandatory benefits for covered groups, namely, low-income children and their parents and aged, blind, and disabled individuals. There are additional groups which may be covered by Medicaid at the discretion of the state. As a partnership, the federal government covers a certain percentage of Medicaid expenditures in each state. This agreed upon rate is the federal medical assistance percentage or FMAP. Tennessee's FMAP is set at 66.1% for 2021 (KFF 2021). Federal matching is unlimited for entitled groups meaning there is no upper limit on how much federal funding a state may receive in a budget period as long as the state is covering the mandatory population and matching expenditures with state dollars. The amount of federal funding received is based on the actual enrollment in the program and determined by the FMAP (Pellegrin 2017).

States can apply for waivers which allow them to waive some of the federal rules and design their own state-specific Medicaid programs. Tennessee's Medicaid program has been operating under a Section 1115 demonstration waiver<sup>1</sup> since 1994 when the program first became known as TennCare (TennCare 2020). This waiver has been renewed every five years since that time with significant amendments made over the years with respect to which groups are entitled to the program and how the program is administered. Most notably, in 2005, TennCare was overhauled in response to a budget crisis and the new waiver amendment allowed for the disenrollment of uninsured and uninsurable adults from the program. This resulted in the

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<sup>1</sup> Section 1115 waivers "allow[s] the HHS Secretary to waive certain provisions of federal law in state Medicaid programs to test policies that are likely to promote program objectives" (Guth, Rudowitz and Musumeci 2021).

disenrollment of approximately 170,000 adults and a reduction in spending of \$1.7 billion (Pellegrin 2017).

### **TennCare III**

Despite a long record of significant policy changes resulting from amendments to TennCare's 1115 waiver, the fundamental funding structure of the entitlement program has remained unchanged. Reimagining that funding structure was the goal of the most recent waiver amendment proposed by the State in 2019 and approved by Centers for Medicare & Medicaid Services (CMS) in early 2021, dubbed "TennCare III".

Many, including the State's own lawmakers, initially referred to the TennCare III waiver proposal as a "Block Grant" waiver, however, in its approval of the waiver CMS takes pains to clarify that TennCare III is not a true block grant as was initially proposed by the State, but rather a financing structure which uses "an aggregate cap budget neutrality financing approach" (CMS & TennCare 2021). Still, this would be a fundamental change to the funding structure of TennCare and a novel approach to Medicaid funding, making Tennessee the first state to depart from the more traditional funding model.

Under the new waiver, the aggregate cap amount is based on actual spending in five enrollee categories (1) children (2) adults (3) disabled individuals (4) individuals over 65 and (5) individuals dually eligible for both Medicare and Medicaid. The costs from 2019 to cover these groups has been trended forward to establish caps for each group for a five-year period beginning in 2021. After the first five years, spending caps will be rebased based on spending under the first five years of the waiver period. If actual spending exceeds these caps, the State could be on the hook to make up the difference. However, the waiver did account for increased costs due to increased enrollment by providing for the cap to rise if enrollment in a year exceeds

the baseline year's enrollment by more than 1%. On the other hand, the cap will also fall if enrollment decreases more than 1%. Historically, TennCare enrollment has often fluctuated by more than 1% from year to year (Pellegrin 2021). Most importantly, the aggregate caps create the potential for "shared savings" under the waiver by allowing the State to keep 45-55% of the federal share of savings i.e. the difference between the aggregate cap amount and what the State actually spends.

### **TennCare III and the State Budget**

It is important to consider the potential impacts of the funding structure of TennCare III on the Tennessee state budget. A little over a third of the entire state budget is typically spent on TennCare when funding from both federal and state sources is considered (Pellegrin 2017). If TennCare III has the potential to allow the State to draw down more federal funding, through the shared savings provision of the waiver, without spending additional state funds, the waiver would positively impact the state's budget and savings could be used to bolster other public health initiatives. However, if spending per capita increases due to rising costs of administration, medical inflation or a public health crisis, the state budget could be negatively impacted, and funding may need to be diverted from other areas in the budget to make up shortfalls from the new federal funding caps.

### **Literature Review**

Because TennCare III was approved recently in January 2021, no formal research has been published analyzing the potential budget implications of the plan. Some policy centers have published preliminary outlines and explainers including the Kaiser Family Foundation and the Sycamore Institute of TN. The Kaiser Family Foundation (KFF) piece focuses on recent 1115

demonstration waiver activity in state Medicaid programs including the approval of TennCare III. KFF explains that Section 1115 waivers “allow[s] the HHS Secretary to waive certain provisions of federal law in state Medicaid programs to test policies that are likely to promote program objectives” and goes on to note that “these waivers generally reflect administration priorities” (Guth, Rudowitz and Musumeci 2021). KFF does not describe TennCare III as a “block grant” but does point to the novel financing structure approved under the waiver.

Although budget neutrality is a key feature of 1115 waivers, meaning the State must demonstrate that federal spending under the waiver will not exceed spending without the waiver in place, TennCare III is unique in setting aggregate caps rather than per capita caps on spending (Guth, Rudowitz and Musumeci 2021). The Sycamore Institute, in their outline of the waiver, do refer to the new financing structure as a “block grant” although they concede that the aggregate cap approved by the waiver differs from the original waiver application submitted by the State which more closely resembled a traditional “block grant” structure (Pellegrin 2021).

