

STATE OF TENNESSEE

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November 26, 2012

Opinion No. 12-106

Permissibility of Modifications to the TennCare Program

QUESTIONS

1. Under *National Federation of Independent Business v. Sebelius*, ___ U.S. ___, 132 S.Ct. 2566 (2012), or other federal law or precedent, can the federal government decrease the federal financial participation in the Medicaid program currently provided to the TennCare program either through a decrease in the rate of such participation or by disallowing a federal match for revenues derived from a provider tax?

2. If the answer to Question 1 is yes, then can the State of Tennessee either (a) reduce benefits or eligibility for the TennCare program in order to respond to the financial exigencies created by such decreases or disallowances or (b) terminate its participation in the Medicaid program in order to respond to the financial exigencies created by such decreases or disallowances?

3. Does the answer to any of the above questions change if the State of Tennessee ceases to operate the TennCare program under its existing federal waivers and returns to operating the program under a Medicaid state plan (traditional Medicaid)?

OPINIONS

1. Yes. Congress has the authority under federal law to reduce the federal government's financial participation in the TennCare program and such a reduction would not appear to raise constitutional concerns.

2(a). With any necessary approval of the United States Department of Health and Human Services' Centers for Medicare and Medicaid Services (CMS), Tennessee may make certain changes to the TennCare program, such as a reduction of optional benefits. But for a specified period of time Tennessee's ability to put in place more restrictive eligibility standards, methodologies, or procedures is limited by the Affordable Care Act's "maintenance of effort" requirement.

2(b). State participation in the Medicaid program is voluntary, and there is no legal impediment that would preclude the State of Tennessee from taking action to terminate its participation in that program.

3. No.

ANALYSIS

In March 2010, Congress passed the Patient Protection and Affordable Care Act, Pub. L. 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. 111-152, together referred to as the Affordable Care Act (“ACA”). Subsequently litigation was commenced in several federal courts by parties alleging that ACA was partially or completely void on various constitutional grounds. Ultimately these issues were presented for argument before the United States Supreme Court, and on June 28, 2012, the Court issued its decision in *National Federation of Independent Business v. Sebelius* (“*NFIB*”), __ U.S. __, 132 S.Ct. 2566 (2012), resolving constitutional challenges to two key provisions of the ACA. Relevant to your questions, one of those provisions requires the states to expand their Medicaid programs to cover non-pregnant individuals under the age of 65 with incomes below 133 percent of the federal poverty level, 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII), or risk losing all existing federal Medicaid funding that they receive under the current Medicaid program.¹ Addressing Congress’ power under the Constitution’s Spending Clause,² in the context of the limits on Congress’ ability to impose conditions on the grant of federal funds to the states, the Supreme Court found that the threatened loss of all existing federal Medicaid funding exceeds Congress’ spending power by impermissibly coercing states into complying with the ACA Medicaid expansion. The new Medicaid expansion was not itself invalidated. Rather, the Court fashioned a limited remedy for the unconstitutional threat of the loss of all federal Medicaid funds, effectively rendering the ACA Medicaid expansion optional for the states: Medicaid funding cannot be withheld from the existing Medicaid programs of states that decline to implement the new expansion. *Id.* at 2607. All other provisions of the ACA were left standing by the *NFIB* decision. *Id.* at 2607-08. Nonetheless open questions remain about the potential application of *NFIB*’s analysis to other Medicaid provisions of the ACA and its implications for the management of existing Medicaid programs.

1. The Medicaid program is a joint financing partnership in which the federal government and participating states share the costs of providing covered health care services to persons meeting Medicaid eligibility requirements. *See generally* 42 U.S.C. § 1396b. The federal medical assistance percentage (“FMAP”) rate that the United States Department of Health and Human Services (“HHS”) uses in determining the amount of federal matching funds for most state Medicaid service expenditures is determined by a formula set in statute, 42 U.S.C. § 1396d(b), and varies by state. *See* Evelyne P. Baumrucker, Cong. Research Serv.,

¹ 42 U.S.C. § 1396c allows the Secretary of Health and Human Services to declare that “further payments will not be made to the State” if she determines that the state is out of compliance with any Medicaid requirement.

