



TennCare Block Grant FAQs

You asked. We answered. Here's what you need to know about the TennCare block grant waiver.

Please refer to [TJC's one-pager](#) for a basic overview of the changes.

Q1: What is the TennCare III waiver and how does it change TennCare?

Tennessee has operated its Medicaid program under a waiver since 1994. Section 1115 of the federal Medicaid act gives the Secretary of the Department of Health and Human Services (HHS) authority to waive certain provisions of the law to test or “demonstrate” how the state can better promote the Medicaid program objectives. A [core objective](#) of the Medicaid program is to serve the health and long-term care needs of vulnerable and low-income individuals and families. This waiver imposes an aggregate cap on federal dollars for the next 10 years giving the state an incentive to cut spending to earn federal dollars. A “budget neutrality” limit has previously applied to section 1115 demonstration waivers, but that is different from a cap on federal matching payments for a state’s Medicaid program, which has never been done. It also allows the state to close its drug formulary and increase red tape and administrative burdens to reap the savings.

Prior to TennCare III, the state’s demonstration waiver gave managed care organizations (MCOs) the responsibility to administer the multi-billion-dollar Medicaid program within parameters set by the state and federal governments. Under the prior waivers, the state received open-ended funding from the federal government to help cover the costs of the program. TennCare III will still be administered by MCOs, but the current waiver changes the financing arrangement by imposing a limit on the amount of funding the state will receive from the federal government and it gives the state flexibility to make certain changes to the program’s parameters without seeking permission from the federal government.

Q2: Is TennCare III a “block grant”?

It depends on who’s talking, and to whom.

Probably because of the widely held view among experts that a block grant is illegal, the federal Centers for Medicare and Medicaid Services (CMS) stated in a [cover letter approving the waiver](#), and in [press materials](#) issued with the announcement of the approval, that the new waiver is *not* a block grant. But the [outgoing head of CMS reported to President Trump](#) that the Tennessee waiver *is* a block grant. [Governor Lee also insists that it is a block grant](#).

After failed attempts by Congress to repeal the Affordable Care Act and cap Medicaid funding, the Trump Administration urged states to apply for a block grant as another way to cap state’s Medicaid funding in return for less accountability and more flexibility to cut the program. Tennessee is the only state that has pursued this risky deal, likely to [distract attention from its refusal to expand Medicaid](#).

A block grant traditionally refers to lump sum funding from the federal government to the state that gives the state broad discretion as to how to spend the funds. A key feature is that the state assumes the financial risk of bearing all costs that exceed a cap on the federal funds. For example, the Temporary Assistance for Needy Families (TANF) program operates as a traditional block grant. There is a finite amount of federal funding, with the state liable for all costs that exceed that amount.

The new TennCare III waiver sets an aggregate 10-year cap that limits the amount of funding the state will receive from the federal government and allows the state to keep a portion of any savings if the program (TennCare) meets certain conditions. Rather than a lump sum, the federal government will pay a percentage of the costs of the TennCare program up to the amount of the aggregate cap. The cap can also be adjusted if the population on TennCare increases or decreases by 1%, which is not usually a feature of a block grant. Financial terms are favorable to the state during the first five years, but federal officials will reset the 10-year cap after five years, opening the state to significant financial risk in later years.

Official statements and press materials have denied that there is any financial risk for the state. However, the legally controlling language is in the [201 pages of Special Terms and Conditions](#). The terms of that document contradict the cover letter, describing the financial risk in stark terms: “78. **Risk.** Tennessee shall be at risk for the aggregate cap and the state accepts risk for both enrollment and per capita costs, subject to the enrollment risk corridors describe in these STCs.”78. [See also STCs 67(g), 77, 79 and 80.]

Q3: Does the TennCare III waiver provide health insurance to more Tennesseans?

No. TennCare III does not expand coverage. There is no commitment to cover anyone who did not already qualify for TennCare in the legally controlling waiver language.

The state has referenced ideas, such as eliminating the waiting list for individuals with disabilities to get services or investing in rural communities, but there is no obligation to use the savings for any defined purpose or to spend them on the Medicaid program, as long as the spending is consistent with the policy principles of the [Healthy Adult Opportunity](#) guidance. Notably, if the state wanted to provide more services to more people and invest in improving the health of Tennesseans, it could have done it years ago – and could do it today – by expanding Medicaid under the Affordable Care Act (ACA). Medicaid expansion would provide an additional \$1.4 billion per year in federal funding at [no cost to the state](#), compared to maybe hundreds of millions of dollars that is contingent under the waiver. If the state expands eligibility to cover additional people with the savings, it will cost the state three times more (at about 35% of costs) than it would to expand Medicaid at the ACA’s 90% federal match rate. If it continues to refuse expansion, [the state could also miss out on an additional \\$1.7 billion to provide services to people who are already covered by Medicaid under a new proposal that is being considered by Congress](#).

Q4: What are the financial risks under the TennCare III waiver?

If the state manages to spend less than estimated, the difference between actual spending and the aggregate cap (which is based on national Medicaid spending estimates) are considered “savings.” Tennessee must meet ten quality metrics that have yet to be defined in order to tap into any shared savings.

If the state does realize savings, it will be difficult and risk other benefits of the program. Our TennCare program is already lean, so their options to generate savings are to close the prescription drug formulary to reduce coverage of drugs, cut provider payments, and/or increase barriers to getting and staying enrolled.

Q5: Does Tennessee's Medicaid management track record make it a good candidate for less accountability and more flexibility?

