



Division of TennCare

TennCare II Demonstration

Project No. 11-W-00151/4

Amendment 42

DRAFT

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Executive Summary

In this amendment, Tennessee proposes to convert the federal share of its Medicaid funding relating to providing its core medical services to its core population to a block grant. This innovative proposal reimagines the Medicaid financing structure in ways that emphasize state accountability for effective program management, while incentivizing performance and ensuring that financial responsibility for Tennessee's Medicaid program continues to be equitably shared between the state and the federal government.

The traditional model of Medicaid financing is an outdated model of fundamentally misaligned incentives. In the current framework, states that spend more money receive additional federal dollars, while states that strive to control costs and reduce spending receive reductions in federal funding. New models of Medicaid financing are needed that reward states for promoting value and health, not merely spending more money.

Tennessee's Medicaid program already operates under an 1115 demonstration waiver (known as "TennCare"). Under this demonstration, Tennessee operates one of the most cost-effective Medicaid programs in the nation, routinely underspending the federal government's projections for what Tennessee's Medicaid program would cost without the 1115 demonstration (otherwise known as the state's "budget neutrality cap") and saving the federal government and taxpayers billions of dollars.

In this amendment, Tennessee proposes to demonstrate how, by using the federal government's projections for the state's program costs without the 1115 demonstration as the basis for its block grant amount, the incentives between the state and federal government can be appropriately realigned so that TennCare can invest in and realize even better health outcomes for the Tennesseans it serves. Consistent with the block grant framework, Tennessee proposes that in any year in which the state underspends its block grant, the state and the federal government share in the resulting savings. This opportunity to share savings with the federal government appropriately recognizes the state's efforts to contain costs and improve program quality, while providing a meaningful incentive to continue building on those efforts to make TennCare a stronger and more effective program.

Key features of the state's proposal include:

- No reductions in who is eligible for or what benefits are currently provided in TennCare.
- The proposed block grant will be calculated based on average TennCare enrollment during State Fiscal Years 2016, 2017, and 2018, then multiplied by the federal government's projections of what Medicaid costs would be in Tennessee absent the existing TennCare demonstration (the "Without Waiver" projections currently used to calculate budget neutrality).

- Any year in which TennCare's enrollment grows beyond its average enrollment during the base period of 2016 through 2018, the block grant amount will be adjusted on a per capita basis to compensate the state for this enrollment growth. This per capita adjustment ensures the state will continue to be able to provide medical assistance to all eligible individuals, regardless of changes in the economy or other factors outside the state's control.
- The amount of the block grant will be inflated annually to account for year-over-year price inflation. The inflator factor will be based on Congressional Budget Office projections of growth.
- In any year in which the state underspends the block grant amount, the state will retain 50 percent of the federal share of those savings.
- Any savings achieved under the block grant will be reinvested in the TennCare program with no requirement that the state must first spend state dollars in order to spend these shared savings. The state will also seek the authority to invest in the *health* of its enrollees, not just their healthcare.
- The costs driving the block grant calculation will only be those covering core medical services to TennCare's core population. All other expenses (e.g., costs of services provided under the state's 1915(c) waivers, costs of targeted case management services provided to children in state custody, administrative costs, uncompensated care payments to hospitals) will be excluded from the block grant and continue to be financed through the processes and mechanisms currently in place. In addition, the cost of outpatient pharmacy services will also be excluded from the block grant calculation.
- All costs excluded from the block grant calculation will continue to be funded in the same manner in which they are currently funded with the same levels of federal match provided based on the FMAP for the applicable year.
- Under the block grant, the state would also have flexibility from excessive or unnecessary federal intervention in its Medicaid program. These flexibilities will allow the state to administer its program more effectively to promote the health of TennCare members.
- The flexibilities requested by the state are focused primarily on issues that will empower the state to implement improvements, efficiencies, and other reforms to make TennCare stronger and more effective, without negatively impacting who is eligible for the program or what services they may be eligible to receive.
- The costs associated with any new population the state opts to cover in the future, even if it would otherwise be considered a core population, will be excluded from the block grant

calculation for a period of years until the state has enough experience paying for services for this population to update the block grant formula in a financially sound manner.

Tennessee's Medicaid block grant proposal represents a natural progression of the state's history of nationally recognized innovation and financial management. It also ensures that TennCare members continue to receive high-quality, cost-effective care well into the future.

It is a bold and ambitious proposal that holds Tennessee accountable for continued leadership in innovation, high-quality care that improves health, and rigorous fiscal stewardship. It challenges the federal government to make good on its commitment to more fully partner with states to move past unnecessary administrative and regulatory burdens.

Tennessee is volunteering to be the leader in reforming the financial incentives in Medicaid to show that it is not only possible but desirable to ensure that states are relentlessly driving quality in care, efficiency in program administration, innovation in serving enrollees, and sustainability in how we serve some of our most vulnerable residents.

Amendment 42 to the TennCare II Demonstration

Tennessee has a long history of innovation in its Medicaid program. Since 1994, Tennessee has operated one of the longest-lasting and most comprehensive Medicaid managed care programs in the nation. In so doing, Tennessee has become a recognized leader in the use of managed care to provide broad access to care, deliver high-quality care that promotes improved health outcomes, and manage the cost of care effectively. Tennessee operates its managed care program under the authority of an 1115 demonstration waiver known as TennCare. In this proposed amendment to the TennCare demonstration, Tennessee proposes a new phase of innovation, both for TennCare and for the Medicaid program generally. Amendment 42 proposes a block grant financing structure for the TennCare program. This new model of Medicaid financing emphasizes performance, accountability, flexibility, and innovation and, most importantly, solves the problem of misaligned financial incentives whereby the federal government invests more federal money into a state Medicaid program only as the state spends more money, an approach that has led to states like Tennessee being punished for being financially well managed.

I. Historical Context and Background

The early 1990s were a period of extreme financial stress for state Medicaid programs. The traditional fee-for-service state Medicaid model was experiencing significant medical inflation driven by increased healthcare costs and service utilization. The option to cut back state Medicaid programs in response to the escalation of medical costs, contemplated by many states, would have the perverse effect of reducing the federal matching funds available to states for their Medicaid programs.

Although the financial pressures facing Tennessee's Medicaid program were no different than those facing every other state, Tennessee chose a new path forward. Rather than scaling back its Medicaid program or continuing to dedicate an ever-increasing share of its state budget to the program, Tennessee chose to engage in a fundamental reform of both its healthcare delivery and financing systems. This new model, known as TennCare, went into effect in 1994.

The TennCare program has gone through multiple iterations and reforms since its inception in 1994. However, the core values of the program—broad access to care, improved health status of program participants, and cost effective use of resources—remain much the same. Under the TennCare program today, Tennessee extends coverage to more people than would otherwise be eligible for coverage under the state's traditional Medicaid program; it offers members a richer package of benefits than was previously covered under Medicaid; and it does so in a more fiscally prudent and sustainable way. Tennessee's success in expanding eligibility and benefits while also managing program costs effectively is a testament to the state's ability to pursue innovation to strengthen the healthcare delivery system and deliver value both for TennCare members and Tennessee taxpayers. In more recent years, TennCare has partnered with providers to implement a number of value-based payment arrangements that have increased or maintained quality of care delivered to members while reducing the cost of

delivering that care; these models have begun to be adopted by commercial payers inside and outside the state of Tennessee.

In 2019, state Medicaid programs again face a period of growing financial strain. The unsustainable growth of healthcare costs in the United States has put enormous financial pressure on states seeking to provide high-quality healthcare to the individuals and families enrolled in Medicaid programs across the country. Continuing to increase state and federal Medicaid spending year after year is not sustainable and has done nothing to alleviate the financial pressures on the state and federal budgets. Clearly the future success of the Medicaid program depends on finding new models to finance the cost of care in ways that promote high-quality care and improved health outcomes while also being cost effective and fiscally responsible for states. These new models should move beyond the traditional Medicaid financing system in which states simply receive additional federal dollars for increasing their spending. Rather, state efforts to improve quality of care and health outcomes while managing costs effectively should be recognized for and supported in their efforts. In particular, federal financial participation (FFP) in Medicaid should be distinguishable across states not just based on a federal matching assistance percentage (FMAP) but also on allowing states opportunities to earn additional federal investment into their state through high performance and good stewardship.

