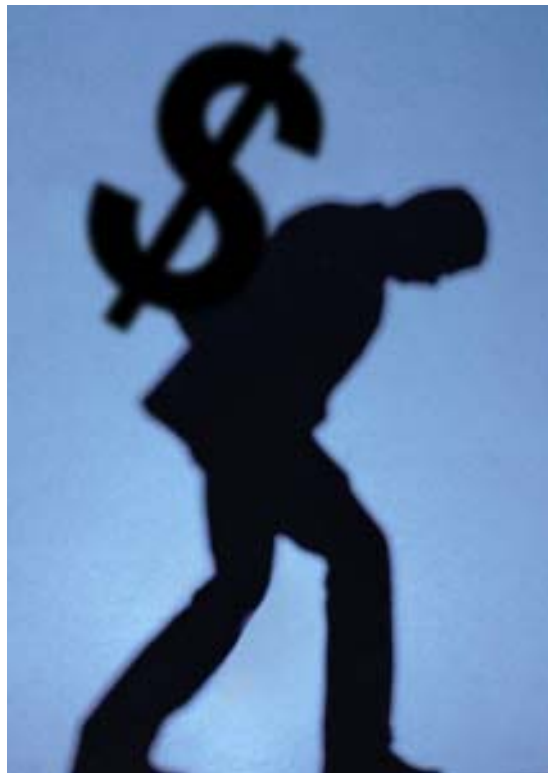


**FINANCING HEALTH CARE
FOR THE UNINSURED:
WHO BEARS THE BURDEN IN TENNESSEE?**



May 2007



STATE OF TENNESSEE

COMPTROLLER OF THE TREASURY

John G. Morgan

Comptroller

STATE CAPITOL

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May 29, 2007

The Honorable Ron Ramsey
Speaker of the Senate
The Honorable Jimmy Naifeh
Speaker of the House of Representatives
and
Members of the General Assembly
State Capitol
Nashville, Tennessee 37243

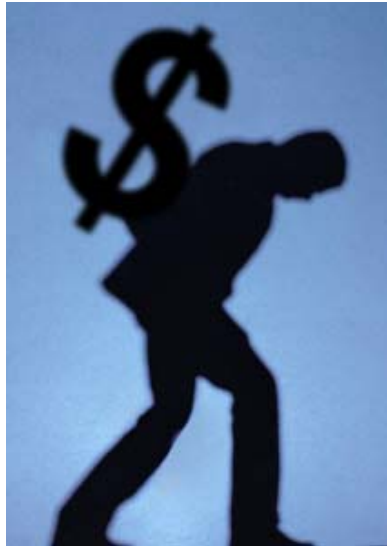
Ladies and Gentlemen:

Transmitted herewith is a study about financing health care for indigent persons in Tennessee as directed by Public Chapter 807 (2006). The report discusses indigent health care costs and government expenditures, the availability of federal matching funds, and health planning in Tennessee. The report contains recommendations for legislative and administrative consideration.

Sincerely,

John G. Morgan
Comptroller of the Treasury

**FINANCING HEALTH CARE
FOR THE UNINSURED:
WHO BEARS THE BURDEN IN TENNESSEE?**



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John G. Morgan
Comptroller of the Treasury

May 2007

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EXECUTIVE SUMMARY

Public Chapter 807 (2006) directs the Comptroller of the Treasury to study the financing of health care for indigent persons in Tennessee (see Appendix A). As requested by the legislature, this report provides an overview of:

- State and local government expenditures for indigent health care, and
- Federal resources available for indigent health care, including procedures and techniques for capturing federal funds and the likelihood of discontinuance or diminution of such funds.

In 2005, 46.6 million Americans lacked health insurance coverage. Measuring the number of uninsured individuals at the local level is difficult. Studies suggest that between 482,000 and 836,000 Tennesseans lacked insurance coverage in 2005. Employer-sponsored insurance (ESI) plans are the most common source of health insurance, yet they are cost-prohibitive for many Tennessee businesses and are not compatible with the state's workforce trends. (pages 3-5)

The state's federal matching dollars for health care mostly flow through Tennessee's Medicaid program, TennCare. However, recent TennCare disenrollment and benefits restrictions reduced the federal contribution to TennCare by \$800 million between actual FY 2005 and projected FY 2007. By contrast, state spending for TennCare is expected to increase by \$60 million during the same period. TennCare officials attribute the increased state spending to provider rate increases and enrollment growth. (pages 5-9)

Conclusions

Tennessee lacks a system to accurately quantify indigent health care costs. Hospital pricing practices vary widely among facilities and by patient type. In addition, the gross charges contained in the Joint Annual Report of Hospitals (JAR) offer little value in quantifying indigent care costs. Thus, any statewide calculation of indigent care expenses will be inexact. (pages 9-12)

Total indigent health care costs in Tennessee likely exceed \$600 million. State and local government expenditures for indigent care likely exceed \$300 million, but indigent care costs and government expenditures are very difficult to measure. Many state and local government programs support indigent health care. Yet, government officials cannot determine what portion of these programs' budgets eventually reaches indigent persons. (pages 12-17)

A proposed federal rule could result in reduced Certified Public Expenditure funding from the federal government. Certified Public Expenditure (CPE) is the uncompensated cost incurred by public hospitals associated with TennCare enrollees and those eligible but not enrolled in TennCare. TennCare officials estimate that a rule proposed by the federal Centers for Medicare and Medicaid Services (CMS), CMS-2258-P, could result in a \$200 million - \$250 million shortfall in the TennCare program. Other states expect similar revenue losses as well. The rule would more strictly define which hospitals are eligible to generate CPE and require more stringent accounting regulations for documenting CPEs. Yet even if the federal government finalizes the proposed rule, the state could continue to maximize federal CPE revenue by increasing the number of government-owned health care providers and by including county health department clinics in the state's CPE program. (pages 17-18)

Fully restoring Medicaid Disproportionate Share Hospital (DSH) payments to Tennessee will require additional federal approval and new state expenditures. Medicaid Disproportionate Share Hospital payments are federal matching funds intended for hospitals serving a large number of Medicaid patients. (pages 18-19)

Unlike Tennessee, many states are using Medicaid to help finance major new health care initiatives. Other states have successfully leveraged federal matching funds for programs similar to Cover Tennessee. (pages 19-23)

Tennessee's health care system is fragmented and lacks overarching goals. Public Chapter 942 (2004) requires the Department of Finance and Administration to develop a comprehensive state health plan, but to date the Department's Health Planning Division is not yet fully operational. A functioning division of state government focused solely on health planning could help reduce health care costs and create a more efficient health care system for all Tennesseans. Other states have launched health planning endeavors that link the Certificate of Need process, data collection, academic research, and policy analysis. (pages 23-26)

Legislative Recommendations (page 27)

The General Assembly may wish to amend *TCA* §68-1-109 regarding the Joint Annual Report (JAR) of hospitals. Amendments could require JAR filings to include:

- More specific indigent care cost data
- A breakdown of state and local government revenue that includes a category for indigent care funding
- Financial data based on net costs rather than gross charges
- A consistent time period for reporting

The General Assembly may wish to require the Bureau of TennCare to provide access to all official correspondence between TennCare and the Centers for Medicare and Medicaid Services (CMS).

The General Assembly may wish to explore policies that would promote hospital pricing transparency.

Administrative Recommendations (pages 27-28)

The Department of Finance and Administration's Health Planning Division should use its authority to establish and enforce a comprehensive state health plan as required by *TCA* §68-11-1625.

The Department of Finance and Administration's Health Planning Division should examine best practices for establishing and maintaining health care accounting standards.

The Department of Finance and Administration should examine various options for obtaining federal funds for the Cover Tennessee initiatives.

The Department of Finance and Administration should continue its efforts to fully reinstate the Medicaid Disproportionate Share Hospital (DSH) program in Tennessee. Under a fully restored Medicaid DSH program, Tennessee could possibly provide hospitals up to \$420 million each year to defray indigent care costs. To reach this level Tennessee would have to contribute about \$116 million in new state funding.

The Department of Finance and Administration should deliver an annual report on Cover Tennessee to the General Assembly. This report could synthesize the monthly reports the Department plans to provide the General Assembly and could offer more thorough, dedicated analysis.

The Department of Finance and Administration should explore various approaches for maintaining Certified Public Expenditure (CPE) revenue for TennCare.

The Department of Health should consider increasing the number of county health departments that qualify as Federally Qualified Health Centers (FQHCs).

See Appendices E through G for response letters from the Bureau of TennCare, the Department of Finance and Administration, and the Department of Health, respectively.

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DEFINITIONS

Definition of Indigent Care

For the purposes of this report, “indigent health care” includes all forms of uncompensated health care. These include bad debt, charity care, and medically indigent services. They are defined in TCA §68-1-109 as follows:

Bad Debt = Uncompensated care for which the hospital directly billed the patient and for which the patient should reasonably be expected to pay

Charity Care = Services provided to medically needy persons for which the hospital does not expect payment. These persons have income below one hundred percent (100%) of the federal poverty level, are not eligible for or have exhausted state or federal medical benefits, and/or have no or very limited insurance.

Medically Indigent = A person who can afford the basics of life, i.e., food, clothing and housing, but has insufficient income and/or assets to pay incurred hospital and medical bills is medically indigent.

Low Income Medically Indigent = Persons with income between one hundred percent (100%) and one hundred fifty percent (150%) of the federal poverty level, who are not eligible for or have exhausted state or federal medical benefits, and/or who have no or limited insurance.

Other Medically Indigent = A patient that does not satisfy the income requirement for low income medically indigent, is not eligible for medical benefits from state or federal programs, and has no or inadequate health insurance. Examples include bankrupt accounts for which there is evidence that the medical bill caused the bankruptcy and unpaid accounts because of catastrophic illnesses which result in medical bills that are in excess of an amount that a patient could ever reasonably be expected to pay.

Definitions of Hospital Price and Cost Terms

Gross Charge = The price listed in a hospital’s chargemaster, or database of all services performed by the hospital.

Net Price = The price for a given service negotiated between a hospital and any payer, including commercial insurance, Medicare, Medicaid, and self-pay. Net prices for a given service at the same hospital frequently differ depending on the payer.

Average Cost = Includes all expenses incurred by a hospital involved in providing a specific service. Average cost includes both the costs of administering the service (i.e. any materials purchased specifically for the service, labor utilized in the delivery of the service, etc.) and all fixed costs (i.e. building maintenance, payment for auxiliary equipment, etc).

Marginal Cost = Includes only the expenses incurred by a hospital directly associated with administering a specific service (i.e. any materials purchased specifically for the service, labor utilized in the delivery of the service, etc.). Marginal cost does not include fixed costs.

DIRECTIVE, SCOPE, AND LIMITATIONS

Public Chapter 807 (2006) directs the Comptroller of the Treasury to study the financing of health care for indigent persons in Tennessee (see Appendix A). As requested by the legislature, this report provides an overview of:

- State and local government expenditures for indigent health care, and
- Federal resources available for indigent health care, including procedures and techniques for capturing federal funds and the likelihood of discontinuance or diminution of such funds.

To collect this information, the Comptroller's Office of Research:

- interviewed relevant officials in the Department of Health, Department of Finance and Administration, and Bureau of TennCare, as well as hospital and clinic administrators, professors, and advocates (see Appendix B),
- surveyed all county mayors and financial officers and select city government officials (see Appendix C), and
- examined available sources of indigent care cost and government expenditure data.

However, indigent care costs and government expenditures are very difficult to quantify. The lack of a comprehensive uniform data system and the fragmentation of the health care system complicate any effort to aggregate these figures. Moreover, government expenditures are rarely earmarked explicitly for indigent care, though many government programs likely treat individuals who are indigent.

In addition, the inexact nature of health care accounting makes it difficult to determine the marginal cost of a specific medical service. Several fixed costs, including labor, capital, and administration, contribute to the cost of medical services. Consequently, providers are not able to separate the exact cost of a specific service from the numerous fixed costs associated with the medical industry. Instead, organizations such as the Tennessee Hospital Association (THA) must estimate cost figures.

Because THA calculates the only statewide database of cost-based health care information for hospitals, this report presents cost information obtained from THA. These data include the total costs of each hospital's operations and thus represent average costs. To determine a hospital's average costs, THA multiplies gross charges by a hospital's cost to charge ratio, which is the ratio of total expenses to total charges. At the total payer level, THA is comfortable that this formula results in a cost that is close to the hospital's average cost of providing services covered by that payer category. While not a perfect measurement of cost, the THA data represents the best available source cost-based information.

$$\text{Estimated Average Cost} = \text{Gross Charges} \times \frac{\text{total expenses}}{\text{total charges}}$$

As a result of the above limitations, this report lists indigent care costs and government expenditures from the best available sources, but it also discusses the limitations of each source. For discussion of these limitations, please see pages 12-17.

BACKGROUND

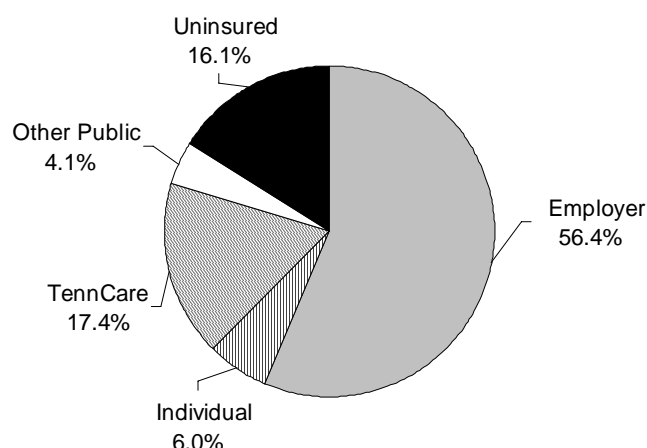
Measuring the number of uninsured individuals at the local level is difficult. Studies suggest that between 482,000 and 836,000 Tennesseans lacked insurance coverage in 2005.² Uninsured Americans “are largely low-income, adult workers for whom coverage is either unavailable or unaffordable.” The majority of the uninsured are in working families – 70 percent are in families with one or more full-time workers, and an additional 11 percent are in families with part-time workers. More than 60 percent of nonelderly uninsured adults did not attend college, making them less qualified for higher-skilled jobs that more typically provide health insurance.

In addition, studies show that

- Two-thirds of the uninsured are low-income individuals or from low-income families.
- The majority of uninsured adults (59 percent) have gone without coverage for a period of at least two years.
- About 33 percent of Hispanics and 21 percent of African Americans are uninsured compared to 13 percent of whites; insurance disparities exist at both lower and higher income levels.
- The privately insured tend to be healthier than the uninsured; almost half of all uninsured, nonelderly adults have a chronic condition.³

In 2005, 46.6 million Americans lacked health insurance coverage.¹

Exhibit 1: Health Insurance Coverage Type, Nonelderly (Age 0-64) Population, Tennessee, 2004-2005



Source: The Henry J. Kaiser Family Foundation, State Health Facts, <http://www.statehealthfacts.org>.

Note: TennCare also covers Medicare premiums for individuals 65 and older who qualify for TennCare.

ESI plans are the most common source of health insurance. Such plans cover 56 percent of individuals in Tennessee and 61 percent nationwide.⁴ However, escalating premiums increasingly put ESI plans out of reach for many employers, particularly small businesses. Moreover, service sector employees, making up the leading projected job growth sector, are the least likely of all sectors to have health insurance.