² The Spending Clause grants Congress the power “to pay the Debts and provide for the . . . general Welfare of the United States.” U.S. Const., art. I, § 8, cl. 1.

RL32950, *Medicaid: The Federal Medical Assistance Percentage (FMAP)* (Sept. 24, 2010). This formula “compares each state’s per capita income, and provides higher reimbursement to states with lower incomes (with a statutory maximum of 83%) and lower reimbursement to states with higher incomes (with a statutory minimum of 50%).” *Id.* at 1. The federal share for certain services, certain populations, and Medicaid administrative costs is not determined using the FMAP formula and is instead specified separately under federal law. *Id.* at 4-6. In addition, a number of exceptions have been added by federal legislation over the years, such as temporary FMAP increases for state fiscal relief and higher federal shares of reimbursement for certain services. *Id.* States have discretion as to the sources of the state share of Medicaid program costs, and current law allows states to use revenue from provider taxes to help make up the state share of Medicaid, subject to federal rules. *See* 42 C.F.R. §§ 433.51 and 433.68.

Because the level of federal financial participation in the Medicaid program is the creation of Congress, that level is subject to change through Congressional action. Congress, through the Appropriations Clause of the Constitution, U.S. Const., art. I, § 9, cl. 7, is vested with exclusive power over the federal purse. The existence of the power of successive Congresses to modify federal legislation and to appropriate funds as they see fit has long been recognized. *See Reichelderfer v. Quinn*, 287 U.S. 315, 318 (1932) (“[T]he will of a particular Congress . . . does not impose itself upon those to follow in succeeding years.”) That power was acknowledged, with respect to potential changes in levels of federal funding of the Medicaid program, by the United States Supreme Court in *NFIB*. In responding to Justice Ginsburg’s observation that state Medicaid spending is projected to increase only minimally after the Medicaid expansion provided for in the ACA, Chief Justice Roberts criticized that argument as “assum[ing] that the Federal Government will continue to fund the expansion at the current statutorily specified levels.” *NFIB*, 132 S.Ct. at 2605 n.12. Similarly, the dissenting Justices, in expressing the view that the new Medicaid expansion will impose substantial costs on the states, noted that “these costs may increase in the future because of the very real possibility that the Federal Government will change funding terms and reduce the percentage of funds it will cover.” *Id.* at 2666 (Justices Scalia, Kennedy, Thomas, and Alito, dissenting). Clearly, then, the Court recognized that the potential exists for a future reduction in federal financial participation in the Medicaid program. And, irrespective of the likelihood of such a decrease in federal funding occurring, whether for the ACA expansion, the existing Medicaid program, or both, the acknowledgement in *NFIB* of Congress’ ability to enact such a change is devoid of any suggestion that such Congressional action would raise constitutional concerns. Of course, the specific question of potential limits on Congress’ authority to reduce the level of federal financial participation in the Medicaid program was not at issue in *NFIB*.

The Court’s analysis of the ACA’s mandated Medicaid expansion began with the “basic principle that the ‘Federal Government may not compel the States to enact or administer a federal regulatory program.’” *Id.* at 2601 (quoting *New York v. United States*, 505 U.S. 144, 188 (1992)). *See, e.g., Printz v. United States*, 521 U.S. 898 (1997) (striking down federal legislation, the Brady Handgun Act, compelling state law enforcement officers to perform federally mandated background checks on handgun purchases). This restriction on federal authority exists “whether Congress directly commands a State to regulate” or “indirectly coerces a State to adopt a federal regulatory system as its own.” *NFIB*, 132 S.Ct. at 2602. Nevertheless, Congress, pursuant to its Spending Clause power, may secure state compliance with federal

objectives by conditioning a grant of federal funds on the states' taking certain action that Congress could not directly require them to take; this conditional grant of federal funds "encourages" a state to regulate in a particular way. *Id.* at 2601-02. *NFIB*, however, recognized that limits exist "on Congress' power under the Spending Clause to secure compliance with federal objectives." *Id.* at 2602. Those limits have led the Court to scrutinize Spending Clause legislation to ensure that Congress is not using financial inducements to indirectly coerce states to act in accordance with federal policies. *Id.*

A challenge to a reduction in the level of federal financial participation in the Medicaid program does not fit comfortably into either the Court's analysis of limitations on Congress' use of its spending power or into the anti-commandeering line of cases. As to the former, a Congressional change to the statutory FMAP formula or the disallowance of a federal match for provider tax revenues would not appear to constitute a grant "condition" on the receipt or use of federal funds. And with respect to the latter, a decrease in the federal share of Medicaid expenditures does not constitute a direct command to the states to regulate in a particular way.