As a mature managed care program that has already implemented the cost management strategies available within the current system, TennCare now finds itself in a position of needing to identify or develop new, innovative care delivery approaches that may require short-term investments of new dollars, but which will—over time—reduce (or at least contain the growth of) the cost of care. And failing to innovate and invest in the health of Tennesseans is also not a responsible option.

Accordingly, Tennessee is proposing in this amendment to build on its history of innovation in its Medicaid program by reimagining the Medicaid financing model, and with it the relationship between the state and federal government. Tennessee's proposal is predicated on the simple idea that in general, the state is in a better position than the federal government to direct TennCare spending in order to most effectively promote the health of the TennCare population. Therefore, if given sufficient flexibility, the state can manage its Medicaid program more effectively within a block grant financing model than under the traditional Medicaid financing model.

The state's confidence that it can manage its program efficiently under a block grant is borne out of its long history of effective program administration. Based on this history of prudent and effective management, TennCare's transformed Medicaid service delivery system has already produced and continues to produce significant value for both Tennessee and the federal government by managing program growth at a lower rate than Medicaid programs nationally. CMS's own projections of the savings achieved on behalf of the federal government under the TennCare demonstration total billions of dollars. However, moving beyond what has already been achieved to pursue additional sources of value and new strategies to promote improved health outcomes will require rethinking the way Medicaid works today. This new approach must emphasize the critical role of states, not the federal government, as the facilitators of meaningful intervention in the lives of Medicaid members and as the

primary drivers of innovation that are particularly suited to the needs of their population in response to the challenges of today's healthcare market.

As in past periods of innovation, Tennessee's response to the challenges of increased costs is *not* to retrench by scaling back program eligibility or benefits. The state's proposal does not rely on reductions to eligibility or benefits in order to achieve savings, and indeed, does not request any significant changes in those areas.¹ Rather, the state believes that there are opportunities to deliver healthcare to its current membership more effectively and that, if given sufficient flexibility to pursue meaningful innovation, TennCare could implement new reform strategies that would reap benefits for both the state and the federal government and produce meaningful impacts in the lives of the members the state serves.

Rather than seeking to reduce eligibility or benefits, Tennessee's block grant proposal is designed to allow the state the flexibility to pursue and promote core healthcare reform principles, such as

- consumer empowerment and choice, so that members have more information and control over their healthcare options;
- member engagement, to allow members to become better healthcare consumers;
- community-based solutions, to recognize the role that factors beyond healthcare play in promoting and maintaining health;
- prevention and wellness, to better ensure that members receive individualized care that is outcomes-oriented and focused on prevention, wellness, recovery, and maintaining independence;
- competition and value, to allow for greater competition between healthcare providers and ensure cost effective purchasing strategies that promote value for taxpayers; and
- pay for performance, to deploy TennCare's purchasing power to encourage and reward service quality and cost effectiveness by linking reimbursement to quality performance measures.

The state is confident that this proposal is a responsible and appropriate policy for Tennessee and for the federal government. It recognizes Tennessee's history of innovation and prudent financial management and opens up new pathways for the state to invest in *health* (not merely healthcare). It continues to ensure an equitable partnership between the state and federal government, while recognizing that it is ultimately the state—as the entity responsible for administering TennCare—that is in the best position to identify and implement solutions that are right for Tennessee, that align with Tennessee values, and that will drive improvements in health outcomes for TennCare members. The flexibilities provided under this proposal will allow the state to manage Tennessee's Medicaid program in ways that best meet the needs and unique consumer context of Tennesseans, as well as afford the state the opportunity to implement additional innovative solutions within the TennCare program to address problems faced by Tennesseans today. The state's proposal will help preserve and build on the

¹ As described in Section IV below, the only additional flexibilities requested by the state with regard to eligibility or benefits are common-sense measures consistent with the larger block grant framework of improving program efficiency, and which are intended to make the TennCare program stronger and more effective.

gains that have already been achieved under the TennCare demonstration and to pursue changes in the organization, finance, and delivery of services that will make the program more effective into the future.

II. Amendment Overview

The proposed demonstration will transform the traditional Medicaid financing structure in Tennessee to a block grant. Within the current Medicaid financing system, states can only access additional federal dollars by increasing their spending of limited state dollars. States seeking to control the growth of healthcare costs face the perverse incentive of reduced federal funding rather than being rewarded for their good stewardship, while the federal government reaps significant financial benefits from the states' efforts to manage, rein in, and lower the cost of care. Under the state's proposal, however, the federal government's financial commitment to the state will be re-worked to create a floor under which federal contribution will not be reduced in any demonstration year, an increasing federal contribution when enrollment increases beyond the experience used to calculate the floor, and a re-investment in the state of a portion of any federal dollars the state saves through good stewardship and financial management of the TennCare program.

This proposed demonstration will allow both the state and the federal government to predict the budget for the TennCare program with increased certainty and will rightfully allow a portion of the federal dollars saved by the state to be reinvested in the state's needy populations. This proposal represents a significant opportunity for the federal government to test a potential innovative, national solution at how to incentivize states' performance in maximizing the value of taxpayer dollars. Tennessee is asking the federal government to hold it to a similar standard as that to which Tennessee holds its managed care organizations—to assume responsibility for the risk of managing care, with corresponding financial incentives to reward efforts to reduce costs, improve quality, and improve outcomes.

Key Considerations

The goal of the state's proposal is to demonstrate that an alternative model of federal participation in state Medicaid programs—a model that emphasizes state flexibility and innovation and that rewards high performance—will lead to Medicaid programs that are more successful in promoting the health of beneficiaries and more financially sustainable for states and the federal government. If implemented thoughtfully, such a model would reap benefits for both states and the federal government and serve as a model for Medicaid reform efforts nationally.

In developing this demonstration proposal, Tennessee has been guided by three key considerations (illustrated in the figure below).



These key considerations have guided and informed the state's proposed demonstration.

Recalibrating the State-Federal Partnership to Share with the State a Portion of the Dollars the State Saves the Federal Government

Like all Medicaid demonstration projects authorized under Section 1115 of the Social Security Act, "budget neutrality" is a condition of TennCare's continued approval and operation. In essence, the principle of budget neutrality means that the TennCare demonstration cannot result in costs to the federal government that are greater than what the federal government would have spent on Tennessee's Medicaid program in the absence of the TennCare demonstration. To assess budget neutrality, CMS subjects each state demonstration to a budget neutrality test, which results in limits that are placed on the amount of federal Medicaid funding the state may receive over the course of the demonstration approval. These budget neutrality expenditure limits are based on CMS's reasonable projections of future spending trends based on methodologies developed and used by the Congressional Budget Office (CBO), and therefore the amount of federal financial participation that CMS estimates the state would receive in the absence of the demonstration.

This context is critical to understanding the state-specific factors that have informed the development of Tennessee's block grant proposal. The TennCare program has operated under the authority of an 1115 demonstration since 1994. The primary principle being demonstrated by TennCare is that a state can organize its Medicaid service delivery system under managed care more cost effectively than it can through a fee-for-service system, without compromising access to or quality of care. This being the case, TennCare is already subject to a budget neutrality expenditure limit that has been in place for a number of years. Under this system, CMS has calculated a set of "Without Waiver" amounts that represent what the state and federal government would have spent on Tennessee's Medicaid program in the absence of the TennCare demonstration. These "Without Waiver" figures are calculated by CMS based on CBO projections and on CMS's own policies and methods for reasonably projecting program costs. CMS monitors TennCare expenditures on a continuous basis, and by CMS's own calculations, the

TennCare demonstration has resulted in billions of dollars of savings for the federal government each year, as reflected in TennCare’s performance against CMS’s budget neutrality projections.

