



Division of TennCare

# **TennCare II Demonstration**

Project No. 11-W-00151/4

Amendment 42

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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The traditional model of Medicaid financing is an outdated model of fundamentally misaligned incentives.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~~ TennCare members, 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

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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.<sup>1</sup> 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. This amendment represents an opportunity for the federal government to recognize—and reward—the state for effective management of its Medicaid program by investing additional resources that are tied directly to state performance.

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. In requesting this flexibility, the state is committed to working with CMS to identify appropriate, state-specific quality goals and performance metrics to ensure that the investment in and flexibility granted to

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<sup>1</sup> 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.



the state are wielded in a way that will have specific, measurable impact on the lives of 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 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

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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

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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:

<b>Enrollee Category</b>	<b>Definition</b>
<b>Blind and disabled</b>	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.
<b>Elderly</b>	Enrollees who are 65 years of age or older who are not in the blind or disabled category.
<b>Children</b>	Enrollees under 21 years of age who are not in the blind and disabled category.
<b>Adults</b>	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.

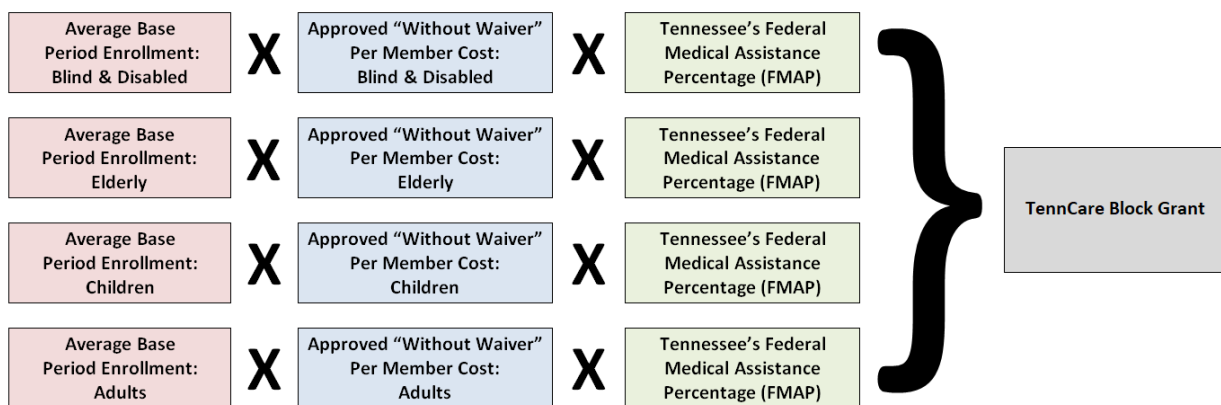
Because the state is proposing to exclude pharmacy costs from the block grant (see “*Excluded Expenditures*” discussion below), Tennessee has adjusted the CMS-calculated “Without Waiver” costs to remove pharmacy-related expenses.

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 [figureFigure 2](#) 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>
<b>Total</b>	<b>15,832,740</b>		<b>\$ 7,858,874,398</b>

\*Tennessee’s proposal excludes individuals enrolled in 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.

\*\*\*For illustrative purposes, .65 is used as a proxy for Tennessee’s federal medical assistance percentage (FMAP).

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.

### ***Explanatory Note***

In response to concerns that were relayed to the state through the public notice process about the calculation of the proposed block grant and, particularly, that the shared savings component of the proposal would create a disincentive for the state to continue to invest in the health of TennCare members, the state takes this opportunity to explain one way the block grant calculation contained within this amendment could be operationalized.

The point of this illustration is to underscore the unique opportunity this amendment provides CMS to allow a state to earn additional dollars to be invested into its Medicaid program. The result of doing so would be to allow the state to demonstrate that, compared to the traditional contribution of federal

dollars based only on the amount of state dollars spent, a value-based approach to federal funding of the Medicaid program can drive better health outcomes, higher quality of care, sustainable spending growth, broad provider participation, coverage of additional individuals, and all with no impact on the overall budget neutrality of the state's demonstration.

One example of how the proposed block grant set forth in Figure 2 above could be operationalized follows. The calculation, which relies upon an annually-updated FMAP, annually-updated per member cost projections, and updated enrollment numbers, could be operationalized in two steps, both of which—taken together—would constitute Tennessee's block grant. First, the state could continue to report all expenditures that would qualify for federal financial participation under Section 1903, similar to the financial reports used for the state's current 1115 demonstration. Second, the state and CMS would periodically (i.e., through monthly or quarterly reconciliations) compare actual total (i.e., state and federal) expenditures on services included in the block grant calculation to the block grant calculation set forth above in Figure 2 for the same monthly or quarterly period. The block grant calculation would be adjusted as needed to reflect the impact if actual TennCare enrollment is higher than enrollment during the base period. The difference between the block grant calculation and the actual program expenditures would then be multiplied by the applicable FMAP to arrive at the amount of federal dollars unspent (i.e., federal savings) the state produced through effective program management for that period. CMS would then transfer to the state one-half of these federal savings, and the state would then invest these additional funds into state health-related priorities.

For the reasons noted above, the state seeks to move away from a system where federal funds are made available based simply on state spending, and instead replace it with one where Tennessee earns federal funds based on quality, efficiency, and responsible stewardship of the TennCare program. The state believes the block grant funding can be provided under the Secretary's Section 1115 authority. If during the course of the demonstration the state's actual expenditures exceed the amount projected by the block grant such that the federal contribution to the state's Medicaid program would fall below the amount otherwise required by statute, the demonstration would be discontinued.