No. Shortly after TennCare began in 1994, Tennessee became one of only three states to be denied accreditation by the National Association of Insurance Commissioners because of its failure to effectively regulate TennCare MCOs. The [mismanagement](#) allowed one of the largest MCOs to fail to pay providers and other MCOs were found by a federal court jury to have bribed a state senator. Tennessee's managed care problems were among many factors that led to the issuance of comprehensive federal managed care regulations in 2002. More flexibility is dangerous considering [the agency's track record](#) of failing to comply with the Americans with Disabilities Act and maintaining eligibility procedures that continue to screen out people with cognitive and physical disabilities.

The state has highlighted its “history of innovation and prudent financial management,” but in laymen's terms, this means the state has [historically misused Medicaid dollars](#) and underspent cost projections by denying medically necessary services, forcing TennCare enrollees to go through a gauntlet of appeals, and suppressing enrollment numbers by failing to do outreach, provide in-person enrollment assistance, and generally making it difficult for people to get and keep their coverage.

Q6: Can the state make cuts to TennCare under this waiver?

Yes. Although the state has promised not to cut enrollees or benefits (aside from the closed drug formulary, which is a benefit reduction), cuts can be achieved in other ways— (1) by lowering provider payment rates and (2) by making it more difficult for qualified Tennesseans to enroll in TennCare or maintain their coverage.

Health care providers contract with MCOs to participate in their plans' networks. This waiver allows the state to reduce reimbursement to providers without federal oversight. TennCare's low rates and paperwork requirements already discourage many providers from taking TennCare patients. Further rate reductions would generate savings for the state, at the price of reducing TennCare enrollees' access to health care, which effectively is a cut to services.

TennCare has previously erected administrative barriers for enrollment, redetermination, and authorization of services. TennCare could ratchet up the red tape, which caused [thousands of children and adults to lose their health insurance](#) without notice in recent years.

Q7: How will the waiver affect children, seniors, and people with disabilities who are currently covered under TennCare?

The waiver will not improve quality of care or access to care. It adds pressure on payments to providers, including pediatric practices and children's hospitals, and pressure to clamp down on home-based care hours.

One of the key flexibilities in the waiver gives the state permission to limit prescription drug coverage. By its nature, such restrictions impact the most vulnerable patients with the costliest medical needs. There will be a yet-to-be developed exceptions process for enrollees who need drugs that are not on the closed drug formulary. But as experience tells us, exceptions are not protections. People with special

health care needs will need to jump through hurdles and face potentially lengthy delays to get the drugs they need.

Cuts to TennCare would reduce access to health care for all TennCare enrollees, including children. However, the closed drug formulary only applies to TennCare enrollees age 21 and over. The federal EPSDT (Early, Periodic, Screening, Diagnosis and Treatment) benefit still applies to enrollees under age 21, which TennCare confirmed and revised its proposal to explicitly state in response to comments from children's health advocates. Under the EPSDT benefit, children are entitled to receive any services, treatments, therapies, and drugs that are medically necessary. So, children are exempt and should not be impacted by the closed drug formulary, but the state could still cut rates to providers to increase savings, which would affect children.

For these reasons, over a dozen [prominent national patient advocacy groups](#) oppose the block grant waiver.

Q8: Is the TennCare III waiver legal?

Legal experts have noted several legal problems. CMS failed to follow its own regulations regarding transparency and the waiver approval process. In addition to these procedural flaws, the waiver's financial provisions exceed the federal agency's waiver authority. The law only permits a three-year extension, and the waiver purports to approve a ten-year extension. The formulary provisions violate specific provisions of the Medicaid Act.

Most fundamentally, CMS can only approve a waiver for the purpose of testing experimental policies that advance the purposes of the Medicaid Act. The Act's purpose is to provide medical assistance to individuals who are unable to afford the cost of necessary medical care. TennCare III instead purports to establish a long term, fundamentally redesigned program that conflicts with that purpose (e.g., by limiting patients' access to needed medications).

Any waiver approval that exceeds the authority of the HHS Secretary and/or does not further the objectives of the Medicaid program can be challenged under federal law. For example, there is pending litigation to set aside the approved work requirement waivers in Arkansas and New Hampshire on these grounds.

Q9: Can the Biden Administration withdraw the TennCare III waiver?

The Center for Medicare and Medicaid Services (CMS) generally has the authority to withdraw an approved waiver at any time if it determines the waiver does not further the program objectives of Medicaid.

In an [executive order](#) issued on January 28, 2021, President Biden directed federal agencies to review agency actions concerning health care, including "demonstrations and waivers...that may reduce coverage under or otherwise undermine Medicaid...", but the agency leaders for CMS and HHS who would be responsible for this review have yet to be confirmed.

Q10: What will happen if the TennCare III waiver is withdrawn?

There would be no immediate impact on the TennCare program, providers, or enrollees, because the TennCare III waiver will take many months to implement. If the TennCare III waiver is rescinded, the program will once again be subject to the terms of the waiver that was previously in effect, known as TennCare II. TennCare II could be reinstated while negotiations continue. TennCare II is due to expire June 30, 2021. The state would need to submit a new application to extend the waiver. If there is insufficient time for the submission and approval of such an application, CMS could extend TennCare II for a short period (e.g., six months) to accommodate the application and review process.

If CMS rescinds TennCare III approval, there would be a new state application to extend the existing TennCare waiver, and the public would have an opportunity to comment during the federal review process.