In Amendment 42, Tennessee is proposing an innovative new financing model for its Medicaid program that reconceives the partnership between the state and federal government. Under the state’s proposal, the state will assume the primary risk for managing its program within available resources. However, based on its performance in managing program costs effectively, the state will also have an opportunity to share in the savings that have historically accrued to the federal government as a direct result of the efficiencies implemented under the TennCare demonstration and the partnership the state has with the many healthcare providers who deliver care to the TennCare members throughout the state.

This new financing model emphasizes state accountability for effective program management, because any shared savings earned by the state will be based directly on the state’s performance in delivering high-quality, cost-effective care to its members, while also incentivizing performance and ensuring that financial responsibility for Tennessee’s Medicaid program continues to be equitably shared between the state and the federal government. In essence, Tennessee is asking the federal government to hold it to a similar standard as that to which Tennessee holds its managed care organizations—to assume responsibility for the risk of managing care, with corresponding financial incentives to reward efforts to reduce costs, improve quality, and improve outcomes.

III. Proposed Financing Model

The state’s proposed financing model consists of three main components:

1. A **block grant amount** calculated based on CMS’s projected cost of providing care to the TennCare member population. This block grant amount will become a floor below which federal financial participation in Tennessee will not fall over the life of the demonstration. The block grant amount will be inflated each year—by specified member categories—on a predetermined index used by the CBO for comparable enrollment categories.
2. **Per capita adjustments** to the block grant amount to reflect growth in TennCare enrollment that may occur in future years that was not present in the base period enrollment on which the block grant is calculated.
3. A **shared savings mechanism** recognizing that all savings to the federal government reflected in TennCare’s actual costs compared to the CMS projected without waiver costs are attributable solely to the state’s hard work and that the state should share equitably with the federal government in those savings by having them directly reinvested into the state.

Block Grant Calculation

The state's block grant amount will be calculated as follows:

1. Base Period Average Enrollment

The state's block grant amount will be based on average TennCare enrollment over the three most recent state fiscal years for which all enrollment data are final. Those state fiscal years are 2016, 2017, and 2018.

The block grant amount will be calculated based on discrete member categories, which have a history of different expenditure patterns or cost profiles and, thus, pose differing levels of risk to the state. These are member categories that CMS currently uses to hold the state accountable for spending under the TennCare demonstration. These categories are:

Enrollee Category	Definition
Blind and disabled	Enrollees who are eligible for TennCare on the basis of being blind or disabled, or who otherwise meet the definition of being blind or disabled.
Elderly	Enrollees who are 65 years of age or older who are not in the blind or disabled category.
Children	Enrollees under 21 years of age who are not in the blind and disabled category.
Adults	Enrollees ages 21 through 64 who are not in the blind and disabled category.

2. Projected Member Cost (Without Waiver Per Member Per Month Projected Cost)

As part of the existing 1115 demonstration agreement between Tennessee and CMS, the federal government requires the state to demonstrate that the TennCare program saves the federal government money. To do so, CMS calculates a projection of what it would otherwise cost to provide medical services to Tennessee's Medicaid population in the absence of the TennCare demonstration. This "Without Waiver" cost is calculated by CMS on a per member per month (PMPM) basis for each of the four member categories included in the block grant. Tennessee is proposing to use these federal projections of per member Medicaid costs in Tennessee as the basis for its block grant.

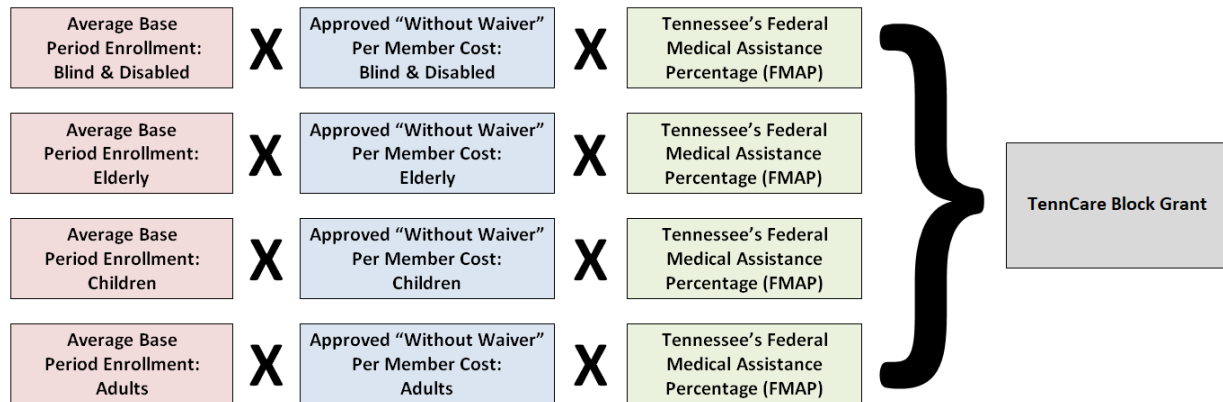
Because the state is proposing to exclude pharmacy costs from the block grant (see *"Excluded Expenditures" discussion below*), Tennessee has adjusted the CMS-calculated "Without Waiver" costs to remove pharmacy-related expenses.

3. Formula for Calculation

- 3.1. For each member category [*blind and disabled, elderly, children, adults*], calculate TennCare's average enrollment over the three years of the base period (SFYs 2016-2018). The resulting averages represent TennCare's base period enrollment.
- 3.2. For each member category [*blind and disabled, elderly, children, adults*], multiply the base period enrollment by the category's "Without Waiver" expenditure amount in TennCare's approved budget neutrality agreement. The resulting products represent the projected cost of providing care to TennCare's member population.
- 3.3. Multiply each of the products calculated in Step 3.2 by the state's federal medical assistance percentage (FMAP) to arrive at the federal share of projected costs for each member category.
- 3.4. The resulting amounts for the four member categories are summed to form the state's block grant amount.

The calculation of Tennessee's proposed block grant is illustrated in the figure below.

Figure 1. Illustration of Tennessee's Block Grant Calculation Methodology



Applying this methodology results in a block grant amount for Tennessee of approximately \$7.9 billion. See figure below.

Figure 2. Calculation of Tennessee's Block Grant Amount, Year 1

(Multiplying these columns may not produce exactly the numbers displayed due to rounding.)

	Base Period Enrollment (Average Member Months, SFYs 2016-2018)	Federal Projection of Per Member Cost ("Without Waiver" Projections)**	Block Grant Amount
Category	(A)	(B)	(C) = (A) x (B) x .65
Children	9,882,651	\$ 513.63	\$ 3,299,403,512
Adult	4,281,728	\$ 1,024.68	\$ 2,851,813,764
Elderly*	64,679	\$ 1,193.59	\$ 50,180,139
Disabled	<u>1,603,682</u>	\$ 1,590.07	<u>\$ 1,657,476,983</u>
Total	15,832,740		\$ 7,858,874,398

*Tennessee's proposal excludes Medicare members from the calculation of the block grant. See "Excluded Expenditures" discussion below.

**Projected "Without Waiver" costs have been adjusted to exclude prescription drug costs. See "Excluded Expenditures" discussion below.

Once calculated, the block grant amount will be trended forward from 2018 to the first year of the demonstration using an inflation factor based on CBO projections for growth in Medicaid spending. The inflation factor will be applied by member category. Then, after the first year (and each subsequent year) of the demonstration, the state's block grant amount will be trended forward annually to reflect inflation in the same manner.

Per Capita Adjustments for Member Growth

As described above, the state's block grant amount will be based on TennCare's average enrollment in four member categories during a specified base period (SFYs 2016-2018). If during the course of the demonstration, TennCare's actual enrollment in any of these categories exceeds the category's average enrollment during the base period, then the state's block grant will be adjusted on a per capita basis to reflect the increase in membership. The per capita adjustment will be equivalent to the federal portion of the appropriate "Without Waiver" expenditure amount (the same number used to calculate the initial block grant amount for the member category in which enrollment has increased), trended forward by the inflation factor, and multiplied by the number of additional members above the average base period enrollment.