The idea of converting the traditional financing structure of Medicaid into a “block grant” is not new and the matter has been the subject of some research. President Ronald Reagan was the first to propose a federal spending cap for Medicaid in 1981. Reagan was a proponent of giving more control of the program to the states and was eager to reign in federal spending on the program. The effort initially gained traction in the Senate before ultimately fizzling out. In 1995 Newt Gingrich, as Speaker of the House, proposed a similar funding cap for Medicaid titled “Medigrant” which also failed to gain traction when Congress was unable to develop a fair and equitable funding formula for the states based on each state’s particular needs. President Clinton also made it clear that he would not sign the legislation. In 2003 President Bush again unveiled a plan to place an aggregate cap on Medicaid funding but instead of going to Congress he went to

the National Governor's Association who were unable to come to bipartisan agreements on the details of the plan (Lambrew 2005).

Following Bush's latest Medicaid block grant proposal, Jeanne M. Lambrew, Ph.D., researched the potential implications of converting Medicaid into a block grant in "Making Medicaid a Block Grant Program: An Analysis of the Implications of Past Proposals". Her research focused on the proposed federal spending limits of the 1981 and 1995 plans compared with actual federal Medicaid spending in subsequent years. Her research showed that the actual federal Medicaid spending outstripped the proposed caps in both cases and that the degree to which this happened varied greatly by state. The conclusion was that it would have been necessary for states to lower their costs to make up for the reduction in federal funding whether by altering benefits, disenrolling beneficiaries or developing administrative efficiencies (Lambrew 2005). The concern is that states forced to make tough calls to balance their Medicaid budget may fail to fulfill the mission of Medicaid to provide health coverage to vulnerable groups including low-income children, their parents and disabled individuals. Lambrew admits that the inability to accurately project which efficiencies and cost-saving measures may have been implemented by the states if they actually had the opportunity to operate their programs under a block grant structure is an area of weakness in her research.

TennCare III is a novel approach to accomplishing the capping of federal spending on Medicaid because it emerged at the state level and has been approved through the use of an 1115 demonstration waiver, an existing policy solution, rather than through federal legislation as has been proposed in the past. There are no real-world examples available to inform research on the



possible implications as Tennessee will be the first state to implement this financing structure on the core of its Medicaid beneficiary population.

As a result, this paper will use a similar research model to the one employed by Lambrew to conduct an analysis of the potential budget and programmatic implications of the implementation of TennCare III by determining what the aggregate cap would have been, using the same formula set forth in TennCare III, had the waiver been implemented in 2014 and comparing those caps with actual spending over the course of the subsequent five years. Because TennCare III has already been approved, this research will benefit from the specificity the waiver provides. In particular, it is clear which administrative flexibilities the State has been granted by CMS and the extent to which improved efficiencies might aid the State in controlling Medicaid spending.

### **Research Design**

The goal of TennCare III, as stated by the State in the demonstration waiver application and reiterated by CMS in the demonstration approval letter, is to obtain increased flexibility from federal oversight in order to run the program more efficiently. In return for lowering overall costs of the program, which would result in savings in both state and federal funds, the State requested the ability to retain a portion of this savings as “shared savings”. The shared savings would allow the State to draw down additional federal funding, for which there would be no mandatory State funding match. The idea being that the shared savings would result in an increase in the overall fraction of federal funding for the program. This shared savings could then be spent on programs that bolster health for Tennesseans that may not normally be reimbursable under Medicaid, freeing up state dollars to be used on other budget items. On the other hand, the aggregate cap

financing structure also leaves the State at risk. If actual expenditures in a waiver year exceed the cap set for that year, the State would be responsible for funding the deficit.

### Main Research Question

- 1. Will Tennessee succeed in increasing the share of federal funding for its Medicaid program under TennCare III?**

Answering the main research question will require the answering of the:

### Secondary Research Question

- 2. How much shared savings can the State expect to gain?**

The following steps outline the research design implemented in this paper:

1. Hypothetical aggregate spending caps will be set for SFYs 2014, 2015, 2016, 2017 and 2018 based on the formula for aggregate caps set forth in TennCare III.<sup>2</sup>
2. The hypothetical aggregate spending caps will then be compared to actual Medicaid expenditures in TN for the same years to determine if the State would have been eligible for shared savings or at risk of a funding deficit.
3. The amount of shared savings or deficit for each year, as determined in step 2, will be used to calculate the federal share of spending under the hypothetical aggregate cap waiver.

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<sup>2</sup> A five-year period was chosen to mirror the first five-year period in TennCare III. These specific years were chosen because they are the most recent years for which complete expenditure and enrollment data is readily available.

4. The hypothetical federal share will be compared with the actual federal share of expenditures in those years to determine if the State would have succeeded in increasing the federal share for its Medicaid program under a waiver similar to TennCare III.
5. From these results, conclusions will be drawn as to the likelihood that TennCare III will allow the State to increase the share of federal funding for its Medicaid program during the first five years of implementation: 2021 through 2025.

The potential for the State to increase the share of federal funding for its Medicaid program hinges on the shared savings provision of the TennCare III waiver. In turn, shared savings is determined by the aggregate caps. The specifics of how aggregate caps and, as a result, shared savings will be calculated are detailed in the TennCare III waiver approved by CMS.

