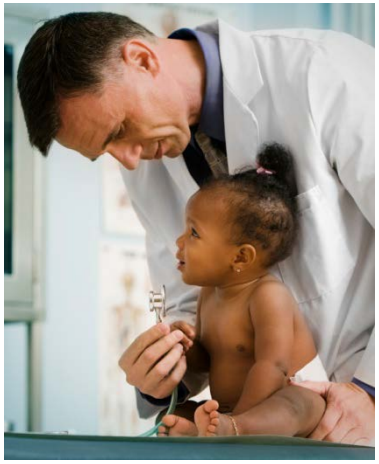
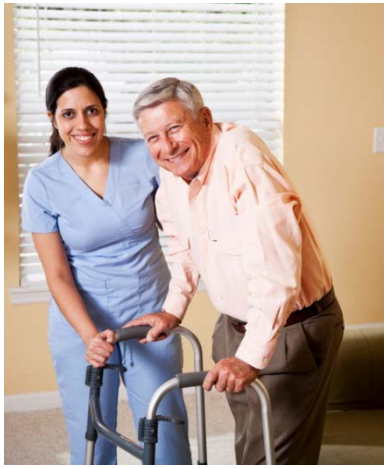


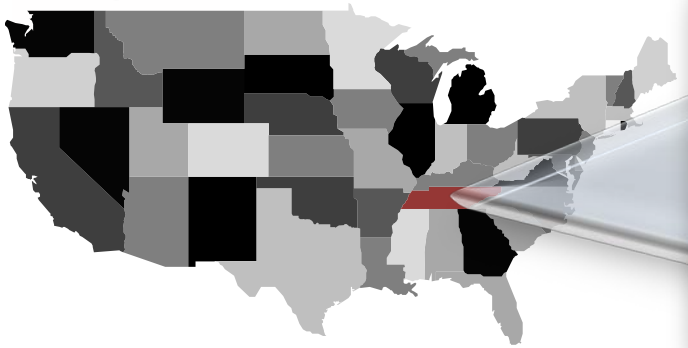




Health Care Finance and Administration
FY 2014 Budget Presentation

Darin Gordon
Dr. Wendy Long
Casey Dungan

Continued Improvement



Because of TennCare's unique history, ability to stabilize a volatile Medicaid program, and status as being the first and only Medicaid program to enroll its entire population into managed care, more than half of the states have requested guidance from the Bureau over the past year. This includes information on a variety of topics including:

- Controlling medical trend
- Program integration
- Implementation of Medicaid managed care
- Integration of Long-Term Services and Supports into managed care

HEDIS Scores 2012

- **Improvement in 88%** of measures tracked since 2006
- **Improvement in 31 of 41** measures introduced more recently

Examples include:

- Access and Availability of Care Measures – Adult and child access to primary care; prenatal and postpartum care
- Prevention and Screening measures – Immunization rates; cervical cancer, breast cancer, and Chlamydia screening in women; weight assessment and counseling for nutrition and physical activity; lead screening in children
- Disease specific measures – Treatment of respiratory conditions, cardiovascular conditions and diabetes
- Effectiveness of care measures – Treatment of behavioral health conditions; medication management

- In addition, TennCare's health plans (MCOs) continue to be ranked **among the top 100 Medicaid health plans in the country**, with our highest ranking plan moving from 37th in 2011 to 30th.

Recognition	Description
• Innovation Award from SXC	Innovation in the enhanced Coordination of Benefits (COB) program
• March of Dimes	Commitment to giving babies a healthy start
• Mercy Award	Outstanding dedication to provide health care services to the underserved in Tennessee
• AARP	Recognized as one of the top Medicaid managed care LTSS programs in the nation

2012 TennCare Satisfaction Survey

93%

TennCare's continued goal is to keep member satisfaction above 90%

TennCare's member satisfaction has remained above 90% for the past 4 years

Program Updates

TennesseeHealth

Electronic Health Record (EHR) Provider Incentive Program – 03/2013

	Providers	Amount	Hospitals	Amount
Year 1	2434	$51,311,686	83	$56,336,796
Year 2	266	$2,212,839	29	$12,643,694