The State is also open to discussions with CMS as to how the proposed funding and shared savings can be accomplished within the more traditional federal-match funding model without sacrificing the goals of the demonstration.

### ***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)<sup>2</sup>;
2. Outpatient prescription drugs;
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; this includes expenditures made on behalf of partial-benefit dual eligibles and full-benefit dual eligibles, including the costs of all TennCare services for these members, as well as Medicare premium and cost sharing assistance; 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.

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<sup>2</sup> 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>).

### ***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**

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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.<sup>3</sup>

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 discussion of rural health transformation](#) below for additional discussion).

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<sup>3</sup> 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.

### ***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.

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.

Maintaining the highest standard of patient care and ensuring access to medically necessary medications will remain a paramount concern even with introduction of a closed formulary. In selecting drugs available in each therapeutic class, the state will ensure that the selected drugs meet the clinical needs of the vast majority of members and that they are cost effective. In

addition, the state will maintain an exceptions process to cover drugs that are not on the formulary when medically necessary, including but not limited to exceptions to address adverse drug reactions, drug interactions, or specific clinical needs of a patient. The exceptions process will be similar to the existing authorization process used for situations such as determining coverage of non-preferred products or off-label indications. In addition, Amendment 42 is not intended to limit the use of off-label use drug for children under age 21.

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.<sup>4</sup> 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

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

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.<sup>5</sup> Alternatively, a state may determine (for example), based on the clinical literature around perinatal health and vertical disease transmission between pregnant 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.<sup>6</sup>

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.

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<sup>5</sup> 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.

<sup>6</sup> 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.

### ***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 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.<sup>7</sup> 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.

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



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 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). In addition, the state is not seeking authority to alter its appeals or fair hearing processes.

### ***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.<sup>8</sup>

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<sup>8</sup> 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>).

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~~ increases to 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.

Given that it is not the state's intention to reduce the benefits received by TennCare members, the state commits that its use of this flexibility will be limited to benefit changes that are additive in nature, based on benefits in place as of the effective date of CMS's approval of this amendment. In other words, the state would be permitted to make enhancements to its benefits package without seeking additional CMS approval; the state would not be permitted to use this authority to make reductions to its benefits package.

The state also notes that no changes would be made to the scope of the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit for children under age 21 under this amendment. The federal EPSDT mandate requires states to provide all medically necessary Medicaid-covered services for children under 21, and the scope of this benefit cannot, by definition, be modified.

### ***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.<sup>9</sup> 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 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

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

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.<sup>10</sup> 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

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<sup>10</sup> See Section 6055 of the Internal Revenue Code.

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. Priorities for Program Innovation**

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The goal of this demonstration amendment is to better align the incentives of the state and CMS regarding management of the Medicaid program from both a quality of care and fiscal perspective, to recognize state efforts to manage its Medicaid program effectively, and then giving the state flexibility to invest federal dollars the state earns through this value-based funding approach in order to address health needs specific to its population. Without straying too far from this philosophical construct, the state lists below five priority areas in which the state would seek to effectuate meaningful innovation with the flexibilities proposed and savings achieved under the block grant demonstration (all of which are dependent upon availability of funds):

1. **Post Partum Coverage Extension** – Tennessee would seek to invest additional dollars to extend post-partum coverage for women from two months to twelve months. TennCare covers low-income pregnant women with incomes up to 195 percent of the federal poverty level; these women would be eligible for this extension of coverage.
2. **Pre-natal and Post Partum Dental Coverage for Adult Women** – Tennessee would seek to invest additional block grant dollars by providing a dental benefit for pregnant women over the age of 21, and for twelve months post partum for women over the age of 21.
3. **Covering Additional Needy Individuals** – Tennessee would seek to cover additional needy individuals who are not currently eligible for coverage under Tennessee’s Medicaid State Plan or the TennCare demonstration.
4. **Clearing the Wait List for Services for Individuals with Intellectual or Developmental Disabilities** – Tennessee would seek to enroll into the Employment and Community First CHOICES program<sup>11</sup> the approximately 5,000 individuals with intellectual and/or developmental disabilities currently in an active status on the program’s referral list.
5. **Addressing Other State-Specific Health Crises** – Tennessee would seek to invest in initiatives that would address significant health challenges that its population is currently facing. Examples of these include continuing to stymie the ravages of the opioid epidemic on adults, children, and infants, decreasing maternal mortality rates in Tennessee, decreasing infant mortality rates in Tennessee, increasing access to healthcare in rural and underserved areas of the state,

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<sup>11</sup> Employment and Community First CHOICES is the state’s program of home- and community-based services for individuals with intellectual and developmental disabilities authorized under the TennCare demonstration.

promoting tobacco cessation among TennCare members, and other similar health issues that might be unique or more pronounced in Tennessee than other states.

While this list is not intended to be an exhaustive listing of every initiative the state might undertake under the auspices of this demonstration, nor does it represent a rank ordering of these priorities, these areas reflect the state's most immediate priorities for investment of block grant dollars in Tennessee.

## **VI. 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 <del>or elimination</del> of optional State Plan benefits shall not require CMS approval. <del>Changes</del> <u>Increases</u> in the amount, duration, and scope of State Plan benefits <del>that do not affect the overall sufficiency of the benefit</del> shall not require CMS approval.	Section 1902(a); 42 CFR Part 430, subpart B
Target benefits to certain populations.	Section 1902(a)(10)(B)
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

State Flexibility	Statute or Regulation to be Waived
Operate a managed care program that does not comply with the requirements of 42 CFR Part 438.	N/A – CNOM, 1115(a)
<a href="#"><u>Cover additional low-income persons not otherwise eligible for coverage under the Title XIX State Plan or TennCare demonstration.</u></a>	<a href="#"><u>N/A – CNOM, 1115(a)</u></a>

## **IVVII. Expected Impact on Budget Neutrality**

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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.