### **Shared Savings**

Under TennCare III, federal matching funds for the core of TennCare's eligible members will be limited by aggregate spending caps. If Tennessee is successful in underspending the aggregate cap amounts for each year, the state is eligible to retain between 45 and 55 percent of the federal share of the savings. Because the aggregate caps are projected based on actual spending increased at a national trend rate set in the President's budget, all the State must do is keep the rate of growth of its spending below the national average for Medicaid programs. The State has a track record of succeeding in this. Under TennCare II, although there were not true spending caps, there was a budget neutrality test with a similarly formulated ceiling. If TennCare spending ever exceeded that ceiling, the federal government would still have to match the State's

spending, but the State would be in danger of losing its 1115 demonstration waiver since one of the stipulations of such waivers is that the State *demonstrates*, by passing the budget neutrality test, that it can more efficiently run its Medicaid program under a waiver which allows for greater flexibilities. So, in the case of “shared savings”, “savings” could be considered a bit of a misnomer. The State is not required to cut real costs in order to obtain these savings. Instead, the savings are theoretical and meant to represent a portion of what the federal government could expect to spend to fund Medicaid in the State in the absence of the TennCare III waiver.

The ability to qualify for these so-called shared savings is also contingent upon to-be-determined quality control provisions known as Shared Savings Quality Measures Protocols (SSQMP). The demonstration approval lays out the process for determining and monitoring the SSQMPs. The State and CMS will work together to agree upon the specific measures following the waiver implementation. The State can retain 45 percent of savings if the reported SSQMP metrics indicate maintenance of performance and has the ability to retain a further 10 percent, for a total of 55 percent of savings, if metrics indicate improvements to the program i.e. covering a new group of members not currently eligible or increasing benefits for some currently enrolled group.

If baseline performance of the program ever decreases according to the SSQMPs, the State risks a reduction in shared savings amount. For the purposes of this research, I will assume that the State will meet or exceed quality control metrics and therefore be eligible for 45 to 55 percent of shared savings.

## **Aggregate Spending Caps**

TennCare III details how the aggregate caps will be determined under the new waiver for each demonstration year (DY). The caps are based on the total expenditures for the five eligibility groups which make up the core of the population covered by TennCare in the most recent year for which data are available, State Fiscal Year 2019 (SFY19). The expenditures will then be trended forward using the national growth rate detailed in the President's budget for each eligibility group.

Another component of the cap setting is the risk corridor adjustment. This adjusts the aggregate cap amount up or down based on fluctuations in enrollment greater or less than 1% compared with the baseline year.

In the case of increased enrollment, the risk corridor adjustment serves the purpose of protecting the State's budget. If enrollment increases more than 1% above the projected enrollment used to determine the aggregate cap for that year, the aggregate cap will also increase to compensate for increased costs due to increased enrollment. This measure protects the State in the case of an economic downturn which results in more Tennesseans becoming eligible for the program.

In the case of decreased enrollment, the risk corridor protects the federal budget and TennCare members. If enrollment decreases more than 1% below the projected enrollment used to determine the aggregate cap for that year, the aggregate cap will also decrease to compensate for the decreased costs due to decreased enrollment. This measure protects the federal budget as well as the goals of the Medicaid program and potential TennCare members by ensuring that disenrollment is not a method that can be utilized by the state to reduce overall costs and increase shared savings.

## **Methods and Findings**

1. *Hypothetical aggregate spending caps will be set for SFYs 2014, 2015, 2016, 2017 and 2018 based on the formula for aggregate caps set forth in TennCare III.*

Following the first step outlined in the Research Design section of this paper, the aggregate cap setting formula set forth in TennCare III was replicated retrospectively for the years 2014 through 2018. A five-year period was chosen because the demonstration approval letter for the TennCare III waiver divides the ten-year demonstration waiver into two five-year periods and bases the aggregate caps for the first five-year period, 2021-2025, upon the State's actual Medicaid expenditures in SFY 2019. Similarly, these hypothetical aggregate spending caps for the State Fiscal Years 2014, 2015, 2016, 2017 and 2018 were based upon actual expenditure data for SFY 2013 as reported by TennCare to CMS in quarterly reports required under TennCare II. These reports are publicly available on Medicaid.gov.<sup>3</sup> The expenditure data in these reports is broken down by the same five Medicaid Eligibility Groups (MEGs) included in TennCare III. The trend rates used to project the actual expenditures from SFY 2013 forward over the five-year period were published in the re-approval for the TennCare II waiver for the period from July 1, 2013-June 30, 2016 as those would have been the rates available if aggregate caps were being implemented in 2013. The results are displayed in Table 1. These caps are labeled as the "Baseline Aggregate Caps" because the Risk Corridor adjustment has not yet been made.