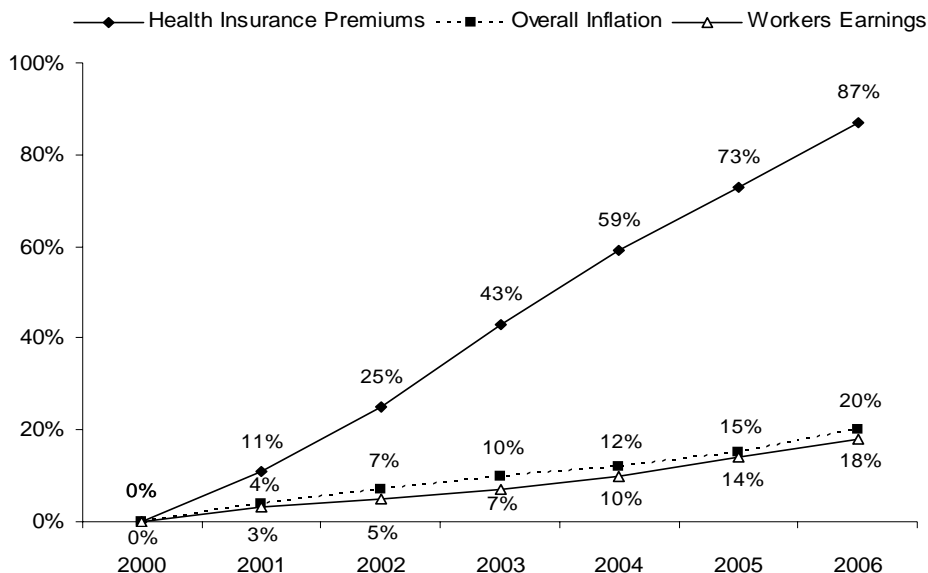
Employer-sponsored insurance (ESI) plans are cost-prohibitive for many Tennessee businesses and are not compatible with the state’s workforce trends.

Premiums for employer-sponsored insurance (ESI) plans have increased drastically over recent years.

Rising health insurance premiums continually outpace growth in overall inflation and workers’ earnings (Exhibit 2). Premiums for family coverage increased substantially from 2000-2006, rising from \$6,438 to \$11,480. During this same period, the average employee’s annual contribution grew from \$1,619 to \$2,973.⁵ Given that inflation overshadowed gains in wages from 2000-2006, health insurance premiums continue to consume an increasing share of family budgets, forcing some to discontinue coverage.

Escalating premiums also render a health insurance benefit cost-prohibitive for many businesses. A survey conducted by the University of Tennessee Center for Business and Economic Research found that over 50 percent of the state’s small employers (businesses with two to 19 employees) did not offer health insurance to any of their employees in 2005.⁶ A separate study conducted by the Kaiser Family Foundation found that, overall, only 53 percent of private sector establishments in Tennessee offered a health insurance benefit in 2003.⁷

Exhibit 2: Cumulative Changes in Health Insurance Premiums, Overall Inflation, and Workers' Earnings, United States, 2000-2006



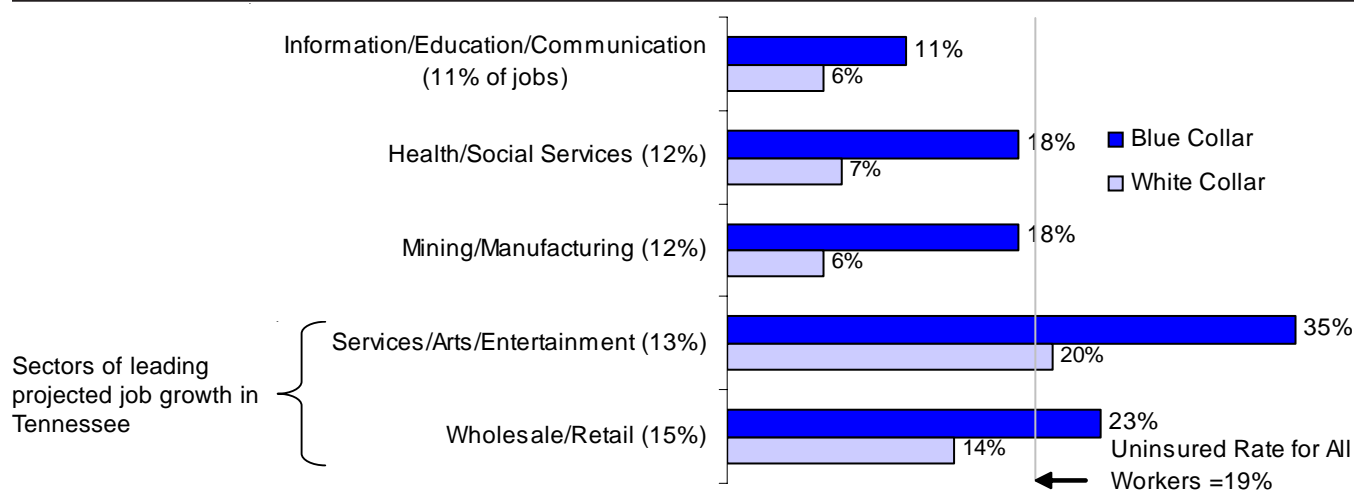
Note: Data on premium increases reflect the cost of health insurance premiums for a family of four.
 Source: Kaiser Family Foundation/Health Research and Educational Trust Survey of Employer-Sponsored Health Benefits, 2001-2006; Bureau of Labor Statistics, Consumer Price Index, U.S. City Average of Annual Inflation (April to

Several factors help explain why ESI plans do not cover the entire population:

- Employer-sponsored health insurance is sensitive to sharp changes in health insurance premiums
- The economic downturn which began in early 2001, coupled with the return of double-digit inflation in health insurance premiums, decreased employer-sponsored coverage
- Total family premiums now exceed the annual salary of a full-time, minimum-wage worker
- Workers from low-income families have less access to job-based insurance, even when benefits from a spouse's job are considered
- The required employee share of premiums makes employer-sponsored coverage unaffordable for some, particularly low-wage workers
- Employees of businesses with fewer than 100 employees are less likely than those in larger firms to have health benefits offered to them⁸

Health insurance coverage also varies significantly by industry and type of occupation.

Exhibit 3 illustrates how employees in service sector and retail jobs are more likely to lack insurance coverage. As "services remain the primary source of job creation for the state economy,"⁹ this presents significant implications for even maintaining insurance coverage in Tennessee and for reducing indigent health care costs. In addition, regardless of the industry, white collar workers, defined as managers and professionals, are more likely to have insurance coverage. By contrast, blue collar workers, which include all other jobs, make up 80 percent of uninsured workers.¹⁰

Exhibit 3: Uninsured Rates, Selected Industry Groups in the U.S., White vs. Blue Collar Jobs, 2005

Note: White collar workers include all professionals and managers; all other workers classified as blue collar.
 Source: Kaiser Commission on Medicaid and the Uninsured, *The Uninsured: a Primer*, October 2006, p. 18.

Medicare is almost exclusively funded by the federal government and covers 41 million mostly elderly individuals, while Medicaid is a partnership between states and the federal government that covers more than 55 million low-income individuals. Medicaid accounts for “roughly one sixth of the nation’s health care spending”¹¹ and 44 percent of federal funds allocated to states in 2005.¹² This makes Medicaid a primary source of federal matching funds to address insurance coverage and indigent health care costs.

The federal government finances a significant portion of U.S. health care mainly through two programs: Medicare and Medicaid.

The state’s federal matching dollars for health care mostly flow through Tennessee’s Medicaid program, TennCare.

As of December 31, 2006, TennCare covers just fewer than 1.2 million individuals and is projected to spend \$7.3 billion in fiscal year 2007. TennCare operates under a Section 1115 waiver that provides the program special leniency to determine benefits, matchable state expenditures, and coverage. However, on June 30, 2007 this waiver will expire. The TennCare Bureau is currently negotiating a new waiver with the Centers for Medicare and Medicaid Services (CMS), the federal agency that administers Medicare and Medicaid. The lack of transparency in the waiver negotiation process makes it difficult to gauge potentially matchable state and local expenditures. Still, many states have recently experienced success in leveraging federal matching funds for innovations in their Medicaid programs to cover the uninsured and to reduce indigent care expenses.

Medicaid operates as a partnership between states and the federal government; each state administers its own program with oversight from CMS. An annual formula based on a state’s average per-capita income determines the Federal Medicaid Assistance Percentage, or FMAP, which sets the amount of the federal match. Exhibit 4 lists the latest percentages for Tennessee. The table also includes the “multiplier,” which is the amount of federal money spent for each one dollar of state Medicaid expenditure. For example, in fiscal year 2007 the federal government contributes \$1.75 for every \$1 of state spending on TennCare, resulting in \$2.75 in total spending. \$1.75 is 63.65 percent of \$2.75. Overall the federal matching rate has declined in recent years as average per-capita income in Tennessee has risen.

Exhibit 4: Tennessee's Federal Medicaid Assistance Percentage (FMAP) and Multiplier, Fiscal Year 2004 – Fiscal Year 2007

	FY 2004	FY 2005	FY 2006	FY 2007	FY 2008
FMAP	67.54	64.81	63.99	63.65	63.71
Multiplier	2.08	1.84	1.78	1.75	1.76

Source: FY 2004 - FY 2007, Kaiser Family Foundation, <http://www.statehealthfacts.org>; FY 2008, National Conference of State Legislatures, "HHS Releases FY 2008 FMAP Figures."

As a result of this funding formula, the state is projected to contribute about \$2.6 billion to the fiscal year 2007 TennCare budget and the federal government will contribute about \$4.4 billion.

Recent TennCare disenrollment and benefits restrictions reduced the federal contribution to TennCare from \$5.2 billion to \$4.4 billion, or by \$800 million, between actual FY 2005 and projected FY 2007. By contrast, state spending for TennCare is expected to increase by \$60 million during the same period.¹³

TennCare estimates that 65,000 people were disenrolled during the reverification process in 2002. An additional 170,000 people were disenrolled in 2005 during TennCare reform.

TennCare officials attribute the increased state spending to provider rate increases and enrollment growth. Altogether, the total TennCare budget has fallen by nearly \$1.3 billion, from just under \$8.6 billion in actual FY 2005 to \$7.3 billion in projected FY 2007.

The TennCare disenrollment and closed enrollment likely contributed to already increasing indigent health care costs and likely shifted significant costs for low-income health care to other sectors, including health care providers, some local governments, and private health insurance.

The Hospital Joint Annual Reports compiled by the Department of Health show that total charity, medically indigent, and bad debt costs in Tennessee hospitals from 2001-2005 grew from \$807 million to \$1.46 billion.¹⁴ The indigent care burden for some local governments has also recently increased. An Office of Research survey of county government indigent care expenditures in Tennessee finds that no county appropriates funds specifically for indigent care. However, some counties such as Davidson, which contributes funding to the safety net Hospital Authority (HA), have absorbed a share of increased indigent care costs. The fiscal year 2007 Davidson County subsidy to the HA is \$49.8 million, \$17.1 million more than before the TennCare disenrollment.

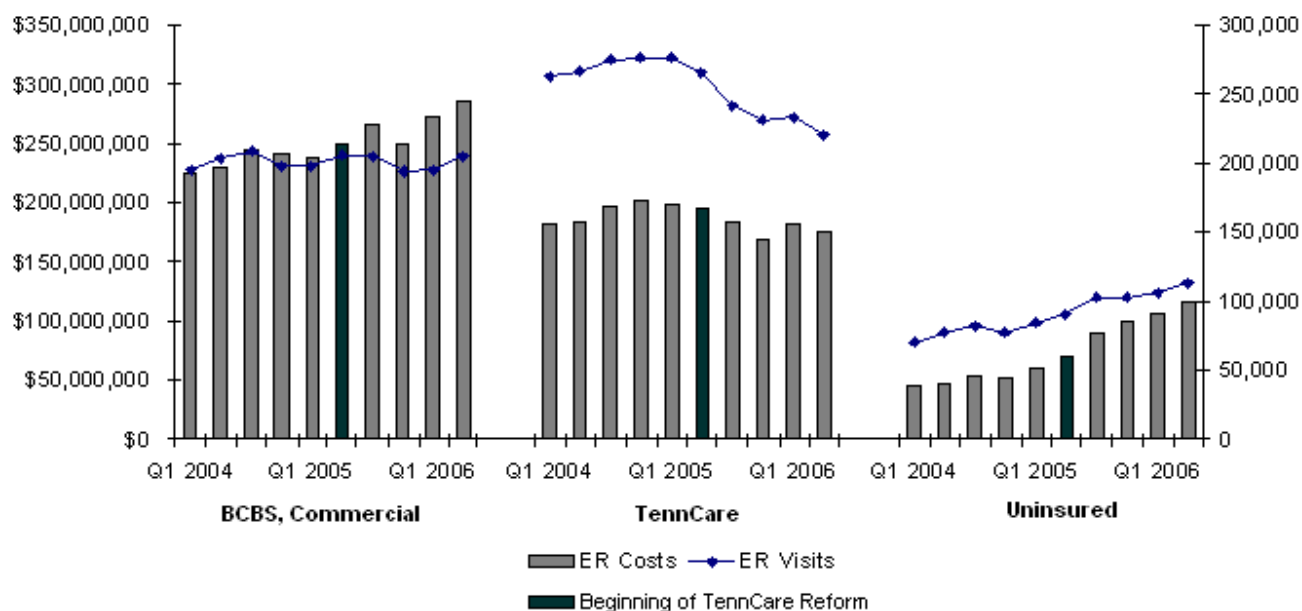
The Tennessee Hospital Association (THA) states that TennCare disenrollment shifted some of the burden for indigent care from the state to hospitals. Since the uninsured lack a medical home, the ER is the most likely place an uninsured individual will go when needing care. Utilizing data compiled by THA, Exhibit 5 examines total ER costs and number of visits for three categories of patients—Blue Cross/commercial, TennCare, and uninsured—before, during, and after TennCare reform. TennCare reforms began in the second quarter (Q2) of 2005. The exhibit shows that:

- During and after TennCare reform, ER visits by TennCare enrollees decreased while ER visits by the uninsured increased. ER visits by Blue Cross/commercial patients remained about the same. This indicates that some disenrolled TennCare patients may have sought treatment in the ER without insurance.
- Total costs of ER treatment for the uninsured increased along with higher numbers of visits. Total costs for Blue Cross/commercial ER visits increased as well, despite the number of visits remaining about the same. Consequently, hospitals accrued increased indigent care costs and likely shifted some of these costs to Blue Cross/commercial patients.
- In the second quarter (Q2) of 2006, ER costs for Blue Cross and commercial patients were up almost 15 percent from the same quarter in the previous year when TennCare

reform began. The medical inflation rate of 4.3 percent for 2005 cannot fully explain this cost increase, so the increased cost of treating the uninsured likely contributed to these higher costs.¹⁵

Ultimately, without a comprehensive health care data tracking system, an accurate measurement of any indigent care cost shift to the private sector eludes calculation. However, Exhibit 5 suggests that TennCare reforms likely contributed to increased indigent care costs borne by hospitals and by the privately insured.

Exhibit 5: ER Visits and Total Costs for Blue Cross/Commercial, TennCare, and Uninsured Patients by Quarter, Q1 2004-Q2 2006



Source: Tennessee Hospital Association

As Exhibit 5 implies, commercial insurance premiums rise with increased indigent health care costs. An analysis by Kenneth Thorpe, co-director of the Emory Center on Health Outcomes and Quality, found that private health insurance premiums in 2005 were inflated by 7.4 percent in Tennessee because of costs attributable to health care for the uninsured.¹⁶ Thus, with the study estimating total ESI premiums at \$6.77 billion for this same year in Tennessee, businesses and individuals participating in ESI plans also absorb a significant share of indigent health care costs.