## **IVVIII. Expected Impact on CHIP Allotment Neutrality**

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

## **IVHIX. Modifications to the Evaluation Design**

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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. [To help ensure that this demonstration supports the delivery of high-quality healthcare to TennCare members and that CMS has objective measures by which it can hold the state accountable for ensuring that the demonstration furthers the objectives of the Medicaid program, the state and CMS will identify specific performance metrics with regard to financial performance, quality of care, and health outcomes \(with intermediate reporting requirements on progress made\) that will comprise the state’s evaluation of this demonstration.](#)

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 [and CMS](#), 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

## **~~IXX.~~ Demonstration of Public Notice and Input**

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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~~ five 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

Location: 499 University Street in Memphis (University of Memphis, University Center)

Date: Tuesday, October 15

Time: 1:30 p.m. Central Time

Location: 1001 Broad Street in Chattanooga (Downtown Branch of the Chattanooga Public Library)

Date: Wednesday, October 16

Time: 2:00 p.m. Eastern 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***

Tennessee received approximately 1,800 comments from various individuals or organizations in response to its public notice. The state is pleased with the high level of public engagement with this proposal and values the thoughtful input and feedback provided in the comments. All comments were reviewed and considered by the state in the development of the final amendment application. The comments received, along with the state's responses, are summarized below.

The comments received by the state are also included as Attachment C.

***General Comments about Block Grant/Block Grant Financing***

A large number of commenters expressed concern that financing TennCare through a federal block grant would lead to reductions in the overall level of federal funding TennCare receives, generally coupled with concerns that the block grant would negatively impact the care received by TennCare members. Various commenters expressed concerns that implementation of the proposed

amendment would result in the elimination of covered benefits, the institution of new benefit limits, rationing of care, reductions in payments to healthcare providers, and/or limitations on access to care.

Some commenters asserted that reducing care to TennCare beneficiaries was the *de facto* aim of state policymakers in pursuing a block grant; other commenters expressed appreciation for the state's assurances that no reductions in care are intended as part of Amendment 42, but nonetheless feared that the financial constraints of a block grant financing mechanism would ultimately make such reductions necessary.

Some commenters expressed concern about specific populations of TennCare members, including those with disabilities, cystic fibrosis, bleeding disorders, cancer, HIV/AIDS, end-stage renal disease, lung disease, and others. These commenters believed that these populations—which tend to make up a small percentage of TennCare's overall membership but who have special medical needs which can be costly—would be especially vulnerable to any reductions made by the state under a block grant. Many commenters spoke about the importance of the TennCare program for many people in Tennessee, often informed by either their own experiences or the experiences of loved ones; these commenters expressed a desire to ensure that the same level of care will continue to remain available for vulnerable Tennesseans.

The state appreciates the many thoughtful comments it received about the possible impact of a federal block grant on care provided under the TennCare program. The state, like these commenters, is committed to ensuring that TennCare provides high-quality care to members that improves health outcomes. The state, however, respectfully disagrees that Amendment 42 will lead to a decrease in federal funding for the TennCare program, or to reductions in coverage or benefits. In fact, Amendment 42 would create more opportunities for the state to invest additional resources in the TennCare program.

Contrary to the assertion of some commenters that TennCare is currently able to receive an unlimited amount of federal money, the state notes that under the terms of the current TennCare demonstration, TennCare may only receive federal funds up to a maximum amount (referred to as a budget neutrality expenditure limit) that has been agreed to in advance with CMS. If TennCare spending were ever to exceed this agreed-upon limit, the state would be required to pay back the excess federal funds to CMS.<sup>12</sup> Since the current phase of the TennCare demonstration—"TennCare II"—began in 2002, the state has never exceeded its budget neutrality expenditure limit, and the state is confident that this will continue to be the case under Amendment 42.

Under Amendment 42, this *already existing* limit on TennCare's federal funding would continue to be enforced, but the state reminds readers that (1) this feature of the TennCare program is not new, and

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<sup>12</sup> See Special Term and Condition (STC) paragraph 72 of the current TennCare demonstration, available at <https://www.tn.gov/content/dam/tn/tenncare/documents/tenncarewaiver.pdf>.

(2) the limit on TennCare’s federal funding would not be any lower under Amendment 42 than it is under the current federal financing system. Under the state’s proposed block grant, the state would, however, have a new opportunity to earn additional federal dollars for the TennCare program, and the state would have significant new flexibility to determine how best to invest those dollars to best improve the health outcomes of TennCare’s member population.

A number of commenters expressed concern that a block grant financing structure for Medicaid would create a dynamic in which the state is incentivized to limit spending on member care to the greatest extent possible. These individuals were generally concerned that savings not be prioritized over member health. Other commenters asserted that the state’s proposal meant that the state intended to reduce TennCare expenditures by as much as \$2 billion per year.

The state thanks these commenters for sharing their concerns. No state—regardless of how its Medicaid program is financed—is immune to the rapid growth of healthcare costs and the pressures they represent to state budgets. However, the state emphatically disagrees that Amendment 42 creates some new incentive for the state to reduce TennCare expenditures on member care. As noted above, TennCare is already subject to a limit on its federal funding by virtue of its existing 1115 demonstration. In Amendment 42, the state proposes to essentially adopt that existing limit (modified as described in the Section III) as the state’s block grant. Whereas under TennCare’s current financing arrangement, the federal government is the primary beneficiary whenever TennCare underspends its federal expenditure limit, Amendment 42 proposes a mechanism by which the state would share in those savings, creating new opportunities for investment in the health of TennCare members.