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<sup>3</sup> See TennCare II Quarterly Reports 2013-2018 <https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/83206>

Medicaid Eligibility Groups	Actual Expenditures in SFY 2013	Trend Rates	Aggregate Caps 2014	Aggregate Caps 2015	Aggregate Caps 2016	Aggregate Caps 2017	Aggregate Caps 2018
MEG Disabled	\$ 2,094,552,767	5.10%	\$ 2,201,374,958	\$ 2,313,645,081	\$ 2,431,640,980	\$ 2,555,654,670	\$ 2,685,993,058
MEG Children	\$ 1,653,963,177	3.40%	\$ 1,710,197,925	\$ 1,768,344,654	\$ 1,828,468,373	\$ 1,890,636,297	\$ 1,954,917,932
MEG Over 65	\$ 183,953,925	4.60%	\$ 192,415,806	\$ 201,266,933	\$ 210,525,212	\$ 220,209,371	\$ 230,339,002
MEG Adults	\$ 1,233,007,614	4.90%	\$ 1,293,424,987	\$ 1,356,802,811	\$ 1,423,286,149	\$ 1,493,027,171	\$ 1,566,185,502
MEG Duals	\$ 1,484,156,028	4.60%	\$ 1,552,427,205	\$ 1,623,838,857	\$ 1,698,535,444	\$ 1,776,668,075	\$ 1,858,394,806
Baseline Aggregate Cap			\$ 6,949,840,881	\$ 7,263,898,336	\$ 7,592,456,158	\$ 7,936,195,584	\$ 8,295,830,300

After determining the baseline aggregate caps, the actual enrollment data reported by TennCare to CMS was used to adjust the caps based on the Risk Corridor provision outlined in TennCare III. Actual enrollment for SFY 2013 was reported on a quarterly basis. Enrollment for each MEG was averaged for all quarters in 2013 to establish an average annual enrollment for each MEG which will be used as the baseline enrollment number for the Risk Corridor adjustment. A decrease in actual enrollment below 99% of the baseline enrollment for that MEG would trigger a reduction in the aggregate spending cap via the Risk Corridor adjustment while an increase in enrollment above 101% of the baseline enrollment number would trigger an increase in the aggregate spending cap via Risk Corridor adjustment. Baseline enrollment numbers and the corresponding lower and upper limits are displayed in Table 2.

SFY 2013 Actual Enrollment							
Medicaid Eligibility Group	Quarter I	Quarter II	Quarter III	Quarter IV	Average Baseline Enrollment	99% of Baseline	101% of Baseline
MEG Disabled	137,701	136,384	135,215	133,692	135,748	134,391	137,105
MEG Children	695,237	700,828	696,874	658,669	687,902	681,023	694,781
MEG Over 65	39	50	50	37	44	44	44
MEG Adults	281,982	285,536	276,834	289,416	283,442	280,608	286,276
MEG Duals	143,001	140,887	136,225	133,701	138,454	137,069	139,838

For the next step in making the Risk Corridor adjustment, the actual enrollment data reported by TennCare to CMS for SFYs 2014, 2015, 2016, 2017 and 2018 for each MEG was compared with the baseline enrollment lower and upper limits to determine if a Risk Corridor

adjustment to the aggregate cap for that MEG in that year was appropriate. Notably, a Risk Corridor adjustment was indicated in all but one MEG for one year. By SFY 2016 an upward Risk Corridor adjustment was indicated for all MEGs. Results are displayed in Table 3.

Medicaid Eligibility Group	SFY 2014 Actual Enrollment	RC Adjustment Necessary?	SFY 2015 Actual Enrollment	RC Adjustment Necessary?	SFY 2016 Actual Enrollment	RC Adjustment Necessary?	SFY 2017 Actual Enrollment	RC Adjustment Necessary?	SFY 2018 Actual Enrollment	RC Adjustment Necessary?
MEG Disabled	137,377	Yes, >101%	141,486	Yes, >101%	143,322	Yes, >101%	144,835	Yes, >101%	143,757	Yes, >101%
MEG Child	663,783	Yes, <99%	713,838	Yes, >101%	766,210	Yes, >101%	790,495	Yes, >101%	773,734	Yes, >101%
MEG Over 65	37	Yes, <99%	31	Yes, <99%	195	Yes, >101%	258	Yes, >101%	364	Yes, >101%
MEG Adult	302,281	Yes, >101%	367,607	Yes, >101%	438,197	Yes, >101%	453,156	Yes, >101%	414,368	Yes, >101%
MEG Duals	132,977	Yes, <99%	138,963	No, within baseline	146,741	Yes, >101%	151,817	Yes, >101%	148,936	Yes, >101%

In order to calculate the Risk Corridor adjustment amount, I used the same formula set forth by CMS in the TennCare III Waiver approval (CMS & TennCare 2021 pg.104)

When actual enrollment exceeds baseline enrollment by more than 1%:

1. Actual enrollment value – 101% of baseline enrollment = Difference
2. Difference \* Per Member Per Month (PMPM) cost for that MEG = Risk Corridor adjustment
3. Risk Corridor adjustment is added to the baseline aggregate cap for that MEG for that year.

When actual enrollment falls below baseline enrollment by more than 1%:

1. 99% of baseline enrollment – actual enrollment value = Difference
2. Difference \* Per Member Per Month (PMPM) cost for that MEG = Risk Corridor adjustment
3. Risk Corridor adjustment is subtracted from the baseline aggregate cap for that MEG for that year.

The Per Member Per Month (PMPM) costs are defined in the TennCare III waiver. For this exercise, I used the PMPM costs set forth in the TennCare II approval for 2013-2016 and trended those forward for 2017 and 2018. PMPM amounts are listed below in Table 4.