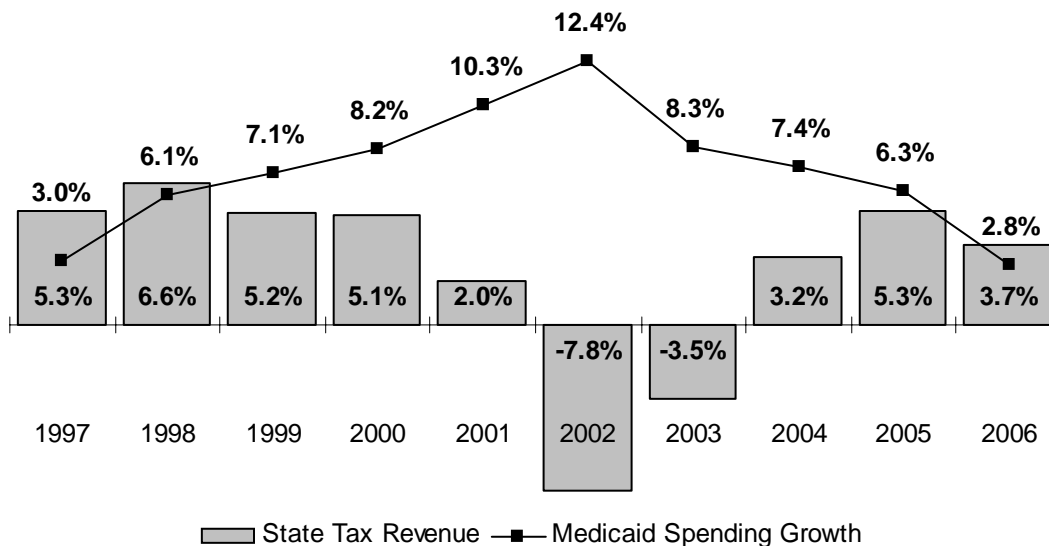
The federal government also partners with states to fund a third and significantly smaller health coverage program, the State Children's Health Insurance Program (SCHIP).

Like Medicaid, SCHIP programs are administered by the states, however income eligibility for SCHIP is broader than for Medicaid. In addition, federal Medicaid matching rates vary by state between 50-78 percent, but federal SCHIP matching rates range from 65-85 percent.¹⁷ Despite this more favorable matching rate for states, federal SCHIP funding is capped for each state. "States that reach their caps may receive some additional funds not spent by other states, but these 'reallocations' are not assured" and their amount is unpredictable. Also, states can use SCHIP funds to expand coverage through a child health program separate from Medicaid, a Medicaid expansion, or a combination of the two approaches.¹⁸ Several states have also used SCHIP funds to cover individuals without any children (see Exhibit 21). The Department of Finance and Administration will establish an SCHIP program for Tennessee, dubbed CoverKids, as part of the Cover Tennessee initiatives (see page 8-9).

Nationally, Medicaid spending growth has strained state budgets, and states have reacted in a variety of ways.

Exhibit 6 illustrates how state spending on Medicaid has far outpaced growth in state tax revenue in recent years. In fact, 2006 represents the first year since 1998 in which Medicaid spending on average grew less than state tax revenue. Even under these dynamic fiscal pressures states continue to approach Medicaid spending with different fiscal and policy perspectives. For instance, recently Tennessee and Missouri significantly restricted eligibility, while Massachusetts and Illinois used federal dollars through Medicaid as a strong base to substantially increase health care coverage.¹⁹

Exhibit 6: U.S. State Tax Revenue and Medicaid Spending Growth, 1997-2006



Note: State Tax Revenue data is adjusted for inflation and legislative changes. Preliminary estimate for 2006.

Source: Kaiser Commission on Medicaid and the Uninsured analysis of CMS Form 64 Data for Historic Medicaid Growth Rates and KCMU/Health Management Association Survey for 2006 Medicaid Growth Estimates; Analysis by the Rockefeller Institute of Government for State Tax Revenue.

Tennessee is moving forward with a new series of initiatives, Cover Tennessee, in an effort to expand health coverage opportunities.

Cover Tennessee is the umbrella name for five new health care initiatives that the Department of Finance and Administration plans to implement in 2007. Exhibit 7 outlines the major features of each initiative. Of these programs, only CoverKids will draw federal matching funds. In 2006 the General Assembly appropriated additional funds for AccessTN specifically to draw federal matching funds, though the department has yet to pursue this federal match, citing possible federal rules that could restrict state policies.

Exhibit 7: Overview of Cover Tennessee Programs and Projected Mature Enrollment

CoverKids (40,400 projected enrollees)	<ul style="list-style-type: none"> Comprehensive health insurance available to uninsured children age 18 and under with household income below 250% of the federal poverty level (FPL). Benefits similar to state employee health plan. No premiums for children below 250% FPL, children above 250% FPL can “buy in” and pay a monthly premium. Draws a 3-to-1 federal match as an SCHIP program.
CoverTN (75,000)	<ul style="list-style-type: none"> Limited benefit health coverage for small business employees. Monthly average premiums of \$150 to be shared equally among the individual, employer, and the state. Premiums will vary depending on age, weight, and tobacco use.
AccessTN (6,000)	<ul style="list-style-type: none"> Comprehensive health insurance for adults who can afford coverage but are deemed “uninsurable” because of a medical condition. Individuals responsible for monthly premiums capped at about 200% of the standard market rate for a similar commercial plan (premiums will range from \$273 to \$1,156, depending on age, weight, and tobacco use).
CoverRx (24,000 +/- 30%)	<ul style="list-style-type: none"> Statewide pharmacy assistance for individuals without pharmacy coverage who are below 250% FPL. Not a health insurance plan. Individual co-payments on sliding scale based on income.
ProjectDiabetes	<ul style="list-style-type: none"> Includes several programs to combat Type 2 diabetes early in life through efforts aimed at children. Provides grants to health care providers for education, prevention, and treatment of diabetes and obesity.

Source: Tennessee Department of Finance and Administration, Cover Tennessee, <http://www.covertn.gov/>.

ANALYSIS AND CONCLUSIONS

Inconsistent provider pricing practices and intermittent data collection impede the development of a comprehensive system to track indigent health care costs. Moreover, available data collection systems, such as the Joint Annual Report (JAR) compiled by the Tennessee Department of Health, must rely on self-reported, largely unaudited financial statements. Without an accountable, comprehensive system it is impossible to accurately quantify total indigent health care costs in Tennessee. Additionally, the lack of such a system makes it difficult to gauge the effectiveness of public resources dedicated to health care and to negotiate for increased federal assistance in reducing indigent care costs.

Tennessee lacks a system to accurately quantify indigent health care costs.

Hospital pricing practices vary widely among facilities and by patient type. In addition, the gross charges contained in the Joint Annual Report of Hospitals (JAR) offer little value in quantifying indigent care costs. Thus, any statewide calculation of indigent care expenses will be inexact.

Hospitals generally have two sets of prices: gross charges and net prices. Hospitals apply the gross charge to every patient; however, insurers negotiate deep discounts well below these charges to arrive at a net price. In 2004, for instance, insurers and patients paid about 38 percent of gross charges to U.S. hospitals.²⁰ Unless a hospital has a special pricing strategy for uninsured patients, hospitals typically charge the uninsured the full amount of the gross charge. As a result

of this pricing system, “hospitals frequently charge uninsured patients two to four times what health insurers and public programs actually pay for hospital services. Nationally, only about one quarter of low-income uninsured adults (those with incomes under 200 percent of the poverty line) report they have received care for free or at reduced rates in the past year.”²¹

Ultimately, a hospital’s net price for a single procedure differs significantly depending on a patient’s payer. In general, private insurance carriers reimburse hospitals above the estimated “cost” of a procedure while public programs and the uninsured reimburse below cost (see page 11 for discussion of uninsured hospital reimbursement). Thus, hospitals rely on privately insured patients to subsidize the cost of care for the publicly insured and the uninsured. Exhibit 8 illustrates the wide-ranging reimbursement provided to hospitals by different types of payers for the same procedure.

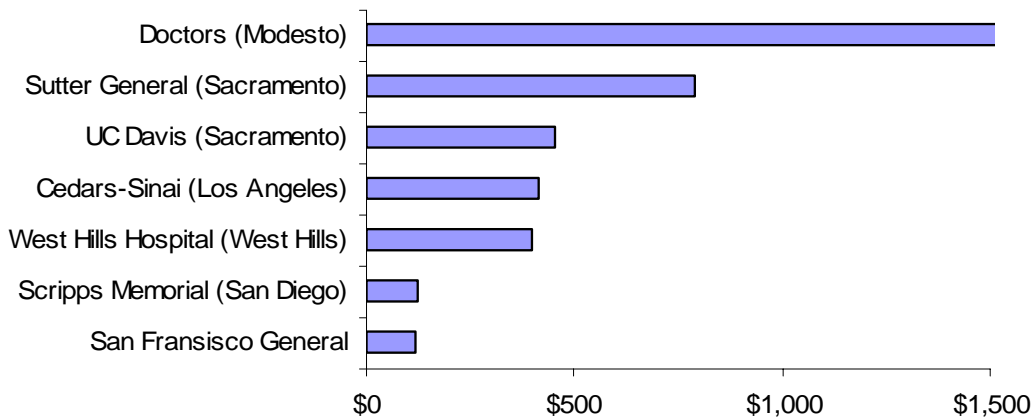
Exhibit 8: Estimated Percent of Average Cost and Charge Reimbursed to Tennessee Hospitals by Payer Type for a Diagnostic Radiology Procedure, 2005

Payer	% of Cost Reimbursed	% of Charge Reimbursed
Commercial	136.91%	49.93%
BlueCross BlueShield	127.29%	47.94%
Medicare	93.33%	33.22%
Self-pay (uninsured)	66.86%	23.85%
TennCare	66.58%	24.74%
Weighted Average	98.44%	35.66%

Source: Office of Research calculations based on data provided by the Tennessee Hospital Association.

In addition to varying prices for different patients, gross charges also differ significantly among hospitals. Hospitals have traditionally considered their chargemasters, or the list of gross charges for every service provided by the hospital, to be proprietary information. However, a 2004 California law required that every hospital in the state open its books so that uninsured patients could compare charges. Exhibit 9 lists the gross charges for a standard chest x-ray from selected California hospitals.

Exhibit 9: Gross Charges for a Chest X-Ray at Selected California Hospitals, 2004



Source: Luvette Lagnado, “Medical Markup: California Hospitals Open Books, Showing Huge Price Differences,” *Wall Street Journal*, Dec. 27, 2004, A1.

To determine their gross charges hospitals may use wide-ranging discretion—no uniform hospital accounting system exists. In fact, describing hospital accounting practices, William McGowan, chief financial officer of the University of California, Davis, Health System told the Wall Street Journal, “There is no method to the madness.”²² This lack of any uniform hospital accounting practices significantly impedes the accurate calculation of actual indigent care expenses. Subsequently, available data collection systems such as the JAR must rely on self-reported, unaudited financial statements. In addition, when hospitals fail to collect the entire gross charge from an uninsured patient, hospitals report in the JAR the difference between the payment and the gross charge as indigent care, not the difference between the payment and actual cost. This further distorts any assessment of total indigent care expenses.

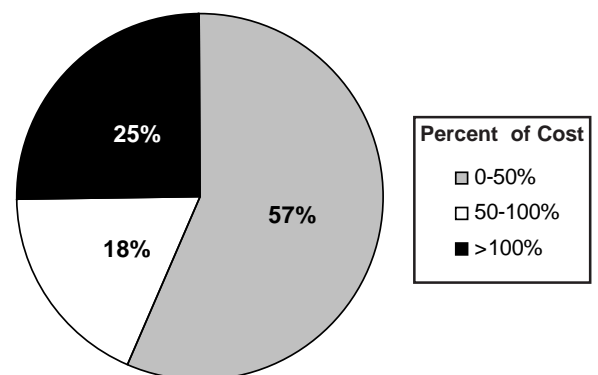
Hospital pricing practices adversely affect the uninsured in Tennessee

Though hospitals typically bill the uninsured the gross charge instead of the net price, the uninsured can rarely afford to pay the full gross charge. Hospitals often contract with collection agencies to recoup as much of the charge as possible, negatively affecting the credit scores of those contacted. A Kaiser Commission survey found that collection agencies had contacted 23 percent of the uninsured within the last year. Moreover, 23 percent of the uninsured report spending less on basic needs such as food and heat in order to pay medical bills, compared with nine percent of insured individuals.²³ In some cases, the amount paid by uninsured patients even exceeds the estimated cost of their care. Exhibit 10 illustrates how an estimated 25 percent of uninsured patients on average reimbursed Tennessee hospitals beyond the cost of a diagnostic radiology procedure.

To protect uninsured individuals from these pricing practices, in 2005 the General Assembly placed limits on the amount hospitals can charge uninsured individuals. TCA §68-11-262 states that hospitals “shall be prohibited from requiring an uninsured patient to pay for services in an amount that exceeds one hundred fifty percent (150%) of the average commercial health insurance reimbursement for the services provided.” The section states that the departments of Finance and Administration, Commerce and Insurance, and Health are supposed to promulgate rules to this effect, however, none have begun the rulemaking process. Still, the Tennessee Hospital Association states that hospitals are aware of and are in compliance with this law.

California and New York passed laws effective January 2007 that are stricter than Tennessee’s charge limits.²⁴ The California law requires hospitals to provide discounted services and/or charity care to individuals at or below 350 percent of the federal poverty level as a condition of licensure. New York sets the bar at 300 percent of the federal poverty level, and hospitals must comply to receive nearly \$850 million from the state’s indigent care pool. Both states require hospitals to disclose understandable charity care and discounted service policies to patients.

Exhibit 10: Estimated Percent of Self-Pay Patients who Paid Specified Percent of Cost at Tennessee Hospitals for a Diagnostic Radiology Procedure, 2005



Note: “Estimated Percentage of Patients who Paid Specified Level of Cost” based on weighted hospital-specific average reimbursements to 112 Tennessee hospitals. Costs and payments do not account for other costs and payments for services delivered during a patient’s visit, which may or may not on average be equal. Hospital costs and revenues estimated based on JAR data and the Tennessee Hospital Association’s Health Information Network.

Source: Office of Research calculations based on data provided by the Tennessee Hospital Association.

Tennessee state and local governments generally do not collect specific indigent care expenditure data.

The only government sources of indigent care data currently available include the JAR and budget schedules for relevant programs such as the Safety Net. (See page 15.) However, as described above, because of hospital accounting practices JAR data cannot accurately portray actual indigent care expenditures, nor is the JAR designed to report local government contributions intended specifically for indigent care.

Finding from Survey of County Governments: Most county governments do not track indigent care expenses within their counties.

While some county governments that directly fund public hospitals can report indigent care expenses for their hospitals, they do not have data collection systems to track total county-wide indigent care costs. These counties include Carroll, Davidson, Knox, Perry, Shelby, and Williamson.

Obion County operates an indigent care trust fund and provided indigent care cost estimates based on an audit of the fund. Beyond these, no county reported the ability to track indigent care costs incurred by public or private providers (see Appendix C).

Though perhaps more tangible than the JAR, budget data on the Safety Net and Cover Tennessee still do not accurately represent state expenditures for indigent care. The figures included in this report for these programs do not necessarily cover the actual cost of providing care for enrollees, some of whom are arguably not even “indigent.” That is, the budgeted amount for CoverTN mainly includes only the state’s contribution to insurance premiums also shared by individuals and their employers. Individuals who enroll in this program may or may not be considered indigent, so determining the portion of the CoverTN budget that will cover truly indigent persons is not possible. Furthermore, Safety Net budget data do not necessarily represent actual costs of care either. For instance, budget information for the case management effort, which seeks to link individuals in need of care with providers willing to treat them at free or reduced cost, reveals only the cost of brokering the care and not the provision of that care.