Several commenters expressed concern about specific aspects of the state’s proposed financing structure and/or made recommendations about the state’s proposed funding structure. Some commenters were concerned that basing the initial block grant amount on average TennCare enrollment in 2016, 2017, and 2018 could underrepresent the actual number of eligible individuals who may need TennCare services during the life of the block grant. Other commenters acknowledged that the state’s proposal would account for increases in TennCare enrollment beyond the base period enrollment, but suggested that the per capita funding increases proposed by the state would not provide sufficient funding to offer care to all eligible persons. Others suggested that the annual growth factor proposed by the state (CBO projections for growth in Medicaid spending) would not keep pace with the cost of inflation in the TennCare program. Still other commenters indicated that it was fallacious to assume that members’ care needs will remain fixed over time, because health needs change over time. One commenter suggested the state should seek to base the funding it receives on the severity or resource intensity within Tennessee’s population, using the University of California San Diego’s Chronic Illness and Disability Payment System or some comparable index; this commenter also suggested that the state could raise additional revenue to provide services to TennCare members through taxes on alcohol, nicotine, opioids, or gasoline, or through premiums charged to TennCare members based on body mass index as an incentive to increase physical activity.

The state appreciates the thoughtful comments submitted regarding the proposed methodology for calculating the TennCare block grant, both initially and on an ongoing basis. Upon consideration, the state has declined to make any revisions to the amendment based on these comments. The state has sought to propose a methodology that is both reasonable and that adequately accounts for factors such as increases in TennCare enrollment and medical inflation. The state is confident that a block grant calculated according to the methodology proposed by the state will be sufficient to meet the needs of TennCare’s member population, both now and in the future.

Several commenters expressed support for the state’s proposal. These commenters believed that various aspects of the proposal, especially the allowance for enrollment growth through per capita increases in the amount of the block grant, as well as the new opportunity for the state to share in savings with the federal government based on program performance, were positive aspects of the state’s proposal that would shield the state from excessive financial risk and create new opportunities for investment in the TennCare program. Other commenters supported the state’s proposal on the grounds that it would give the state much-needed program control, help the state better target resources at the most needy, help the state enhance reimbursement to healthcare providers, and support the state’s efforts to reduce TennCare fraud.

The state thanks the commenters for their support. No changes were made to the amendment based on these comments.

### **Oversight and Transparency**

A number of commenters expressed concern that the block grant proposed by the state would result in inadequate federal oversight of the TennCare program. Some commenters asserted that the state’s proposal would effectively remove TennCare from any federal oversight whatsoever. These commenters generally indicated that federal regulations protect patients and play an important role in ensuring that state Medicaid programs meet certain standards of care, and that weakening the oversight role of the federal government could result in negative impacts to TennCare members. Several commenters cited the delayed implementation of TennCare’s eligibility determination system, recent declines in TennCare enrollment, and other instances of perceived “mismanagement” as evidence for why the state should not be trusted to administer TennCare without a high degree federal oversight.

The state respectfully disagrees with commenters who suggest that TennCare will no longer be subject to federal oversight under Amendment 42. Although Amendment 42—like virtually all state 1115 demonstration requests—includes requests to waive certain provisions of federal law, there are a myriad of federal laws, regulations, policies, and standards that the state has not requested to waive and to which the state will still be subject under Amendment 42. These include a host of federal standards around Medicaid eligibility, benefits, cost sharing protections, appeals, program integrity, and others. The state values its partnership with the federal government in the administration of the TennCare program and looks forward to continuing that partnership under Amendment 42.

However, the state does not regard all current federal requirements and regulations as providing equal value to either the state or to TennCare members, and many of these requirements represent significant administrative burdens for both the state and CMS, without improving access to or quality of care. The state believes that its requested waiver and expenditure authorities are reasonable, and will better enable TennCare to provide care that is higher quality, more cost effective, and more responsive to the needs of Tennesseans.

The state also notes that the federal government is only one source of oversight for the TennCare program. As a state agency, TennCare is also subject to oversight by the Tennessee General Assembly, whose members are elected directly by Tennessee citizens. The Tennessee General Assembly has a long history of rigorous oversight of the TennCare program, and TennCare expects this to continue to be the case under Amendment 42.

**A number of commenters expressed concern that Amendment 42 would result in a loss of public transparency regarding the TennCare program, including the loss of opportunities for members of the public to provide input on program changes. Many of these commenters asked the state to ensure that adequate opportunities for public input will continue to be available if the state's proposal is approved. A few commenters suggested that a second public notice period on the state's proposal should be held after CMS approval.**

The state appreciates the commenters' concerns and is committed to ensuring adequate transparency regarding the ongoing operations of the TennCare program. Contrary to the assertions of some commenters, Medicaid regulations currently require states to issue public notice of State Plan Amendments only in limited circumstances, and these would not be affected by Amendment 42. Under Amendment 42, any proposed changes to the TennCare demonstration as a whole would continue to be subject to the existing federal notice and transparency requirements regarding 1115 demonstrations. In addition, as a practical matter, any changes to aspects of the TennCare program affecting public rights (e.g., changes regarding eligibility, covered benefits, cost sharing) generally require amendments to TennCare's administrative rules, which must be promulgated through a public rulemaking process that complies with the requirements of Tennessee's Uniform Administrative Procedures Act.