Medicaid Eligibility Group	Trend Rate	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018
MEG Disabled	5.10%	\$ 1,561.46	\$ 1,641.09	\$ 1,724.79	\$ 1,812.75	\$ 1,905.21
MEG Children	3.40%	\$ 468.46	\$ 484.39	\$ 500.86	\$ 517.89	\$ 535.49
MEG Over 65	4.60%	\$ 1,022.17	\$ 1,069.19	\$ 1,118.37	\$ 1,169.82	\$ 1,223.63
MEG Adults	4.90%	\$ 917.79	\$ 962.76	\$ 1,009.94	\$ 1,059.42	\$ 1,111.34
MEG Duals	4.60%	\$ 652.99	\$ 683.03	\$ 714.45	\$ 747.31	\$ 781.69

Using the formula outlined above, I calculated the Risk Corridor adjustments for all MEGs and added them to the baseline aggregate caps for each year to determine the final aggregate cap displayed in Table 5.

Medicaid Eligibility Groups	Aggregate Caps 2014	Aggregate Caps 2015	Aggregate Caps 2016	Aggregate Caps 2017	Aggregate Caps 2018
Baseline Aggregate Cap	\$ 6,949,840,881	\$ 7,263,898,336	\$ 7,592,456,158	\$ 7,936,195,584	\$ 8,295,830,300
Risk Corridor adjustment	\$ 4,356,633	\$ 94,707,456	\$ 205,027,075	\$ 249,578,131	\$ 204,805,844
Final Aggregate Caps	\$ 6,954,197,514	\$ 7,358,605,792	\$ 7,797,483,233	\$ 8,185,773,715	\$ 8,500,636,144

*2. The hypothetical aggregate spending caps will then be compared to actual Medicaid expenditures in TN for the same years to determine if the State would have been eligible for shared savings or at risk of a funding deficit.*

After setting aggregate caps for the years 2014-2018, the second step in the research design for this paper was to compare the hypothetical aggregate cap amounts with actual Medicaid expenditures for those same years in order to determine the range of possible shared savings the State would have retained had TennCare III been in place. Under TennCare III, Tennessee will be eligible to draw down additional federal funding annually when actual expenditures are lower than the aggregate cap for that year. The formula used to determine the amount of shared savings is outlined below:

1. Aggregate Cap – Actual Expenditures = Surplus
2. Surplus \* FMAP = Federal Share of Surplus
3. Federal Share of Surplus \* Shared Savings rate (45%-55%) = Shared Savings amount

The rate of shared savings ranges from 45%-55% based on to-be-determined quality control measures. There is also the potential for the State to lose out on the opportunity for shared savings if actual expenditures exceed the aggregate cap or quality control measures indicate a reduction in overall program performance. In this study, actual expenditures did not exceed the aggregate cap for any years, and it is assumed that the State will meet or exceed quality measures. The potential for shared savings at either the 45 or 55% rate for each year of the hypothetical aggregate cap waiver test is shown in Table 6.

	Aggregate Caps	Actual Expenditures	Surplus	Federal Share of Surplus	Shared Savings (45%)	Shared Savings (55%)
SFY 2014	\$6,954,197,514	\$ 6,634,665,472	\$ 319,532,042	\$ 208,622,470	\$ 93,880,112	\$ 114,742,359
SFY 2015	\$7,358,605,792	\$ 7,128,578,575	\$ 230,027,217	\$ 150,184,770	\$ 67,583,146	\$ 82,601,623
SFY 2016	\$7,797,483,233	\$ 7,442,188,256	\$ 355,294,977	\$ 231,972,090	\$ 104,387,441	\$ 127,584,650
SFY 2017	\$8,185,773,715	\$ 7,533,559,855	\$ 652,213,860	\$ 425,830,429	\$ 191,623,693	\$ 234,206,736
SFY 2018	\$8,500,636,144	\$ 7,519,940,112	\$ 980,696,032	\$ 640,296,439	\$ 288,133,398	\$ 352,163,042
Total					\$ 745,607,789	\$ 911,298,409

These results answer the secondary research question:

**How much shared savings can the State expect to gain?**

The results indicate that if an aggregate cap waiver similar to TennCare III had been approved in 2013, the State could have potentially drawn down an additional \$100 to \$350 million dollars each year for the first five years of the waiver approval beginning in 2014 and ending in 2018. This would have resulted in a total amount of additional funding of \$745 to \$911 million dollars over the course of those five years or approximately 2-2.5% of the over \$36

billion in actual Medicaid expenditures for those same years. This result is not surprising given the State’s track record in maintaining a slower than national average rate of growth for its Medicaid program. In an FAQ regarding the TennCare III waiver, the State cites this history (TennCare 2021). “Historically, TennCare’s comparable annual rate of growth has been below this [national trend rates for growth in Medicaid spending] rate. In fact, Tennessee’s Medicaid trend has consistently outperformed the average Medicaid program trend, which makes Tennessee uniquely suited to enter into this type of arrangement with the federal government.”

*3. The amount of shared savings or deficit for each year, as determined in step 2, will be used to calculate the federal share of spending under the hypothetical aggregate cap waiver.*

As previously mentioned, in this study the State was eligible for shared savings in each year. Adding those shared savings to the federal share of actual expenditures for each year equals the total federal share under the hypothetical aggregate cap waiver. These results are displayed in Tables 7 and 8 in the “Total Federal Share (Share of Expenditures + Shared Savings)” columns.