- "Direct" – Health Information Exchange (HIE) through secure email.
- Continued support of RHIOs and more robust exchange functionality.
- Controlled Substance Monitoring Database (CSMD) enhancements.
  - Real-time reporting from pharmacies
  - "Provider friendly" interface/reports

Strategic Planning and Innovation Group

Multiple existing functions were consolidated to form the Strategic Planning and Innovation (SPI) Group. The responsibilities of this group include:

- Provide technical assistance concerning the federal insurance exchange to Tennessee industries and stakeholders upon request and continue to press for changes to draft federal regulations in order to minimize adverse affects on Tennessee insurance market.
- Identification and support of implementing alternative payment methodologies in Tennessee. These are methodologies that will reward quality of care versus quantity of care.
- Evaluation and modification of Cover Tennessee programs as may be needed beginning in 2014.

COVER TENNESSEE

Cover Kids

- CoverKids continues to be in high demand as a result of the economic downturn. Enrollment increased by 16% in FY 2012 bringing total enrollment to approximately 56,871.
- CoverKids continues to improve quality of care. Overall, **the program improved in 57% of the quality measures** compared to last year.

Cover TN

- While enrollment to new businesses remained closed in FY 2012, the 3,040 businesses currently participating in the program were allowed to enroll new employees bringing current enrollment to more than 17,000.
- CoverTN is a limited benefit program. In CY 2011, **less than 1% of members hit the annual $25,000 coverage limit.**

Cover Rx

- Experienced a 15% increase in enrollment FY 2012 bringing total enrollment in the pharmacy assistance program to more than 54,000 Tennesseans.
- **High generic utilization of 91%** - compared to ~78% nationwide.*

Access TN

- At the close of FY 2012, more than 3,000 Tennesseans were covered under this high-risk insurance program.
- AccessTN has had **no increase in member premiums for the past two years.**
- **AccessTN assessment on insurers was reduced by 21%** during FY 2012 based on improved trend.

