

Waiver Amendment Request
TennCare Demonstration Amendment #25
INSURE TENNESSEE

Purpose

Pursuant to discussions between Governor Bill Haslam and U.S. Health and Human Services Secretary Sylvia Burwell, and contingent upon authorization of the Tennessee General Assembly, Tennessee is requesting an amendment to the TennCare demonstration for the purpose of adding a new component to be called "Insure Tennessee." This new component will operate as a two year pilot program intended to demonstrate an alternative plan for providing services to persons in the optional Medicaid eligibility category described in Section 1902(a)(10)(A)(i)(VIII) of the Social Security Act. The two year period will begin on the date that the program is implemented and available to enrollees.

We are aware that there are many low income uninsured persons in our state who either do not have access to subsidized coverage in the Federally Facilitated Marketplace or who cannot afford the coverage that is available to them. Preliminary estimates are that more than 200,000 people are in this group.

We are also concerned about the health status of Tennesseans. Tennessee ranks as one of the five worst states in both smoking and obesity.¹ A national survey published in 2014 concluded that "Tennessee residents were among the most likely to have a variety of physical health problems in 2013, including diabetes, high cholesterol, high blood pressure and chronic pain."² At least some of these physical health problems can be attributed to poor health behaviors such as infrequent exercise, smoking, and inadequate management of daily stress.

We believe that both challenges—lack of access to insurance and poor health behaviors—can be addressed by Insure Tennessee. This alternative approach is the logical next step in Tennessee's payment and delivery system reform initiative, which was launched by Governor Bill Haslam in 2013 to shift health care spending towards paying for value rather than paying for volume. This initiative creates financial incentives for providers to furnish high quality care in an efficient and appropriate manner so as to reduce costs and improve health outcomes. Recently Tennessee was awarded a \$65 million State Innovation Models (SIM) grant from the Centers for Medicare and Medicaid Services to further support the goal of making health care in Tennessee a value-based system focused on efficiency, quality of care, and the patient experience.

Insure Tennessee builds on this reform initiative by creating new participant incentives that align with the existing provider incentives. Insure Tennessee is designed to align incentives at the consumer level by promoting personal responsibility so that both patient and provider will

¹*America's Health Rankings*. United Health Foundation. 2014.

²*Gallup-Healthways Well-Being Index*. 2014.

be working toward the common goal of improved health outcomes. Insure Tennessee will not only provide coverage for low-income Tennesseans, but it will prepare these members for a transition to private market coverage by promoting participant engagement and personal responsibility and by incentivizing appropriate use of the health care system.

Overview of Proposed Amendment

The target population for this amendment is the so-called "VIII" group, which is the optional Medicaid eligibility category described in Section 1902(a)(10)(A)(i)(VIII) of the Social Security Act.

Individuals in this group are often referred to as "Newly Eligibles," which is the term we will use for them in this proposal. They are between the ages of 19 and 64, are not otherwise eligible for Medicaid, and have family incomes that do not exceed 138 percent of the Federal Poverty Level. Federal matching dollars are available for services to persons in this population at the 100 percent level through December 31, 2016, dropping to 95 percent in 2017, and eventually to 90 percent in 2020.

Insure Tennessee will have several distinct parts. One part will be tailored to 19- and 20-year olds, who are considered children for Medicaid purposes. The main proposal will cover adults 21-64 and will offer them their choice of two plans: the Volunteer Plan and the Healthy Incentives Plan. Those in the first part will move into the program covered by the main proposal when they turn age 21.

The Volunteer Plan will provide subsidized coverage for the working poor in private insurance plans. In the first year of Insure Tennessee, private health plans will be limited to Employer-Sponsored Insurance (ESI) plans. The Healthy Incentives Plan will offer regular Medicaid benefits but with the addition of new cost-sharing requirements and special accounts that will enable members to receive rewards for engaging in healthy behaviors.