Two points that appear to have been key to *NFIB*'s analysis of the limits on Congress' power should be examined. First was the Court's view of the ACA's required Medicaid expansion as going beyond modifications and adjustments to the Medicaid program that Congress was unquestionably entitled to make under its reserved right, in 42 U.S.C. § 1304, to "alter" or "amend" the program. Rather, the Medicaid expansion "accomplished a shift in kind, not merely degree," resulting in a transformation of Medicaid into "a new health care program." *NFIB*, 132 S.Ct. at 2606. Second, that transformational change was coupled with the coercive effect of the threatened loss of all existing federal Medicaid funding, which accounted for over 20 percent of the average state's total budget. *Id.* at 2604.

Assuming that this type of analysis would be triggered by a legal challenge to a congressional decrease in federal financial participation in the Medicaid program, it does not appear that such a challenge would be likely to succeed. Whether the decrease in federal matching funds at issue would amount to more than a "shift in degree" and cross into the territory of a substantial transformation of the Medicaid program will, of course, depend on a fact-specific exercise in line-drawing. But it would be difficult to argue that the critical element of coercion would be present since, at the point at which the reduction of federal financial participation is so extreme as to have fundamentally transformed the program, the potential loss of that minimal federal funding could not easily be said to coerce the states into acquiescing in the new financial arrangement by continued participation in Medicaid. States at that point would have a genuine choice about their future course of action. *See South Dakota v. Dole*, 483 U.S. 203, 211-12 (1987) (In an action challenging the constitutionality of a federal statute conditioning states' receipt of a portion of federal highway funds on the states' adoption of a minimum drinking age of 21, the Court rejected a claim of coercion, finding the threatened loss of 5 percent of the funds otherwise obtainable amounted only to "relatively mild encouragement.")

2(a). Tennessee's ability to make changes to the TennCare program is limited by what is referred to as the "maintenance of effort" ("MOE") requirement of the ACA. At 42 U.S.C. §

1396a(gg)(1) the ACA provides that, with certain exceptions,³ as a condition of receiving any federal Medicaid funding, during the period beginning March 23, 2010 (the date of enactment of the ACA) and ending on the date on which the Secretary of HHS determines that a state's new health insurance "Exchange" under the ACA is fully operational,⁴ a state must maintain "eligibility standards, methodologies, or procedures" that are no more restrictive than those in effect on March 23, 2010. (This end date is expected to be January 2014 under the ACA, since that is the date of expected Exchange implementation, *see* 42 U.S.C. § 18031(b), but the date is not fixed in the MOE provision itself.) For children on Medicaid up to age 19 the ACA MOE requirement continues through September 30, 2019. 42 U.S.C. § 1396a(gg)(2).

The MOE provision does not prohibit states (with any necessary approval from the Centers for Medicare and Medicaid Services) from cutting Medicaid in ways that do not constitute more restrictive "eligibility standards, methodologies or procedures" than those in effect on March 23, 2010, such as by changing optional benefits, reducing provider reimbursement rates, or increasing cost sharing. See Medicaid Cost-Savings Opportunities, HHS Publication (Feb. 3, 2011), *located at* <http://www.hhs.gov/news/press/20110203tech.html>.

The question posed is whether *NFIB* invalidates the MOE requirement, such that it cannot be enforced by the HHS Secretary's authority to withhold federal Medicaid funding pursuant to 42 U.S.C. § 1396c. In adopting the limited remedy prohibiting the Secretary from withholding all Medicaid funding from states that fail to implement the ACA Medicaid expansion, the Court's decision did not specifically address, or suggest concern regarding, any of the other Medicaid amendments in the ACA, such as the MOE provision. Indeed, with respect to the question whether the Court's holding affects other provisions of the ACA, the Chief Justice concluded that the rest of the ACA's Medicaid reforms are preserved and remain fully operative. *NFIB*, 132 S.Ct. at 2607-08.

