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Proposed Medicaid Expansion in Tennessee

In January 2015, Tennessee released a proposed amendment to its current Section 1115 demonstration to implement the Affordable Care Act's (ACA) Medicaid expansion. The two-year demonstration would cover newly eligible adults – parents from 103-138% of the federal poverty level (FPL, up to $16,242 per year for an individual in 2015) and childless adults from 0-138% of the federal poverty level – an estimated 200,000 beneficiaries.[1] The ACA provides 100% federal matching funds for newly eligible adults through December 31, 2016, decreasing to a 95% match on January 1, 2017. Tennessee hospitals will fund the state's costs of the Medicaid expansion through an increased state assessment on hospitals. To be implemented, the waiver amendment, called Insure Tennessee, would need to be approved by the Centers for Medicare and Medicaid Services (CMS) following the state public comment period, which ends February 8, 2015, and a federal public comment period. The proposal would also need state legislative approval. Tennessee's Governor has called a special legislative session to consider the amendment on February 2, 2015.[2]

If implemented on January 1, 2016, the waiver amendment would:

- Expand Medicaid coverage to newly eligible adults ages 21-64 primarily through capitated Medicaid managed care organizations (MCOs) already operating in the state. Under the Healthy Incentives Plan, most newly eligible adults would receive an Alternative Benefits Package consisting of the same benefits as provided to other Medicaid beneficiaries. MCOs would administer health savings accounts in which newly eligible adults would accrue credits by participating in certain designated healthy behaviors. These credits could then be used to decrease premiums and co-payments. Tennessee seeks waiver authority to require monthly premiums up to 2% of income (approximately $20 per month) for newly eligible adults from 100-138% FPL and would impose copays within existing limits in federal regulations. Tennessee proposes disenrolling beneficiaries for failing to pay premiums for 60 days and reserved the right to seek waiver authority for a lock-out period before these individuals could re-enroll based on CMS's decision on Indiana's pending lock-out request. CMS subsequently did approve a six-month lock-out after disenrollment for failure to pay premiums for individuals from 100-138% FPL who are not medically frail in Indiana.
- Offer newly eligible adults with access to employer-sponsored insurance (ESI) the option of receiving premium assistance through a defined contribution from the state toward ESI.[3] Under the Volunteer Plan, the amount of the state's contribution is still to be determined but is expected to cover the beneficiary's share of premiums and may partially cover the ESI plan deductible and copays. After the employer and state contributions, Tennessee would require newly eligible adults receiving premium assistance for ESI to pay all remaining premium, deductible, and co-payment costs and seeks to waive the 5% out of pocket cost-sharing cap in federal Medicaid law for these beneficiaries. Tennessee would

seek separate § 1916(f) waiver authority for this cost-sharing pilot program. Tennessee proposes waiving wrap-around coverage for Medicaid benefits not offered through ESI (including non-emergency medical transportation) and also seeks wavier authority to permit appeals of coverage decisions to be determined through ESI plans and not the Medicaid state fair hearing process.

- Enroll individuals ages 19 and 20 into the regular TennCare Medicaid managed care program and provide them with all TennCare benefits, including Early and Periodic Screening, Diagnosis, and Treatment;
- Waive 3 months retroactive eligibility for all newly eligible adults.

To date, CMS has approved Medicaid expansion waivers in five other states (Arkansas, Iowa, Indiana, Michigan and Pennsylvania).[4] Some provisions in Tennessee's proposal are similar to provisions approved in other waivers, such as premiums of 2% of income for beneficiaries between 100-138% FPL (equivalent to Marketplace premiums for this group) and healthy behavior incentives administered through health savings accounts. Like Michigan and some populations in Iowa, Tennessee is choosing to expand Medicaid through its existing, well-established capitated managed care delivery system, administered by private health plans. If granted, Tennessee's § 1916(f) waiver of the 5% cost-sharing cap for beneficiaries who choose to receive premium assistance for ESI would be unique. In addition to Tennessee, Utah has a proposal pending at the state level. New Hampshire has a waiver application pending with CMS. Table 1 describes the major elements of Tennessee's proposed amendment to their Section 1115 demonstration.

Table 1: Tennessee's Proposed Section 1115 Medicaid Expansion Demonstration Waiver

Element	Tennessee Waiver Proposal
Overview:	Would cover approximately 200,000 newly eligible adults. Healthy Incentive Plan: most newly eligible adults ages 21-64 would be covered through existing capitated Medicaid managed care plans. Those who participate in healthy behavior activities can accrue credits in health savings accounts to reduce premiums and co-payments. Volunteer Plan: individuals with access to ESI could choose to receive a defined contribution from the state toward ESI costs. Newly eligible adults ages 19 and 20 would be enrolled in Tennessee's existing Medicaid managed care program, TennCare, and receive full benefits including EPSDT.
Duration:	1/1/16 to 12/31/17
Coverage Groups:	Covers newly eligible adults ages 19-64 (parents with incomes 103-138% FPL and childless adults with incomes 0-138% FPL).
Financial Eligibility:	Seeks waiver authority to require newly eligible adults receiving institutional or home and community-based long-term services and supports (LTSS) to contribute their monthly income toward the cost of LTSS, less a personal needs and spousal maintenance allowance.[5] This would treat these beneficiaries the same as previously eligible beneficiaries receiving LTSS.
Enrollment:	State will provide options counseling to assist beneficiaries with access to ESI with choosing between premium assistance for ESI and Medicaid managed care. Individuals receiving premium assistance for ESI can move into Medicaid managed care at any time. Individuals wishing to move from Medicaid managed care to premium assistance for ESI need to do so