In the following pages of this amendment request, we will address the following subjects:

- I. Basic Concept
- II. The Volunteer Plan
- III. The Healthy Incentives Plan
- IV. Choosing and Moving Between Plans
- V. Post-Eligibility Treatment of Income (PETI) and Estate Recovery
- VI. Cost-Sharing
- VII. Appeals Procedures
- VIII. Modification of the Unreimbursed Hospital Cost Pool
- IX. Program Support and Opt-Out Provision
- X. List of Waivers Requested

Finally, we will address the remaining topics required by Paragraph #7 of the Special Terms and Conditions for any waiver amendment request. These topics are:

- An explanation of the public process used by the state to reach a decision regarding the requested amendment
- A description of how the evaluation design will be modified to incorporate amendment provisions
- Data analysis identifying the specific “with waiver” impact of the proposed amendment on the current budget neutrality agreement

I. Basic Concept

Insure Tennessee is distinct from the regular Medicaid program in several important ways. It will leverage opportunities in the private market, such as Employer-Sponsored Insurance that is already available to certain applicants, and it will seek to reward behaviors that lead to better health, increased personal responsibility, and reduced health care costs.

We will start by dividing the population into two groups.

1. **Persons ages 19 and 20.** Newly Eligibles under the age of 21 are entitled to all allowable Medicaid benefits including EPSDT (Early and Periodic Screening, Diagnosis, and Treatment). We are proposing to enroll all members of the Insure Tennessee population who are under 21 into the regular TennCare Medicaid program, where they will get the same benefits as all other TennCare Medicaid enrollees who are under age 21. They will receive their medical and behavioral benefits through a TennCare Managed Care Organization (MCO), as well as their Long-term Services and Supports (LTSS) if they have physical disabilities requiring special medical care. They will access their pharmacy benefits through the TennCare Pharmacy Benefits Manager (PBM), and their dental benefits through the TennCare Dental Benefits Manager (DBM).
2. **Persons ages 21-64.** There will be two new plans available to people in this population: the **Volunteer Plan** and the **Healthy Incentives Plan**. Each plan will include new service delivery models.

A discussion of each plan is presented below.

II. The Volunteer Plan

The Volunteer Plan is a premium assistance plan. It is a plan for persons who, with assistance from Insure Tennessee, could participate in qualified private insurance plans.

In the first year of the Insure Tennessee program, qualified private insurance plans will be limited to plans available to individuals through their work, or Employer-Sponsored Insurance (ESI for short). About 54 percent of the population of Newly Eligibles are currently working or

have worked within the past year³ and may therefore have an opportunity to join the Volunteer Plan.

Volunteer Plan members will receive coverage through their ESI plan rather than through TennCare. Insure Tennessee will provide support for this arrangement by making a defined contribution each month toward the costs of ESI coverage for each Volunteer Plan member. The state or its contractor may make a direct payment to the employer or insurer for the member's share of the premium, and/or may make direct payments to providers for the member's share of deductibles and copays, and/or may reimburse the member for expenses incurred in the form of premiums, deductibles, and/or copays. Operational details will be finalized with input from employers.

The member will be responsible for all costs associated with the ESI plan other than those covered by the state's defined contribution (and the portion of the premium paid by the employer). Medicaid's cost sharing requirements will not apply to Volunteer Plan enrollees; the state is seeking a waiver of these requirements under Section 1916(f) of the Social Security Act. There will thus be no need for the state to track copays for members of the Volunteer Plan.

Qualifying criteria. In order for an ESI plan to be an eligible option under the Volunteer Plan, the employer contribution must cover at least 50 percent of the premium cost. Small group plans⁴ that are neither self-insured plans nor grandfathered plans are generally required to meet certain ACA requirements (e.g., coverage of Essential Health Benefits and preventive services). We are seeking CMS approval to automatically approve these small group plans when the employer contribution threshold is met. In addition to meeting the employer contribution threshold, large group plans⁵ will be asked to attest to coverage of all Essential Health Benefits prior to being approved as an option under the Volunteer Plan.