The lack of accurate data impedes the state’s ability to effectively target public resources at indigent health care and may hamper state efforts to negotiate increased federal matching funds.

Without a strategic effort to accurately quantify indigent care costs, the state is now pursuing programs such as Cover Tennessee at a disadvantage. Expanding health care coverage is one of the main options for reducing indigent health care costs, and while reducing such costs is not one of the explicit goals of Cover Tennessee, the initiative remains the principal option available to Tennessee to reduce indigent care costs. Yet, at this point the state has no way of knowing the effect of Cover Tennessee on statewide, much less local, indigent care costs. By demonstrating that Cover Tennessee could reduce federal health care spending in Tennessee, the state could increase its bargaining power should it choose to pursue federal matching funds for Cover Tennessee or any other health care initiative.

Total indigent health care costs in Tennessee likely exceed \$600 million. State and local government expenditures for indigent care likely exceed \$300 million.

Indigent care costs and government expenditures are very difficult to measure. The lack of a comprehensive uniform data system, the nature of health care accounting, and the fragmentation of the health care system complicate any effort to aggregate these figures. In addition, government expenditures are rarely earmarked explicitly for indigent care, though many government programs likely treat individuals

who are indigent. Therefore, this section lists indigent care costs and government expenditures from the best available sources, but it also discusses the limitations of each source.

Indigent Care Costs

Federally Qualified Health Centers (FQHCs)

FQHCs are not-for-profit or public clinics that meet rigorous federal standards and receive annual federal grants. There are 23 FQHC grantees with 108 sites in Tennessee.²⁵ Fifteen of these sites also serve as county health departments. Federal law, *42 United States Code § 254b*, requires FQHCs to serve either a Medically Underserved Area (MUA) or a Medically Underserved Population (MUP). FQHCs must also offer sliding scale discounts based on income and family size to uninsured patients, officially termed “self-pay” patients. Over half of all FQHC patients in Tennessee are below 100 percent FPL. Because FQHCs treat a disproportionate share of self-pay and Medicaid patients, federal law stipulates that Medicare and Medicaid reimburse FQHCs based on net cost instead of standard Medicare and Medicaid rates, which typically fall below net cost. Other benefits enjoyed by FQHCs include medical malpractice coverage through the Federal Tort Claims Act, eligibility to purchase prescription and non-prescription medications at reduced cost through the 340B Drug Pricing Program, and enhanced physician education loan repayment.²⁶

The main source of FQHC indigent care costs stem from sliding scale discounts provided to qualifying self-pay patients. While not a perfect measurement of indigent care costs, these discounts represent uncompensated costs that must be recouped in other areas. Moreover, despite discounted services, some self-pay patients still fail to pay, resulting in bad debt. The Bureau of Primary Care in the federal Health Resources and Services Administration administers the FQHC program and collects appropriate data each year through the Uniform Data System (UDS). Thus, data on FQHCs are fairly comprehensive and accurate. Based on the figures contained in the UDS 2005 Aggregate Reports, FQHCs in Tennessee recorded \$23,503,586 in uncompensated costs.

Exhibit 11: Uncompensated Indigent Care Provided to Self-Pay Patients in Federally Qualified Health Centers, Calendar Year 2005

Percent Self-Pay Patients	34.8%
Sliding Scale Discounts	\$22,174,742
Bad Debt	\$1,328,844
Total	\$23,503,586 *

*Of the 108 FQHC clinics, 15 are operated by county health departments, thus some crossover exists between indigent care costs reported for FQHCs and county health departments.

Source: U.S. Health Resources and Services Administration, Bureau of Primary Care, Uniform Data System, 2005.

County Health Departments

The Bureau of Health Services (BHS) in the Tennessee Department of Health (TDH) administers the state’s network of county health departments. In partnership with 89 rural county governments, BHS has direct co-operational authority over most of the network but oversees contracts with the remaining six “metro” counties. Like FQHCs, the 89 rural health departments offer sliding scale discounts based on income. Of note, nearly three-quarters of patients at these rural clinics are self-pay. Also similar to FQHCs, discounted fees for self-pay patients represent by far the largest indigent care expense. Again, these discounts represent costs that must be recouped by other areas or by state government funding. Based on figures reported by BHS, uncompensated costs in the 89 rural counties totaled \$23,183,434.

Because BHS contracts with the metro health departments to provide services, Office of Research staff contacted the metro health departments directly to obtain their indigent care costs. Each metro health department does not derive these costs consistently, though these costs mostly represent sliding scale discounts based on income for services provided to self-pay patients.

The sliding scale discounted services provided by county health department clinics may represent matchable state and local government expenditures. If included in the state’s certified public expenditure (CPE) program, these costs would count as the state’s match towards

Medicaid spending, drawing federal reimbursement at the FMAP matching rate (see page 17 for a discussion of CPE). Additionally, since some county health departments are FQHCs, these clinics are able to utilize the many benefits of the FQHC program. There may be further opportunities for county health department clinics to join existing FQHC grantee networks and thus leverage the benefits of FQHC status.

Exhibit 12: Uncompensated Indigent Care Provided to Self-Pay Patients in Rural County Health Departments, FY 2006

Percent Self-Pay Patients	34.1%
Sliding Scale Discounts	\$23,180,904
Bad Debt	\$2,530
Total Indigent Care	\$23,183,434 *

*Of the 89 rural health departments, 15 are FQHCs, so some crossover exists between indigent care costs reported for rural health departments and FQHCs.

Source: Tennessee Department of Health, Bureau of Health Services.

Exhibit 13: Uncompensated Indigent Care Provided to Self-Pay Patients in Metro County Health Departments, FY 2006

Davidson	\$1,472,100
Hamilton	\$2,815,900
Knox	\$1,365,000
Madison	\$6,306,000
Shelby (FY 2005)	\$9,500,000
Sullivan	\$2,400,000
Total	\$23,859,000

Source: Appropriate county financial officers.

Hospitals

Hospitals represent the largest source of indigent care costs of all providers. Unfortunately, the nature of hospital accounting impedes an accurate determination of total indigent care costs (see pages 9-11). Still, the TDH Division of Health Statistics compiles the most comprehensive source of hospital data currently available through the Joint Annual Report (JAR). JAR data is not audited, though each hospital CFO is now required to sign off on his or her hospital's report. Hospitals also initially report indigent care cost information to TDH in the form of gross charges, so an estimation technique is required to determine each hospital's indigent care net costs.²⁷

In addition to general accounting concerns raised by the JAR methodology, many hospitals find it difficult to comply with the indigent care cost reporting definitions stated in *TCA* §68-1-109 (for definitions see page 1). These definitions require hospitals to determine an individual's income and ability to pay, which hospital administrators say consumes needless resources. As a result, when reporting information for the JAR, many hospitals combine charity care with medically indigent care. In the 2005 JAR, for instance, only 31 of 169 hospitals reported uncompensated costs for "medically indigent" persons. It is very likely that almost all—if not all—hospitals during this time treated individuals who meet the *TCA* definition of medically indigent. Thus, because of inconsistent reporting, the costs of charity care and medically indigent care as reported in the JAR are combined in this report.

Exhibits 14 and 15 denote uncompensated gross charges and net cost figures, respectively, for Tennessee hospitals as reported in the 2005 JAR. Because of the ambiguity and frequent exaggeration associated with gross charges presented in Exhibit 14, Exhibit 15 offers a more accurate picture of the financial burden shouldered by hospitals for indigent care.

Exhibit 14: Uncompensated Gross Charges Reported in the 2005 Joint Annual Report of Hospitals

Total Charity & Medically Indigent	\$619,021,997
Total Bad Debt	\$844,765,663
Total	\$1,463,787,660

Source: Tennessee Department of Health, Division of Health Statistics, Joint Annual Report of Hospitals, 2005.

Exhibit 15: Uncompensated Average Costs Estimated from the 2005 Joint Annual Report of Hospitals

Total Charity & Medically Indigent	\$184,680,423
Total Bad Debt	\$306,390,529
Total	\$491,070,952

Source: Tennessee Hospital Association.

Indigent Care Government Expenditures

Many state and local government programs support indigent health care. Yet, government officials cannot determine what portion of these programs' budgets eventually reaches indigent persons. For instance, government programs in Tennessee help provide insurance to the otherwise uninsured, help coordinate free care for the uninsured, and/or subsidize public providers who typically offer a lot of indigent care. None of the following state and local government expenditures can be framed unequivocally as indigent care expenditures, however each program in some way contributes to the health care of Tennessee's low income, disabled, or mentally ill citizens.

The Safety Net

Throughout 2005 TennCare disenrolled over 170,000 people. In an effort to catch these individuals and transition them to other sources of care, the Department of Finance and Administration (F&A) established the Safety Net in partnership with the Department of Health and the Department of Mental Health and Developmental Disabilities. Major initiatives within the Safety Net included prescription drug assistance, expansion of county health department primary care capacity, and case management to match individuals in need with providers willing to offer free care. While some elements of the Safety Net, such as increased staffing at county health departments, will continue, F&A intended for most initiatives to transition into Cover Tennessee or become obsolete.

Expenditures for the Safety Net do not necessarily disclose specific indigent care costs. For example, capacity building grants to primary care providers, whether state or privately administered, represent just that—the cost of increasing capacity for primary care providers. Part of these funds will allow services for increased numbers of indigent patients, but part will expand capacity for non-indigent patients. It is impossible to determine precisely how much indigent care the Safety Net has actually provided or made possible. However, in general Safety Net expenditures have been targeted toward programs aimed at disproportionate numbers of low income, disabled, or mentally ill persons.

Exhibit 16: Safety Net Actual State Expenditures at Program Maturity, FY 2006

Finance and Administration	\$36,638,100
Mental Health & Developmental Disabilities	\$6,545,372
Department of Health	\$23,993,067
Total	\$67,176,539

Source: Tennessee Department of Finance and Administration.

Fiscal year 2006 represented the height of Safety Net activity and state spending. Prescription drug assistance accounted for nearly \$32.5 million. Capacity building grants to county health departments and mental health clinics totaled \$23.8 million. Other significant expenditures included \$5.3 million in grants to FQHCs and \$1.3 million for drug case management of individuals with severe and persistent mental illness (SPMI).

While most Safety Net programs will expire once Cover Tennessee becomes fully operational, F&A estimates that at least through fiscal year 2009 the Safety Net will continue to account for about \$41.6 million in annual spending. Most of these expenditures will support increased clinic capacity in county health departments, mental health clinics, and FQHCs. According to Department of Health (TDH) officials, the Department has practically maximized federal matching funds for all current TDH programs. However, these new Safety Net expenditures are not drawing a federal match and therefore present a potential opportunity for new federal revenue.

Cover Tennessee

Cover Tennessee is the umbrella name for five new health care initiatives being implemented by the Department of Finance and Administration. Of these, as an SCHIP program only CoverKids is slated to receive any federal funding. All budget figures reported for Cover Tennessee are state dollars. Excluding Project Diabetes, which is largely an educational outreach program, the programs offer voluntary membership. Thus, it is misleading to present budgeted funds for these programs until they reach membership maturity. To more accurately illustrate the state's anticipated expenditures for Cover Tennessee, Exhibit 17 presents the fiscal year 2009 projected budget and maximum enrollment made possible by state expenditures.

Similar to the Safety Net, it is difficult to attach all expenditures for Cover Tennessee specifically to indigent health care. For example, participants in Project Diabetes may or may not have

insurance, and not all CoverTN participants are likely to be considered "indigent." Still, Cover Tennessee is reducing indigent care costs by providing limited health care coverage to low-income employees who otherwise might lack coverage, and directly subsidizes prescription drug costs for other low-income individuals. Since it is impossible to determine what portion of the Cover Tennessee budget will be spent on behalf of indigent persons, Exhibit 17 presents the total projected budget schedules as reported by the Department of Finance and Administration.

Once enrollment in Cover Tennessee fully matures, F&A estimates the state's combined spending on Cover Tennessee and the ongoing portions of the Safety Net

Exhibit 17: Cover Tennessee Projected Budget at Projected Membership Maturity, FY 2009²⁸

	Projected Enrollment at Maturity	Projected Budget
Project Diabetes	N/A	\$7,000,000
Cover RX	24,000 +/- 30%	\$16,959,400
Access TN	6,000	\$23,049,200
Cover Kids	40,400	\$35,000,000
Cover TN	75,000	\$57,000,000
Total	~145,400	\$139,008,600

Source: Tennessee Department of Finance and Administration, Division of Insurance Administration

will exceed \$180 million annually, each program largely unmatched by the federal government except for CoverKids.

Local Government Expenditures for County Health Departments and Public Providers

Local government contributions to county health departments offer a proxy for how much local governments are spending on public health care programs, portions of which serve indigent populations. Thus, local government funding to county health departments is not a true illustration of local government expenditures for indigent health care, but it does offer an idea of the health care burden faced by local governments. In fact, Tennessee's local governments share this

burden disproportionately. While Davidson and Shelby counties fund large subsidies to public providers in their communities, Hamilton County provides a significantly smaller subsidy by proportion. Davidson and Shelby counties are under no legal requirement to continue providing these subsidies but face pressure to do so.

Exhibit 18: County Government Appropriation to County Health Departments, FY 2007

89 Rural Counties (FY 06)	\$9,539,743
6 Metro Counties	\$92,486,149
Davidson	\$35,561,700
Hamilton*	\$9,091,249
Knox	\$30,369,735
Madison	\$1,203,600
Shelby	\$12,307,000
Sullivan	\$3,952,865
Total	\$102,025,892

*The Hamilton County Department of Health's FY 2006 budgeted expenses for the department were \$18,660,200. The Hamilton County government provided 48.72% of this funding, which is the amount listed above.

Source: Tennessee Department of Health, Bureau of Health Services, and appropriate county financial officers.

Exhibit 19: Largest Local Subsidies to Safety Net Hospitals, FY 2006

The Med (Memphis)	\$24,367,000
Metro General (Nashville)	\$31,429,159
Erlanger (Chattanooga)	\$3,000,000

Source: Appropriate hospital financial officers.

In addition, particularly for the rural counties, local funds for county health departments are largely providing in-kind space and paying capital costs. Most operational funds for county health departments come through the TDH Bureau of Health Services.

Finding from Survey of County Governments:

County governments do not earmark funds specifically for indigent care. Other than to provide health care for inmates, no county earmarks general funds specifically to compensate providers for indigent care. Some counties, such as Shelby and Davidson, appropriate large subsidies to public hospitals and clinics. Yet, these funds cannot be traced through each clinic and hospital's accounting system to determine what portions of these subsidies go to indigent care. However, these funds substantially increase the capacity to treat more indigent patients (Appendix C).

Certified Public Expenditure (CPE) is the uncompensated cost incurred by public hospitals associated with TennCare enrollees and those eligible but not enrolled (EBNE) in TennCare. Federal law allows states to use CPE to leverage federal Medicaid matching funds. Tennessee's CPE matching methodology determines federal funding to be the sum of unreimbursed TennCare costs plus 96 percent of all charity, medically indigent, and bad debt costs in public hospitals as reported in the JAR multiplied by the federal match rate. More simply stated:

A proposed federal rule could result in reduced Certified Public Expenditure funding from the federal government.

$$(\text{unreimbursed TennCare} + 96\% \text{ of indigent care}) \times \text{FMAP} = \text{federal CPE revenue}$$

Federal CPE revenue has contributed an average of \$220 million to the TennCare budget during fiscal years 2000-2006. The state is then able to use federal CPE revenue as the state match to draw down additional federal funds to help fund TennCare.

A proposed federal rule would significantly reduce Tennessee's federal CPE revenue by strictly defining which hospitals are eligible to generate CPE.

TennCare officials estimate that a proposed rule by CMS, CMS-2258-P, could result in an approximately \$200 million - \$250 million shortfall in the TennCare program. Other states expect similar revenue losses as well.