*2012 GAO report *Drug Pricing: Research on Savings from Generic Use*

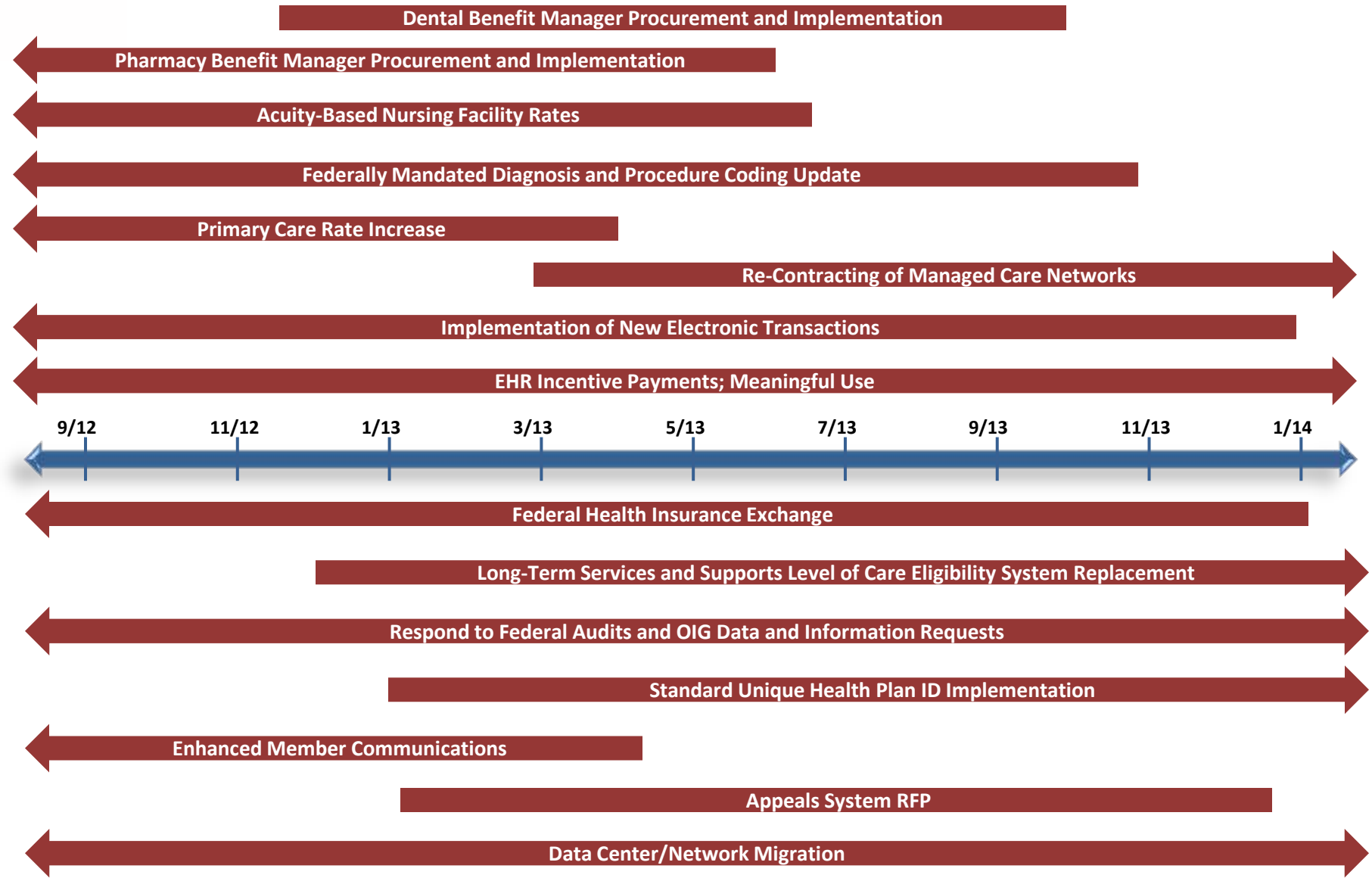
Top to Bottom Review Update

	Goals	Update
Design Advanced Integrated and Coordinated Programs	**Integrate Health Care-Related Agencies into a Division of HCFA** • Incorporation of several agencies into one umbrella agency in 2012: TennCare, the Cover Tennessee Programs, the Insurance Exchange Planning Initiative, and eHealth. • Review contracts and opportunities to align health care resources.	**Integration into Division of HCFA** Ongoing integration of HCFA agencies. Health planning transitioned to DOH. Multiple Cover Tennessee contracts consolidated with estimated savings of $2.85 million for Jan-June 2012.
	Dual Integration/Coordination • Integration/coordination of services for those with both Medicaid and Medicare. • Improve quality of care and reduce cost of care through coordination of benefits, management of chronic conditions and care transitions.	**Dual Integration/Coordination** Strengthened coordination requirements in contracts with existing D-SNPs. Working to leverage existing Medicare Part C authority and education efforts to help align members' enrollment in the same plan for the Medicare and Medicaid benefits.

Proper Alignment of Incentives	**Alternative Payment Methodologies**
	• Explore and develop new ways to pay TennCare providers to encourage high-quality cost-effective care including:
	  • Bundled payments;
	  • Quality incentives; and
	  • Capitated arrangements.
	• Increase member participation in patient-centered medical home and develop evaluation matrix for all medical home arrangements.
		Alternative Payment Methodologies
		Joined Catalyst for Payment Reform initiative to drive toward value-based purchasing. Analysis in process to support development of methodology for non-recurring supplemental acuity-based payments to nursing facilities for FY 2013 and implementation of a new NF reimbursement methodology to better reflect acuity and incentivize quality. Applied for a federal grant aimed to help states design and test multi-payer payment and delivery models.