Benefit wraps. States operating Medicaid premium assistance programs such as the Volunteer Plan generally "wrap" benefits covered by Medicaid but not covered by the private plan so that the member continues to have access to all Medicaid benefits, even though he is enrolled in a premium assistance plan with its specific set of benefits. Because Insure Tennessee members have a clear choice of plans, we are requesting that there be no Medicaid benefit "wraps" for persons choosing the Volunteer Plan. The state will make options counseling available to members to help them decide which plan is best for their individual circumstances.

Cost effectiveness test. The Volunteer Plan will be a cost-effective premium assistance program. Two primary factors are considered in evaluating cost-effectiveness on an individual basis: the cost of the "baseline" and the cost of the premium assistance program.

³ Familles USA, "Medicaid Expansion in Tennessee: Health Insurance for Working Individuals and Families," Issue Brief, August 2014.

⁴ ACA defines small group plans as those with fewer than 50 Full-Time Equivalent employees. Effective January 1, 2016, small group plans will be those with fewer than 100 FTE employees.

⁵ ACA defines large group plans as those with 50 or more FTE employees. Effective January 1, 2016, large group plans will be those with 100 or more FTE employees.

- *Baseline* = the average per person cost to TennCare of serving a person of similar age, sex, and eligibility characteristics in the Healthy Incentives Plan.
- *Premium assistance program* = the cost of the defined contribution + any other costs TennCare may incur on behalf of a member in the Volunteer Plan.

If the per-person cost of the premium assistance program is less than the per-person cost of the baseline, then the program by definition is cost effective for that member.

The amount of the defined contribution is still to be determined in accordance with the recommendations of independent actuaries.

III. The Healthy Incentives Plan

The Healthy Incentives Plan will be an Alternative Benefit Plan (ABP) that is fully aligned with the TennCare benefit package.⁶ Because the Healthy Incentives Plan covers all TennCare/State Plan benefits, and because any adult participating in Insure Tennessee can enroll in the Healthy Incentives Plan at any time, there is no need to have a separate mechanism for identifying persons who are Medically Frail⁷ and providing them with access to State Plan benefits. Anyone who believes that he is Medically Frail can simply request enrollment in the Healthy Incentives Plan and gain access to these benefits.

The Healthy Incentives Plan will be a product offered by the Managed Care Organizations participating in the TennCare program, with covered outpatient prescription drugs being furnished through the Pharmacy Benefits Manager contracted with the TennCare program.

HIT (Healthy Incentives for Tennesseans) Accounts. A new feature to be offered by the Healthy Incentives Plan will be HIT Accounts, which will be similar to Health Reimbursement Accounts. The HIT Account concept will be operationalized by the MCOs.

The individual HIT Account will be pre-loaded with a small sum at the beginning of coverage. Members can “earn” additional credits for their HIT Account by engaging in certain desirable behaviors and enrolling in participation-based initiatives such as an annual health risk assessment or certain population-based health programs. Credits can then be used by members to offset their premiums and copays.

In making decisions about strategies for identifying and rewarding selected behaviors, we will require that the MCOs make use of:

- Credits for accessible/achievable actions/behaviors related to improved health and/or appropriate utilization of healthcare services.
- Member engagement in use of account credits for cost-sharing obligations.

⁶ The “Alternative Benefit Plan” refers to coverage described in 42 CFR Part 440, Subpart C.

⁷ See 42 CFR § 440.315(f).

- An easily understandable and administratively simple process.

Use of HIT Accounts by members with incomes below poverty. Members with incomes below the poverty level will not have premiums but will have pharmacy copays to which HIT Account funds could be applied. Additionally, we propose to deduct from these members' HIT Accounts the amount that they would have paid if they had the same copays as the members above the poverty level, but to permit the member to use whatever remains at the end of the year to be reimbursed for out-of-pocket expenditures for specified items and services that TennCare does not cover for adults, such as over-the-counter drugs and dental care. This way, lower income members will have very similar incentives (both to engage in healthy behaviors to earn money into their account and to use services appropriately) as the members above the poverty level.