While this rule would fundamentally restructure the financing of Medicaid in possibly every state, it would affect TennCare primarily in three ways.

- First, it would clarify that the only hospitals allowed to draw a federal match through the CPE process are "government-owned." Currently, states have fairly broad discretion to determine which hospitals may generate CPE. TennCare officials estimate that the proposed rule would reduce the number of CPE-eligible hospitals from 25 to possibly one (Nashville's Metro General) and also reduce participating nursing homes from 20 to as few as seven.
- Second, in the case that a hospital is not government-owned, the proposed rule would base federal CPE revenue on the amount of funding specifically appropriated for Medicaid services by local governments. Local governments make no such appropriations at this time.
- Third, it would require more stringent accounting regulations for documenting CPEs. Currently the state is able to use financial data from the JAR to leverage federal CPE revenue. Left unchanged, this practice would likely fail to comply with the proposed rule, which would require "that a CPE must be supported by auditable documentation" and "demonstrate the actual expenditures incurred by the contributing unit of government in providing services to Medicaid recipients or in administration of the State plan."²⁹

A number of organizations have expressed opposition to this proposed rule, including the National Governor's Association, the National Association of Public Hospitals and Health Systems, the American Hospital Association, and the National Association of State Medicaid Directors. If finalized, the proposed rule will go into effect September 1, 2007.

The state and the federal government are currently finalizing the provisions of Tennessee's extended 1115 waiver.

TennCare and CMS have agreed upon a new 1115 waiver, which is now awaiting approval from the federal Office of Management and Budget. Though negotiations are ongoing, the proposed waiver language would modify the CPE formula to include all expenditures incurred by government operated hospitals for TennCare enrollees and uninsured patients. According to TennCare officials, this would eliminate the "96 percent" component of the state's current CPE methodology, possibly increasing the state's potential federal CPE revenue. Current language also allows the state to continue to define which hospitals are eligible to generate CPE.

However, the proposed waiver language would also require the state to document CPEs from a CMS approved source no later than July 1, 2008, a change that could possibly reduce federal funding. TennCare officials believe that CMS will likely require this documentation to come from the Medicaid section of the Medicare cost report instead of from the JAR; hospitals are currently not required to complete the Medicaid section. TennCare officials predict that this change in methodology would reduce federal funding but are unsure of the amount.

If ultimately finalized, the proposed federal rule discussed above would preempt several provisions of Tennessee's waiver, including the determination of which hospitals may generate CPE, and would require an earlier conversion to a CMS-approved source of CPE documentation.

Even if the federal government finalizes its proposed rule, the state could continue to maximize federal CPE revenue by increasing the number of government-owned health care providers and by including county health department clinics in the state's CPE program.

According to Section 1903 of the Social Security Act, states are authorized to generate a Medicaid match by using state and local government expenditures for the health care of Medicaid-eligible individuals. The costs incurred by government-owned providers in treating such individuals may be used to leverage federal CPE revenue. Therefore, by increasing the number of government-owned providers, Tennessee could likely increase its federal CPE revenue. This process could involve transferring the ownership of several not-for-profit hospitals to the state or local governments. In many cases such a transfer may not be practical, but in some instances the benefits of retaining federal CPE revenue could outweigh the drawbacks associated with the transfer.

In addition, some of the sliding scale discounted services provided by county health department clinics may also represent matchable state and local government expenditures. Though the state currently does not include county health departments in its CPE program, the state can likely use county clinics' uncompensated costs to leverage new federal CPE revenue.

Fully restoring Medicaid Disproportionate Share Hospital (DSH) payments to Tennessee will require additional federal approval and new state expenditures.

Medicaid Disproportionate Share Hospital (DSH) payments are federal matching funds intended for hospitals serving a large number of Medicaid patients. In late 2006, Congress temporarily and partially restored DSH payments to Tennessee for one year. According to the Bureau of TennCare, in fiscal year 2008 Medicaid DSH will provide about \$84 million in federal funds (matched by about \$46

million in state funds) to help cover indigent care costs incurred by Tennessee hospitals, a net increase of about \$20 million in federal funds over the current Essential Access Hospital (EAH) payment system.

Given the political challenges Tennessee's congressional representatives experienced when attempting to restore Medicaid DSH, a full restoration of Medicaid DSH payments by the federal government will likely prove very difficult. In addition, a fully restored Medicaid DSH program in Tennessee will require new state expenditures to match increased federal dollars.

Under a fully restored Medicaid DSH program, Tennessee could possibly provide hospitals up to \$420 million each year to defray indigent care costs. To reach this level Tennessee would have to contribute about \$116 million in new state funding.

The federal government caps Medicaid DSH amounts for each state. Tennessee reached its cap in the early 1990s, prompting the state to seek a way around the cap during the creation of TennCare. Ultimately, Tennessee discontinued its Medicaid DSH program in 1994 by using would-be Medicaid DSH funds to help finance coverage for the TennCare expansion population. Theoretically, this reduced hospital indigent care costs by decreasing the number of uninsured. However, given recent reductions in TennCare enrollment, indigent care costs in hospitals are expected to rise. This creates a case for restoring a full Medicaid DSH program to help providers cover the costs of treating indigent patients no longer on TennCare. The Tennessee Hospital Association predicts fully restored Medicaid DSH payments could be as much as \$420 million based on states with similarly sized Medicaid programs.³⁰

From 1998 to 2006, Tennessee operated a scaled down version of Medicaid DSH called Essential Access Hospital (EAH) payments. EAH payments are distributed based on each hospital's TennCare patient population, payer mix, and relative ability to make up unreimbursed TennCare costs. CMS capped EAH payments at \$100 million annually (\$35,292,500 in state dollars), though CMS allowed a one-year exception of \$150 million in fiscal year 2006. As an alternative to a fully restored Medicaid DSH program, maintaining a higher EAH cap may represent a more politically feasible strategy. Congressional delegations from other states are wary of giving more funds to Tennessee and consequently reducing their states' share of Medicaid DSH funds. However, a higher EAH payment cap would likely not provide as many federal dollars as a fully restored Medicaid DSH program.

Exhibit 20: Estimated New Federal and State Funding Required to Fully Reinstatement Medicaid DSH in Tennessee

Current federal allocation for EAH	\$63,710,000
Current state allocation for EAH	\$36,290,000
	\$100,000,000
New federal dollars required	\$203,872,000
New state dollars required	\$116,128,000
	\$320,000,000
Total DSH Allotment	\$420,000,000

Note: This estimate, based on information compiled by the Tennessee Hospital Association, is along the lines of Bureau of TennCare estimate of \$410,000,000.

Source: Tennessee Hospital Association. Calculations for new state and federal dollars required based on the Tennessee FY 2008 FMAP.

Medicaid represents 44 percent of all federal funds allocated to states.³¹ As health care continues to dominate public policy discussions nationwide, many states have recently sought to utilize Medicaid matching funds to finance creative expansions of health care coverage, reduce cost, increase quality, and/or improve access. States are using these federal dollars in a variety of ways. Some states, such as Arkansas and New Mexico, have used Medicaid funds to help purchase insurance for uninsured individuals. Other states, like Maine, have woven Medicaid into a comprehensive health care reform effort addressed at cost, access, and quality. Notably, these states have made significant financial investments and are subject to terms and conditions to draw federal matching funds. Yet through Cover Tennessee and other programs, the state is investing in many initiatives without acquiring the federal matching funds other states have managed to obtain for similar programs.

Unlike Tennessee, many states are using Medicaid matching funds to help finance major new health care initiatives.

Exhibit 21: Selected State Medicaid Actions

Arkansas Safety Net Benefit Program (HIFA waiver)	Subsidizes ESI coverage for up to 50,000 currently uninsured individuals with both SCHIP and Medicaid funds. Employer participation voluntary. Individual premiums will not exceed \$15 and out-of-pocket payments per year will not exceed \$1,000.
California Safety Net Care Pool (1115 waiver)	Provides \$766 million per year to reinforce the state's safety net providers and to cover the uninsured. The state's match comes from certified public expenditures (CPE) from public providers and allowable intergovernmental transfers (IGT).
Florida Medicaid Reform (1115 waiver)	Preserves \$1 billion in a Low Income Pool to provide services to the uninsured and underinsured. The waiver also replaces Medicaid defined benefits with defined contributions and allows managed care plans to set the scope, duration, and level of benefits.
Kentucky KyHealth Choices (DRA)	Separates Medicaid enrollees into four tiers of benefits: standard Medicaid population, children, individuals with mental illness, and individuals needing long-term care.
Maine Dirigo Health Plan (1115 waiver, comprehensive reform)	Uses Medicaid funds and a reduction in indigent care costs to help finance comprehensive health care reform aimed at delivering near-universal coverage. Implements a state health plan and focuses on cost containment.
New Mexico State Coverage Initiative (HIFA waiver)	Subsidizes insurance coverage for up to 40,000 currently uninsured individuals with SCHIP funds, including individuals without children. Individual premiums range from \$20 to \$35 depending on income, and co-payments apply.
New York Federal-State Health Reform Partnership (1115 waiver)	Provides \$1.5 billion in federal funding over five years to increase efficiency of New York's health care system by reducing excess capacity, shifting long-term care to community and home-based settings, and establishing an electronic medical records system. Certain programmatic milestones are required to continue the federal funding.
Oklahoma Employer/Employee Partnership for Insurance Coverage (HIFA waiver)	Provides health coverage for up to 50,000 small business employees/spouses. The state, businesses, employees, and the federal government share the costs. Employee is required to contribute no more than 15 percent of their premium or 3 percent of their gross premium.
Utah Primary Care Network (1115 waiver)	Finances primary care coverage for up to 25,000 uninsured adults by applying limited benefits and cost-sharing to certain groups of Medicaid enrollees.
Vermont Medicaid Global Commitment to Health (1115 waiver)	Gives the state wide-ranging flexibility in determining benefits and enrollment for "expansion" Medicaid enrollees; subsidizes sliding-scale premium assistance for private insurance enrollees. Though the waiver imposes a cap on federal Medicaid spending, state officials estimate that the waiver will result in up to \$335 million in new federal matching funds for fiscal relief or to expand non-Medicaid health initiatives.
West Virginia Comprehensive Medicaid Redesign Program (DRA)	Medicaid enrollees who comply with behavioral standards obtain expanded benefits, and program eligibility is based on income instead of federally mandated categories.

Source: Centers for Medicare and Medicaid Services (CMS) and state Medicaid websites.

Note: To receive federal funding, state Medicaid actions authorized under a waiver require state financial participation and are subject to terms and conditions negotiated between the state and CMS.

States that have sought to expand health coverage through Medicaid have relied on several tools, including various waivers and amendments to Medicaid state plans.

The Health Insurance Flexibility and Accountability (HIFA) waiver allows states to use Medicaid and/or SCHIP funds to expand private health insurance coverage. Additionally, in 2005 Congress also granted states increased flexibility to manage their Medicaid programs through the Deficit Reduction Act (DRA). This allowed states to impose increased cost sharing arrangements and restructure benefits for certain groups of enrollees. Finally, some states continue to pursue Section 1115 waivers to use Medicaid as the funding base for creative health coverage initiatives. Exhibit 21 outlines several recent changes and additions to state Medicaid programs.

Many states have successfully leveraged federal matching funds for programs similar to Cover Tennessee and the Safety Net. CoverKids is the only Cover Tennessee program slated to receive federal funding. Tennessee could negotiate for federal funds to match current state expenditures for the remaining Cover Tennessee programs and the Safety Net.

Cover Tennessee is partly an answer to the uncontrolled cost growth formerly associated with TennCare and represents the state's long-term effort to reduce uninsurance through defined spending levels. However, of the five major programs included under the Cover Tennessee umbrella, only CoverKids, Tennessee's new SCHIP program, will receive federal matching funds. With other states already leveraging federal matching funds through Medicaid for programs similar to Cover Tennessee, the remaining programs may represent the best chance for federal matching funds.

For example, Arkansas, through its Safety Net Benefit Program, uses federal funding to help subsidize employer-based coverage. The program shares many elements with CoverTN, including a limited benefit structure and a cap on the size of employers that may participate. The program will ultimately cover up to 50,000 individuals with both SCHIP and Medicaid dollars.

Department of Finance and Administration officials expect elements of Tennessee's Safety Net to complement Cover Tennessee over the long-term. For instance, the state will annually fund \$20 million for increased county health department staffing. While these state funds currently do not draw a federal match, Utah uses Medicaid funding to provide care to uninsured individuals through the state's county health department clinics.

Exhibit 22: Key Elements of a Health Insurance Flexibility and Accountability (HIFA) Waiver Demonstration

In order to be considered a HIFA demonstration, a proposal MUST:

- Include a coverage expansion;
- Include a public-private coordination component;
- Set a goal and include a methodology for monitoring changes in the rate of uninsurance;
- Promise to meet maintenance of effort (if a state-funded program is being federalized); and
- Meet a test of budget neutrality (for Medicaid funds) or allotment neutrality (for SCHIP funds).

A HIFA proposal may NOT:

- Reduce services to mandatory Medicaid eligibles
- Provide coverage to individuals with incomes above 200 percent FPL (with certain exceptions).

Under HIFA, a state MAY:

- Reduce benefits and/or increase cost-sharing, including the ability to provide only a primary care benefit package to certain populations;
- Impose enrollment caps;
- Federalize a state-funded program (provided maintenance of effort is met);
- Use unspent SCHIP funds to finance increased coverage; and
- Divert DSH funds to finance increased coverage

Source: "Medicaid and SCHIP Waivers," State Coverage Initiatives, <http://www.statecoverage.net/matrix/waivers.htm>.

Because each state is different, each state has its own health care financing relationship with the federal government. Tennessee is in a good position to negotiate for new federal matching funds for a variety of programs.

No two states' Medicaid programs are identical. Eligibility, benefits, federal financial participation, conditions for receiving federal funds, and other financing arrangements differ. Many interviews revealed that the process of acquiring federal matching funds through Medicaid for creative health care initiatives is more of an art than a science. Yet the successes other states have experienced in acquiring federal matching funds to expand health care coverage, improve quality, and reduce cost suggest that federal monies may be available to Tennessee.

One such program may be AccessTN, the state's high risk pool under Cover Tennessee. For fiscal year 2007 the General Assembly appropriated nearly \$17 million for AccessTN as well as an additional one-time \$25 million to help leverage federal matching funds through a HIFA waiver. Yet, even with the authority from the General Assembly to apply for a HIFA waiver, the Department of Finance and Administration has refrained, citing concerns that federal funds would force the program to accept individuals outside of the original targeted population.

Exhibit 22 summarizes the key elements of acceptable state policies under a HIFA waiver. As the exhibit suggests, obtaining a HIFA waiver for AccessTN and/or CoverTN would most likely not affect the current policies of either program. However, obtaining new federal matching funds through a HIFA waiver for either program could greatly improve the benefits package, increase possible enrollment, or both, at no additional cost to the state. A resulting increase in the benefits package could likely reduce concerns recently raised by Tennessee providers about CoverTN's limited benefits and low reimbursement rates.³²

Still, obtaining new federal matching funds requires a coordinated strategy accounting for politics, policy, and data. It took Arkansas four years to win approval for its Safety Net Benefit Program. Now with a precedent in place, though, Tennessee gains increased leverage to pursue similar federal matching funds for CoverTN and AccessTN. In addition, a coordinated strategy could

Exhibit 23: Summary of New or Improved Federal Matching Opportunities for Tennessee through Medicaid

State Program Currently receives federal match	Likely Authority for Federal Match
Safety Net No	Amendment to 1115 Waiver <ul style="list-style-type: none"> ▪ Increased staffing at county health clinics ▪ Case management initiatives
CoverTN No	HIFA Waiver <ul style="list-style-type: none"> ▪ State portion of CoverTN premiums
AccessTN No	HIFA Waiver <ul style="list-style-type: none"> ▪ State premium assistance payments
Certified Public Expenditure (CPE) Yes	Section 1903 of the Social Security Act <ul style="list-style-type: none"> ▪ Proposed federal rule could reduce CPE revenue ▪ State could possibly retain federal CPE funds by <ul style="list-style-type: none"> ○ transferring hospital ownership to the government ○ including local health departments in CPE process
Disproportionate Share Hospital (DSH) payments Yes	Congressional Appropriation or CMS approval <ul style="list-style-type: none"> ▪ Pending federal approval, the state could increase its current DSH payments ▪ Other states have successfully used their DSH apportionment to help fund programs similar to CoverTN

help leverage federal funds for the remaining Safety Net programs. For example, the case management system and expanded primary care through county health departments are state revenues spent coordinating or directly providing indigent care. Through each of the above programs, the state reduces overall health care costs either by covering uninsured individuals or by finding the most efficient way to deliver care.

