Tennessee Section 1115 Waiver Amendment Proposal Fact Sheet

Status as of October 2004

- Draft waiver amendment released for public comment on August 19, 2004
- Waiver amendment proposal submitted to CMS on September 24, 2004
  (available at http://www.tn.gov/governor/tenncare.htm)

Background

Tennessee's Medicaid program, TennCare, has operated under an 1115 waiver since 1994. The program covers 1.3 million people, accounting for 25% of Tennessee population. The original 1994 waiver broadly expanded coverage for children and adults and placed all beneficiaries in managed care. Everyone enrolled had the same benefits; some with incomes above poverty had premiums and cost sharing. Over the years, TennCare eligibility has been scaled back and enrollment has been closed for some groups due to state budget constraints. A 2002 waiver authorized the state to restrict eligibility and created a new TennCare Standard coverage category that reduced benefits and increased premiums and copayments for some existing beneficiaries.[1] The state later abandoned the TennCare Standard changes as part of a court settlement. The state views its new waiver proposal as a way to avoid eligibility reductions in the face of rapidly rising TennCare costs.[2]

Key Changes in Waiver Amendment Proposal[3]

In May 2004, at the Governor's request, the state legislature enacted major changes to TennCare. In August 2004, the state released a draft waiver amendment proposal for public comment. Following the public comment period, the proposal was submitted to CMS for review.

New Medical Necessity Definition. The legislature enacted a new definition of "medical necessity" (services are covered under Medicaid only when they are medically necessary).[4] Under this new definition, to be covered, an item or service must be required to diagnose or treat a medical condition, be safe and effective, be the least costly option that is adequate for the medical condition of the enrollee, and must not be experimental or investigational. A service will be considered experimental or investigational if there is inadequate empirically-based objective clinical scientific evidence of its safety and effectiveness for the particular use in question. Responsibility for determining medical necessity will ultimately rest with the TennCare Bureau. The legislative definition would apply to all TennCare enrollees and, as written, is more restrictive than the definition currently used by Tennessee and the standard relied on by other state Medicaid agencies, Medicare, Federal Employee Health Benefits contractors, and in private sector plans.[5] Although the change is noted in the waiver proposal, the state is not seeking federal approval for the change because it asserts that it does not need waiver authority to implement the new definition.

Broad New Authority to Make Program Changes Necessary to Meet New State Spending Target. The state would target the total amount of state funds spent each year on TennCare to 26% of state tax revenues. The waiver seeks broad authority to make a wide range of TennCare program changes relating to eligibility, benefits and beneficiary costs for children and adults as necessary to meet this target without further CMS review. The waiver includes scenarios of program changes that might be made under the "pre-approval" authority it requests CMS to provide. Under this authority, the state could expand coverage or it could implement additional reductions for all TennCare enrollees (those in TennCare Medicaid and Standard). An Advisory Commission would be formed to "recommend whatever changes are needed to keep program spending within 26% of state tax revenues."[6] The Governor would make final decisions regarding changes and could modify the Commission's recommendations.

Specified Eligibility, Benefit, Premium, and Cost sharing Changes. In addition, the waiver seeks authority to make a number of specified changes in coverage for beneficiaries:

- *The waiver would move over 120,000 additional people (mostly children and people with disabilities or a medical condition) from TennCare Medicaid into the "Standard" group* (Table 1). Mandatory eligibles (pregnant women, children, parents, and SSI recipients), dual eligibles, individuals residing in institutions, and individuals receiving home and community-based waiver services would remain in TennCare Medicaid. The state estimates that 19% of all children and 39% of all adults, for a total of 30% of all TennCare enrollees, would be in Standard, compared to a total of 21% before the change. TennCare Standard would include most optional children and adults as well as some people with disabilities.