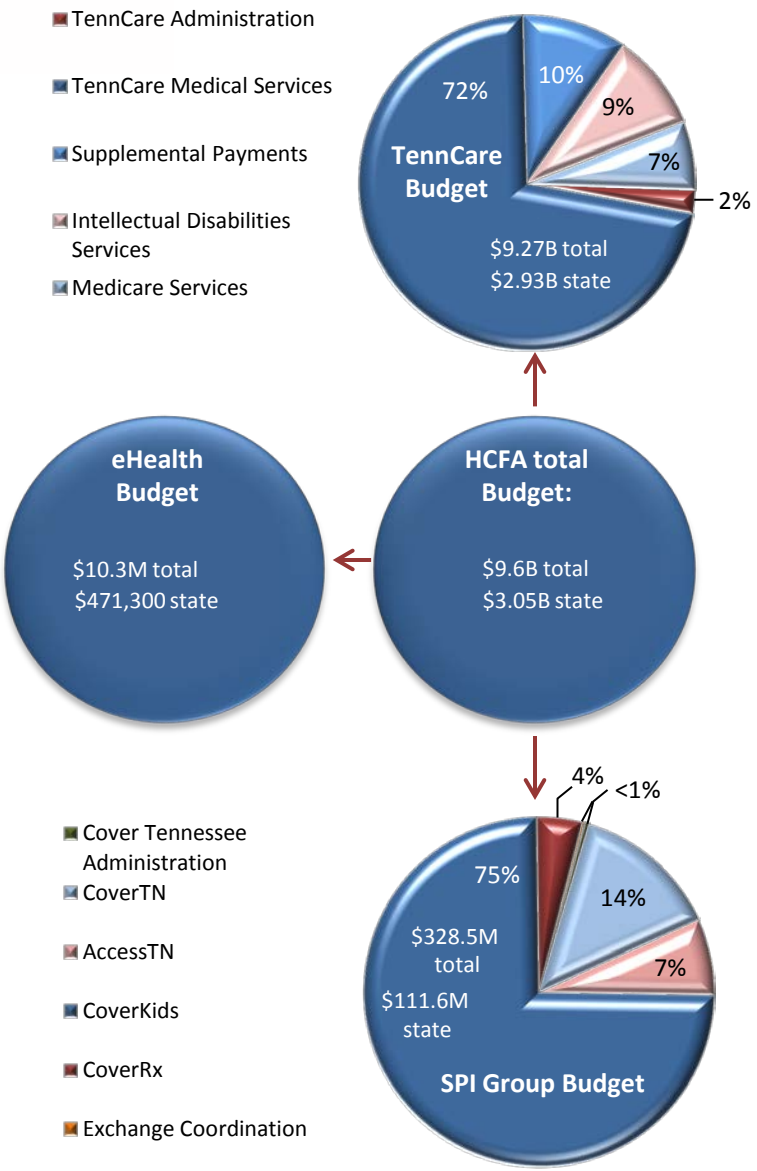
Enhance Customer Experience	**Modernize Member Experience** • Simplify the member enrollment process and make certain member functions available online. • Explore the possibility for members to opt to receive email communication to make it easier for the member and save state resources.	**Modernize Member Experience** Eligibility system RFP will allow applicants to file a single online application for multiple insurance products. IT changes in process to support member email communication options.
	Improve Provider Services • Leverage web-based technologies to simplify and improve provider registration processes, conduct provider training, and support ongoing communication processes.	**Improve Provider Services** Implemented Online Provider Registration Portal for individual providers (in process for provider groups). Web-based training initiated for LTSS providers.