The per capita adjustment ensures the state will continue to be able to provide medical assistance to all eligible individuals, regardless of changes in the economy or other factors outside the state's control that may result in an increase in TennCare enrollment.

Shared Savings

The shared savings component of the block grant is a key feature and a necessary component of the state's proposal. The current Medicaid financing system is built around misaligned incentives in which states must increase their Medicaid spending in order to draw down additional federal dollars, even after a state like Tennessee has worked diligently to manage the cost of care, resulting in billions of dollars of savings to the federal government. States that partner with providers to implement efficiencies to improve program administration, engage in reform efforts to drive down the cost of care, and improve the lives of members by emphasizing the purchase of high-quality care are "rewarded" for these significant efforts with reductions in federal funding. Any serious effort to reform Medicaid financing must recognize the role of states as equity partners with the federal government in the financing of Medicaid and re-align incentives so that states are rewarded, not penalized, for effectively managing the cost of care (while still maintaining access and quality). New financing mechanisms should also support, not discourage, the state investments necessary to implement large-scale value-based payment and delivery system reform initiatives. In short, the better a state performs in the administration of its Medicaid program, the more opportunity it should have to attract federal investment in its state to enhance the services it provides in order to drive even larger-scale improvements in the health of its population.

Under the state's proposal, any year in which the state does not spend the entirety of its federal block grant represents a year in which the state has saved money for the federal government (since the block grant amount is calculated based on the federal government's projection of what it would have otherwise spent on Tennessee's Medicaid program absent the program efficiencies implemented by the state under its demonstration). In recognition of this, the state and federal government will share in any savings generated under the block grant. Specifically, the state will retain half (50 percent) of the saved amount, and the federal government will retain half (50 percent) of the saved amount.

Excluded Expenditures

As described above, the calculation of the state's block grant amount will be based on projected medical assistance expenditures for individuals in various member categories. Some TennCare expenditures are outside the scope of the regular medical assistance furnished to beneficiaries. Other expenditures lie either wholly or partially outside the state's ability to manage or control. Therefore, the state proposes to exclude certain expenditures from the block grant financing model described above. Specifically, the state proposes to exclude:

1. Services that are currently carved out of the state's 1115 demonstration (e.g., services provided to individuals with intellectual disabilities under the authority of a separate 1915(c) waiver; targeted case management services provided to children in state custody)²;
2. Outpatient prescription drugs;

² See Table 3 of the TennCare demonstration for list of Medicaid services carved out of the TennCare 1115 demonstration (<https://www.tn.gov/content/dam/tn/tenncare/documents/tenncarewaiver.pdf>).

3. Disproportionate Share Hospital (DSH) payments, Critical Access Hospital (CAH) payments, Essential Access Hospital (EAH) payments, and similar payments made directly to hospitals from the uncompensated care funds authorized under the TennCare demonstration;
4. Expenditures on behalf of individuals who are enrolled in Medicare, including cost sharing and premium assistance (including Medicare Part D “claw back” payments) paid on behalf of individuals who are dually enrolled in Medicare and TennCare; and
5. Administrative expenses which are not treated as medical assistance expenditures for FMAP purposes.

These expenditures, and any comparable expenditures agreed upon by the state and CMS, will continue to operate under the payment and financing processes currently in place (based on annual updates to the state’s FMAP). Accordingly, they are also excluded from the calculation of the block grant amount described above.

Avoiding Disincentives for Future Program Changes

Given the proposed changes to the state’s federal funding, it is expected that Tennessee will be exempt from any new federal mandates over the life of the demonstration that could have a material impact on the state’s Medicaid expenditures (e.g., mandates concerning eligibility or covered benefits). To the extent that Congress or CMS imposes additional requirements on the state during the course of the demonstration, the state’s block grant amount must be adjusted to account for any new expenses.

It is also possible that the state may elect to initiate programmatic changes that may have a material impact on expenditures during the life of the demonstration (e.g., coverage of a new population). In general, the state anticipates that such expenditures would be financed outside of the block grant via the traditional Medicaid financing model for a period of up to three years. Once the state and CMS have sufficient experience with the program modification, the state’s block grant amount will be adjusted accordingly so that the new expenditures can be integrated into the block grant.

State Maintenance of Effort

Under this proposal, the financing of Tennessee’s Medicaid program will no longer operate under the traditional Medicaid financing model. Instead of drawing down federal dollars based on a fixed percentage, the federal government will provide a block grant of federal funds to the state for the operation of its Medicaid program. In order to ensure adequate funding for the state’s program and to preserve the nature of the state-federal partnership that has historically characterized the Medicaid program, under this proposal the state commits to maintenance of effort with regard to the non-federal share of TennCare funding based on state expenditures on TennCare during state Fiscal Year 2019, trended forward each year the block grant is in effect.

Medicare Wage Index Adjustment

In addition to the core block grant model described above, the state also proposes that when considering the state's block grant amount, CMS recognizes the low levels of federal reimbursement that hospitals in Tennessee receive from Medicare. These low levels of Medicare reimbursement are based in large part on how CMS has historically calculated the Medicare Wage Index. Under the historic wage index, hospitals in states like Tennessee that have a large number of rural counties served by small community hospitals receive disproportionately low reimbursement from Medicare.

The state acknowledges and supports CMS's recent action to promulgate regulations revising certain aspects of the Medicare Wage Index calculation. While these regulations will mitigate the extent to which small hospitals in rural communities are unfairly disadvantaged by the wage index calculation, under the new methodology many of these facilities may continue to suffer from inadequate federal support. The state urges CMS to consider this in determining the amount of the state's block grant.

IV. State Flexibilities

A key benefit of a block grant is the flexibility afforded the state to manage its Medicaid program without unnecessary or excessive interference or mandates from the federal government. Simply put, the state is in a better position than the federal government to direct TennCare spending in order to most effectively promote the health of the TennCare population. This flexibility is essential both to ensuring that the state can be successful in managing its Medicaid program within the new block grant financing arrangement, as well as achieve its policy goals of improving the cost effectiveness, quality of services, and health outcomes achieved by the TennCare program.

Given this understanding, it is not the intention of the state to enumerate in detail in this document every innovation, reform, or policy change that might take place over the life of the demonstration, since the purpose of the block grant is precisely to give the state a range of autonomy within which it can make decisions about its Medicaid program. Rather, the state has identified a discrete set of reasonable flexibilities that will provide the context in which the state can make meaningful decisions about program management without the need for unnecessary federal approvals; initiate new policies designed to drive program improvement; or respond to changes in demographics, economic conditions, or emerging public health issues. The state will work with CMS to determine what reporting processes (if any) are necessary in order to keep CMS adequately apprised on the progress of the state's demonstration; however, consistent with the conceptual framework of the block grant, routine programmatic changes will not require CMS approval.

The flexibilities requested by the state as a part of its block grant model are as follows:

Investing in Health, Not Just Healthcare

CMS has long used the authority afforded by Section 1115 of the Social Security Act to allow states to spend federal Medicaid funds on “costs not otherwise matchable,” when CMS determines that such expenditures are likely to advance the objectives of the Medicaid program. Under the financing mechanism envisioned in this demonstration, Tennessee will receive a block grant of federal funds to support the operation of the TennCare program. While it is anticipated that the bulk of the block grant will be spent on traditional TennCare expenses—that is, paying to provide medically necessary covered services to members—under the proposed demonstration the state will have the flexibility to spend block grant dollars on items and services not otherwise covered under TennCare, or not otherwise eligible for federal match, if the state determines that such expenditures will benefit the health of members or are likely to result in improved health outcomes.