Ultimately, if the state can show that it is creating savings for the federal government through state-funded initiatives, the state might find opportunities for federal matching funds. Exhibit 23 summarizes opportunities for new or increased federal matching funds.

The state's health care system includes numerous public and private sector entities. In state government alone, multiple departments and agencies have a direct role in the health care of Tennesseans. These include:

- Health
- Finance and Administration
- Commerce and Insurance
- Education
- Labor and Workforce Development
- Correction
- TennCare Bureau
- Mental Health & Developmental Disabilities
- Health Services & Development Agency
- Commission on Aging and Disability
- Tennessee Commission on Children and Youth
- Division of Mental Retardation
- General Assembly

Tennessee's health care system is fragmented and lacks overarching goals.

These state government bodies are seldom involved in programmatic, goal-oriented collaboration.

Additionally, local governments, regional health councils, county health departments, hospitals, medical schools, TennCare's managed care organizations, private insurance companies, physicians, and consumers have a role in the health care of Tennesseans. Coordinating these fragments of the health care system requires a central nexus for health planning.

Tennessee has the legal basis to create a central nexus for health planning but has not.

Health planning was a function of the Health Facilities Commission and the Health Planning and Advisory Board, during 1973-2002 and 2002-2004 respectively. During these years, the state's health planning goal was to manage the growth of services and facilities by assuring that health care projects were completed in an orderly, economical manner.

In 2004 (Public Chapter 942), the General Assembly broadened the goals for health planning by creating the State Health Planning Division of the Department of Finance and Administration. This Division assumed the duties of guiding the development of and funding for health care programs and policies. According to TCA §68-11-1625, Division responsibilities include:

Creating a state health plan to

- guide program development and allocation of the state's health care resources
- coordinate health policies and programs in various state entities

Providing policy guidance by

- recommending legislation to the general assembly
- reviewing federal laws that influence the health care industry and the health care needs of Tennesseans

Assessing resources and outcomes by

- evaluating the accessibility of Tennessee's financial and geographic resources
- reviewing the health status of Tennesseans

However, the State Health Planning Division is not yet fully operational and has neither developed a comprehensive state health plan nor recommended legislation to the General Assembly.

Without state-level health planning and goals, the state makes health planning decisions in a quasi-judicial process.

The Tennessee Health Services and Development Agency regulates the expansion and modification of Tennessee’s health care industry through a Certificate of Need (CON) program. A CON is a permit for the “establishment or modification of a health care institution, facility or covered health service, at a designated location” [TCA §68-11-1602(3)]. In theory, the CON program serves as a growth management and cost savings process.

According to TCA §68-11-1602(18), the Agency is to consider the state health plan as guidance when issuing certificates of need. However, without a statewide health plan, the Agency continues to use the 2000 edition of the *Guidelines for Growth*³³ as the basis for certificate of need proposal decisions. The major criteria are need, economic feasibility, and contribution to the orderly development of adequate and effective health care.

Without statewide health goals and data, the Tennessee Health Services and Development Agency cannot accurately determine a proposal’s “need” and “contribution to the orderly development of adequate and effective health care.” Without a central nexus for statewide health planning, the Tennessee Health Services and Development Agency cannot accurately determine how each CON decision will affect the state’s health related agencies and programs, much less health outcomes. Consequently, the CON process must rely more on personal testimony and lobbyists than data.

Exhibit 24: Certificate of Need Criteria

Need	Economic Feasibility	Orderly Development
Population served, including the extent of service to Medicare, Medicaid, and medically indigent patients	Availability of less costly or more effective alternative methods of providing the intended benefits	Proposal’s relationship to the health care system (i.e. contractual agreements or affiliation with health schools)
Proposal’s relationship to existing applicable plans	Reasonableness of the proposed costs	Effects attributed to duplication or competition
Existing or certified services or institutions in the area	Anticipated revenue and the impact on existing patient charges	Availability and accessibility of human resources (i.e. consumers and providers)
Special needs of the service area population	Availability of adequate funds to the applicant	Quality of the project in relation to governmental or professional standards
Utilization/occupancy trends of area providers	Participation in state/federal revenue programs	
Reasonableness of the service area		

Source: The Tennessee Health Services and Development Agency, *Guidelines for Growth: Criteria and Standards for Certificate of Need*, 2000 Edition.

A functioning division of state government focused solely on health planning could likely help reduce health care costs and create a more efficient health care system.

Health planning incorporates far more than just the CON process. A comprehensive statewide strategy to address all facets of health could help target resources and minimize costs. Such a strategy could coordinate and inform the CON process to make the state’s health care system more efficient.

Moreover, the CON process is not integrated with the state's health policy, health needs, or health outcomes. Because the CON process relies on outdated data and arbitrary arguments, the process ultimately fails to improve health outcomes in Tennessee. Using the CON process to address health needs and improve health outcomes, however, requires a comprehensive state health plan that coordinates up-to-date data, research, and policy.

A functioning division of health planning could identify health goals for Tennessee and facilitate programmatic, goal-oriented collaboration to reduce fragmentation within the health care system. Such collaboration could help eliminate programmatic redundancies, target defined needs, and maximize federal health care funding.

Additionally, a state health plan can help control overall health care costs. One of the leading drivers of indigent care costs is the fact that many of the uninsured do not have a medical home. As a result, they often seek care in the emergency room. Yet, knowing the cost of treatment in the ER, these individuals often postpone seeking care until their conditions become unmanageable, drastically increasing the cost of treatment. Informed by research and data, a central nexus for health planning would enable policymakers to develop initiatives to target specific populations and drivers of indigent care costs. For example, these initiatives could help link the uninsured with primary care and thus reduce the overall cost of health care while improving health outcomes.

Data Warehouse: First Step in Developing a Tennessee Health Plan

Tennessee's Health Planning Division in the Department of Finance and Administration acknowledges that in order to fulfill their functions "in a timely, cost effective manner, a new decision support system such as a data warehouse application is needed to collect, organize, analyze, and report health related information."

The proposed data warehouse would include data related to population demographics, health care utilization and cost, location and capacity of facilities and personnel, and insurance coverage. This data "currently resides in a wide range of internal and external computing platforms and database structures," including multiple state agencies, BlueCross BlueShield of Tennessee, regional health information organizations, the Centers for Disease Control and Prevention (CDC), and county health departments.

Reduce Health Care Costs

Using the proposed Health Planning Division data warehouse could eliminate programmatic redundancies, thus reducing the state's health-related expenditures and enhancing the fiscal management of health care resources. Projected fiscal benefits of using a data warehouse include:

- The Health Planning Division could purchase one subscription to external health data feeds. Currently, TennCare and the Departments of Health and Mental Health each purchase subscriptions.
- A shared common data warehouse and reporting tool could minimize duplication in processing data required to submit federal reports, thus minimizing administrative expenditures.

Create an Efficient Health Care System

Projected decision-making benefits of using a data warehouse include:

- Improved access to and analysis of health cost and utilization data,
- Enhanced identification and analysis of gaps in access to care, and
- Enhanced insight on the migration and use of health care providers.

Source: Tennessee Department of Finance and Administration, "Health Planning Decision Support System Project Proposal," June 28, 2006.

Other states have launched health planning endeavors that link the Certificate of Need process, data collection, academic research, and policy analysis. Initiatives in Arkansas and Kentucky are examples of programmatic, goal-oriented collaboration.

Arkansas Center for Health Improvement (1998)

The University of Arkansas for Medical Sciences (UAMS) and the Arkansas Department of Health and Human Services (DHHS) joined efforts in response to the poor health status of Arkansas residents. The resulting Arkansas Center for Health Improvement (ACHI) links and coordinates academic personnel, health professionals, and DHHS's policy and regulatory activities in health program development and health policy analysis. ACHI's director Dr. Joseph Thompson, who functions as the state's health policy officer, was instrumental in negotiations with CMS to secure the Arkansas Safety Net Benefit Program. (<http://www.achi.net/>)

Kentucky's Office of Health Policy (2005)

Kentucky's Governor Ernie Fletcher created the Office of Health Policy in the State's Cabinet for Health and Family Services to ensure coordinated, timely, efficient and cost effective health planning and policy research. The Office consists of the Division of Certificate of Need (CON) and the Division of Health Policy Development (HPD). The CON division controls growth of unnecessary, duplicative and underused health care services. The HPD division is responsible for coordinating various health-related state government departments and collecting and analyzing statewide health data. (<http://chfs.ky.gov/ohp/>)

Tennessee recently launched a similar endeavor – the Tennessee Institute of Public Health (TNIPH).

Tennessee Institute of Public Health (TNIPH) (2006)

Partners include:

- Tennessee Higher Education Commission
- Tennessee Department of Health
- University of Tennessee System, and
- Tennessee Board of Regents System.

The TNIPH mission is to “facilitate and promote health education research, practice, and policy analysis through collaboration among public and private health organizations and higher education.”

The goal of this collaboration is to “strengthen workforce development, public health research and education, health practice, and health services.”

Created through a memorandum of understanding, TNIPH received legislative authorization through Public Chapter 42 (2007) under the umbrella of THEC. (<http://state.tn.us/tniph/>)

TNIPH brings data collection and academic research together to inform health policy. Therefore, officials of both organizations agree that, once fully operational, the functions of TNIPH and F&A's Division of Health Planning could complement one another. TNIPH could provide focused research and studies to support the state's plan development, while the state's health data warehouse could support TNIPH's research initiatives.

RECOMMENDATIONS

Legislative:

The General Assembly may wish to amend TCA §68-1-109 regarding the Joint Annual Report (JAR) of hospitals. Amendments could require JAR filings to include:

- More specific indigent care cost data
- A breakdown of state and local government revenue that includes a category for indigent care funding
- Financial data based on average and marginal costs rather than gross charges
- A consistent time period for reporting

The General Assembly may wish to require the Bureau of TennCare to provide access to all official correspondence between TennCare and the Centers for Medicare and Medicaid Services (CMS).

TCA §3-15-508(d) requires the Bureau of TennCare to submit proposed waivers and waiver amendments to the TennCare Oversight Committee for comment prior to submission to CMS. However, the Committee is not immediately privy to subsequent correspondence that could significantly alter the proposed waiver or amendment. Access to this correspondence would allow the General Assembly to better oversee the largest source of federal funds coming into the state and would give the General Assembly a more informed role in the development of a state health plan.

The General Assembly may wish to explore policies that would promote hospital pricing transparency.

Providing hospital data in forms that are accessible to the public would allow health care consumers to make more informed decisions regarding the cost and quality of their care. Once operational, the Division of Health Planning in the Department of Finance and Administration could assist the General Assembly with this initiative.

Administrative:

The Department of Finance and Administration's Health Planning Division should utilize its authority to establish and enforce a comprehensive state health plan as required by

TCA §68-11-1625. Responsibilities of the health planning division should include:

- Establishing and evaluating progress towards health care goals and action steps
- Developing and maintaining a database of appropriate statistics (i.e., number of uninsured, state and local financial information, health indicators, indigent care expenditures, etc.)
- Identifying procedures and techniques for capturing federal funds available to Tennessee for indigent care
- Advising the legislature and departments on policy decisions
- Leading collaborative policymaking efforts between federal, state, local, and private agencies
- Formulating budget requests for appropriate agencies and programs
- Coordinating health services to maximize efficient delivery of care
- Analyzing needs and services
- Creating a state health map to geographically represent health indicators, socioeconomic indicators, and health care services
- Coordinating regional planning councils

The Department of Finance and Administration's Health Planning Division should examine best practices for establishing and maintaining health care accounting standards. Such standards would improve the accuracy of JAR data and are essential for creating a reliable, transparent health care cost tracking system.

The Department of Finance and Administration should examine various options for obtaining federal funds for the Cover Tennessee initiatives. The Department may consider integrating Cover Tennessee into its Section 1115 waiver once programmatic concerns have been resolved.

The Department of Finance and Administration should continue its efforts to fully reinstate the Medicaid Disproportionate Share Hospital (DSH) program in Tennessee. If obtained, these funds could be used to help finance Tennessee's health care system in a variety of ways. For instance, some states have used DSH to help finance programs similar to CoverTN.

Under a fully restored Medicaid DSH program, Tennessee could possibly provide hospitals up to \$420 million each year to defray indigent care costs. To reach this level Tennessee would have to contribute about \$116 million in new state funding.

The Department of Finance and Administration should deliver an annual report on Cover Tennessee to the General Assembly. This report could synthesize the monthly reports the Department plans to provide the General Assembly and could offer more thorough, dedicated analysis. Such a report could include the following:

- Progress on reducing the number of uninsured Tennesseans
- Analysis of the effect on the state's private insurance market
- Program utilization data
- Analysis of participant satisfaction, adequacy of provider reimbursement rates, and adequacy of the health benefits package

The Department of Finance and Administration should explore various approaches for maintaining Certified Public Expenditure (CPE) revenue for TennCare. Given a new proposed federal rule that would significantly reduce the number of CPE-eligible hospitals in Tennessee, the Department should promptly examine the effects of transferring the ownership of newly ineligible public hospitals to state or local governments. The Department should also include county health department clinics in the state's CPE program.

The Department of Health should consider increasing the number of county health departments that qualify as Federally Qualified Health Centers (FQHCs). Currently, 16 of 89 rural county health departments are designated as FQHCs. This designation offers numerous benefits including medical malpractice coverage through the Federal Tort Claims Act, eligibility to purchase prescription and non-prescription medications at reduced cost through the 340B Drug Pricing Program, and enhanced physician education loan repayment.

See Appendices E through G for response letters from the Bureau of TennCare, the Department of Finance and Administration, and the Department of Health, respectively.