Sample of Other Significant HCFA Implementations*



*Does not include ongoing day-to-day operations activities

Current HCFA Budget and Reduction Plan

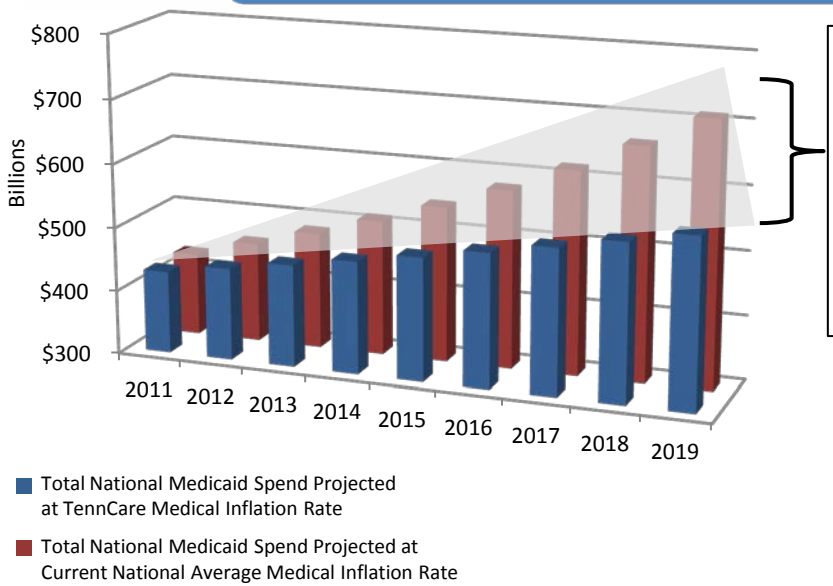


FY 2014 Recommended Reduction Items

Budget Item	State	Total
Administrative reduction in CoverTN program	$897,000	$897,000
Transition to 100% electronic claims submission	175,000	700,000
Non-coverage of allergy medications for adults	864,600	2,506,100
$1.50 copayments for generic prescriptions for adults	2,112,300	6,122,600
Pharmacy integration (increased federal revenue)	29,538,500	---
Chronic pain management protocols (injections/TENS)	4,241,300	12,293,500
Back brace pricing parity	1,345,500	3,900,000
Establish drug testing frequency protocol	1,725,000	5,000,000
CoverKids program network changes	9,540,000	39,750,000
Delivery reimbursement adjustment	1,688,200	4,893,300
Early elective delivery reduction initiative	1,897,500	5,500,000
TOTAL	**$54,024,900**	**$81,562,500**

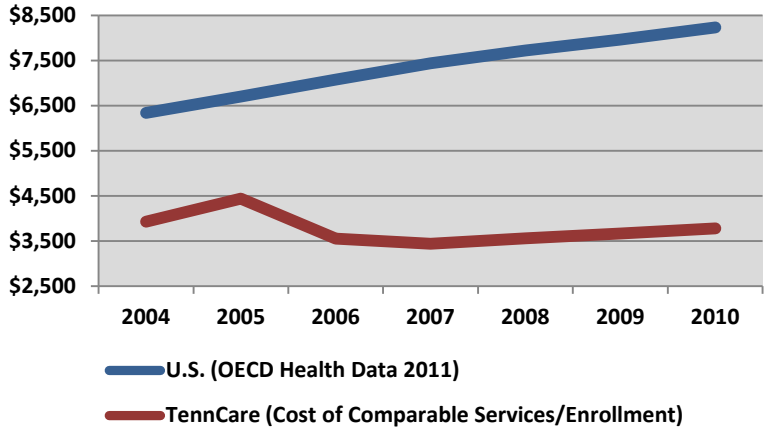
Non-Health Reform Related Base Cost Increases

National Medicaid Expenditures at the Current National Rate and What the Expenditures Would be if at the TennCare Rate



Medicaid costs nationwide would be approximately $745 Billion less over the next 6 years (2014-2019) if national Medicaid costs grew at the TennCare rate of inflation

U.S. Expenditure on Health Care Per Capita Vs. Comparable TennCare Per Member Cost



HCFA has been able to keep medical inflation well below the national Medicaid and commercial averages. PriceWaterhouseCooper projected an average of 7.5% medical inflation for commercial insurance. TennCare's trend is projected to be 3.5% for FY 2014. Even with a low rate of inflation, some cost increases are expected due to rising health care costs and enrollment.