Such expenditures could include services for members in Institutions for Mental Diseases (IMDs) when such services are determined to be medically necessary and appropriate, services to address social factors with a direct impact on member health (e.g., nutritional assistance, housing supports), transition services for individuals preparing to exit correctional settings who are likely to be eligible for TennCare, health home strategies to better coordinate care for members with intellectual or other developmental disabilities, and other items and services as determined appropriate by the state.³

The state commits that its use of block grant funds will be limited to items and services with a demonstrable connection to TennCare member health. In other words, block grant funds will not be used by the state for other purposes, such as tourism development, financial institution regulation, routine infrastructure maintenance, etc. However, the state may elect to use block grant funds on public health initiatives that are not specifically targeted at the TennCare population but which can reasonably be expected to result in health benefits for the TennCare population (e.g., supporting provider transformation efforts in rural or underserved areas of the state that support access to care for TennCare members and other Tennesseans; see section on rural health transformation below for additional discussion).

Freedom to Use the Same Tools as Medicare and Commercial Payers to Lower Drug Costs

Rapidly growing pharmaceutical spending poses an important risk for the financial sustainability of TennCare and of state Medicaid programs generally. It is for this reason that the state has proposed to exclude outpatient prescription drugs from the block grant. However, the expense associated with prescription drugs, especially specialty and orphan drugs, is a challenge of such severity that the state’s inability to implement strategies to control the growth of drug prices will undermine the effectiveness of this proposal.

³ This list is intended to be illustrative only. The state is not committing to spend block grant dollars on the services listed in this paragraph, or to limit its potential use of block grant funds to only these services. The point being made is that under the block grant the state will have flexibility to spend its federal dollars in ways that it determines will best promote the health of its members, even if such expenditures are not traditionally eligible for federal match under the Medicaid program.

Although pharmacy benefits are technically optional benefits for adults, Tennessee is committed to ensuring that its Medicaid beneficiaries have access to needed medications. However, the federal government has deprived state Medicaid programs of basic formulary management tools commonly used by other payers to manage prescription drug spending. Whereas commercial payers can elect whether or not to cover drugs based on considerations such as clinical efficacy and affordability, TennCare is required to cover any drug for which the manufacturer participates in the federal Medicaid drug rebate program. This coverage mandate, coupled with the volatility of prescription drug costs and the state's lack of authority to meaningfully manage its prescription drug benefit, leads to extreme financial pressures for states.

The state proposes that it have the flexibility under this demonstration to adopt a commercial-style closed formulary with at least one drug available per therapeutic class. Adopting this strategy would allow the state to negotiate more favorable rebate agreements with manufacturers, since—for each therapeutic class—the state could offer manufacturers an essentially guaranteed volume in exchange for a larger rebate, which would generate savings for the state and federal government and would help mitigate the state's exposure to ever-increasing trends in the growth of pharmaceutical prices. In addition, much of the current volatility in prescription drug prices is driven by new drugs coming to market through the FDA's accelerated approval pathway. Despite the enormous costs of some of these new drugs, many of them have not yet demonstrated actual clinical benefit and have been studied in clinical trials using only surrogate endpoints. The state proposes that it have flexibility to exclude these new drugs from its formulary until market prices are consistent with prudent fiscal administration or the state determines that sufficient data exist regarding the cost effectiveness of the drug. Adopting these practices would allow TennCare to implement the same basic formulary management strategies available to virtually all other payers and avoid exorbitant spending on high-cost drugs that are not medically necessary, which do not provide additional clinical benefit, and/or which actually pose health risks for members when prescribed without sufficient medical evidence, while continuing to ensure that members have access to at least one effective, medically necessary medication in every therapeutic class.

If the state is permitted this flexibility to apply reasonable formulary management tools to help control the cost of its prescription drug benefit, then the state is open to the possibility of incorporating its prescription drug benefit into the block grant financing system in the future.

Leveraging Medicaid as a Catalyst to Promote Rural Healthcare Transformation

Healthcare for patients in rural communities across the United States remains an enduring challenge. This challenge is magnified in disproportionately rural states like Tennessee. In many rural states, Medicaid is uniquely positioned to provide leadership for rural health transformation initiatives as the largest statewide payer (other than Medicare) with member and provider relationships in all areas of the state.

Under the proposed demonstration, the state will have the flexibility to strategically invest block grant funds to support rural health transformation efforts intended to either improve access to care for members in rural communities or improve the quality of care those members receive. This could include working with healthcare providers to support the adoption of technologies to overcome some of the traditional challenges associated with ensuring patient access to up-to-date specialist care (e.g., electronic consultation, telemedicine). This could also include working with providers in rural communities to develop and implement new payment and service delivery models that incentivize value and outcomes to drive improvements in both individual and population health, while ensuring that the cost of care is sustainable for healthcare providers, their communities, and the state. One significant challenge to the sustainability of the cost of care in many rural communities is the expense of infrastructure required by current regulations; with additional flexibility to support rural health transformation efforts, the state could help support the transition of facilities to more sustainable, community-appropriate models.

Delivering the Right Care to the Right Members

Like all Medicaid programs, TennCare covers a variety of discrete member populations. These include children, elderly individuals receiving long-term care, pregnant women, individuals with physical or intellectual disabilities, parents of dependent children, foster care children (including young adults who have recently aged out of foster care), individuals receiving treatment for breast or cervical cancer, and others.⁴ Although the federal government allows states some flexibility in establishing their Medicaid benefits packages, in general states are constrained by the requirement of *comparability*. This federal restriction requires that within a state, covered benefits must be the same (i.e., covered in the same amount, duration, and scope) for all covered populations (with certain exceptions). Although this Medicaid requirement is longstanding, it is not obvious that the actual medical needs of a pregnant woman and those of a disabled SSI recipient (for example), or those of a member of any of Medicaid's diverse other member populations, are in fact the same.

The current policy framework is unnecessarily limiting and constrains states in a number of important ways. For example, the comparability requirement prevents a state that wishes to explore emerging therapies and treatment modalities from implementing limited pilot programs designed to assess their clinical efficacy and potential cost effectiveness, or to use a small-scale pilot process to inform the statewide rollout of a new benefit or service.⁵ Alternatively, a state may determine (for example), based on the clinical literature around perinatal health and vertical disease transmission between pregnant

⁴ See Table 1a of the TennCare demonstration for a complete listing of populations covered by TennCare (<https://www.tn.gov/content/dam/tn/tenncare/documents/tenncarewaiver.pdf>).

⁵ In 2017, for example, Tennessee wished to implement a pilot program to test whether a medication therapy management (MTM) benefit would improve health outcomes and reduce costs for certain high-risk members with multiple prescriptions. In order to implement the pilot program, the state requested and received a waiver of the federal comparability requirement under the authority of Section 1115(a)(1). Although there was no question that MTM was a reimbursable Medicaid benefit or that the state's proposed waiver was consistent with the purpose of Section 1115 to test new service delivery models, the process of seeking and securing federal approval for this waiver was unnecessarily long and onerous. The state's ability to implement similar innovative pilot projects in the future is currently limited by the administrative burden associated with seeking such waivers.

women and their children, that providing a limited dental benefit to pregnant women would lead to improved health outcomes both for women and newborn children. However, unless the state has sufficient funds to provide dental services to all adults, the federal government will not allow the state to implement such a targeted benefit.⁶

The state proposes that it have the flexibility under this demonstration to vary benefits packages for different members based on medical factors or other considerations. TennCare already has significant experience with waivers of comparability, particularly in the TennCare demonstration's managed long-term services and supports programs, where the state has demonstrated the potential for achieving both improved outcomes and lower costs by targeting benefits to members based on their actual level of need. The state believes the use of this flexibility can be expanded to better focus delivery of benefits or marshal resources to respond to specific health needs, so that members receive the care most relevant for their needs while the state is able to maximize the use of its available funding. The state notes that it is not its intent under this proposal to reduce covered benefits for members below their current levels.