Other features of HIT Accounts. The member will not "own" the credits in the HIT Account, and the account will not be redeemable for cash or anything other than uses specified by the state. There will be a maximum balance that can be accrued in the HIT Account, and once the account is exhausted, the member will be responsible for premiums and all copays up to the aggregate cost sharing cap, which will be calculated on a quarterly basis.

Members will receive quarterly statements detailing activity in their HIT Accounts, similar to Explanations of Benefits (EOBs). At the end of the year, any credits remaining in the HIT Account may roll over to the following year, provided the member has complied with all requirements associated with the account.

Concerns or complaints. Persons who have concerns or complaints about matters relating to their HIT accounts will have a telephone number they can call at their MCOs to resolve their concerns or complaints. MCO call center staff will have protocols for responding to these concerns or complaints and will work with the member to resolve these issues. This may include reviewing a member's HIT Account and related documentation to verify that completed wellness activities have been recorded and credited. In some cases, call center staff may determine that the member needs assistance in understanding what the HIT Account is and how to use it; in those cases, the staff will follow up with additional education and outreach.

IV. Choosing and Moving Between Plans

New enrollment. Newly Eligibles ages 21-64 who have access to qualified ESI plans will be given the opportunity to select either the Healthy Incentives Plan or the Volunteer Plan at the time they enroll in Insure Tennessee. Persons who do not have access to a qualified ESI plan, either because they are not working or because their employer does not offer an ESI plan that meets Insure Tennessee's requirements, may enroll directly into the Healthy Incentives Plan.

Options counseling services. The state will furnish, as part of Insure Tennessee, an Options counseling service to assist persons who need help deciding which plan is better for them.

Moving between plans. Individuals in the Volunteer Plan have the discretion to move into the Healthy Incentives Plan at any time. Individuals will continue to have access to Options Counseling services to help them determine if or when they should switch plans.

While individuals can transfer at any time to the Healthy Incentives Plan, members of the Healthy Incentives Plan will only be able to transfer to the Volunteer Plan during an open enrollment period for the ESI plan or when there is a qualifying event triggering a special enrollment period. When a person in the program for 19- and 20-year olds turns 21 years of age, that will be considered a “qualifying event” that will allow that person to enroll in the Volunteer Plan, if he chooses.

V. Post-Eligibility Treatment of Income (PETI) and Estate Recovery

PETI. Some Newly Eligibles may have medical needs that would make them eligible for Nursing Facility care. CMS currently permits states to exempt people in this group from the post-eligibility treatment of income (PETI) that is normally required of persons entering Nursing Facilities.⁸ We believe that it would be fundamentally unfair to exempt Newly Eligibles from the (PETI) process that is applicable to all other Long-Term Services and Supports (LTSS) enrollees and that is described at 42 CFR Part 435, Subpart H. Therefore, we are requesting waiver authority to be able to require use of a PETI process for those Newly Eligibles who have been found medically qualified to receive Nursing Facility care.

Estate recovery. With respect to estate recovery, CMS policy allows states to seek recovery from certain MAGI eligibles who use LTSS.⁹ It is Tennessee’s intent to pursue available recovery under existing policies and procedures.

VI. Cost-Sharing

A summary of premium and cost-sharing requirements is presented in the table below.

Premium and Cost-Sharing Requirements in Insure Tennessee

Group	Premiums	Deductibles and Copays
Volunteer Plan members	The member’s share of ESI Plan premiums will be covered by the state through the state’s defined contribution	ESI plan deductibles and copays will be applicable and may be covered at least in part by the state through the state’s defined contribution

⁸ CMS State Medicaid Director Letter #14-001, February 21, 2014, page 6.

⁹ Ibid.