In addition to these formal public notice and input mechanisms, which are unaffected by the provisions of Amendment 42, TennCare regularly seeks and receives input from stakeholders through less formal settings and mechanisms, and the state anticipates that this will continue to be the case if the state's proposal is approved. No changes to the amendment were made based on these comments.

**Several commenters objected to the state's request that CMS approve the TennCare demonstration for longer periods of time between required renewals ("pathway to permanency"). These commenters suggested that the periodic demonstration renewal process is an important oversight mechanism and source of public transparency.**

The state acknowledges the commenters' concerns. However, in the state's view, the value of the periodic demonstration renewal process in terms of transparency is outweighed by the level of onerousness associated with the process. States can spend as much as two years preparing for and subsequently going through the CMS demonstration renewal process; however, demonstrations are typically renewed by CMS in three-year increments, meaning the renewal process itself can take almost as much time as the demonstration approval itself. In the case of mature demonstrations that have been re-approved by CMS multiple times and which have a history of positive results, the state believes that the administrative resources devoted to the renewal process can best be used elsewhere. The state notes that CMS itself has begun to explore the possibility of approving such demonstrations for longer periods of time. As noted above, there will continue to be many opportunities for public transparency and input into the operation of the TennCare demonstration under Amendment 42. No modifications were made to the proposal based on these comments.

### **Benefits**

**A few commenters expressed concern about the state's proposed waiver of federal comparability requirements. Some commenters expressed concern that this waiver would be used by the state to reduce benefits for certain populations, or that an overutilization of such a waiver could exacerbate disparities in health outcomes experienced by vulnerable populations. Commenters also noted that a block grant is not needed to obtain flexibility from federal comparability requirements, as states can obtain such flexibility through separate 1115 demonstrations or through the use of alternative benefit plans.**

Although TennCare members generally receive the same benefits package, the state believes there are circumstances when it may be beneficial to provide additional benefits to certain populations to help achieve specific health outcomes or to respond to specific health needs. The state understands the options that are available to waive comparability requirements through separate 1115 demonstrations or to implement alternative benefit plans; however, the state maintains its view that the administrative processes currently associated with these options are unnecessarily cumbersome, and an example of how reducing administrative processes can enable the state to operate more efficiently and be more responsive to the needs of its membership. The state does not agree that the proposed waiver is likely to contribute to the continuation of health disparities among vulnerable populations. As noted elsewhere, the state will not use the flexibility afforded by this amendment to reduce the amount, duration, or scope of covered services below the levels in place on the date of the amendment's approval; modifications to benefits effectuated through this amendment will be additive in nature only. No modifications were made to the amendment based on these comments.

**Several commenters were critical of the state's proposal to be allowed to make changes to its benefits package without the need for a State Plan Amendment or a demonstration amendment. Commenters noted that this authority, if granted, would allow the state to implement new benefit limits or to eliminate certain optional benefits entirely. These commenters expressed concern that any such reductions in benefits could negatively impact TennCare members.**

The state understands the commenters' concerns; however, the state respectfully disagrees that Amendment 42 would give TennCare any new authority to implement benefit limits or to eliminate optional benefits. Under existing Medicaid law, it is already the state's prerogative to decide whether to cover optional Medicaid benefits, and CMS cannot prevent a state from choosing to begin covering (or stop covering) an optional Medicaid benefit. Likewise, existing Medicaid law allows states to establish benefit limits or otherwise define and/or make changes to the amount, duration, and scope of covered benefits, and CMS generally cannot disapprove such requests from states (provided the amount, duration, and scope of the benefit remains sufficient to reasonably achieve the benefit's purpose). The state's inclusion of this flexibility in Amendment 42 does not reflect a need for any additional authority, but rather a desire to eliminate an unnecessary administrative process.

The state acknowledges, however, that the inclusion of this request in Amendment 42 has been interpreted by some stakeholders as a signal of an intent to reduce TennCare benefits, which is not the case. To address the concerns raised by these stakeholders and to clarify the intent of the state's proposal, the state has adjusted the relevant section of the amendment to clarify that any changes made by the state using this authority would be additive in nature only. The state would not be permitted to use this authority to make reductions to the TennCare benefits package; such reductions would be facilitated through the processes currently in place. (Again, the state reminds readers that no such reductions are planned or anticipated.)

**A few commenters expressed concern that under Amendment 42, the state would have authority to modify the scope of the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services received by children under age 21 enrolled in TennCare.**

The state appreciates the opportunity to clarify this portion of its proposal. No modification of EPSDT benefits for children was intended in Amendment 42, and it is the state's position that nothing in Amendment 42 would allow the scope of the EPSDT benefit to be modified. Under federal law, EPSDT is a mandatory benefit for children enrolled in Medicaid, and the state has not requested to be allowed to waive any mandatory Medicaid benefit. The scope of the EPSDT benefit—essentially a mandate to provide children with access to all medically necessary Medicaid services—cannot, by definition, be modified. The state has revised the relevant section of the amendment to clarify that no modification of EPSDT would be permitted under Amendment 42.

**A few commenters wrote specifically about TennCare's non-emergency medical transportation (NEMT) benefit. These commenters emphasized the importance of providing transportation services as a mechanism for ensuring that TennCare members have meaningful access to covered services and requested assurances that the state will not seek to eliminate the existing TennCare NEMT benefit under a block grant.**

The state thanks the commenters for their comments and confirms that Amendment 42 does not contemplate the elimination of TennCare's NEMT benefit. NEMT is a mandatory Medicaid benefit, and

state has not requested to be allowed to waive any mandatory Medicaid benefit. No modifications were made to the amendment based on these comments.