Disentangling Misaligned Incentives to Promote Value for Providers

As a condition of the original TennCare demonstration in 1994, Tennessee essentially agreed to give up its Medicaid Disproportionate Share Hospital (DSH) funding from the federal government. (Congress has since created a small DSH allotment for Tennessee.) As a result, most of TennCare's uncompensated care payments to hospitals are authorized through the TennCare demonstration. The TennCare demonstration currently authorizes payments to hospitals from two uncompensated care funds—a “virtual DSH” fund and an uncompensated care fund for charity care. The criteria for hospitals to qualify for payments from these funds, as well as the state's distribution methodology for these funds, are prescribed in the terms and conditions of the TennCare demonstration, and thus require a demonstration amendment to modify.

The state proposes that it have the flexibility under this demonstration to modify the participation criteria and distribution methodology associated with the state's two uncompensated care funds without the need to seek CMS approval through a separate demonstration amendment. This flexibility will allow the state to be more responsive to the actual experience of Tennessee hospitals providing uncompensated care, and could also be used to support value-based payment or delivery system reform initiatives (for example, by conditioning a hospital's participation in one or both uncompensated care funds on its participation in outcomes- or quality-based payment initiatives). As the state continues to engage in systematic delivery system reform strategies to incentivize the delivery of high-quality, appropriate care in the lowest-cost setting, this flexibility could also be used to reduce the misalignment

⁶ Federal policy provides some flexibility for states to vary benefits by developing “alternative benefit plans” (or “ABPs”) for certain populations. However, the federal government's process for developing and securing approval of these ABPs is administratively cumbersome to an extent so as to not be a meaningful source of useful flexibility for states. It is notable that virtually no states deemed the ABP option worth taking advantage of prior to 2014, when the federal government required it as a condition of receiving the enhanced federal match rate for Medicaid expansion populations.

of incentives inherent in the current system. For example, in some cases a hospital may be able to treat a patient effectively and at a lower cost on an outpatient basis instead of an inpatient setting, but reimbursement policies often incentivize more inpatient admissions rather than recognizing the value of providing care in less expensive settings when appropriate. The flexibility to leverage existing resources to support and reward hospitals—rather than penalize them—for removing costs from the system by connecting the member with the right level of care in the right setting will reinforce and enhance the overall effectiveness of larger delivery system reform initiatives.

Appropriately Penalizing Member Fraud

Like all state Medicaid programs, TennCare devotes considerable resources to preventing and identifying member fraud, including taking action when appropriate with regard to members who are suspected of or have been determined to be guilty of member fraud. However, historically the federal government has not allowed states to take the most basic and obvious corrective action of terminating or suspending a member's eligibility when he has been determined to have committed fraud or abuse against the Medicaid program. This federal policy defies common sense, demonstrates a distressing lack of concern for public resources, undermines the integrity of the Medicaid program, and does nothing to disincentivize the misuse of public resources dedicated to provide assistance to needy individuals and families.

The state proposes that it have the flexibility under this demonstration to suspend or terminate the eligibility of individuals who have been determined to be guilty of TennCare fraud, and to prevent such individuals from re-enrolling in TennCare for a period of up to 12 months. For purposes of this demonstration, "determined to be guilty of TennCare fraud" means a judgment of conviction entered against the individual in a federal, state, or local court; a finding of guilt against the individual by a federal, state, or local court; a plea of guilty or *nolo contendere* by the individual that has been accepted by a federal, state, or local court; or the individual's agreement to enter into participation in a first offender, deferred adjudication, or other arrangement where judgment of conviction has been withheld.

Within the flexibility afforded by the block grant, the state will develop its own policies—based on the nature of the underlying offense—regarding when it is appropriate to terminate or suspend a member's eligibility, the appropriate length of the termination or suspension (up to 12 months), and whether specific actions on the part of the member could serve as an alternative to termination or suspension of benefits. For example, if an individual has been convicted of fraudulently using his TennCare coverage to obtain access to prescription opioids, the state could decide that securing the member's agreement to participate in appropriate substance use disorder treatment would be a preferable alternative to suspension of benefits. Alternately, the state could decide to suspend only a portion of the member's benefits. In the example of the member who has used his TennCare coverage to fraudulently obtain prescription opioids, the state could decide to suspend the member's pharmacy benefit for up to 12 months. This flexibility to impose meaningful consequences for members who have abused a public benefit is both reasonable and will improve the integrity of the TennCare program.

Pathway to Permanency

Unlike traditional Medicaid programs, 1115 demonstration programs like TennCare are subject to periodic re-approvals and under current CMS policy must typically be renewed every three to five years. The TennCare demonstration has been renewed no fewer than six times since its original approval in 1994.

The process for renewing 1115 demonstrations is unnecessarily onerous and cumbersome, both for states and for CMS. For example, Tennessee's most recent request to renew the TennCare demonstration was submitted to CMS in 2015. This request required 12 months of discussion with CMS to secure CMS approval, or fully one third of the three-year approval period that was in place at the time.⁷ CMS required an entire year to review the state's renewal request despite the fact that extensions of the TennCare demonstration had already been approved on five previous occasions and despite the fact that the state explicitly requested no substantive changes to the TennCare program or its underlying authorities. The level of resources required on the part of both the state and CMS to engage in this ongoing cycle of constant demonstration renewals is needless and costs dollars that could be better invested on the health of members.

In the cases of mature demonstrations like TennCare (which have been re-approved multiple times and which have demonstrated positive results), CMS should re-evaluate its current policy to allow for a more permanent approval status (or at least less frequent renewals). As noted elsewhere, the principle being demonstrated by TennCare is that a state can organize its Medicaid service delivery system under managed care more cost effectively than it can through a fee-for-service system, without compromising access to or quality of care, and in the case of TennCare this outcome is not in question. Today, TennCare is a mature, data-driven managed care program that extends coverage to many people not otherwise eligible for Medicaid in Tennessee and provides its members a more generous package of covered benefits than was previously covered under Medicaid, all at a cost that is significantly below the federal government's own projections for how much would be needed to care for Tennessee's Medicaid population in the absence of the TennCare demonstration. Approving longer operating periods with less frequent renewals would be an important first step to reduce an unnecessary administrative burden and allow both the state and CMS to re-purpose resources for more productive uses. The logical, long-term solution, however, is for CMS to approve of the TennCare 1115 demonstration waiver on a permanent basis and only require amendments to the waiver to go through the approval process.

Improving Administrative Efficiency

Central to the design of the state's proposal is flexibility for the state to manage its Medicaid program without unnecessary involvement or interference from the federal government. The state's proposal is predicated on the proposition that the state is in a better position than the federal government to direct TennCare spending in order to most effectively meet the needs and promote the health of Tennessee residents. Within the scope of the state's existing authorities and the new authorities that are part of

⁷ Tennessee submitted its renewal application to CMS on December 22, 2015, and the renewal request was approved by CMS on December 16, 2016.

this proposal, the state proposes that it have the flexibility to make changes to enrollment processes, service delivery systems, and comparable program elements without seeking additional CMS approvals via State Plan Amendments or demonstration amendments. For example, the state currently contracts with multiple managed care organizations, a prepaid inpatient health plan, and two prepaid ambulatory health plans for delivery of covered TennCare benefits. Should the state elect to alter its service delivery system in the future, a demonstration amendment will not be required.

In addition, the ability of states to administer their Medicaid programs effectively is often constrained by overly prescriptive and unnecessary federal regulations that do not take into account the unique needs and consumer contexts within each state. Under the state's proposal, the state will have relief from the federal requirements at 42 CFR Part 438 (concerning Medicaid managed care programs) in order to have the flexibility necessary to structure its managed care service delivery system in a manner that meets the needs of state residents and optimizes effectiveness and efficiency of operation. TennCare is one of the oldest and most comprehensive Medicaid managed care programs in the country, and as such, Tennessee has a demonstrated history of effective administration of its managed care program. Given the necessary flexibility, the state believes it can structure its program in a way that better meets the needs of its members. Within a context in which the state bears the primary risk for the cost of delivering care to members, there is no reason for the federal government to be involved in prescribing the details of managed care contracts, sanctions applied to contractors, how the state establishes capitation rates for managed care contractors, dictating changes to the state's managed care quality improvement strategy, or other aspects of program administration. Such flexibility to structure the state's service delivery system free of unnecessary federal interference is essential to the state being able to operate within a capped funding structure.