FY 2014 Est. Cost Increases

Cost Increases due to Trend	State	Total
TennCare funding request for medical inflation/enrollment growth	$93,950,000	$272,318,900
CoverKids funding request for medical inflation/enrollment growth	8,168,400	29,197,100

Replacement of One-Time Funds with Recurring Funding	State	Total
Replace use of one-time funds for pharmacy and Medicare expenditures with recurring	$51,585,600	$182,291,200
Continuation of funding for existing Standard Spend Down Program (FY 2013 funded with non-recurring funds)	11,121,800	32,237,100

National Health Reform Overview

- We do not believe the health reform plan passed into law is the best solution to address problems within the current health care delivery and payment system. However, states must make the changes mandated by the law unless or until the law is amended or repealed.

- The law requires some of the more significant changes to be made by Jan. 1, 2014. Many of the programmatic changes will take months of preparation in order to meet the current aggressive federal timeline.

- We estimate the net cost of health reform to the state could be approximately $1.2 billion over the first five and a half years (Jan. 1, 2014 – June 30, 2019) **depending on programmatic/policy decisions.**

- The majority of that cost is unavoidable and will be incurred by the state regardless of its decision on Medicaid expansion.

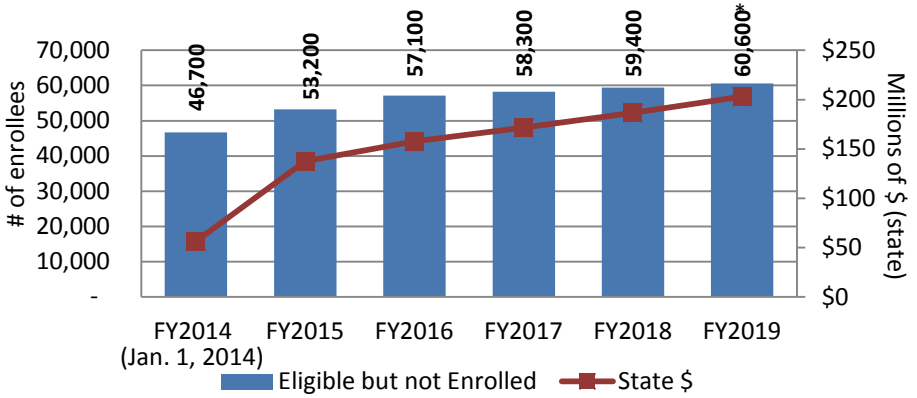
Unavoidable Cost Increases Due to Health Reform

The majority of costs associated with health reform will be experienced by the state regardless of its decision on Medicaid expansion.

Eligible but not Enrolled Population (EBNE)

These are individuals who come on to Medicaid after Jan. 1, 2014 and would have been eligible under current eligibility guidelines. This population will draw down the current match rate of 65% not the enhanced match rate of 100%. Experts believe this will be due to the federal mandate that most people carry insurance, the requirement that individuals must be screened for Medicaid before purchasing insurance in the Exchange and the increased publicity and outreach on health insurance leading up to Jan. 1, 2014.

Est. Unavoidable Cost of Medicaid Enrollment due to Health Reform



Year	FY2014^	FY2015	FY2016	FY2017	FY2018	FY2019
EBNE (in millions)	$56.5	$137.5	$157.6	$171.5	$186.6	$203.1

Estimated EBNE State Cost: | **FY 2014 $56.5 Million** | **5.5 year $912.8 Million**

*Some national estimates for TN range as high as 80,000 – 100,000

Excise Tax on Health Plans

This is a federally-mandated broad-based tax imposed on health insurance companies including Medicaid managed care companies. This tax will be reflected as a cost to the state for states utilizing Medicaid managed care.