Group	Premiums	Deductibles and Copays
Healthy Incentives Plan members	Approximately \$20 (2014) ¹⁰	<p data-bbox="927 264 1149 296">Medical copays:¹¹</p> <p data-bbox="927 302 1349 443">Inpatient - \$75 per admission; Outpatient - \$4 per service; Non-emergency use of the ER - \$8 per occasion</p> <p data-bbox="927 485 1170 516">Pharmacy copays:¹²</p> <p data-bbox="927 522 1276 590">\$1.50 for generics; \$3.00 for brand name drugs</p>

Cost sharing in the Volunteer Plan. Once the state’s defined contribution has been spent, the member will be responsible for any remaining cost sharing, even if that means the member will pay cost sharing in excess of the Medicaid limits. There will thus be no need for the state to track copays for members of the Volunteer Plan, since there is no aggregate annual limit.

We are requesting a waiver of the Medicaid cost sharing requirements for these purposes under Section 1916(f) of the Social Security Act. Cost sharing is one of the factors that the state’s Options Counseling service (described above in Part VI) will assist Insure Tennessee applicants in evaluating when they make their choices of plans.

Cost sharing in the Healthy Incentives Plan. Copays will be enforced for persons with incomes above poverty, meaning that providers may refuse to deliver services to these members when they fail to make required copays.

In addition to copays, members of the Healthy Incentives Plan whose incomes are above the federal poverty level will be required to pay a monthly premium. Implementing this provision will require a waiver, as the Medicaid statute limits the imposition of premiums to individuals with incomes above 150 percent of the Federal Poverty Level.

Consistent with 42 CFR § 447.55(b)(2), the state will disenroll persons who have failed to pay premiums for 60 days or more. We recognize that CMS has not approved to date a provision whereby a state could impose a time limit before individuals in such circumstances could re-enroll. We understand that such a provision has been requested by Indiana, and if that provision should be approved, we reserve the right to request a similar provision in our demonstration.

¹⁰ The premium is applicable only to persons with incomes above 100 percent of poverty. The amount of the premium is 2 percent of poverty. In 2014, the poverty level for one person is \$972.50 per month. The premium that would accompany this poverty level is 2 percent of \$973.50, or \$19.45. (Federal regulations do not allow premiums for Medicaid enrollees with incomes below 150 percent of poverty; we are requesting a waiver to require premiums for those with incomes above 100 percent of poverty.)

¹¹ Consistent with federal regulations, medical copays are applicable only to those members with incomes above 100 percent of poverty.

¹² Pharmacy copays are applicable to members at any income level.

VII. Appeals Procedures

Appeals in the Healthy Incentives Plan. Appeals related to Healthy Incentives Plan services will be handled in a manner consistent with the existing TennCare appeals process.

Appeals in the Volunteer Plan. Volunteer Plan members desiring to file appeals of an ESI benefit decision must do so through their ESI plan. Members who remain unsatisfied with a final decision from their ESI plan appeal may choose to move to the Healthy Incentives Plan. Members contemplating a move to the Healthy Incentives Plan following benefit denial will have access to Options Counseling services (See Part VI). Counselors will be able to verify whether the service the member is seeking is a covered benefit in the Healthy Incentives Plan. They will not, however, be able to advise the member as to whether or not the Healthy Incentives Plan would consider the service to be medically necessary in the member's particular situation.

Volunteer Plan members will not be able to access the Medicaid appeals process for ESI benefit decisions.

VIII. Modification of the Unreimbursed Hospital Cost Pool

We are proposing to increase the maximum of the Unreimbursed Hospital Cost Pool to \$600 million to offset documented unreimbursed cost.

IX. Program Support and Opt Out Provision

It is expected that expenditures for Insure Tennessee will be matched with 100 percent federal dollars through December 31, 2016. On January 1, 2017, the federal match rate will adjust to 95 percent.

Tennessee hospitals have committed to supporting Insure Tennessee through an increase in a state assessment on hospitals, so there will be no impact on the state's budget even when the federal match rate declines.

Insure Tennessee will end if either of the following events occurs: (1) the federal match rate available for the program is reduced below the amount available under ACA as it exists on January 1, 2015, or (2) revenues available from the assessment on hospitals fails to cover any remaining state share of expenditures in the event of a reduction in the federal match rate.