Examples of unnecessary federal requirements include (but are not limited to):

- Federal approval unnecessarily required for states to contract with managed care organizations to provide services to Medicaid beneficiaries (42 CFR § 438.3(a))
- Federal approval unnecessarily required for states to partner with their managed care contractors to pursue healthcare delivery system reform initiatives (42 CFR § 438.6(c))
- Arbitrary restrictions on the ability of managed care contractors operating fully at-risk to provide a full continuum of care for members with mental health or substance use disorder treatment needs (42 CFR § 438.6(e))
- Federal approval unnecessarily required for actuarially certified capitation rates paid to managed care contractors (42 CFR § 438.7(a))
- Unnecessary federal reporting requirements, despite the fact that CMS has not articulated a purpose for these required reports and that no comparable requirements exist for fee-for-service programs (42 CFR § 438.66(e))

Eliminating these unnecessary requirements and approvals, as well as increased flexibility from other overly prescriptive or unnecessary federal regulations, will allow the state to maximize program efficiency while also implementing reforms to better meet member needs.

In administering its program, the state commits that it will not alter any requirements related to compliance with federal non-discrimination laws (including Title VI of the Civil Rights Act of 1964; the Age Discrimination Act of 1975; the Rehabilitation Act of 1973; Title IX of the Education Amendments of 1972; Titles II and III of the Americans with Disabilities Act; and section 1557 of the Patient Protection and Affordable Care Act).

Streamlining Unnecessary Approvals

Federal Medicaid policy distinguishes between mandatory Medicaid benefits (which states must make available to their members) and optional Medicaid benefits (which states may elect, at their discretion, to make available to their members). For both mandatory and optional benefits, states have flexibility to determine the amount, duration, and scope of covered benefits. Due to the savings realized under the TennCare demonstration, Tennessee covers a far richer array of benefits under TennCare than were historically covered under Tennessee's Medicaid program prior to the TennCare demonstration.⁸

The state proposes that it have the flexibility under this demonstration to make changes to its benefits package, including the addition or elimination of optional benefits and changes in the amount, duration, and scope of covered benefits, without the need for CMS approval. It is important to note that this flexibility does not confer new authority on the state; it is already the state's prerogative to elect to cover or not cover optional benefits. The federal government cannot compel a state to cover an optional benefit, nor can it disapprove a state's election to cover an optional benefit. Nevertheless, current federal policy requires states to submit such changes to CMS for "approval" via a State Plan Amendment and/or demonstration amendment. Likewise, changes to the amount, duration, and scope of covered benefits, which are also determined at the discretion of the state, are similarly subjected to a CMS "approval" process. To the extent that the state, under this demonstration, will be operating its Medicaid program under a block grant, the state should have autonomy to make adjustments to its package of covered benefits as it determines necessary to best promote the health of its members. Eliminating an unnecessary federal approval process is a common-sense reform that will reduce administrative burden for the state (and CMS) and increase program efficiency.

Strengthening Medicaid's Status as Payer of Last Resort

In some cases, TennCare members have access to other insurance in addition to their TennCare coverage. In these cases, the member's other insurance is considered "primary," and his TennCare coverage is considered "secondary." Medicaid's status as the "payer of last resort" has long been provided for in federal law, meaning that TennCare only pays for services when all other responsible parties have paid their required portions.⁹ In cases when a Medicaid payment has already been made (e.g., the billing healthcare provider or the state were unaware of the member's other coverage), the

⁸ See Table 2a of the TennCare demonstration for a listing of benefits covered under the TennCare demonstration that are not covered under Tennessee's Medicaid State Plan

(<https://www.tn.gov/content/dam/tn/tenncare/documents/tenncarewaiver.pdf>).

⁹ See Section 1902(a)(25) of the Social Security Act and implementing regulations at 42 CFR Part 433, Subpart D.

state may bill the member's primary coverage for any payments expended on behalf of the covered individual.

However, states' ability to seek payments from other parties that may be legally responsible for the cost of care provided to Medicaid beneficiaries is currently inhibited by inconsistent and conflicting federal policies. Under federal law, state Medicaid programs have three years from the date on which a service occurred to review and bill a claim that should have been another party's responsibility to pay. However, Medicare (Parts A and B) and TRICARE both limit Medicaid's ability to bill for services to a mere 12 months. This unnecessary limitation compromises Medicaid's intended status as the payer of last resort and inappropriately shifts healthcare costs that should be the responsibility of the federal government to states. Tennessee expects CMS to work in good faith with the state to identify strategies to mitigate the effects of these misaligned policies.

In addition, CMS should work with the state to ensure the state has the ability to bill Medicare directly when appropriate for the cost of care provided to Medicare enrollees. Currently, Medicare does not allow states to bill Medicare directly, meaning that when the state identifies a claim which should have been paid by Medicare, the state must recover a payment that has already been made to a healthcare provider, and the provider must then submit a new claim to Medicare before Medicare's timely filing deadline. This process is unnecessary and administratively cumbersome for both providers and the state. The simple step of allowing the state to bill Medicare directly for the cost of care already provided will increase efficiency and help preserve Medicaid's status as the payer of last resort.

Building on Proven Solutions

Having long been a leader in the use of the tools of managed care to deliver high-quality care in a financially sustainable manner, in recent years Tennessee has continued and amplified its leadership through its implementation of a variety of value-based payment and delivery system reform initiatives. These include episodes of care, a performance and financial management framework that is being adopted in both public and commercial healthcare operations across the United States to improve quality and reduce costs, as well as patient-centered medical home initiatives in both acute care and behavioral health.

Initially supported by State Innovation Model (SIM) grants, the state's efforts are demonstrating positive results in terms of improved quality and reduced costs. In the current state fiscal year, the state's episodes of care initiative is estimated to have reduced the cost of care by more than \$40 million, which benefits both the state and the federal government. As part of the proposed block grant, Tennessee commits to not only continue its existing efforts to reform delivery systems but to deepen its commitment to find new ways to ensure Medicaid dollars drive increasing quality and improvements in health.

Eliminating Unnecessary Administrative Requirements

The Affordable Care Act (ACA) created an individual mandate for almost all Americans to maintain health insurance. Non-exempt individuals who did not maintain health insurance were subject to a tax penalty, also known as a “shared responsibility payment.” Like other insurers, state Medicaid programs were required to provide their members with an annual notice confirming that their members had minimum essential coverage.¹⁰ However, the Tax Cuts and Jobs Act essentially eliminated the individual mandate by reducing the shared responsibility payment to \$0. Nonetheless, despite the fact that the individual mandate is no longer being enforced, the federal government continues to require states to mail these coverage notices to members *despite the fact that they no longer serve any useful purpose*. Mailing these annual notices to TennCare’s 1.4 million members is a costly and fruitless exercise. CMS should provide assurances to the state that there will be no negative enforcement action taken against the state should it choose not mail minimum essential coverage notices to members in any year when the shared responsibility payment is \$0.

V. Proposed Waiver and Expenditure Authorities

All waiver and expenditure authorities currently approved for the TennCare demonstration will continue to be in effect. In addition, the state requests the waiver and expenditure authorities (“CNOMs”) enumerated below.