**The state received a number of comments expressing concern about the possible impacts of a closed formulary and the possibility of limitations on access to necessary medications. These commenters noted that prescription drugs have different indications, different mechanisms of action, and different side effects, depending on an individual's diagnosis and comorbidities. Several commenters noted that individuals with mental health conditions often need to try several medications before finding the combination of medications that best meets their needs. Some commenters noted that the least expensive drugs are not always the most cost effective, and that the state should not seek to exclude new medications with disease-curing potential simply because they are expensive. In general, commenters believed that restricting TennCare's drug benefit to a closed formulary would harm patients by potentially limiting access to new and effective therapies.**

The state thanks the commenters for the thoughtful input provided on this aspect of its proposal. The state has added additional language to the amendment to further clarify its intention to continue providing medically necessary medications and details about an exceptions process to cover drugs that are not on the formulary when medically necessary, including but not limited to exceptions to address adverse drug interactions or specific clinical needs of a patient. The process for requesting exceptions will be similar to the current process to request prior authorization for a non-preferred drug on the current TennCare formulary. The state will approach the process of implementing a closed formulary, if approved, with a strong emphasis on ensuring continued access, especially with respect to vulnerable populations who require medications to treat mental health and substance use, cystic fibrosis, HIV, Hepatitis C, and other serious conditions. In addition, the state plans to continue to engage closely with stakeholders during the implementation process. The relevant section of the amendment has been revised to reflect these clarifications and revisions.

**In commenting on the formulary component of the state's proposal, some individuals questioned how the state intended to review pharmaceuticals approved through the FDA's accelerated pathway for potential inclusion on the TennCare formulary. Other commenters objected to the suggestion that the state should need any opportunity to review these drugs at all, noting that the FDA is the world standard for drug review and approval, and that the FDA has determined that drugs approved through the fast track approval process are safe and meet an urgent and unmet need.**

State law establishes a TennCare Pharmacy Advisory Committee comprised of clinical experts. This committee currently meets quarterly (or more often if needed) to review and make recommendations regarding TennCare's preferred drug list. Under the state's proposal, this committee will continue to review all new FDA-approved products to make recommendations about each new drug's inclusion on the TennCare formulary (based on whether the drug adds incremental clinical benefit within its therapeutic class, compared to existing alternatives), preferred/non-preferred status, appropriate authorization requirements, and use in special TennCare populations. It is not the state's intent to duplicate the FDA's approval process; however, especially in instances when new drugs are approved



prior to the release of the evidence on which the FDA's approval was based, the state has a responsibility to ensure that new drugs are prescribed in a safe and effective manner, which may require a prior authorization process, medical necessity criteria, as well as any special considerations that may pertain to specific TennCare populations.

### **Administrative Flexibilities**

**A number of commenters expressed concern about the state's proposal to not be required to comply with certain federal regulations governing Medicaid managed care programs. These commenters generally noted that these regulations provide for a range of beneficiary protections and safeguards, including requirements for states to establish network adequacy standards, use actuarially sound rates, provide for certain beneficiary appeal rights and grievance procedures, and others. These commenters expressed concern that, absent the requirement to comply with these federal regulations, TennCare members would not be sufficiently protected from managed care organizations seeking to reduce costs by improperly or inappropriately limiting access to care. A number of commenters noted that the Medicaid managed care regulations also address parity in the coverage of mental health and substance use disorder services and expressed concern that Amendment 42 would result in more stringent restrictions imposed on the state's coverage of mental health and substance use disorder treatment services.**

The state thanks the commenters for these comments and agrees that vigorous oversight of managed care organizations is a vital aspect of any effective Medicaid managed care program. If Amendment 42 is approved, the state is committed to continuing to have meaningful network adequacy standards, to use certified, actuarially sound capitation rates, to provide robust appeals and grievance procedures for members, and to maintain other member protections that are currently in place. However, the state maintains its position that some of the requirements currently in federal regulation are unnecessarily prescriptive and/or create unnecessary administrative burdens for both the state and CMS, and that the flexibility requested by the state will create opportunities for more effective and efficient program administration, without negatively impacting access to or quality of care.

With regard to mental health and substance use disorder services, the state is committed to providing meaningful access to a broad array of behavioral health services in a manner that is comparable to and no more restrictive than the access it provides to medical/surgical services. The state notes that state law requires managed care organizations participating in the TennCare program to comply with both the Mental Health Parity and Addiction Equity Act and its implementing regulations. See Tennessee Code Annotated § 71-5-154. Thus, these requirements will continue to apply to TennCare under Amendment 42.

**Some commenters expressed concern about the provision of the proposed amendment in which the state requests to be exempt from future federal mandates over of the life of the block grant demonstration. Commenters were concerned that, if approved, this would mean that TennCare beneficiaries may not receive future treatments or services to which they would otherwise be**

**entitled, or that the state could elect not to cover new populations that might otherwise be entitled to TennCare coverage in the future.**

Although, in general, the state believes that Medicaid needs fewer—not more—federal mandates, the state appreciates the commenters’ concerns. To the extent that the methodology for calculating the block grant is based on TennCare’s current program configuration, the costs of any future, unforeseen federal mandates will not be reflected in the state’s block grant amount. Thus, if Congress or CMS imposes new requirements on states during the life of the demonstration that can reasonably be expected to have a material impact on program expenditures, the state has requested either to be exempt from such requirements or that the block grant amount be adjusted to adequately account for the new, federally-mandated expenditures. The state believes this protection is both a reasonable and necessary condition for it to operate its Medicaid program under a block grant. No changes were made to the amendment based on these comments.