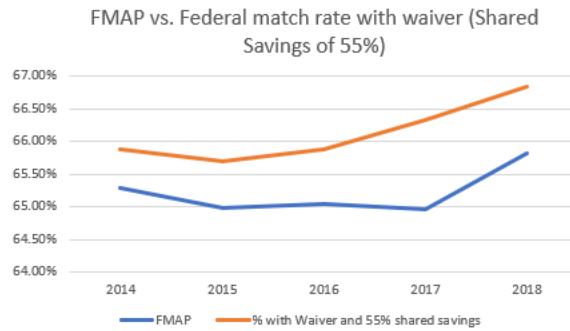
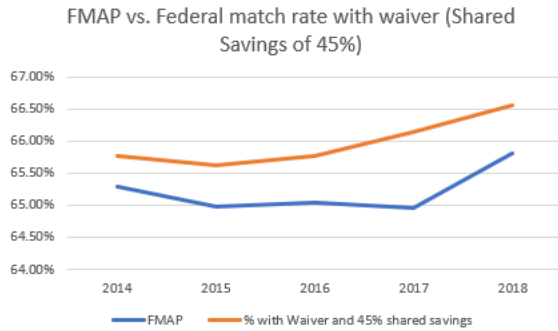
Table 7: Federal Share with 45% Shared Savings

	Actual Expenditures	Shared Savings at 45%	Actual Expenditures + Shared Savings	Federal Share of Actual Expenditures	Total Federal Share (Share of Expenditures + Shared Savings)	Federal Match Rate w/Waiver	FMAP	Rate Increase with Waiver
SFY 2014	\$ 6,634,665,472	\$ 93,880,112	\$ 6,728,545,584	\$ 4,331,773,087	\$ 4,425,653,198	65.77%	65.29%	0.48%
SFY 2015	\$ 7,128,578,575	\$ 67,583,146	\$ 7,196,161,721	\$ 4,654,248,952	\$ 4,721,832,098	65.62%	64.99%	0.63%
SFY 2016	\$ 7,442,188,256	\$ 104,387,441	\$ 7,546,575,697	\$ 4,859,004,712	\$ 4,963,392,153	65.77%	65.05%	0.72%
SFY 2017	\$ 7,533,559,855	\$ 191,623,693	\$ 7,725,183,548	\$ 4,918,661,229	\$ 5,110,284,922	66.15%	64.96%	1.19%
SFY 2018	\$ 7,519,940,112	\$ 288,133,398	\$ 7,808,073,510	\$ 4,909,768,899	\$ 5,197,902,297	66.57%	65.82%	0.75%
Total	\$36,258,932,270	\$ 745,607,789	\$37,004,540,059	\$ 23,673,456,879	\$ 24,419,064,668	65.99%	65.22%	0.77%

	Actual Expenditures	Shared Savings at 55%	Actual Expenditures + Shared Savings	Federal Share of Actual Expenditures	Total Federal Share (Share of Expenditures + Shared Savings)	Federal Match Rate w/Waiver	FMAP	Rate Increase with Waiver
SFY 2014	\$ 6,634,665,472	\$ 114,742,359	\$ 6,749,407,831	\$ 4,331,773,087	\$ 4,446,515,445	65.88%	65.29%	0.59%
SFY 2015	\$ 7,128,578,575	\$ 82,601,623	\$ 7,211,180,198	\$ 4,654,248,952	\$ 4,736,850,575	65.69%	64.99%	0.70%
SFY 2016	\$ 7,442,188,256	\$ 127,584,650	\$ 7,569,772,906	\$ 4,859,004,712	\$ 4,986,589,362	65.88%	65.05%	0.83%
SFY 2017	\$ 7,533,559,855	\$ 234,206,736	\$ 7,767,766,591	\$ 4,918,661,229	\$ 5,152,867,965	66.34%	64.96%	1.38%
SFY 2018	\$ 7,519,940,112	\$ 352,163,042	\$ 7,872,103,154	\$ 4,909,768,899	\$ 5,261,931,941	66.84%	65.82%	1.02%
Total	\$36,258,932,270	\$ 911,298,409	\$37,170,230,679	\$ 23,673,456,879	\$ 24,584,755,288	66.14%	65.22%	0.92%

4. *The hypothetical federal share will be compared with the actual federal share of expenditures in those years to determine if the State would have succeeded in increasing the federal share for its Medicaid program under a waiver similar to TennCare III.*

The results displayed in the rightmost columns in Tables 7 and 8 compare the increase in federal match rate under the hypothetical aggregate cap waiver with the Federal Medical Assistance Percentage (FMAP), the match rate set by CMS each year. Without the TennCare III waiver, the rate of federal funding match is limited by the FMAP. For example, the actual FMAP for SFY 2018 was 65.82%. This means the State's share of spending was 34.18%. Put another way, for every dollar spent on Tennessee's Medicaid program, the federal government reimbursed the State \$.6582 cents. Under an aggregate cap financing structure, like the one approved in TennCare III, the FMAP still sets the rate of federal reimbursement for spending within the cap; however, the shared savings the state receives as a credit for underspending the aggregate cap is 100% funded by federal dollars with no matching requirement for the State. The overall rate of federal funding reimbursement per dollar increases when shared savings are considered part of the federal share of expenditures. In this study the % of total federal share of expenditures in SFY 2018 under an aggregate financing structure with shared savings would have increased to 66.84% or \$.6684 per \$1 compared with the FMAP of 65.82%.