That said, it has been suggested that the MOE requirement should be considered part of the new ACA Medicaid expansion that, following the *NFIB* decision, the states cannot be compelled to implement. Proponents of that argument could point to the fact that the MOE requirement is contained in the same section of the ACA, Section 2001, as is the delineation of the new Medicaid expansion group. And it could be said that, in a sense, the MOE requirement "expands" states' Medicaid programs by mandating, until the indicated dates, the continued coverage of all eligibility categories in effect in the state as of March 23, 2010. This argument was essentially presented by the State of Maine in a recently filed petition for injunctive relief

³ Between January 1, 2011 and December 31, 2013, states with a certified budget deficit may be exempted from the ACA's MOE provisions for non-pregnant, non-disabled adults with incomes greater than 133 percent of the federal poverty level. 42 U.S.C. § 1396a(gg)(3). In addition, according to guidance from CMS, a state whose Medicaid program operates under a "Section 1115" demonstration waiver (*see* 42 U.S.C. § 1315(a)(1)) can make changes explicitly allowed under the waiver's Special Terms and Conditions in order to stay within budget neutrality limits. *See* State Medicaid Director Letter, Feb. 25, 2011, *located at* <http://www.cms.gov/smdl/downloads/SMD11001.pdf>.

⁴ The new regulations of the Department of HHS implementing the ACA's Affordable Insurance Exchanges ("Exchange") define the term "Exchange" as referring to a state Exchange, regional Exchange, subsidiary Exchange, and a federally-facilitated Exchange. 45 C.F.R. §155.20. *See also* 26 C.F.R. § 1.36B-1(k) (Internal Revenue Service regulations relating to the ACA's health insurance premium tax credit, defining the term Exchange as having "the same meaning as in 45 C.F.R. 155.20.")

with the United States Court of Appeals for the First Circuit. Maine had filed a state plan amendment (SPA) with CMS seeking changes that would cause Maine to fall below the MOE. When CMS failed to act on the SPA, Maine sought an injunction to either compel CMS to approve the SPA by a date certain or to require the federal government to pay Maine's share of the Medicaid coverage in question pending resolution of the litigation. *First Circuit Refuses to Order Immediate Agency Action on Maine's Proposed Medicaid Cuts*, Health Lawyers Weekly, Vol. 10, Issue 38 (Sept. 21, 2012). In its petition, Maine challenged the ACA's MOE as unconstitutional under the Supreme Court's decision in *NFIB*. *Id.* The First Circuit ultimately denied Maine's petition. *Mayhew v. Sebelius*, No. 12-2059, 2012 WL 4762101 (1st Cir. Sept. 13, 2012).

The ACA, at 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII), also establishes a new eligibility group consisting of "all persons who are under age 65, not pregnant, not entitled to, or enrolled for benefits under Part A of Title XVIII [Medicare], . . . and are not previously described [elsewhere in Medicaid's mandatory categorically needy eligibility categories], and whose income does not exceed 133 percent of the federal poverty line. . . ." Enhanced federal funding is available for this new eligibility group, beginning at a 100 percent FMAP in 2014 and declining to 90 percent in 2020 and thereafter. 42 U.S.C. § 1396d(y). This enhanced FMAP contrasts with a federal share of 50 to 83 percent of the costs of covering individuals currently enrolled in Medicaid. *See* 42 U.S.C. § 1396d(b). Moreover, these newly eligible individuals under the ACA are to receive a level of coverage that is less comprehensive than the traditional Medicaid benefit package. *See* 42 U.S.C. § 1396a(k)(1).

These elements of the ACA "Medicaid expansion" were the focus of the Court's analysis under the Spending Clause. *NFIB*, 132 S.Ct. at 2601 (characterizing the challenged "Medicaid expansion" as a mandate for coverage of "all individuals under the age of 65 with incomes below 133 percent of the federal poverty line," citing 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII)); *id.* at 2606 (citing the structure of the "Medicaid expansion" as reflecting a separate funding provision, under § 1396d(y)(1), and a different benefit package, under § 1396a(k)(1)). The MOE requirement, in contrast, is not attached to the new ACA enhanced expansion funds; rather, it is tied to current Medicaid funding at current levels of federal participation and applies to a state's current Medicaid population and existing eligibility categories. It seems apparent, then, that the ACA "Medicaid expansion" that *NFIB* addresses is the extension of Medicaid coverage to the new ACA 133 percent eligibility group for which enhanced federal matching funds will be provided beginning January 1, 2014. The *NFIB* decision thus contains no clear indication of any intention on the part of the Court to give the term "Medicaid expansion" a broader reach that would encompass the ACA MOE requirement.