**Several commenters expressed concern about the state’s request to temporarily suspend or terminate the eligibility of individuals who have committed TennCare fraud. Some commenters questioned whether such a policy promotes the objectives of the Medicaid program. Others expressed concern about potential disruptions to care, especially for individuals receiving cancer treatment. Other commenters questioned whether the magnitude of member fraud experienced by TennCare is sufficient to warrant granting such authority to the state. Others expressed concern that suspending any portion of these members’ benefits would shift the costs of their care to providers, especially hospitals. Another commenter pointed out that there are certain circumstances in which TennCare can already disenroll individuals who are guilty of TennCare fraud, and that additionally, TennCare is not obligated to pay for members’ care if they are incarcerated for TennCare fraud. Finally, some commenters suggested that a cumbersome new administrative process would be needed to make the kinds of determinations described in the state’s proposal (e.g., about whether to suspend a member’s benefits in whole or in part or to refer a member to substance use disorder treatment as an alternative to suspension of benefits), and expressed skepticism that TennCare’s current administrative structure could implement such processes effectively.**

The state thanks the commenters for the many thoughtful responses to this aspect of the state’s proposal. TennCare members are recipients of a public benefit, and the state does not believe it is unreasonable that some meaningful accountability should be in place for individuals who abuse that benefit. In fact, such policies strengthen the overall integrity of the Medicaid program. No changes were made to the amendment based on these comments.

**The state received a number of comments on its proposal to have flexibility to spend block grant dollars on items and services not otherwise covered under TennCare, or not otherwise eligible for federal match, when the state determines that such expenditures will benefit the health of members or are likely to result in improved health outcomes. Many commenters expressed support for TennCare to increase spending on a broader array of services to promote member health. Some commenters provided specific recommendations for how TennCare could invest block grant dollars,**

such as extending TennCare coverage to victims of domestic violence, or providing dental benefits for adults seeking to improve their work readiness. Some commenters suggested that the state should provide more concrete detail about its priorities for new investments, or commit to a public input process that would allow stakeholders to work with the state to identify the most important areas for new investment.

In contrast, some commenters criticized this portion of the state’s proposal, claiming that spending federal Medicaid dollars on “costs not otherwise matchable” in the manner described by the state would essentially divert funds intended to provide healthcare services to TennCare members and allow the state to spend them on other funding priorities.

The state appreciates the range of input received on this aspect of its proposal. The state regards the additional flexibility that would be afforded the state to make decisions about how to invest block grant dollars in order to best promote the health of TennCare members as one of the key advantages of a block grant model over the traditional Medicaid financing structure.

The state appreciates that its draft amendment did not provide a comprehensive list of planned new investments and policy interventions. The state believes it is important to retain some level of flexibility over the expenditure of block grant funds in order to respond to future public health crises, emerging public health needs, or other unforeseen issues. However, the state has modified the amendment to supply additional information about its most immediate priorities for innovation under the block grant. (See Section V above.)

Several commenters requested additional information about specific goals or public health initiatives the state plans to pursue under the block grant, and/or what health outcomes or performance metrics the state plans to use to assess program performance under the block grant.

The primary goals of the TennCare program will remain unchanged under Amendment 42—namely, to provide broad access to high-quality care that leads to improved health outcomes for members, within a predictable and sustainable budget. The premise of Amendment 42 is that a block grant financing model that rewards performance, along with accompanying administrative flexibilities for the state, will enable the state to achieve those goals more effectively than the current Medicaid financing system. The state looks forward to working with CMS and stakeholders to identify key measures of access, quality, and health outcomes that will be used to track state performance under the block grant.

Some commenters noted that the state’s proposal did not directly address the issue of member appeals and requested clarification as to whether Amendment 42 would entail any changes to appeals processes for TennCare members.

The state confirms that no changes to the member appeals process are contemplated in Amendment 42. The state has not requested to waive any of the regulatory requirements pertaining to member fair

hearings described at 42 CFR Part 431, Subpart E. Therefore, these requirements will continue to be in effect under Amendment 42.

**One commenter recommended that the state could use the flexibility afforded by the block grant to establish a presumptive eligibility process for TennCare members receiving long-term services and supports (LTSS).**

The state thanks the commenter for this recommendation. Medicaid eligibility determinations for individuals receiving LTSS generally involve reviews of a wide range of financial assets. The state is uncertain that such a determination could be reliably predicted through a presumptive eligibility process that does not take into consideration all relevant assets and resources. The state has declined to incorporate the commenter's recommendation into Amendment 42. However, if Amendment 42 is approved, the state is interested in working with stakeholders to explore how the additional administrative flexibility can be used to improve the application and enrollment process for individuals receiving LTSS.

**One commenter suggested that the state's proposal should include a provision that would allow the state to retain a greater share of monies it recovers as a result of fraud or overpayments. Currently, when the state recovers such monies, approximately two thirds must be returned to the federal government (based on the state's federal match rate). This commenter noted that under a block grant, the state should benefit from such recoveries to a greater degree.**

The state thanks the commenter for this suggestion. Upon consideration, the state has decided not to modify its proposal based on this recommendation. To the extent that recoveries based on fraud or overpayments represent a recoupment of both state and federal dollars, the state believes it is appropriate to continue the current policy of returning the appropriate portion of recovered funds to the federal government. No changes were made to the amendment based on this comment.