X. List of Waivers Requested

The State asks CMS to add the following waivers of Title XIX requirements to the TennCare II demonstration pursuant to Section 1115(a)(1) of the Social Security Act:

- 1) Amount, Duration, Scope and Comparability. Section 1902(a)(10)(B)
 To the extent necessary to allow Insure Tennessee members to choose to participate in the Volunteer Plan and receive the benefits provided through an employer-sponsored insurance plan, without Medicaid wrap-around benefits, and to allow the state to offer different benefit packages to Insure Tennessee members, depending on the plan option in which they choose to participate.

- 2) Premiums. Sections 1902(a)(14), 1916, and 1916A
 To the extent necessary to enable Tennessee to charge premiums to Insure Tennessee members with incomes between 100-138 percent of the FPL.

- 3) Cost Sharing. Sections 1902(a)(14), 1916, and 1916A
 To the extent necessary to allow Volunteer Plan members to enroll in employer-sponsored coverage with cost sharing that exceeds the Medicaid allowable levels, and to the extent necessary allow Tennessee to forego the tracking of cost sharing for Volunteer Plan members.

- 4) Statewideness/Uniformity. Section 1902(a)(1)
 To the extent necessary to allow Volunteer Plan members to choose employer-sponsored coverage that is not offered statewide.

- 5) Methods of Administration: Transportation. Section 1902(a)(4) insofar as
it incorporates 42 C.F.R § 431.53
 To the extent necessary to enable Tennessee not to assure non-emergency transportation to and from providers for the Volunteer Plan.

- 6) Freedom of Choice. Section 1902(a)(23)
 To allow Tennessee to limit the choice of providers for Volunteer Plan members to only those providers participating in the employer-sponsored coverage selected by the member.

- 7) Healthy Incentive Plan Benefits. Section 1902(k)(1)
 To the extent necessary to permit the Healthy Incentives Plan to mirror coverage in the regular TennCare program.

- 8) Post-Eligibility Treatment of Income. 42 C.F.R. Part 435, Subpart H
 To allow Tennessee to apply post-eligibility treatment of income rules in 42 C.F.R. Part 435, Subpart H to Insure Tennessee members.

- 9) Appeals. Section 1902(a)(3)

To the extent necessary to relieve Tennessee of the obligation to provide appeals in compliance with the requirements in 42 C.F.R. Part 431, Subpart E for benefits decisions made by employer-sponsored plans for Volunteer Plan members.

10) Retroactive Eligibility. Section 1902(a)(34)

To enable the state not to extend eligibility for Insure Tennessee prior to the date that an application for assistance is made.

The State asks CMS to add the following expenditure authorities to the TennCare II demonstration pursuant to Section 1115(a)(2) of the Social Security Act:

- 1) Employer-sponsored insurance. For expenditures for premium assistance for employer-sponsored coverage, without Medicaid wrap-around benefits, for Volunteer Plan members that does not offer Alternative Benefit Plan or state plan benefits.
- 2) Pool payments. For expenditures for Graduate Medical Education, Essential Access Hospital, Critical Access Hospital, Meharry Medical College, Unreimbursed Public Hospital Costs for Certified Public Expenditures, Unreimbursed Hospital Cost, and Public Hospital Supplemental Payment pool payments to the extent specified in paragraph 55.d.-h. and j.-l. (Extent of Federal Financial Participation for the Demonstration) of TennCare II's STCs, through December 31, 2016.

XI. Other Components of the Amendment Request

An explanation of the public process used by the state. The state will comply with the public process described in Paragraph #15 of the Special Terms and Conditions.

Description of how the evaluation design will be modified to incorporate the amendment provisions. The state believes that the current evaluation design, with its emphasis on global objectives and specific performance measures, is appropriate for the Insure Tennessee population.

Data analysis which identifies the specific "with waiver" impact of the proposed amendment on the current budget neutrality agreement. To be added upon completion of actuarial analysis.