



Health Care Finance and Administration FY 2016 Budget Presentation

Darin Gordon
Dr. Wendy Long
Casey Dungan



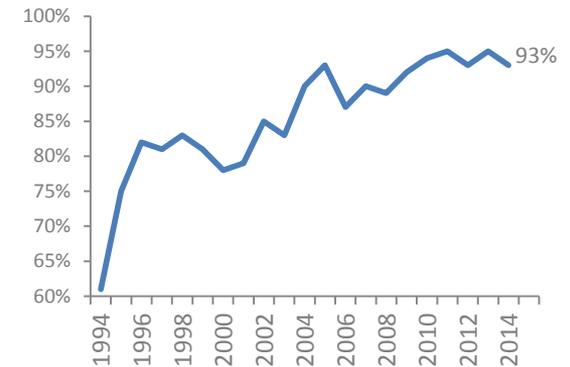
Continued Focus on Quality and Fiscal Trends

2013 HEDIS Scores and NCQA Rankings

- Out of 47 HEDIS measures tracked since 2007, 81% have shown improvement over time. These measures include access and availability, prevention and screening, and effectiveness of care.
- 5 of TennCare's 7 health plans are ranked in the top 10 of all the Medicaid Managed Care Plans in the Southeast.
- All TennCare health plans continue to be ranked among the top 100 Medicaid health plans in the country with the top three TennCare health plans being ranked 32, 33, and 36 out of the more than 260 Medicaid health plans evaluated.

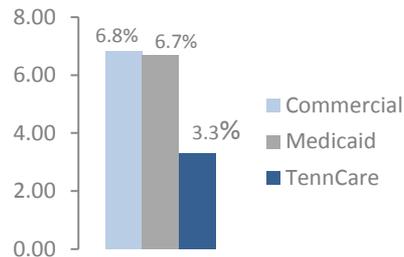
Member Satisfaction

- UT conducts an annual survey of TennCare members.
- Satisfaction has remained above 90% for the past 8 years.



Financial Trends

According to a GAO report released in June 2014, TN was tied for the 4th lowest Medicaid spend per enrollee nationwide.



This graph shows projected medical trend for commercial insurance, Medicaid nationally, and TennCare. (Sources: Price WaterhouseCooper, CMS National Health Expenditure Data, and TennCare budget data)

Recognition

- Tennessee ranks in the top five states for increasing rebalancing in LTSS toward HCBS from 2010-2012 according to a report from April 2014 conducted by Truven Health Analytics and CMS.
- The Bureau of TennCare received the Commitment Award in the annual Excellence in Tennessee recognition program administered by the Tennessee Center for Performance Excellence (TNCPE). TNCPE is the only statewide quality program and is patterned on the Baldrige Performance Excellence Program, the national standard for recognizing organizational excellence.



Eligibility

Applicant must be both:

Categorically eligible – e.g. child, pregnant woman, disabled, caretaker relative, breast and cervical cancer

Financially eligible – i.e. meets category-specific income/resource criteria

Affordable Care Act (ACA) Eligibility Changes

Created additional options for how individuals apply for coverage

- Prior to ACA: state government processed all applications.
- After ACA:
 - New pathway through the federally facilitated marketplace (FFM), including online access through healthcare.gov.
 - States were required to choose between being an “assessment” or “determination” status.
 - Assessment- FFM refers those potentially eligible for Medicaid to the state for a determination.
 - Determination- FFM determines Medicaid eligibility for MAGI categories and transmits to the state those eligible to be enrolled.

Mandates use of a uniform, standardized methodology (Modified Adjusted Gross Income - MAGI) for determining financial eligibility for most categories

- Required that states modify their eligibility determination computer systems.
- State to state variation in status of pre-ACA eligibility systems.
- Tennessee’s decades old mainframe legacy computer system (ACCENT) used for Medicaid, TANF and SNAP could not be modified to become MAGI compliant.
- Competitive bid to procure development of a new system.



Eligibility

Mitigation Plan

Implemented on January 1, 2014 to ensure Tennessee citizens could access Medicaid.

Developed with and approved by CMS.

CHOICES and Medicare Savings Program applications continue to be submitted to the state and are processed in ACCENT – “non-MAGI” categories.