Endnotes

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- ⁹ Matthew Murray, An Economic Report to the Governor of the State of Tennessee, Center for Business and Economic Research, University of Tennessee, January 2006, accessed Feb. 22, 2006, <http://cber.utk.edu/erg/erg06sum.pdf>.
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- ¹⁵ U.S. Department of Labor, Bureau of Labor Statistics, Medical Care Inflation in 2005, June 20, 2006, accessed Feb. 22, 2007, <http://www.bls.gov/opub/ted/2006/jun/wk3/art02.htm>.
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- ¹⁸ Ibid., p. 36.
- ¹⁹ Smith, et al., p. 5.
- ²⁰ Uwe Reinhardt, "The Pricing of U.S. Hospital Services: Chaos behind a Veil of Secrecy," Health Affairs, Vol. 25, No. 1, p. 57.
- ²¹ Kaiser Commission, The Uninsured: a Primer, p. 9.
- ²² Luvette Lagnado, "Medical Markup: California Hospitals Open Books, Showing Huge Price Differences," Wall Street Journal, Dec. 27, 2004, A1.
- ²³ Kaiser Commission, "The Uninsured: a Primer," p. 8.
- ²⁴ California Public Chapter 755, <http://www.assembly.ca.gov/acs/acsframeset2text.htm>; New York CLS Pubic Health §2807-k, <http://public.leginfo.state.ny.us/menugetf.cgi?COMMONQUERY=LAWS>.
- ²⁵ Tennessee Primary Care Association, "Health Centers," accessed Jan. 15, 2006, <http://www.tnpca.org/hcenters/hcmain.html>.
- ²⁶ Rural Assistance Center, "FQHC Frequently Asked Questions," last updated August 14, 2006, accessed Jan. 15, 2007, http://www.raonline.org/info_guides/clinics/fqhcfqa.php#whatis.
- ²⁷ To determine a hospital's net costs, the Tennessee Hospital Association multiplies gross charges by a hospital's cost to charge ratio, which is the ratio of total expenses to total charges including newborns from the JAR. See further discussion of this estimation technique on page 3 of this report.
- ²⁸ Participation in CoverRx depends on the availability of other programs for mental health (SPMI) drugs. If individuals with severe and persistent mental illness can obtain their medications from another source, CoverRx will be able to offer coverage to more individuals who otherwise cannot be covered.
- ²⁹ "Medicaid Program; Cost Limit for Providers Operated by Units of Government and Provisions To Ensure the Integrity of Federal-State Financial Partnership," Federal Register, Proposed Rules, Vol. 72, No. 11, January 18, 2007, pg. 2241.
- ³⁰ Tennessee Hospital Association DSH projections through FY 2011.
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- ³³ The Tennessee Health Services and Development Agency, Guidelines for Growth: Criteria and Standards for Certificate of Need, 2000 Edition, accessed September 25, 2006, <http://www2.state.tn.us/health/statistics/PdfFiles/Guidelines%20for%20Growth.pdf>.

APPENDIX A: Public Chapter 807 (2006)

CHAPTER NO. 807

HOUSE BILL NO. 3042

By Representative Hackworth

Substituted for: Senate Bill No. 3367

By Senators Herron, Burks

AN ACT to amend Tennessee Code Annotated, Title 8, Chapter 4 and Title 9, relative to financial practices of state government.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF TENNESSEE:

SECTION 1: Tennessee Code Annotated, Title 8, Chapter 4, Part 1, adding the following language as a new, appropriately designated section:

The comptroller of the treasury is directed to determine all state and local government expenditures for care of indigent persons and all federal resources available to the state of Tennessee for such care of indigent persons. The comptroller shall report to the finance ways and means committees of the senate and the house of representatives by January 15, 2007 on procedures and techniques for capturing any federal funds available to Tennessee for indigent care. The comptroller shall also report on the likelihood of discontinuance or diminution of any federal funds for indigent care in Tennessee.

SECTION 2. This act shall take effect upon becoming a law, the public welfare requiring it.

PASSED: May 17, 2006


JIMMY RAIFEH, SPEAKER
HOUSE OF REPRESENTATIVES


JOHN S. WILDER
SPEAKER OF THE SENATE

APPROVED this 2nd day of June 2006


PHIL BREDESEN, GOVERNOR

APPENDIX B: Persons Contacted for this Report

Richard Baer Chief Operations Officer UT Medical Group	Melvin Everette Executive Director Committee on TennCare Oversight
Dr. James Bailey Division of General Internal Medicine University of Tennessee Health Science Center	Dawn Fitzgerald Chief Operations Officer QSource
Linda Bedrin Director, Healthcare Quality Improvement Program QSource	Dave Geotz Commissioner Department of Finance and Administration
Beth Berry Vice President of Government Affairs Tennessee Hospital Association	Darin Gordon Director Bureau of TennCare
James Blumstein Director, Health Policy Center Vanderbilt Institute for Public Policy Studies; Professor of Health Law and Policy, Vanderbilt University Law School	Dr. Albert Grobmyer Former CEO, QSource
Betty Boner General Counsel, Bureau of TennCare	Gregg Hawkins Assistant Director, State Audit Tennessee Comptroller of the Treasury
Gordon Bonnyman Executive Director, Tennessee Justice Center	Tere Hendricks Division of Health Statistics Tennessee Department of Health
Steve Burkett President and CEO UT Medical Group	Bruce Harrington Director of Development and CFO Christ Community Health Services
Dr. Cyril Chang Director, Methodist LeBonheur Center for Healthcare Economics; Professor of Economics, The University of Memphis	Michael D. Huggins Senior Vice President and Chief Operations Officer Tennessee Hospital Association
Dick Chapman Executive Director Division of Insurance Administration Department of Finance and Administration	Leslie Humphreys Tennessee Department of Health
Susan Cooper Former Director of the Safety Net Department of Finance and Administration	Brenda Jeter Chief Financial Officer UT Medical Group
Dean Daniel Bureau of Health Services Tennessee Department of Health	Cato Johnson Senior Vice President of Corporate Affairs Methodist Healthcare, Memphis
Dr. Jo Edwards Interim Director Tennessee Institute of Public Health	Gayle Jones Vice President of Corporate Development Qsource
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University of Tennessee Health Science Center

Theresa Lindsey
Deputy Commissioner
Bureau of Health Services
Department of Health

Alisa Malone
Director
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Department of Health

Dr. Cindy Mann, Executive Director
Center for Children and Families
Health Policy Institute
Georgetown University

David Manning, Director of Finance
Nashville/Davidson Metropolitan Government

Manny Martins
Former Director of Tennessee Medicaid and
TennCare

Tony Mathews
Chief Financial Officer
Division of Insurance Administration
Department of Finance and Administration

Kathy McLendon
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Tennessee Primary Care Association

Dr. Chuck Milligan
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Dr. David Mirvis
Department of Preventive Medicine
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Clayton Moore
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Mike Nesbit
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Methodist Healthcare, Memphis

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Tennessee Comptroller of the Treasury

Scott Pierce
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Steve Reed
Centers for Medicare and Medicaid Services

Gary Shorb
President and CEO
Methodist Healthcare, Memphis

Jim Shulman
Executive Assistant to the Commissioner
Department of Finance and Administration

Dr. Bruce Steinhauer
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The Regional Medical Center at Memphis

Shannon Tacker
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UT Medical Group

Jennifer Tolbert
Principal Policy Analyst
Kaiser Commission on Medicaid and the Uninsured

Mary Layne Van Cleave
Chief Information Officer
Tennessee Hospital Association

Burt Waller
Executive Director
Christ Community Health Services

APPENDIX C: Survey of Local Governments

To determine local expenditures for indigent care and whether county governments have mechanisms to track indigent care costs, Office of Research staff surveyed all 95 counties. The following 33 counties responded.

Benton	Hawkins	Marshall	Sequatchie
Bledsoe	Haywood	Maury	Shelby
Blount	Houston	Moore	Sullivan
Campbell	Johnson	Obion	Sumner
Carroll	Knox	Perry	Trousdale
Crockett	Lauderdale	Pickett	White
Davidson	Madison	Roane	Williamson
Grainger	Marion	Rutherford	Gibson
Hamblen			

Because of overall incomplete information and possible redundancy of reporting,^a this report does not include financial figures collected by the survey. However, survey responses indicated that:

Tennessee does not have a comprehensive system to track total indigent care costs.

Neither the state nor local governments have mechanisms for tracking indigent care costs of private and public providers. No county reported the capability to determine indigent care costs incurred by private providers. For public providers, only some counties with public hospitals reported the capability to determine such costs, notably Carroll, Davison, Knox, Perry, Shelby, and Williamson counties. Obion County operates an indigent care trust fund and provided indigent care cost estimates based on an audit of the fund. Beyond these, no county reported any ability to track indigent care costs incurred by private and/or public providers.

It is not likely that any local government in Tennessee appropriates funds specifically for indigent care.

Other than to provide health care for inmates, no county earmarks general funds specifically to compensate providers for indigent care. Some counties, such as Shelby and Davidson, appropriate large subsidies to public hospitals and clinics. Yet, these funds cannot be traced through each clinic and hospital's accounting system to determine what portions of these subsidies go to indigent care. However, these funds substantially increase the capacity to treat more indigent patients.

^a The Tennessee Department of Health keeps books for all 89 rural local health departments. To provide consistent reporting of financial information, this report relies on figures provided by the Department available on pages 13-14, 16.

APPENDIX D: Office of Research Response to Bureau of TennCare Letter

Office of Research staff met with Deputy Commissioner Darin Gordon and key Bureau of TennCare staff to discuss the report. The Office of Research made necessary technical changes as requested. However, the Office of Research and the Bureau of TennCare have some differences of opinion about the report's conclusions and recommendations. Our positions on concerns raised by the Bureau are presented below.

Lessons Learned from the TennCare Experience: In Public Chapter 807 (see Appendix A) the General Assembly directs the Comptroller of the Treasury to identify federal matching fund opportunities for indigent health care in Tennessee. Accordingly, the report takes a forward-looking approach by focusing on current federal matching opportunities available to the state.

Methodology to Determine Indigent Care Costs: Given the ambiguity involved with health care accounting, the report uses the best available information to arrive at conservative estimates of total indigent care costs and government expenditures. Hospital charges offer little value in attempting to quantify indigent care costs, but we include them to illustrate the large difference between cost-based and charge-based figures and to offer a basic illustration of the indigent health care situation in Tennessee. A statewide system for quantifying indigent health care costs as called for in the report would substantially improve the accuracy and usability of these figures.

Availability of Federal Matching Funds for Tennessee: The federal contribution to TennCare declined by approximately \$800 million as a result of TennCare Reform, bringing Tennessee back to levels comparable to other states beginning to experiment with innovations of their own. At the same time, the state is spending new money on creative health care initiatives—without a federal match.

The state is projected to spend over \$180 million on Cover Tennessee and ongoing Safety Net programs in fiscal year 2009. Yet, other than CoverKids, these initiatives largely forgo federal matching funds. Since other states are using Medicaid to finance similar health care initiatives, Tennessee stands out in not taking advantage of federal matching funds. Therefore, we see the need for an in-depth public discussion of the specific costs, benefits, and risks of obtaining federal matching funds.

Potential Exposure to Litigation: Despite repeated attempts, Office of Research staff did not receive specific information regarding the issue of litigation and federal matching funds. Furthermore, the Tennessee Justice Center has agreed that the outstanding TennCare consent decrees will not apply to AccessTN if financed by TennCare.

Tennessee's Health Care Goals: The fragmentation of Tennessee's health care system points to the lack of overarching goals that would orient all of the state's health care entities in a coordinated direction. The goal of one program cannot be an overarching goal if it does not actively work in harmony with other programs to achieve overarching objectives.

As the report discusses, a comprehensive state health plan would serve as the roadmap for reaching the state's overarching goals. For example, programs such as Cover Tennessee could prove to be even more effective if linked to the sound data, objectives, and other initiatives driven by a coordinated state health planning effort.

Yearly Assessment of Cover Tennessee: While the Department of Finance and Administration has provided multiple Cover Tennessee enrollment and program development updates to the General Assembly, the report calls for the Department to provide a more detailed yearly assessment, including:

- Progress on reducing the number of uninsured Tennesseans
- Analysis of the effect on the state's private insurance market
- Analysis of participant satisfaction, adequacy of provider reimbursement rates, and adequacy of the health benefits package

TennCare Disenrollments Contributing to Already Increasing Charity Care Costs: The report includes JAR data from 2001-2005 to illustrate the growing charity care costs leading up to TennCare Reform. Thus, the report implies that the loss of TennCare coverage to 170,000 individuals in 2005 likely contributed to additional charity care cost growth.

APPENDIX E: Response Letter from Bureau of TennCare



STATE OF TENNESSEE
BUREAU OF TENNCARE
 DEPARTMENT OF FINANCE AND ADMINISTRATION
 310 Great Circle Road
 NASHVILLE, TENNESSEE 37243

May 15, 2007

Ms. Ethel Detch
 Director, Office of Research
 Comptroller of the Treasury
 505 Deaderick Street, Suite 1700
 Nashville, Tennessee 37243-7911

RE: Report on indigent health care in Tennessee

Dear Ms. Detch:

Thank you for the opportunity to review your office's report on indigent health care in Tennessee.

We have concerns about the report and its presentation of TennCare within the overall picture of how indigent health care is, or could be, addressed in Tennessee. We believe that the report shows a lack of understanding of how the current TennCare program works and a lack of recognition of the lessons learned from the TennCare experience.

Our responses to the Conclusions section and the Recommendations section are presented below.

CONCLUSIONS

1. Tennessee lacks a system to accurately quantify indigent health care costs.

We concur. The report looks at two possible sources of information—the Joint Annual Report and hospital charges. We do not agree that hospital charges are useful for the purpose of quantifying indigent health care costs. Costs, rather than charges, are the measures that should be used to calculate these costs.

2. Total indigent health care costs in Tennessee likely exceed \$600 million. State and local government expenditures for indigent care likely exceed \$300 million.

We concur that the costs likely exceed these figures, but we do not concur with the methodology used to arrive at this conclusion. The report bases its estimates on uncompensated care reported by FQHCs and rural and urban county health departments,

uncompensated gross charges and net costs reported on the Joint Annual Report, indigent care government expenditures, expenditures associated with the Safety Net, and local government expenditures for county health departments and public providers. Each of these sources of information, as the report points out, has limitations; therefore, combining the information provided by each one is unlikely to yield a meaningful total. The report also fails to mention the UB-92 report, which includes claims-based data for hospital services, regardless of payer type.

3. A proposed federal rule could result in reduced Certified Public Expenditure funding from the federal government.

We concur, although we have some concerns about how CPE is characterized in the report. The report implies that the state uses CPE revenue as a source of state match to draw down federal dollars. A more accurate description of the process is that CPE funds are actual expenditures that have been made by local governments (which are an arm of the state) to reimburse providers for uncompensated care. The state considers these to be allowable expenditures and claims federal match on them, just as the state claims federal match on other Medicaid expenditures. The matching dollars received from Certified Public Expenditures are revenues to the state which can be spent on TennCare or on other programs. The proposed rule has the potential to significantly reduce the pool of providers available to participate in the CPE process, as well as to change the manner in which these expenditures are documented.

4. Fully restoring Medicaid Disproportionate Share Hospital (DSH) payments to Tennessee will require additional federal approval and new state expenditures.

We concur. Tennessee has not had a true DSH program since 1993, the year before TennCare began. The program that was in effect prior to TennCare made use of a provider tax to assist the state in drawing down federal funds. Rules on use of provider taxes are more restrictive now than they were in 1993, and the current federal administration has expressed interest in seeing states redirect DSH dollars to premium assistance programs for uninsured people. A significant source of state revenue would have to be found to support full restoration of a DSH program.

5. Unlike Tennessee, many states are using Medicaid to help finance major new health care initiatives.

We do not concur. It is true that many states are using Medicaid to help finance major new health care initiatives, but it is untrue that these actions are “unlike Tennessee.” TennCare is generally recognized as one of the pioneer programs in the country in capturing federal funds for indigent care.

The report implies that TennCare is bypassing opportunities to secure federal funds, while other states are moving aggressively to capture these funds. The fact is that these states are just starting to experiment with things that Tennessee has already done.

The report cites Massachusetts and Illinois as examples of states that have “used federal dollars through Medicaid as a strong base to substantially increase health care coverage,” while Tennessee and Missouri have “significantly reduced eligibility.” The clear inference here is that Tennessee is missing federal funding opportunities and therefore reducing its rolls, while other states are bringing in federal dollars to add to theirs. The

report fails to state that Tennessee could cover fewer people and still have a more generous program than most states. Prior to TennCare Reform, TennCare was covering a larger portion of the state population than any other state except Maine, which was one percentage point ahead of Tennessee. In 2003, 28% of Tennessee's population was enrolled in TennCare. Massachusetts' enrollment was 19%, and Illinois's was 17%.¹ Even after TennCare Reform, TennCare still covers about 20% of the Tennessee population.²

Tennessee was undeniably successful in expanding the percentage of our population with access to health insurance. However, we learned that ultimately the state could not finance the cost of its share of that expansion and also meet its other obligations in the areas of education, public safety, and other important public priorities.