The more difficult question is whether the MOE requirement is an unconstitutional grant condition under the precedent of *NFIB*, such that states cannot be compelled to maintain their March 2010 "eligibility standards, methodologies, or procedures" or face losing all current federal Medicaid funding. That is a question as to which there is no definitive answer at this point; that will necessarily await the results of further litigation or a determination by the Secretary of HHS that her enforcement power over the MOE requirement is limited by *NFIB*. In *NFIB* the Court expressly declined to set out a test to be applied to future coercion challenges. *NFIB*, 132 S.Ct. at 2606.

Nonetheless an analysis of the specific circumstances surrounding the particular exercise of Congress' spending power at issue in *NFIB* provides guidance regarding the potential scope and implications of that decision for purposes of challenges to other federal grant conditions. Two broad factors appear to have been central to the Court's analysis of the ACA Medicaid expansion. First, the expansion was viewed as a dramatic transformational change in relation to prior Medicaid law, constituting "a shift in kind, not merely degree," that the states could not have anticipated and to which they could not be said to have knowingly and voluntarily agreed. *Id.* In reaching this conclusion, the Chief Justice characterized the Medicaid expansion as a "new health care program," distinct from existing Medicaid, with a separate funding provision and different benefits package, intended to function as "an element of a comprehensive national plan to provide universal health insurance coverage." *Id.* Second, the threatened loss of all federal Medicaid funding to states that decline to implement the ACA Medicaid expansion, coupled with the impact of such a penalty given Medicaid's size in relation to states' overall budgets, was "economic dragooning that leaves the states with no real option but to acquiesce in the Medicaid expansion." *Id.* at 2604-05. In sum, the *NFIB* decision appears to limit the ability of the federal government to withhold all federal funding of an existing Medicaid program in order to achieve state compliance with an unanticipated and transformational requirement that effectively gives rise to a program that is different in kind – that is, to threaten the states with the loss of all funds to an existing program in an effort to get them to adopt what is effectively a new one.

Thus, after *NFIB*, issues that may be relevant to challenges to the constitutionality of other federal grant conditions, such as the ACA MOE requirement, are the extent to which such conditions amount to transformational changes to an existing program – resulting in a program different in kind, not merely degree – and the extent and relative impact on state budgets of the threatened withhold of federal funds from the existing program, such that the condition crosses the line "where persuasion gives way to coercion." *Id.* at 2606.

Before examining the potential application of these factors to the ACA MOE requirement, it is appropriate to look at the details and context of that provision. The "maintenance of effort" requirement did not originate with the ACA. As part of the American Recovery and Reinvestment Act of 2009 ("ARRA"), Pub. L. 111-5, Congress created a program in response to the economic downturn, providing states with the option of obtaining a temporary enhanced FMAP in return for maintaining until December 31, 2010, the Medicaid "eligibility standards, methodologies, or procedures" that were in effect in the state on July 1, 2008. ARRA, § 5001(f)(1)(A).⁵ In 2010 the availability of the enhanced ARRA federal matching rate was extended through June 30, 2011, again on the condition that a recipient state maintain the Medicaid "eligibility standards, methodologies, or procedures" in effect in that state as of July 1, 2008. Pub. L. 111-226. Under the ARRA MOE, states that restricted their programs' eligibility

⁵ Federal Medicaid law requires that participating states provide coverage to certain specified classes of individuals as a condition of receiving federal funding. See 42 U.S.C. § 1396a(a)(10)(A)(i). Medicaid also gives states the option to cover certain other eligibility groups, often made up of individuals whose incomes are low but exceed the mandatory eligibility standard. See 42 U.S.C. § 1396a(a)(10)(A)(ii). The Secretary of HHS also has the authority under § 1115 of the Social Security Act, 42 U.S.C. § 1315, to allow states to operate their Medicaid programs as demonstration projects, or "waivers," covering additional classes of individuals not recognized under Medicaid law.