No change in process for “deeming” babies born to pregnant women enrolled in TennCare or in determining presumptive eligibility for pregnant women and women with breast and cervical cancer.

Applicants in MAGI categories are directed to the FFM for eligibility determination.

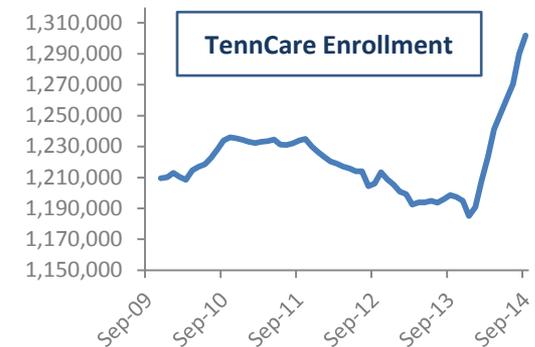
2014 Experience



New Application process:

- Majority of applications filed online
- For those needing assistance, computer kiosks, telephones and in-person assistance from certified application counselors are available in every DHS office. In-home assistance is also available for disabled individuals through AAADs.

- Enrolled more than **120,000** since Jan. 1
- **3rd** highest new enrollment in 20 years
- More than **1.3 million** members as of Sept. 2014



FFM Challenges – Solutions Implemented by TennCare*:

- Pregnant women – extension of Presumptive Eligibility
- Babies born to non-TennCare mothers – Newborn Presumptive Eligibility
- Income inconsistencies – review and resolution process



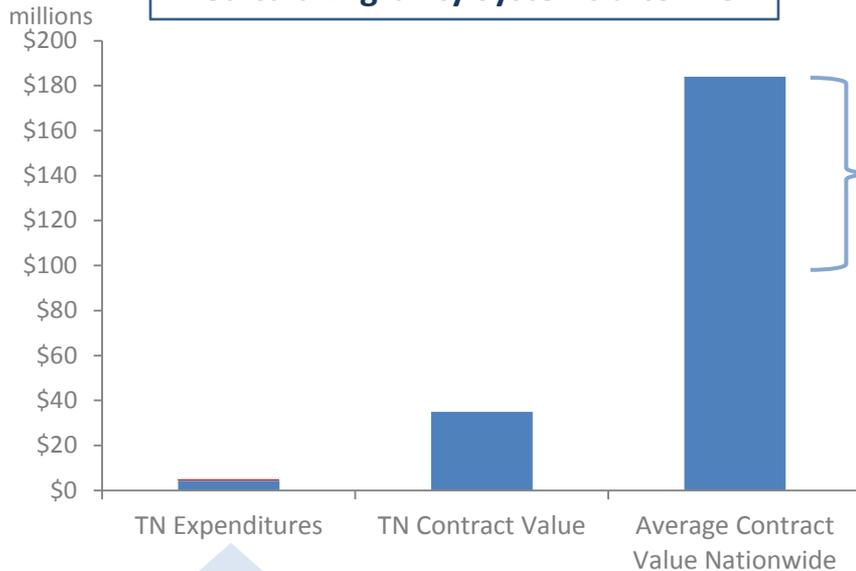
*More information about this can be found at www.tn.gov/tenncare/tenncare-responses.shtml



Eligibility System Update

TennCare's eligibility system, ACCENT, could not be modified so the state released an RFP which was won by Northrup Grumman. At the time the RFP was issued, federal regulations regarding eligibility system requirements were not complete. Additionally, there was very limited information/experience available nationally to use in projecting the resources necessary to build an ACA-compliant eligibility system.

Medicaid Eligibility Systems after ACA



TennCare has paid approximately \$4.6 million of the \$35 million contract – of which \$468,000 is state funding. Approved design, development and implementation of new Medicaid eligibility determination systems are matched at 90%.

\$98 - \$184 million is average contract value nationwide. At the time TennCare selected a vendor, other states had not procured contracts for these systems and federal regulations were still in flux.

Moving Forward

- The state brought in an outside consultant, KPMG, to provide an objective third party assessment of the project timeline and options for the best path forward.
- The state is currently in discussions with the consultant regarding their assessment and options for the state. Three current options:
 1. Continue with the current vendor.
 2. Select a new vendor that will continue with current technology.
 3. Select a new vendor that will bring their own technology and build a new system.