Estimated Excise Tax State Cost: | **FY 2014 $55.9 Million** | **5.5 year $335.3 Million**

Other Costs

There are other state costs associated with the law including:

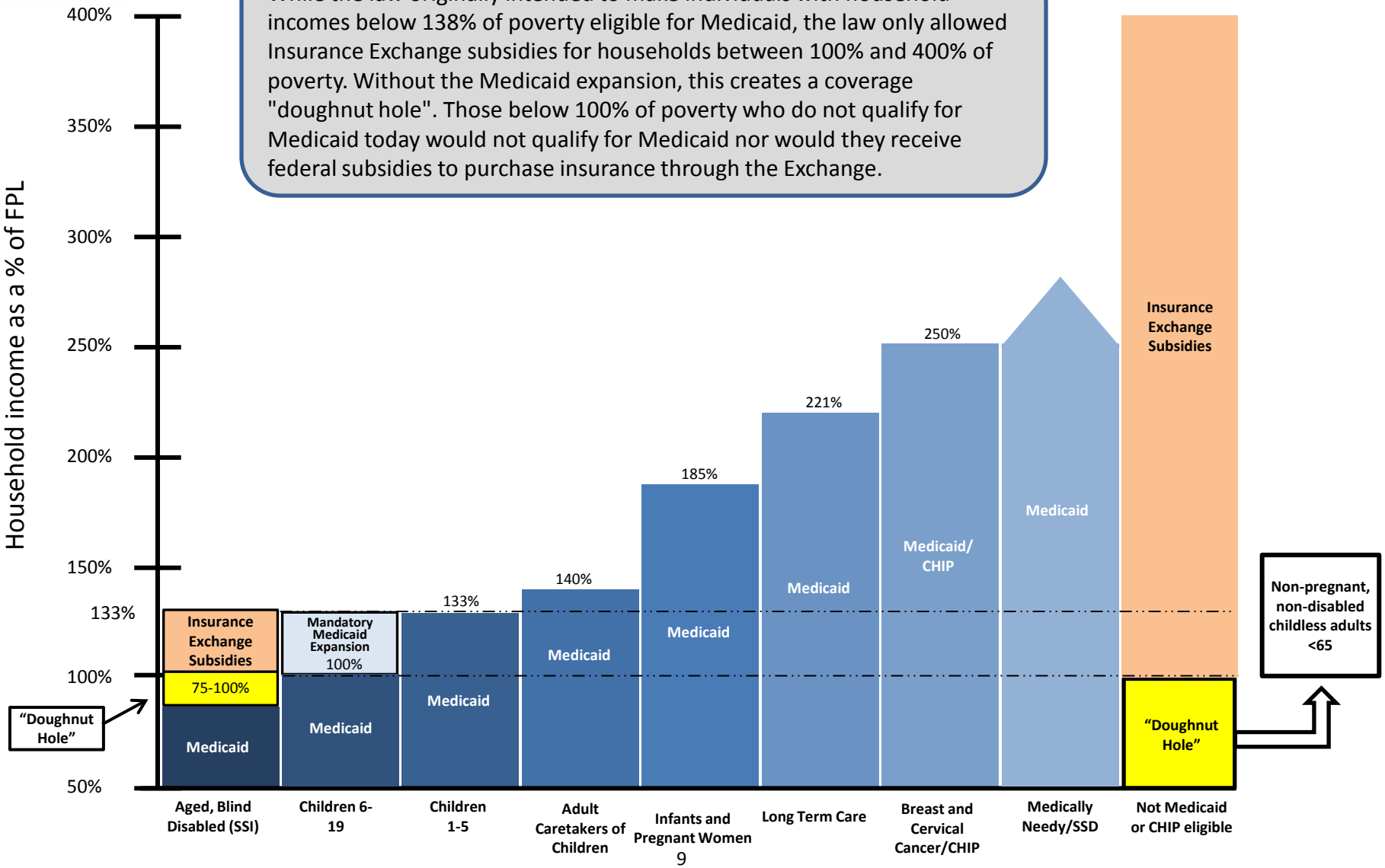
- the requirement that Medicaid agencies cover benzodiazepines and barbiturates – drugs that TennCare does not currently cover
- the reduction in the state share of pharmacy rebates
- the continued increase in pharmacy costs due to pharmaceutical companies reacting to the impacts of health reform on their industry
- initial personnel costs due to required changes to Medicaid and CHIP eligibility processes
- the requirement that Medicaid agencies cover foster children up to age 26

Costs related to the items immediately above are included in the budget and will be offset by changes to the CoverTN, CoverRx and AccessTN programs.