standards prior to June 30, 2011, risked losing their enhanced Medicaid funding.⁶ Under the ACA, state Medicaid programs, “as a condition for receiving any Federal payments,” 42 U.S.C. § 1396a(gg)(1), are required to maintain the eligibility standards that were in effect as of March 23, 2010. In other words, as contrasted with the ARRA MOE requirement, the ACA MOE requirement puts a state at risk of losing all of its federal Medicaid funding, not just the amount of an enhancement, and extends the duration of the freeze of states’ eligibility standards.

Returning to the issues that appear to have been central to the *NFIB* analysis, the ACA MOE requirement meets the factor of the threatened loss of all federal Medicaid funding for noncompliant states, leaving the states with no real choice but to acquiesce. But that is arguably also the case with respect to other changes to the Medicaid program over the years that have expanded eligibility and conditioned all federal funding on states’ compliance, modifications that the Chief Justice characterized as simply adjustments to the Medicaid program that Congress was entitled to make. *NFIB*, 132 S.Ct. at 2605. And, of course, the narrow remedy fashioned by the Court in *NFIB* did not broadly invalidate 42 U.S.C. § 1396c, which gives the Secretary of HHS authority to withhold all further Medicaid payments to a state found out of compliance with a Medicaid requirement. *Id.* at 2607.

It would appear, then, that the critical issue is whether the MOE requirement of the ACA is merely a modification of the existing program or amounts to a “shift in kind, not merely degree,” that has transformed the Medicaid program. The rationale of *NFIB* suggests that, since states are required by the MOE provision to simply maintain their current Medicaid programs for a period of time, not to expand them, the ACA MOE requirement does not amount to a transformational “shift in kind”; rather, it is arguably akin to the previous eligibility adjustments to the Medicaid program that Chief Justice Roberts’ opinion suggests raise no constitutional concerns. *Id.* at 2605. On the other hand, it could be argued that the ACA MOE provision effectively changed a voluntary aspect of the program into a mandatory one. As previously discussed, states had the choice, under the ARRA MOE provision, of freezing their programs’ July 1, 2008 eligibility standards, including any optional Medicaid eligibility categories then covered by their programs, through June 30, 2011, in order to obtain enhanced federal matching funds. State could choose to not request the extra Medicaid funds and therefore remain free to restrict eligibility standards with respect to optional Medicaid categories. And states that chose to request the ARRA “stimulus” funding and temporarily maintain their Medicaid eligibility standards as in effect on July 1, 2008, put only the enhanced funding at risk if, prior to June 30, 2011, they restricted those eligibility standards. In contrast, the ACA MOE requirement not only extends the period of maintenance of eligibility but, more significantly, threatens states with the loss of *all* of their federal Medicaid funding for failure to comply. This effectively renders mandatory the freeze of eligibility, forcing states, during the timeframe of the freeze, to continue to cover in their Medicaid programs individuals above and beyond the original mandatory Medicaid eligibility groups. But whether this change is so substantial as to be considered transformational and a “shift in kind” within the meaning of *NFIB*’s constitutional analysis is debatable.

⁶ The ARRA, at § 5001(f)(1)(A), provided that “a State is not eligible for an increase [in funding]” if its eligibility standards, methodologies, or procedures are more restrictive than those in effect on July 1, 2008.

In the final analysis, one point seems clear: until the question of the constitutionality of the ACA MOE requirement after *NFIB* is definitively resolved, either through further litigation or HHS policy pronouncement that would shield the states from the sanction available to the Secretary under 42 U.S.C. § 1396c, the State of Tennessee cannot adopt “eligibility standards, methodologies, or procedures” that are more restrictive than those in effect on March 23, 2010, without subjecting itself to the threat of a withhold of all of its federal Medicaid funding.