Table 1: TennCare Eligibility Under Proposed Waiver Amendment

"TennCare Medicaid"	"TennCare Standard"	
	Moving from "Medicaid" to "Standard"	Previously in "Standard"
Pregnant women <185% FPL Children <age 1, <185% FPL; age 1-6, <133% FPL; age 6-19, <100% FPL Parents <66% FPL and those leaving TANF due to earnings (for 18 months) SSI beneficiaries (elderly people and disabled adults and children with incomes <76% FPL) Dual eligibles (enrolled in Medicaid and Medicare) All children and adults in institutions or receiving Home and Community-Based waiver services as an alternative to institutional care (including Medically Needy individuals and individuals with incomes under 300% of SSI standard) Other[7]	Medically needy adults and children who are not in institutions and not dual eligibles (including disabled people in their Medicare waiting period and parents and children who "spend down" to Medicaid eligibility through medical expenses) Women with breast and cervical cancer	"Medically eligible" children and adults <100% FPL* Uninsured children <200% FPL & adults <100% FPL without access to group coverage and "medically eligible"* individuals >100% FPL who "roll over" from a TennCare Medicaid category " Grandfathered groups" (new enrollment has been closed for these groups since 2002): • "Medically eligible" children and adults >100% FPL who enrolled in TennCare before July 2002* • "Medically Eligible" dual eligibles who enrolled in TennCare before January 2002* • Uninsured children <200% FPL & adults <100% FPL without access to group coverage who enrolled in TennCare before July 2002 • Uninsured children <200% FPL with access to group coverage who enrolled in TennCare before January 2002

Note: *"Medically eligible" are people who cannot obtain private coverage due to a medical condition.

- *The state would also make a number of specified changes in premiums, benefits, and cost sharing.* As noted, the new medical necessity definition would apply to all TennCare beneficiaries. Proposed changes also include a new tiered pharmacy formulary that would apply to all TennCare beneficiaries and create three groups of drugs. Access would be restricted for drugs in two of these groups and would require authorization that would be granted in limited circumstances.[8] Additionally, coverage for antihistamines and gastric acid reduction drugs would be eliminated for all adults. The waiver proposal also specifies changes in premiums and cost sharing and other benefit changes that would affect groups covered under "TennCare Standard." Not all groups in TennCare Standard would be affected by all of these changes[9] and none of these changes would apply to the groups in TennCare Medicaid. There would also be new limits on appeals for TennCare Standard enrollees. (See Tables 2 and 3 for more details.)

Table 2: Summary of Key Proposed Changes in TennCare

	TennCare Medicaid Enrollees	TennCare Standard Enrollees
Subject to new restricted Medical Necessity definition	✓	✓
Subject to waiver of EPSDT (EPSDT waived in 2002)[10]	No	✓
Subject to new tiered pharmacy formulary	✓	✓
Coverage eliminated for antihistamines & gastric acid reduction drugs	Adults	Adults
Subject to Specified:		
Benefit Limits (eg., limits on drugs, physician visits)	No	Adults who do not meet disability definition[11]
Premium Increases	No	Adults >100% FPL
New Copayments	No	All adults (copays that had been imposed on children would be dropped)
Services can be denied based on unpaid copayments	N/A	✓
Limits on appeal rights	No	✓[12]
Subject to further benefit limits, premium and cost sharing increases, and other changes that might be made to meet spending target[13]	✓	✓

Table 3: Overview of TennCare Standard Specified Premium, Benefit, and Cost Sharing Changes[14]

New medical necessity definition	Applies to all enrollees					
Subject to specified benefit limits & premium and cost sharing increases	Uninsured Adults <100% FPL without access to group coverage who were enrolled before July 2002 or who "rolled over" from a TennCare Medicaid category after July 2002 (no new enrollment) "Medically eligible" adults (New enrollment closed to those with incomes above 100% FPL) Medically needy adults who are not institutionalized and not dual eligibles (enrolled in Medicaid and Medicare) Women w/breast & cervical cancer Exemptions: Individuals defined as disabled[15] exempt from specified benefit limits, but not from premiums or cost sharing; all TennCare Standard children (including uninsured children <200% FPL and "medically eligible" children) exempt from specified benefit limits (other than medical necessity change), premiums, and cost sharing, although EPSDT has been waived for children in this group; benefit limits, except pharmacy, do not apply to certain behavioral services provided through the behavioral health network, such as acute inpatient psychiatric inpatient hospitalization or psychological counseling.[16]					
Specified premiums		Individual	Family			
	100-149% FPL:	$24	$48			
	150-199% FPL:	$42	$84			
	200-249% FPL:	$120	$300			
	250-300% FPL:	$180	$450			
	300%+ FPL:	$240-$660	$600-$1650			
	Premiums could be increased annually					
Specified benefits limits & cost sharing	**Specified benefit limits (All coverage subject to new medically necessity definition)**	**Specified cost sharing**	**<49% FPL**	**50-99% FPL**	**100- 299% FPL**	**300% FPL+**
Inpatient Hospital	45 days/year		$30	$50	$100	$250
Outpatient Hospital and Facility Services, including Emergency Rooms (ERs)	8 visits/year, including ER visits[17]	Non-ER visit	$3	$15	$25	$40
		ER visit that does not result in admission	$10	$20	$40	$60
Outpatient Professional Services		Non-specialist	$1	$10	$20	$30
		Specialist	$3	$15	$25	$40
Physician Services	12 visits/year	Non-specialist	$1	$10	$20	$30
		Specialist	$3	$15	$25	$40
Lab and X-ray	10 occasions/year					
Prescription Drugs	6 drugs/month No coverage for antihistamines and gastric acid reduction drugs for adults New tiered formulary; limited access to B and C drugs[18]	A Drugs	$1	$3	$5	$10
		B Drugs	$2	$7	$10	$20
		C Drugs	$3	$10	$15	$40
Physical therapy, occupational therapy, and speech therapy		Services outside of home health visit	$1	$10	$15	$20