We have also learned that gaining new federal funds does not come without an agreement to certain concessions, such as giving up DSH, as Tennessee did. When lists are made of other states' successes in developing new health care initiatives financed by Medicaid, these lists should include the concessions agreed to by these states in securing these funds.

The report should also consider the fact that the federal position regarding existing Medicaid matching arrangements is changing. As an example, legislation has been proposed that would prohibit states from using SCHIP funds to cover non-pregnant adults. There are other significant proposals "on the table" at the federal level that, if enacted, would drastically reduce the amount of federal funding available to all states, including Tennessee. The President's current budget proposal contains \$101 billion in cuts for Medicare and Medicaid; the impact of these cuts on Tennessee would be in excess of \$300 million. Such a loss would obviously have a dramatic effect on the state's ability to deliver health care to poor and needy Tennesseans.

6. Tennessee's health care system is fragmented and lacks overarching goals.

We concur that the state's health care system is fragmented, but we do not concur that it lacks overarching goals. We think the overarching goals that the Governor has stated for both TennCare and Cover Tennessee are quite clear.

When Governor Bredesen announced his plans for TennCare Reform to the General Assembly on February 17, 2004, he stated four goals:

- Fix the problem rather than passing it off to someone else, including to the federal government.
- Protect children, pregnant mothers, and the disabled.
- Eliminate fraud and abuse.
- Offer a set of benefits that we can afford.

When he announced his plans for Cover Tennessee to the General Assembly on March 27, 2006, he said that he did not want to launch another big government entitlement

¹Kaiser Family Foundation, "Medicaid Enrollment as a Percent of Total Population, 2003," accessed April 13, 2007. <http://www.kff.org>.

²This percentage was calculated using the March 31, 2007, enrollment figure of 1,204,852 and the Department of Health's estimate of Tennessee's 2007 population (6,054,830).

program but wanted to develop a plan that represented a partnership between the state, individuals, and small businesses. He articulated the following principles:

- Affordability.
- Portability.
- Identification of upfront costs and implementation of a program design to assure that costs remain firmly under state control.
- Making children a priority (CoverKids), as well as people who can't buy insurance because of pre-existing conditions (AccessTN).
- Prevention.

We have found these goals to be quite instructive in thinking about the kind of structure that the public health care system in Tennessee should have.

RECOMMENDATIONS: Legislative

- 1. The General Assembly may wish to amend TCA §68-1-109 regarding the Joint Annual Report (JAR) of hospitals.**

We concur. We believe this report could be more useful if it contained actual cost information.

- 2. The General Assembly may wish to give the TennCare Oversight Committee access to all official correspondence between TennCare and the Centers for Medicare and Medicaid Services (CMS).**

We concur that the TennCare Oversight Committee should have access to all official correspondence between TennCare and the Centers for Medicare and Medicaid Services (CMS). It should be pointed out that this correspondence is contained on the CMS website and is available for anyone to view.

- 3. The General Assembly may wish to explore policies that would promote hospital pricing transparency.**

We concur. Making hospital pricing data available to the general public would have some usefulness.

RECOMMENDATIONS: ADMINISTRATIVE

- 1. The Department of Finance and Administration's Health Planning Division should utilize its authority to establish and enforce a comprehensive state health plan as required by TCA §68-11-1625.**

We concur, although we recognize that the development and implementation of Cover Tennessee has required an enormous amount of the staff resources available to the Department of Finance and Administration. We believe that putting in place an actual program that actually delivers services to people is an effort that should take priority over developing a plan.

2. **The Department of Finance and Administration’s Health Planning Division should examine best practices for establishing and maintaining health care accounting standards.**

We concur.

3. **The Department of Finance and Administration should examine various options for obtaining federal funds for the Cover Tennessee initiatives.**

We concur, as long as these options are consistent with the overarching goals stated by the Governor. See response to Finding #6 in the “Conclusions” section.

It should be recognized that federal dollars are not “free”—they must be matched by state dollars. Any federal funds that can be tapped will require state matching dollars, as well as some concessions on the part of the state.

An important point not stated in the report is that the use of federal funds increases the state’s exposure to litigation. When a state agrees to accept federal funds, the state must also agree to accept all of the federal statutory and regulatory requirements that go along with those funds. TennCare is an entitlement program. As an entitlement program with federal financial support, TennCare has been the subject of several lawsuits that have been far-reaching and expensive. We have seen that the federal courts are inclined to impose a wide variety of onerous mandates on TennCare, some of which are directly contrary to the concepts of enrollee responsibility and managed care principles that are characteristic of more traditional insurance programs. The Cover Tennessee programs have been specifically set up not to be entitlement programs. To decide not to accept federal funds because of the litigation risk involved is a reasonable policy position for the state to take, given its history with TennCare and class action lawsuits.

4. **The Department of Finance and Administration should continue its efforts to fully reinstate the Medicaid Disproportionate Share Hospital (DSH) program in Tennessee.**

We concur, as long as there is funding that can be made available for the program, since it will require significant new revenues.

5. **The Department of Finance and Administration should deliver an annual report on Cover Tennessee to the General Assembly.**

We defer comment to the Department of Finance and Administration. It should be noted that regular reporting of the status of the Cover Tennessee products to the General Assembly has occurred in multiple meetings to date.

6. **The Department of Finance and Administration should explore various approaches for maintaining Certified Public Expenditure (CPE) revenue for TennCare.**

We concur, although we believe the suggestion offered with this recommendation to transfer the ownership of newly ineligible public hospitals to state or local governments is impractical.

7. The Department of Health should consider increasing the number of county health departments that qualify as Federally Qualified Health Centers (FQHCs).

We concur, although we believe that the Department of Health has already made attempts in this area. It is our understanding that the state and local control of county health departments is an issue for the federal Bureau of Primary Health Care in the Health Resources Service Administration (HRSA) and CMS. Generally, FQHCs operate under independent boards.

ADDITIONAL COMMENT:

The report draws conclusions about how TennCare disenrollments have affected increasing health care costs by using data for a period of time before the disenrollments took effect.

There is a statement that “TennCare disenrollment likely contributed to increasing health care costs. . . .” The statement is supported by JAR data from 2001-2005 that was said to show that charity care was growing during that period. It should be noted that this period was pre-TennCare Reform and so would not have been representative of what happened after TennCare disenrollments occurred. If anything, these facts suggest that TennCare’s expanded coverage did little to reduce the growth trends for indigent care.

The discussion of disenrollments that have occurred at particular points in time treats these as though they were all the same. That is not true. The disenrollments that occurred in 2002 were disenrollments of people who were determined not to meet the eligibility criteria for the program; the reason so many were disenrolled in one year was that the state had been enjoined from disenrolling these people for several years previously because of the *Rosen* lawsuit. The disenrollments that occurred in 2005 were caused by the elimination of certain non-Medicaid categories, which was part of TennCare Reform.

As always, we are available to discuss in more detail any questions you may have regarding these very complicated issues as they relate to TennCare.

Sincerely,



Darin J. Gordon
Deputy Commissioner

APPENDIX F: Response Letter from the Tennessee Department of Finance and Administration



STATE OF TENNESSEE
 DEPARTMENT OF FINANCE AND ADMINISTRATION
 DIVISION OF INSURANCE ADMINISTRATION
 312 Eighth Avenue North
 Suite 2600 William R. Snodgrass Building
 Nashville, Tennessee 37243-0287
 Phone (615) 253-2861 Fax (615) 253-8556

DAVE GOETZ
 COMMISSIONER

LAURIE LEE
 DEPUTY EXECUTIVE DIRECTOR

May 22, 2007

Ms. Ethel Detch
 Director, Office of Research
 Comptroller of the Treasury
 505 Deaderick Street, Suite 1700
 Nashville, Tennessee 37243-7911

RE: Report on indigent health care in Tennessee

Dear Ms. Detch:

Thank you for the opportunity to review your office's draft report on indigent health care in Tennessee. We have focused our comments on sections related to Cover Tennessee and Health Planning and have referenced the TennCare Bureau's response dated May 15, 2007.

ANALYSIS AND CONCLUSIONS

1. Tennessee lacks a system to accurately quantify indigent health care costs.

We agree with this statement and with TennCare's suggestion that one should use hospital costs, rather than charges, to calculate indigent health care costs.

From a planning perspective, having a consistent, widely used method to quantify indigent health care costs would help gauge the amount (not necessarily the effectiveness) of public resources dedicated to indigent care. This would assist in developing policies that address the issue of providing access to the uninsured and underinsured.

2. Total indigent health care costs in Tennessee likely exceed \$600 million. State and local government expenditures for indigent care likely exceed \$300 million.

No additional comment.

3. Recent TennCare reforms and a proposed federal rule increase Tennessee's risk of losing Certified Public Expenditures funding from the federal government.

No additional comment.

4. Fully restoring Medicaid Disproportionate Share Hospital (DSH) payments to Tennessee will require additional federal approval and new state expenditures.

Page 1

No additional comment.

5. Unlike Tennessee, many states are using Medicaid to help finance major new health care initiatives.

We agree with TennCare's comments.

As noted in the report, the CoverKids program will receive a federal match through the SCHIP program. As we are in the first few months of program startup for all programs, our focus is on making sure the program operations are in place and that we have a solid foundation for further program development before pursuing other funding options that may require program design changes.

The State has not ruled out the potential to seek federal funds for the CoverTN or AccessTN programs in the future. In fact, in the Governor's remarks to the General Assembly on March 27, 2006 regarding the Cover Tennessee programs, the Governor specifically addresses this possibility:

"Cover Tennessee starts out as a Tennessee initiative, but there is the possibility of later federal participation as well. I've described what we're seeking to do to Health and Human Services Secretary Leavitt — we've talked as recently as last Friday — and he is encouraging and actively considering how the federal government might join the partnership. He understands and agrees that Cover Tennessee would not work if put under the current TennCare constraints. But once we prove the concept, we will be in a strong position; if we could bring the federal government in as another partner without all the Medicaid rules and the legal baggage, it would be a big win indeed."

Likewise, with respect to the one-time \$25 million appropriated by the General Assembly to help leverage federal matching funds through a HIFA waiver, our initial concern was the potential legal constraints that the federal matching funds would bring, as Tennessee's HIFA grant would likely be limited to Title XIX funding. Since we spoke with the Comptroller's staff in December, the AccessTN board and the Tennessee Justice Center jointly sought and obtained relief from TennCare consent decrees if the State were to pursue the HIFA waiver for the purposes outlined in the legislation for the AccessTN program. The State will evaluate this opportunity once the TennCare bureau completes the waiver renewal process this summer.

6. Tennessee's health care system is fragmented and lacks overarching goals.

Tennessee's health care system is indeed, fragmented, as is the rest of the country. It reflects the way health coverage has developed over the last 75 years in the United States—with an eroding base of employer-sponsored coverage as its foundation.

The Governor, however, has clearly communicated his overarching priorities and goals, with an emphasis on reforming TennCare, expanding coverage, attacking the diabetes epidemic and improving administrative processes through ehealth technology.

We agree with the report's observations regarding the potential of health planning to help focus the programs of various public and private entities around the Governor's key initiatives. In that way, policy goals of each department or organization could more closely align with the Governor's overall priorities. In addition, an integrated health data warehouse will help break

down the silos of health information throughout state government and will help various stakeholders implement and measure programs using a common set of data, with a common view of the healthcare landscape.

RECOMMENDATIONS: Legislative

1. **The General Assembly may wish to amend TCA §68-1-109 regarding the Joint Annual Report (JAR) of hospitals.**

We agree.

2. **The General Assembly may wish to give the TennCare Oversight Committee access to all official correspondence between TennCare and the Centers for Medicare and Medicaid Services (CMS).**

No additional comment.

3. **The General Assembly may wish to require Tennessee hospitals to make their chargemasters (the list of gross charges for every service provided by the hospital) available to the public.**

No additional comment.

RECOMMENDATIONS: ADMINISTRATIVE

1. **The Department of Finance and Administration's Health Planning Division should utilize its authority to establish and enforce a comprehensive state health plan as required by TCA §68-11-1625.**

We agree and concur with the TennCare comment. As Darin Gordon noted, our focus has been on implementing programs to address the Governor's key priorities, which directly relate to the emphasis of SB3367 on indigent care.

2. **The Department of Finance and Administration's Health Planning Division should examine best practices for establishing and maintaining health care accounting standards.**

We agree. No additional comment.

3. **The Department of Finance and Administration should examine various options for obtaining federal funds for the Cover Tennessee initiatives.**

We agree and concur with TennCare's comment. See response to #5 above.

4. **The Department of Finance and Administration should continue its efforts to fully reinstate the Medicaid Disproportionate Share Hospital (DSH) program in Tennessee.**

No additional comment.

- 5. The Department of Finance and Administration should deliver an annual report on Cover Tennessee to the General Assembly.**

The Cover Tennessee legislation already stipulates this requirement, so no additional recommendation is required.

- 6. The Department of Finance and Administration should explore various approaches for maintaining Certified Public Expenditure (CPE) revenue for TennCare.**

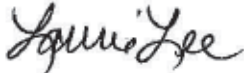
No additional comment.

- 7. The Department of Health should consider increasing the number of county health departments that qualify as Federally Qualified Health Centers (FQHCs).**

No additional comment.

Thank you for the opportunity to comment on this report.

Sincerely,



Laurie Lee
Deputy Executive Director

APPENDIX G: Response Letter from the Tennessee Department of Health

STATE OF TENNESSEE
DEPARTMENT OF HEALTH
CORDELL HULL BLDG.
425 5TH AVENUE NORTH
NASHVILLE TENNESSEE 37247

PHIL BREDESEN
GOVERNOR

SUSAN R. COOPER, MSN, RN
COMMISSIONER

May 16, 2007

Ms. Ethel Detch, Director
Office of Research and Education Accountability
Comptroller of the Treasury
505 Deaderick Street, Suite 1700
Nashville, Tennessee 37243

Dear Ms. Detch:

Thank you of the opportunity to review and respond to the Office's report on financing indigent health care in Tennessee. The report included two recommendations that involve the Department of Health that I will address below.

The Department has previously explored, with the Bureau of TennCare, the possibility of generating certified public expenditures with county health department clinic expenditures. In the past, due to federal match and maintenance of effort requirements for the Department's funding, both parties agreed that it was not feasible. We would be glad, in the future, to reassess this possibility at TennCare's request.

The report also recommends that the Department should increase the number of county health departments that qualify as Federally Qualified Health Centers (FQHCs). The Department of Health has attempted in the past to seek FQHC status and funding for additional county health department clinics. Those attempts have not been successful. Federal officials have indicated that a federal statute that took effect in 2002 prohibits the Secretary of Health and Human Services from awarding more than 5% of the annual appropriation to public entities. It is our understanding that the 5% threshold is met and exceeded by appropriations to public FQHCs that were in place prior to 2002. The Department works collaboratively with the Tennessee Primary Care Association and the non-state FQHCs in Tennessee to maximize resources available to Tennessee to provide medical services to those who have difficulty accessing health care services.

The Department of Health is committed to continued exploration of ways to enhance the availability of health care services to Tennesseans.

Sincerely,

A handwritten signature in black ink that reads "Susan R. Cooper, MSN, RN".

Susan R. Cooper, MSN, RN
Commissioner

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