Payment Reform

The goal of this initiative is to make health care in Tennessee a value-based system focused on efficiency, quality of care, and the patient experience.

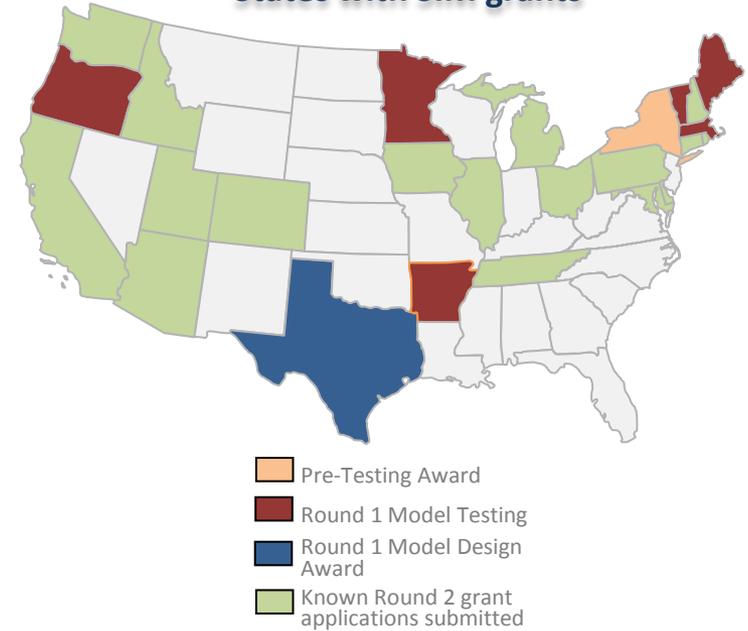
Delivery System

- First three episode-based models released.
- Submitted Round 2 SIM grant proposal in July 2014.
- Received 70 letters of support in response to grant proposal.
- Design of next five episodes of care to be completed by end of 2014.
- Stakeholder consultation on Patient Centered Medical Home (PCMH) and health home design to begin in spring of 2015.
- Shared care coordination tool pilot project began in November.

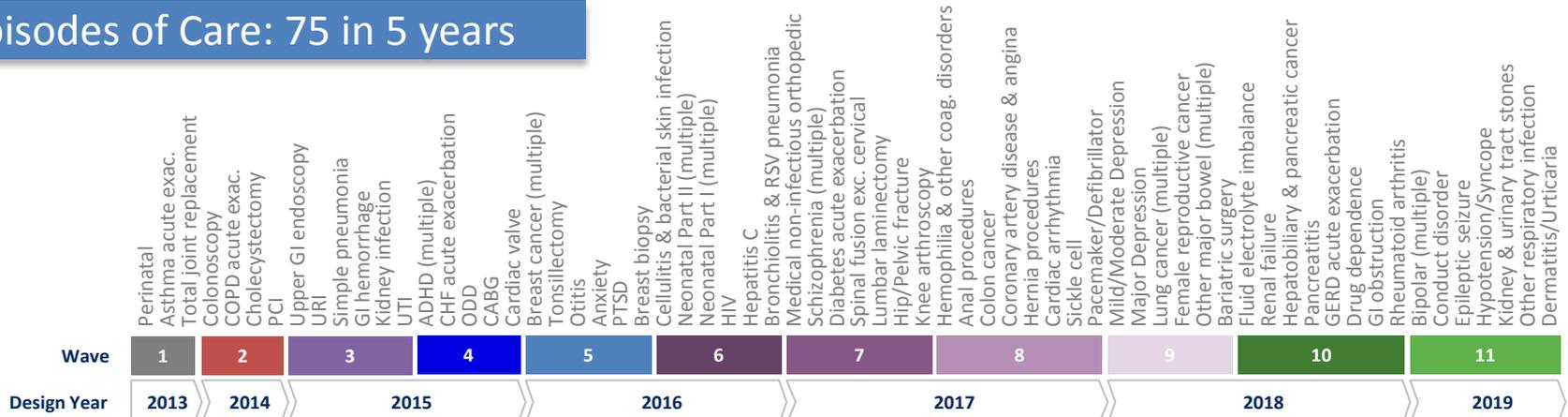
Long-Term Services and Supports

- Quality Improvement in Long-Term Services and Supports (**QuILTSS**) is a TennCare initiative to promote the delivery of high quality Long-Term Services and Supports for TennCare members.
- TennCare intends to create a new payment system (aligning payment with quality) for nursing facilities and certain HCBS based on performance on those measures.