State Flexibility	Statute or Regulation to be Waived
Cap the state’s Medicaid expenditures at the annual block grant amount.	N/A
Disenroll individuals who have been determined to have committed TennCare fraud and prevent them from re-enrolling for a period of up to 12 months.	Section 1902(a)(8); Section 1902(a)(10)
Establish a formulary that does not comply with Section 1927(d)(4) of the Social Security Act.	Section 1902(a)(54), insofar as it incorporates Section 1927
Addition or elimination of optional State Plan benefits shall not require CMS approval. Changes in the amount, duration, and scope of State Plan benefits that do not affect the overall sufficiency of the benefit shall not require CMS approval.	Section 1902(a); 42 CFR Part 430, subpart B
Target benefits to certain populations.	Section 1902(a)(10)(B)

¹⁰ See Section 6055 of the Internal Revenue Code.

State Flexibility	Statute or Regulation to be Waived
Modify the requirements for hospitals to receive payments from the uncompensated care funds authorized under the TennCare demonstration.	N/A – CNOM, 1115(a)
Spend federal block grant dollars on items or services not otherwise reimbursable under Title XIX but which have an impact on enrollee health.	N/A – CNOM, 1115(a)
Modify enrollment processes, service delivery system, and comparable program elements without the need for a demonstration amendment.	N/A
Operate a managed care program that does not comply with the requirements of 42 CFR Part 438.	N/A – CNOM, 1115(a)

VI. Expected Impact on Budget Neutrality

The state's proposal will not have an impact on budget neutrality under the TennCare demonstration. The state is proposing that the federal government cap its expenditures at the amount already agreed to in the state's approved budget neutrality agreement.

VII. Expected Impact on CHIP Allotment Neutrality

This amendment will not result in any changes to Tennessee's CHIP allotment neutrality.

VIII. Modifications to the Evaluation Design

As discussed in Section II, the goal of the state's proposal is to demonstrate that an alternative model of federal participation in state Medicaid programs will lead to Medicaid programs that are more financially sustainable for states and the federal government, without compromising access to care, quality of care, or health outcomes.

The state intends to contract with an independent evaluator to develop a plan for evaluating the hypotheses indicated below. The state, in consultation with its evaluation partner, will identify appropriate performance measures that assess the impact of the demonstration. It is the intent of the state to follow all CMS evaluation design guidance in working with the state's independent evaluator to draft an evaluation plan.

The table below presents an overview of the state’s preliminary plan for evaluating its demonstration. This evaluation plan is subject to change and will be further refined based on input from CMS and the state’s evaluation partner.

Hypothesis	Methodology	Data Sources and Metrics
TennCare expenditures under this demonstration will grow at a slower rate than the average Medicaid expenditures nationally.	Comparison of TennCare growth rate compared to Medicaid national growth rate	Expenditure data
The demonstration will not negatively impact access to care or health outcomes for TennCare members.	Comparison of key access and health outcome measures prior to implementation of the demonstration and during the demonstration.	Provider participation and access data Key health outcome metrics

IX. Demonstration of Public Notice and Input

The state has used multiple mechanisms for notifying the public about this amendment and for soliciting public input on the amendment. These public notice and input procedures are informed by—and comply with—the requirements specified at 42 CFR § 431.408.

Public Notice

The state’s public notice and comment period began on September 17, 2019, and lasted through October 18, 2019. During this time, a comprehensive description of the amendment to be submitted to CMS was made available for public review and comment on an amendment-specific webpage on the TennCare website. An abbreviated public notice—which included a summary description of Amendment 42; the locations, dates, and times of three public hearings; and a link to the full public notice on the state’s amendment-specific webpage—was published in the newspapers of widest circulation in Tennessee cities with a population of 50,000 or more. TennCare disseminated information about the proposed amendment, including a link to the relevant webpage, via its social media (i.e., Twitter, Facebook). TennCare also notified the members of the Tennessee General Assembly of Amendment 42 via an electronically transmitted letter.

The state held three public hearings to seek public comment on Amendment 42. These hearings took place as follows:

Middle Tennessee

Location: 2400 Clifton Avenue in Nashville (Family and Children’s Service)

Date: Tuesday, October 1

Time: 2:00 p.m. Central Time

East Tennessee

Location: 4614 Asheville Highway in Knoxville (Burlington Branch of the Knox County Library)

Date: Wednesday, October 2

Time: 2:30 p.m. Eastern Time

West Tennessee

Location: 433 East Lafayette Street in Jackson (Jackson-Madison County Library)

Date: Thursday, October 3

Time: 2:30 p.m. Central Time

Members of the public also had the option to submit comments throughout the notice period by mail and/or email. Documentation of the state's public notice process is included as Appendix B.

Public Comments

[RESERVED FOR SUMMARY OF PUBLIC COMMENTS RECEIVED]

Appendix A

Public Chapter No. 481



State of Tennessee

PUBLIC CHAPTER NO. 481

HOUSE BILL NO. 1280

By Representatives Timothy Hill, Mr. Speaker Casada, Matthew Hill, Gant, Doggett, Zachary, Howell, Griffey, Sherrell, Byrd, Todd, Cepicky, Crawford, Bricken, Carter, Terry, Smith, Curcio, Carr, Farmer, Reedy, Van Huss, Boyd, Hulsey, Rudder, Moody, Holt, Ragan, Cameron Sexton, Weaver, Russell, Cochran, Littleton, Kumar, Helton, Tillis, Sanderson, Coley, Powers, Daniel, Lafferty, Haston, Todd, Halford, Carter, Sherrell, Reedy, Ragan, White

Substituted for: Senate Bill No. 1428

By Senators Bailey, Gardenhire, Yager, Stevens, Roberts, Niceley, Mr. Speaker McNally, Southerland, White, Jackson, Pody, Massey, Lundberg, Crowe, Hensley, Briggs, Bowling, Watson, Haile, Gresham, Swann, Reeves, Johnson, Powers

AN ACT to amend Tennessee Code Annotated, Title 4; Title 33; Title 56 and Title 71, relative to medical assistance.

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

SECTION 1. Tennessee Code Annotated, Title 71, Chapter 5, Part 1, is amended by adding the following as a new section:

(a) The governor, acting through the commissioner of finance and administration, is directed to submit to the federal centers for medicare and medicaid services a waiver amendment to the existing TennCare II waiver, or to submit a new waiver, in order to provide medical assistance to the TennCare II waiver population by means of a block grant in accordance with this section no later than one hundred eighty (180) days after the effective date of this act. The block grant authorized by this section may convert the federal share of all medical assistance funding for this state into an allotment that is tailored to meet the needs of this state and that:

(1) When determining the base amount for the block grant, factors the current inaccurate reflection of the state's labor costs in the state's Medicare Wage Index and the index's negative impact on healthcare delivery in this state;

(2) Is indexed for population growth;

(3) Is indexed for inflation and other costs;

(4) Excludes from the block grant financing amount any expenses that are not included in the state's existing 1115 demonstration waiver;

(5) Excludes administrative costs from the block grant financing amount and permits the state to continue to draw federal matching funds for administrative costs;

(6) Provides the state with maximum flexibility with regard to existing federal mandates and regulations and with implementing cost controls as determined appropriate by the state, and either exempts the state from the requirements of any new mandates, regulations, or federal court orders during the period of block grant financing or increases the amount of block grant financing to offset any cost increases to the state from such mandates, regulations, or federal court orders;

(7) Provides the state with maximum flexibility regarding pharmacy benefits including fluctuation of prescription drug costs, diabetic testing supplies, and over-the-counter medications;

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(8) Provides the state with maximum flexibility to serve other needy populations with distinct financial or healthcare needs; and

(9) Remains at the level set according to the block grant without any decrease in the federal share of all medical assistance funding for this state based on deflation or a reduction in population.

(b) A waiver amendment to the existing TennCare II waiver requested pursuant to subsection (a), if approved by the federal government and the commissioner of finance and administration, does not take effect unless subsequently authorized by joint resolution of the general assembly.

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

HOUSE BILL NO. 1280

PASSED: May 2, 2019



GLEN CASADA, SPEAKER
HOUSE OF REPRESENTATIVES



RANDY MCNALLY
SPEAKER OF THE SENATE

APPROVED this 24th day of May 2019



BILL LEE, GOVERNOR