2(b). The Medicaid program, created in 1965 when Congress added Title XIX to the Social Security Act, 42 U.S.C. §§ 1396 to -1396W-5, provides federal financial assistance to states that choose to reimburse certain costs of medical treatment for needy persons. State participation in Medicaid is purely voluntary, and all states have chosen to participate. *See NFIB*, 132 S.Ct. at 2581; *Harris v. McRae*, 448 U.S. 297, 301 (1980). While no state has ceased its participation in Medicaid, there is no legal impediment that would preclude the State of Tennessee from taking action to terminate its participation in the Medicaid program.⁷

TennCare is a demonstration program operating under a section 1115 waiver approved by CMS (hereinafter “the Section 1115 Waiver”). *See* Section 115 of Title XIX of the Social Security Act, 42 U.S.C. § 1315. *See also St. Thomas Hospital v. Sebelius*, 705 F. Supp.2d 905, 908-09 (M.D. Tenn. 2010). Medicaid waiver programs are time-limited and include an expiration date in the waiver’s special terms and conditions. The waiver under which TennCare is operating extends through June 30, 2013. *See* TennCare II Medicaid section 1115 Demonstration, *located at* <http://www.tn.gov/tenncare/forms/tenncarewaiver.pdf>. The issue of a state’s termination of its section 1115 waiver, short of the state withdrawing entirely from participation in the Medicaid program, is affected by the ACA MOE requirement, discussed above. The MOE provision does not require a state to request that CMS continue a demonstration program after the date that it would expire under its terms; in other words, the MOE requirement does not operate to force a state to renew its 1115 waiver. If a state chooses to not renew its waiver at the end of the waiver approval period, that would not constitute a MOE violation. On the other hand, if a state were to choose to terminate its waiver before the expiration of its approval period, that would violate the ACA MOE provision to the extent that such termination results in more restrictive eligibility standards, methodologies, or procedures. *See* State Medicaid Director Letter (Feb. 25, 2011), *located at* <http://www.cms.gov/smdl/downloads/SMD11001.pdf>.

3. The Medicaid federal matching payment formula is the same, whether a state operates its Medicaid program under a section 1115 waiver or a Medicaid State plan.⁸ There is no basis

⁷ The United States Constitution does not set forth an explicit right to health care, and the United States Supreme Court has never interpreted the Constitution as guaranteeing a right to health care services from the states or the federal government for those who cannot afford it. *See* Kathleen S. Swendiman, Cong. Research Serv., R40846, *Health Care: Constitutional Rights and Legislative Powers* (July 9, 2012). The State of Tennessee has explicitly provided that “participation in the TennCare program, or its successor programs, is not an entitlement and is conditional upon, among other things, specific appropriations for the program.” Tenn. Code Ann. § 71-5-102(b)(1).

⁸ The federal matching payment formula is a Medicaid program element that the Secretary of HHS does not have authority to waive. Section 1115(a)(1) of the Social Security Act, 42 U.S.C. § 1315(a)(1), only authorizes the Secretary to waive Medicaid provisions included in section 1902 of the Social Security Act, 42 U.S.C. § 1396a.

to conclude that the ability of the federal government to decrease the level of federal financial participation in the Medicaid program, as discussed in response to question 1 above, depends on whether the state operates its program under a section 1115 waiver or a State plan.

The limitation on the State’s ability to put in place more restrictive eligibility standards, methodologies, or procedures arising from the ACA MOE requirement, as discussed in response to question 2(a) above, applies to both a Medicaid State plan and any waiver. *See* 42 U.S.C. § 1396a(a)(74) (maintenance of effort must be provided for “under the State plan or under any waiver of the plan in accordance with subsection (gg)”); 42 U.S.C. § 1396a(gg)(1) (“ . . . a State shall not have in effect eligibility standards, methodologies, or procedures under the State plan under this title or under any waiver of such plan”)

Accordingly, the existence of a legal impediment to the State taking action to terminate entirely its participation in the Medicaid program does not depend on whether the State operates its Medicaid program under a waiver or a State plan. However, as discussed in the analysis in response to question 2(b) above, and as described more fully by CMS in the cited letter to State Medicaid Directors, the timing of a termination of TennCare’s current 1115 waiver could subject Tennessee to the loss of federal Medicaid funding arising from a violation of the ACA MOE requirement.

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The formula setting the federal medical assistance percentage (FMAP) rate that HHS uses in determining the amount of federal matching funds is found at 42 U.S.C. § 1396d(b).