States with SIM grants



Episodes of Care: 75 in 5 years





FY 2015 Budget and FY 2016 Cost Increases

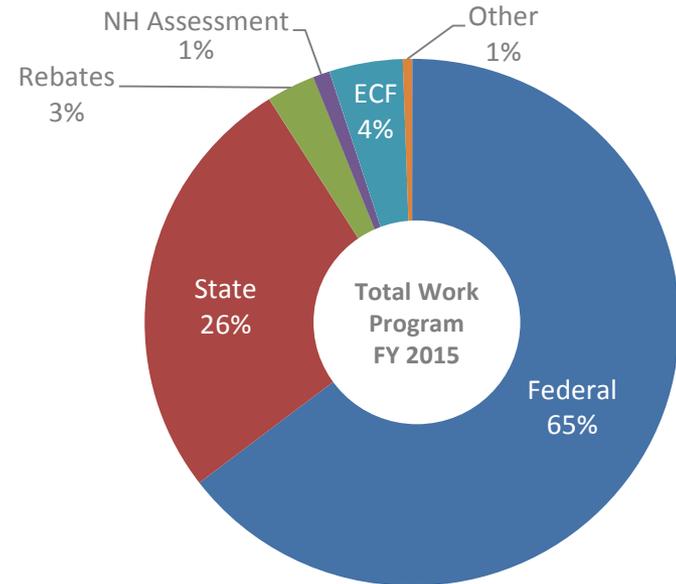
FY 2015 HCFA Budget Breakdown

Total FY 2015 Budget : \$10.3 billion (\$3.3 billion state)

TennCare Clinical Services: 72%

Supplemental Payments: 9.1%	Intellectual Disabilities Services: 8.7%
Medicare Services: 5.8%	HCFA Administration: 2.1%
CoverKids: 2.2%	AccessTN: <1%
CoverRx: <1%	Office of eHealth: <1%

Funding Sources



FY 2016 Est. Cost Increases*

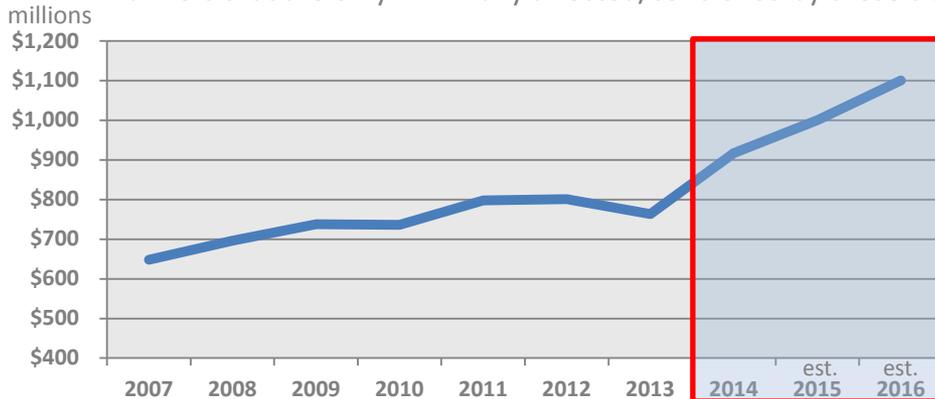
Cost Increases	State	Total
Medical and Pharmacy Inflation and Utilization	\$62,774,900	\$277,040,900
FMAP Rate Change	2,226,700	-
Public Chapter 926 Related to Inmates	1,151,300	2,265,300
TOTAL	\$66,152,900	\$279,306,200

*Figure does not include increases made by other agencies funded by TennCare



Pharmacy Increases

TennCare has been successful in managing pharmacy trend over the last 6 years. This has been accomplished through the aggressive use of prior authorization and other tools designed to drive utilization to the most cost effective medications and to control unnecessary utilization. The more recent increase in pharmacy trend is attributable to cost drivers that are only minimally affected/controlled by these traditional utilization management techniques.