A rate increase of 1% may not seem significant but due to the large budget for Medicaid, this represents an additional \$350 million dollars in federal funding coming into the State without any increase in State spending on the program or a 6.6% increase in federal funding for TennCare during SFY 2018. Percentage increases in overall federal funding for TennCare estimated based on shared savings are displayed in Tables 9 and 10.

Table 9: Federal Funding amount with 45% Shared Savings

	Actual Expenditures	State Share of Actual Expenditures	Federal Share of Actual Expenditures (w/o Shared Savings)	Shared Savings at 45%	Total Federal Share (w/ Shared Savings)	% Increase in Federal Funding amount
SFY 2014	\$ 6,634,665,472	\$ 2,302,892,385	\$ 4,331,773,087	\$ 93,880,112	\$ 4,425,653,198	2.12%
SFY 2015	\$ 7,128,578,575	\$ 2,474,329,623	\$ 4,654,248,952	\$ 67,583,146	\$ 4,721,832,098	1.43%
SFY 2016	\$ 7,442,188,256	\$ 2,583,183,544	\$ 4,859,004,712	\$ 104,387,441	\$ 4,963,392,153	2.10%
SFY 2017	\$ 7,533,559,855	\$ 2,614,898,626	\$ 4,918,661,229	\$ 191,623,693	\$ 5,110,284,922	3.75%
SFY 2018	\$ 7,519,940,112	\$ 2,610,171,213	\$ 4,909,768,899	\$ 288,133,398	\$ 5,197,902,297	5.54%

Table 10: Federal funding amount with 55% Shared Savings

	Actual Expenditures	State Share of Actual Expenditures	Federal Share of Actual Expenditures (w/o Shared Savings)	Shared Savings at 55%	Total Federal Share (w/ Shared Savings)	% Increase in Federal Funding amount
SFY 2014	\$ 6,634,665,472	\$ 2,302,892,385	\$ 4,331,773,087	\$ 114,742,359	\$ 4,446,515,445	2.58%
SFY 2015	\$ 7,128,578,575	\$ 2,474,329,623	\$ 4,654,248,952	\$ 82,601,623	\$ 4,736,850,575	1.74%
SFY 2016	\$ 7,442,188,256	\$ 2,583,183,544	\$ 4,859,004,712	\$ 127,584,650	\$ 4,986,589,362	2.56%
SFY 2017	\$ 7,533,559,855	\$ 2,614,898,626	\$ 4,918,661,229	\$ 234,206,736	\$ 5,152,867,965	4.55%
SFY 2018	\$ 7,519,940,112	\$ 2,610,171,213	\$ 4,909,768,899	\$ 352,163,042	\$ 5,261,931,941	6.69%

5. *From these results, conclusions will be drawn as to the likelihood that TennCare III will allow the State to increase the share of federal funding for its Medicaid program during the first five years of implementation: 2021 through 2025.*

It is evident, from the results of this study, that had an aggregate cap financing structure similar to the one approved in TennCare III been in place for SFYs 2014 through 2018, the State would have succeeded in increasing the share of federal funding for its Medicaid program. Not only do we see the State successfully underspending caps in each year and drawing down shared savings, but the amount of shared savings also increases year over year as does the share of federal funding.

To what extent do these results answer the main research question of this study?

### **Will Tennessee succeed in increasing the share of federal funding for its Medicaid program under TennCare III?**

If expenditures and enrollment continue to increase at a similar rate to that seen during the years examined in this study, there is a strong likelihood that similar results will be seen during the first five-year period of TennCare III: 2021-2025. However, there are other relevant factors which could affect the success of TennCare III.

The Covid-19 pandemic is unprecedented but relevant to this paper as aggregate caps have already been set for 2021 by TennCare III and were based upon expenditure and enrollment data from 2019, before the pandemic began. During the Covid-19 pandemic, Medicaid enrollment has increased nationwide (KFF 2021). Along with increased enrollment, 80% of 37 states surveyed by Kaiser Family Foundation reported that they expect FY 2021 Medicaid

expenditures to outstrip their original projections, presumably due to increased utilization costs associated with members seeking testing and treatment related to Covid-19.<sup>4</sup> At the time of this study, no official spending data for Tennessee had been released.

As seen in this study, increased enrollment alone does not put the State at risk of overspending the aggregate caps. This is due to the generous structure of the risk corridor adjustment which more than makes up for increased enrollment because the adjustment is made based on per member per month (PMPM) costs which exceed historical per capita TennCare costs. The PMPM costs are then trended forward at a higher rate of inflation than TennCare has historically experienced.