^The cost in FY 2014 is only one half of a state fiscal year due to a Jan. 1, 2014 start date

Post SCOTUS ACA Eligibility Expansion

While the law originally intended to make individuals with household incomes below 138% of poverty eligible for Medicaid, the law only allowed Insurance Exchange subsidies for households between 100% and 400% of poverty. Without the Medicaid expansion, this creates a coverage "doughnut hole". Those below 100% of poverty who do not qualify for Medicaid today would not qualify for Medicaid nor would they receive federal subsidies to purchase insurance through the Exchange.



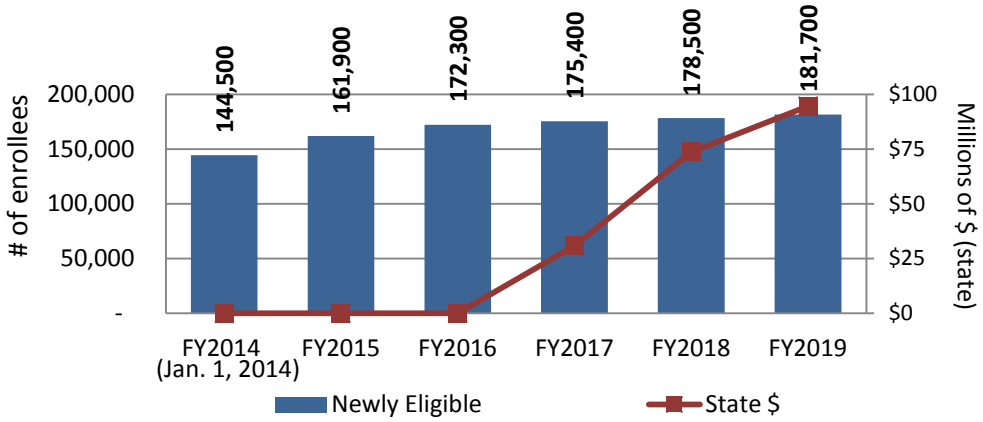
Potential Medicaid Expansion Costs

Although much of the cost increases to Medicaid are unavoidable, there is still a very real cost impact associated with the potential Medicaid expansion. Looking over the next 5.5 years, the cumulative fiscal impact would be approximately $200 million. Annual projections thereafter could exceed $100 million per year.

This cost estimate assumes the federal government continues a match rate of 90% for the Newly Eligible population. Due to federal budget pressures, the match rate could be reduced in future years. However, this cost could be reduced by other programmatic changes.

Expand Medicaid up to 138% of Poverty Option

The law, as originally written, required state Medicaid agencies to expand Medicaid eligibility to 133% of poverty. This coupled with a 5% income disregard makes the true level of qualification 138% of poverty. However, the Supreme Court ruled the mandatory Medicaid expansion unconstitutional, making this optional for states. This population is referred to as "Newly Eligible" or NE.



Year Match Rate	FY2014 100%	FY2015 100%	FY2016 100%	FY2017 95%	FY2018 94%	FY2019 93%
NE (in millions)*	$0	$0	$0	$30.8	$73.7	$94.6

Estimated NE up to 138% State Cost: **FY 2014 $0** **5.5 year $199.1 Million**

*These Medicaid expansion cost estimates do not include the EBNE costs which will be incurred regardless of the state's expansion decision.

Summary

- Over the past several years we have received recognition from across the country for our expertise, dedication and innovation in the design and implementation of creative health care solutions.
- We have managed HCFA programs in a manner that continues to beat national health care inflation trends while simultaneously improving quality. Keeping costs down has better prepared us to address the upcoming financial changes we will face due to health reform.
- We have many decisions before us related to health reform. Regardless of those decisions, there are unavoidable costs the state will bear as a consequence of health reform.
- The most significant reform related decision before us at this time is whether to expand Medicaid. This is a complicated issue with major financial implications for the state which affect many different stakeholders – providers, insurers, consumers and business owners.