While TennCare pharmacy spend has been below \$1 billion since 2007, estimates for FYs 2015 and 2016 are exceeding \$1 billion. TennCare projected pharmacy trend for FY 2016 is 10% (based on National Health Expenditure data, projected pharmacy trend nationally is 10.8%).

Innovator Drugs

- Two Hepatitis C drugs were recently introduced to the market – Sovaldi and Harvoni. The cost of a 12-week course of treatment with these drugs can range from \$84,000 to \$94,500.
- If every TennCare member with a Hepatitis C diagnosis were to qualify for treatment with Sovaldi, it would cost more than \$1.6 billion. This would nearly double TennCare pharmacy expenditures.
- Prior authorization criteria will be applied to ensure innovator drugs are approved only when medically necessary. Even with such controls in place, the cost to the program can be substantial if the price is high, there is no competition, and the drug has a proven clinical benefit (i.e. there is no lower cost, similarly effective alternative).

Rising Cost of Generics

- Pharmacy payors across the country are seeing an increase in the cost of generic drugs.
- For instance, from 2012 to 2014 the cost of doxycycline increased from \$0.20 to more than \$3.00 per pill. As a consequence, TennCare spend jumped from \$760,000 to \$7.75 million.
- Albuterol increased from \$0.14 to more than \$4.00 per pill. As a consequence, TennCare spend increased from \$580,000 to \$8.7 million.
- Congress is currently investigating this national phenomenon.



HCFA FY 2016 Reduction Plan

Item	State	Total
ACA-Related Changes	\$22,697,700	\$40,257,200
Health Insurer Fee Budget Adjustment	9,440,500	27,000,000
AccessTN Transition	13,257,200	13,257,200
Program Modifications	13,986,000	40,000,000
Level 2 Mental Health Case Management	10,489,500	30,000,000
Value-Based Provider Reimbursement	3,496,500	10,000,000
Targeted Utilization Management Strategies	7,741,800	22,141,600
Buprenorphine Limits (Suboxone)	1,588,000	4,541,600
Compound Prescription Management	909,100	2,600,000
Drug Test Criteria Change	1,398,600	4,000,000
CHOICES 3 Enrollment Limit	3,846,100	11,000,000
Benefit Changes	6,005,200	17,175,000
Eliminate Hospice Benefit	6,005,200	17,175,000
Provider Reimbursement Changes	84,032,500	240,332,800
Reimbursement Rate for Pharmaceuticals	6,084,700	17,402,400
Therapy Related Payments	5,277,600	15,094,100
Medicare Rates for Targeted Therapy Codes	400,300	1,145,000
Reduce Provider Rates by 4% (Non-Waiver Services)	72,269,900	206,691,300

Item	State	Total
Reductions in Grant Funding	8,419,300	17,195,600
Eliminate Discretionary Hospital Grants	6,146,500	12,650,000
Eliminate Perinatal Grant Program	2,272,800	4,545,600
Revenue Options	22,524,000	22,524,000
HMO Assessment Increase	17,414,500	17,414,500
CoverKids Transition	5,109,500	5,109,500
Total Reductions	\$165,406,500	\$399,626,200

Total FY 2016 Budget Including 7% Reduction Plan and Projected Cost Increases*

HCFA: \$10.3 billion (\$3.3 billion state)

Of which, \$10.0 billion (\$3.2 billion state) is TennCare

*Figures include non-recurring sources of revenue such as the enhanced coverage fee and the nursing home assessment which total approximately \$1.6 billion total (\$556.9 million state). Also, adjusted for program expenditures not scheduled to continue in 2016 (e.g., the temporary primary care services rate increase).



Past, Present and Future

Past

12 MCOs – not competitively bid

LTSS and specialized mental health services carved out

Quality of data - poor

TennCare member satisfaction 1994 – 61%

Present

2 experienced, well-capitalized MCOs per region

CHOICES and behavioral health under managed care

Use of dashboards; data driven decision making

TennCare member satisfaction 2014 – 93%

Future

MCO transition to 3 MCOs statewide

Cont. integration and delivery system reform

Continued use of data to drive payment reform

Improved member experience