**One commenter objected to the state's request that it not be required to mail minimum essential coverage notices to members in any year in which the Affordable Care Act's shared responsibility payment is \$0. This commenter noted that some Medicaid beneficiaries, primarily those receiving limited Medicaid benefits packages and medically needy members who qualify for Medicaid after incurring medical expenses, may qualify for premium tax credits or other savings to enroll in Marketplace insurance plans; the commenter recommended that the state continue to mail minimum essential coverage notices so that these members could be made aware of their coverage options.**

The state respectfully disagrees with the commenter. All TennCare members receive comprehensive healthcare coverage and are not eligible for premium tax credits or other Marketplace subsidies. Likewise, under the terms of the TennCare demonstration, TennCare has long provided 12 months of comprehensive coverage to all medically needy members. The state maintains that the required mailing of minimum essential coverage notices to 1.4 million members who do not need them is an example of

a federal requirement that represents a costly administrative burden for the state, while not providing any meaningful value to members. The state declined to adopt the commenter’s recommendation.

### *Duals*

A number of commenters requested clarification about the state’s proposal to exclude expenditures made on behalf of individuals dually enrolled in Medicare and TennCare (“dual eligibles”) from the calculation of the block grant. Some commenters questioned why the state reported a non-zero number of members in the “elderly” member category if it intended to exclude dual eligibles. Other commenters asked whether state referred to “partial-benefit” dual eligibles, “full-benefit” dual eligibles, or both. Another asked why the draft amendment’s explanatory note about the exclusion of dual eligibles appeared next to the “elderly” member category but not the disabled category. One commenter acknowledged the language in the draft amendment excluding duals from the calculation of the block grant, but questioned whether the new flexibilities requested by the state would apply to dual eligibles.

The state thanks these commenters for the opportunity to clarify this aspect of its proposal. The state’s intent is to exclude all expenditures made on behalf of individuals who are dually enrolled in Medicare and TennCare from the calculation of the block grant. Under the state’s proposal, these services would continue to be financed according to the systems and processes currently in place. This includes both full-benefit dual eligibles and partial-benefit dual eligibles, and for full-benefit dual eligibles, this includes both the member’s Medicare premium and cost sharing assistance as well as his TennCare benefits. The state has added new language to the relevant section of the amendment to clarify the intended policy. Commenters are correct that Figure 2 should have included an explanatory note for both the “elderly” and “disabled” member categories. The state regrets this oversight and has corrected the figure.

The state agrees that a significant majority individuals in Tennessee age 65 and over have Medicare; however, the state consistently has a small but non-zero number of non-dual members age 65 and older who are enrolled in TennCare, and these are the expenditures represented in the “elderly” category of the state’s block grant in Figure 2.

Lastly, although the calculation of the state’s proposed block grant excludes certain expenditures, the new flexibilities proposed by the state in Amendment 42 are intended to apply to the TennCare demonstration as a whole (including dual eligibles).

### *Legality*

A number of commenters questioned the legality of the state’s proposal. These individuals generally asserted that Section 1115 of the Social Security Act does not permit the Secretary to approve a request from a state to operate its Medicaid program through a block grant. Several commenters

speculated that, if approved, Amendment 42 would result in costly legal challenges to the state and/or federal government.

The submission of Amendment 42 implements—and is in fact required by—state law. See Tennessee Code Annotated § 71-5-163. Under Section 1115, the Secretary is ultimately responsible for determining what he is legally permitted to approve. Especially in light of the clear statutory directive to submit the amendment to CMS, TennCare must leave that determination to the Secretary. No changes were made to the amendment as a result of these comments.

#### *Other Frequently Received Comments*

A number of commenters raised concerns about the rate of hospital closures in Tennessee, particularly in rural parts of the state, and the impact that these hospital closures have on access to care. These commenters generally criticized the state’s proposal for not addressing the issue of rural hospital closures and/or encouraged the state to pursue a Medicaid demonstration that would prevent additional hospital closures in lieu of the current proposal.

The state shares commenters’ concerns about ensuring access to care in rural parts of the state. As noted elsewhere, the primary of purpose of Amendment 42 is to implement a state law that requires TennCare to submit a proposal to CMS to receive a portion of its federal funding through a block grant. As such, rural hospital closures are not the subject of Amendment 42, *per se*. However, if approved, Amendment 42 would afford the state more flexibility in how to use federal dollars to best support the health of TennCare members, and the state in its proposal has specifically identified targeted investments in rural health infrastructure as an area of interest to the state. The state looks forward to working with stakeholders to identify opportunities for TennCare to support access to care in all parts of the state.

Many commenters recommended that the state expand TennCare eligibility to low-income adults under Section 1902(a)(10)(A)(i)(VIII) of the Social Security Act in lieu of pursuing the current proposal. Many of these commenters noted that such an expansion of TennCare eligibility would provide health coverage to a large number of Tennesseans. Many also noted that a 90 percent federal match rate is available for states that expand Medicaid to cover all low-income adults, and that Tennesseans’ tax dollars are being used to benefit Medicaid expansion recipients in other states but not in Tennessee. Some commenters indicated that Medicaid expansion has produced economic benefits for states that have adopted it. Several commenters suggested that the state implement “Insure Tennessee,” an alternative to Medicaid expansion proposed in 2015.

These comments are outside the scope of the amendment. Amendment 42 has been developed in accordance with state law requiring TennCare to submit a demonstration application to CMS to receive a portion of its federal funding via a block grant. See Tennessee Code Annotated § 71-5-163. Medicaid expansion is not the subject of Amendment 42.

Under Tennessee state law, any expansion of Medicaid under Section 1902(a)(10)(A)(i)(VIII) of the Social Security Act must be authorized by the Tennessee General Assembly. See Tennessee Code Annotated § 71-5-126. No changes were made to the amendment based on these comments.

Appendix A

Public Chapter No. 481



## Appendix B

### Documentation of Public Notice Process

## Appendix C

### Public Comments Received