While increased enrollment is controlled for by the risk corridor, increased utilization is not. One scenario in which utilization of members may increase unexpectedly is in a health crisis like the Covid-19 pandemic. One mitigating factor, in the case of Covid-19, is that the federal government has increased the FMAP rate, by 6.2%, for states who comply with certain provisions of Coronavirus relief legislation like the Families First and Coronavirus Response Act.<sup>5</sup> An increased FMAP will lead to a larger share of federal spending within the aggregate cap. Although the increased FMAP will not increase the cap itself, the increased rate would mitigate, to some extent, any potential overspending of the cap. It remains to be seen how significantly the current pandemic may impact the success of TennCare III.

Another factor that is unable to be tested by this study is the degree to which flexibilities granted to the State by CMS in TennCare III could benefit the State in terms of cost reduction

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<sup>5</sup> <https://www.kff.org/medicaid/issue-brief/medicaid-maintenance-of-eligibility-moe-requirements-issues-to-watch/#:~:text=The%20Health%20and%20Economic%20Recovery,the%20COVID%2D19%20pandemic%20continue>

since those flexibilities were not in place during the years studied. Although flexibility and efficiency are referred to throughout the waiver approval for TennCare III in terms of cost reduction, most of the flexibility the State has been granted relates to the ability to increase benefits or expand enrollment eligibility without CMS approval. Increasing benefits and expanding enrollment eligibility would increase overall costs of the program, not decrease costs. The only flexibility granted in TennCare III with the potential to reduce costs is the closed prescription drug formulary. The closed formulary would apply to adult members only but does have the potential to reduce costs associated with prescription coverage for those members. No other states have a closed Medicaid prescription formulary so it is not possible to predict how significantly this flexibility may reduce costs.

### **Discussion and Recommendations**

While it does appear that the aggregate cap financing structure approved in TennCare III gives the state the ability to increase the share of federal funding for its Medicaid program, how significant is the potential increase? The results of this study indicate that the State could expect to increase federal funding for the TennCare program by approximately 2%-7%. To put this into a dollar amount, the estimated increase in federal funding for Medicaid from 2014-2018 under an aggregate cap waiver would have been \$745-\$911 million dollars.

To illustrate the potential impact of this level of increased funding, in 2019 TennCare pitched an extension of post-partum coverage for pregnant women covered by TennCare from 60 days following the birth of their child to a full 12 months. TennCare cited the deaths of 52 new mothers whose pregnancies had been covered by TennCare in 2017. Overwhelmingly, the deaths were deemed preventable and TennCare officials argued that access to health insurance through



an extended post-partum coverage period may have prevented them (Kelman 2019). The estimated cost of the pilot was \$19 million per year, of which approximately \$12.5 million would have been reimbursed with federal funding, assuming CMS approved the amendment.

Ultimately, Governor Lee did not take up this proposal in his budget for the year due to the remaining state funded liability of \$6.5 million connected with the proposal. Considering that estimated shared savings, in each year of this study, exceeded that figure it is clear that the additional federal funding the State stands to receive as a result of TennCare III could have a significant impact on the health and well-being of Tennesseans if applied to programs such as this.

This potential to expand Medicaid coverage and access to health care to more Tennesseans is promising; however, advocacy groups and policy experts have expressed skepticism that this will be the ultimate use of the increased federal funding under TennCare III. In the waiver approval, CMS does restrict the use of shared savings to certain programs including charitable clinics, the State's primary care and behavioral health safety net programs, school nurses and social workers and prescription drug assistance for low-income Tennesseans. However, these are programs that are already largely funded by state dollars, so any amount of shared savings used toward these programs is simply freeing up state dollars to be used for another purpose. As Andy Schneider and Alexia Gardner of Georgetown University point out in their health policy blog, "Say Ahhh!", when discussing the application of shared savings resulting from TennCare III "...since federal dollars are fungible once they hit a state's treasury, the [restrictions on use of shared savings] is simply optical. Practically speaking, the state will be free to use the "savings" in federal Medicaid funds as it pleases, on items that have nothing to do with Medicaid." (Gardner & Schneider 2021). Advocacy groups like the Tennessee Justice

Center point to the State's failure to expand Medicaid coverage in the past through the generous provisions to do so under the Affordable Care Act, including an un-capped federal match rate of 90% for adults who would be newly covered under Medicaid Expansion, as evidence that expanding access to care may not be the primary motivation behind TennCare III. "Compare this [TennCare III] to the guaranteed \$1.4 billion a year that our state could unlock if they accepted federal dollars to provide coverage to 300,000 more Tennesseans. Expanding Medicaid would provide a lot more money and it's a tried-and-true program, compared to the block grant." (Tennessee Justice Center, 2021).

Recommendations resulting from this study include:

- 1) CMS should address the potential for federal funding for Medicaid to be diverted to other uses which may not further the goals of the Medicaid program.
- 2) CMS should utilize possible policy solutions to increase monitoring of the TennCare program and spending of any shared savings.

One possible solution could be to amend the TennCare III waiver to address the use of any State dollars supplanted by federally funded shared savings. Another solution may lie in the to-be-determined Shared Savings Quality Measures Protocols (SSQMPs) already established by the waiver. In the TennCare III approval, CMS requires that the State meets or exceeds certain quality measures in order to qualify for shared savings. The specific measures have not been determined yet and will be negotiated and agreed upon by the State and CMS. CMS should use these measures to require that the State demonstrate how shared savings are used to truly expand access to health coverage, through coverage extensions such as the post-partum proposal, and not merely replace state funding for already existing programs.

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