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	during the ESI's open enrollment period or when an event triggers a special enrollment period.
Premiums:	Healthy Incentives Plan: individuals from 100-138% FPL enrolled in Medicaid managed care will pay premiums equal to 2% of their income (approximately $20 per month). (State seeks waiver authority for premiums for those from 100-150% FPL.) State also proposes disenrolling beneficiaries for failure to pay premiums for 60 days and reserved the right to request waiver authority for a lock-out period before such individuals could re-enroll, based on CMS's decision on Indiana's pending lock-out request. CMS subsequently approved a six month lock-out after disenrollment for failure to pay premiums for individuals from 100-138% FPL who are not medically frail in Indiana. Volunteer Plan: individuals choosing to receive premium assistance for ESI would be responsible for any portion of the ESI premium not covered by the state's defined contribution.[6] Employers must cover at least 50% of the premium costs, and the amount of the state's defined contribution is still to be determined.
Co-Payments:	Healthy Incentives Plan: individuals from 100-138% FPL enrolled in Medicaid managed care would have copays in amounts under existing law, including $75 per inpatient admission, $4 for outpatient services, and $8 for non-emergency use of the emergency room. All beneficiaries are subject to pharmacy copayments of $1.50 for generic drugs and $3 for brand name drugs. Volunteer Plan: individuals choosing to receive premium assistance for ESI would be responsible for all ESI plan deductibles and co-payments remaining after the employer and state's contributions. State seeks separate § 1916(f) waiver of the 5% cap on Medicaid cost-sharing for these beneficiaries.
Health savings accounts:	Healthy Incentives Plan: individuals enrolled in Medicaid managed care will be provided with a Healthy Incentives for Tennesseans (HIT) health savings account, administered by the MCO. The account will be pre-loaded at the beginning of coverage with an unspecified "small sum," and individuals may earn additional credits by engaging in state-specified healthy behaviors and participating in initiatives such as an annual health risk assessment or certain population-based health programs. Individuals may apply account credits to offset premiums and copayments and will receive a quarterly statement with account activity. The accounts will have a maximum balance that can be accrued. Once account funds are exhausted, the beneficiary is responsible for all premiums and copays up to the cost-sharing cap of 5% of quarterly income. Any account credits remaining at the end of the year can roll over to the next year. For beneficiaries below 100% FPL (who are not subject to premiums and most copays), the state proposes deducting from their HIT accounts the amount that they would have paid if they were subject to the copays that apply to beneficiaries above 100% FPL. These beneficiaries could then use any remaining HIT account funds at the end of the year for reimbursement for out-of-pocket expenditures for certain items not covered by TennCare,

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	such as over-the-counter drugs and dental care.
Delivery System and Benefits:	Healthy Incentive Plan: individuals ages 21-64 would receive an Alternative Benefits Plan that includes the same benefits covered by Tennessee's existing Medicaid benefit package for adults. Benefits would be delivered through existing capitated MCOs. Volunteer Plan: individuals who choose premium assistance for ESI would be limited to the benefits covered by the ESI plan. State seeks waiver of responsibility to provide wrap-around coverage for any services covered by Medicaid but not available in the ESI plan, including non-emergency medical transportation. Individuals ages 19 and 20 would be enrolled in Medicaid managed care and would receive full benefits, including EPSDT.
Appeals:	Volunteer Plan: for beneficiaries who choose to receive premium assistance for ESI, state seeks waiver authority to have coverage appeals determined through the ESI plan appeals process and not the Medicaid state fair hearing process
Financing:	The ACA provides 100% federal matching funds for newly eligible adults through December 31, 2016, decreasing to a 95% match on January 1, 2017. Tennessee hospitals will fund the state's costs of the Medicaid expansion through an increased state assessment on hospitals.
Next Steps:	Waiver amendment is open for state-level public comment until Feb. 8, 2015. State must get state legislative approval (special session called by the Governor for February 2, 2015), submit proposal to CMS, allow for federal 30 day public comment period, and obtain federal approval of the waiver amendment.

Endnotes

[1] Insure Tennessee Proposal (January 2015), available at http://www.tn.gov/tenncare/pol-notice.html.

[2] Holly Fletcher and David Boucher, "Haslam calls special session for Insure Tennessee," *The Tennesseean*, (Knoxville, TN), January, 9, 2015. http://www.tennessean.com/story/news/politics/2015/01/08/haslam-calls-special-session-insure-tennessee/21446767/

[3] The state estimates that approximately 54% of the newly eligible population are either currently working or have worked within the past year and might have access to ESI. Insure Tennessee Proposal (January 2015), available at http://www.tn.gov/tenncare/pol-notice.html.

[4] Pennsylvania's new governor, Tom Wolf, has indicated that he is planning to expand the state's existing Medicaid program through a State Plan Amendment rather than use the§ 1115 waiver approved in August 2014.

[5] CMS has determined that the current post-eligibility treatment of income regulations do not apply to beneficiaries subject to the MAGI financial methodology. However, CMS also has determined that the statute provides the agency with authority to expand these rules to MAGI beneficiaries who receive LTSS, and for equity reasons, CMS is considering future rule-making in this area. CMS State Medicaid Director Letter #14-001 RE: Application of Liens, Adjustments and Recoveries, Transfer-of-Asset Rules, and Post-Eligibility Income Rules to MAGI Individuals (Feb. 21, 2014), available at http://www.medicaid.gov/Federal-Policy-Guidance/Downloads/SMD-14-001.pdf.

[6] State will: 1) pay beneficiary's employer or insurer directly for beneficiary's share of premium; 2) pay provider directly for beneficiary's share of deductibles and co-payments; and/or 3) reimburse beneficiary for premiums, deductibles, and/or co-payments. State is finalizing the operational details with input from employers.