Other Provisions

Cost sharing: No out-of-pocket maximums. Providers can deny care based on unpaid copays.

Appeals: Tennessee will not grant requests for fair hearings when an enrollee is challenging the state's policy of imposing benefit limits and copayments. Individuals will have the right to a fair hearing for "legitimate factual disputes" relating to benefit limits and copayments; the state retains authority to determine whether factual disputes are legitimate. The state will provide notice of eligibility determinations (including applicable benefit limits, copayments, and premiums); enrollees will have the right to appeal these determinations.

Notification of benefit limits and copayment policy: Enrollees will receive notice of their copayment obligations and benefit limits, the consequences for failing to pay copayments, and their financial responsibility for services that are non-covered because they exceed benefit limits. State will provide enrollees with written notification when a payment for a service is denied due to exceeding a benefit limit; providers will give enrollees oral and/or written notification when they deny services due to exceeding a benefit limit or failing to make a copayment. Enrollees will not receive notice that they are nearing a benefit limit or have reached a benefit limit. (Waiver proposal, pg. 32.)

NOTES

[1] The state notes that many of the people coverage was expanded to under the original TennCare waiver, including all those subject to premiums and cost sharing and later enrollment closures, were "waiver-eligibles" or "non-Medicaid eligible" individuals that would not have been eligible without the TennCare waiver; Communication between David Goetz, Commissioner, Tennessee Department of Finance and Administration, and Diane Rowland, Executive Director, Kaiser Commission on Medicaid and the Uninsured, October 6, 2004. Some of the groups covered by TennCare could not be covered without a waiver (e.g., some adults within the group TennCare refers to as "medically eligible"); however, many of those who are covered under the TennCare waiver expansions could be and are covered without a waiver in other states as an optional Medicaid group (e.g., children and parents living with children).

[2] Proposed Amendment to the TennCare Demonstration Project, Office of the Governor, State of Tennessee, September 24, 2004 and Letter from Phil Bredesen, Governor of Tennessee, to Diane Rowland, Executive Director, Kaiser Commission on Medicaid and the Uninsured, October 1, 2004. Proposal and other waiver materials can be accessed at http://www.tn.gov/governor/tenncare.htm.

[3] Proposed Amendment, op. cit.

[4] See Letter from Phil Bredesen, op. cit. for the state's rationale for the new medical necessity definition.

[5] Schneider, A., *Tennessee's New "Medically Necessary" Standard: Uncovering the Insured?,* Kaiser Commission on Medicaid and the Uninsured, July 2004.

[6] Proposed Amendment, op. cit., pg. 42.

[7] There are 800 people in this group, representing less than 1% of the TennCare population. Most of the individuals in this small group are aliens and refugees, David Goetz Communication, op. cit.

[8] New Drug Formulary creates three new groups of drugs: "A" Drugs: Preferred drugs that do not require prior authorization. One or two drugs per therapeutic class—representing the least expensive alternatives among therapeutically comparable drugs. In some drug classes, there may be no A drugs. "B" Drugs: Preferred drugs that require authorization. Drugs that are therapeutically comparable to and yet higher-cost than A Drugs, but, for which, there are clinically-based scenarios for which their use is more appropriate. "C" Drugs: All drugs not designated as A or B; excluded from formulary and generally only covered in "very rare, unique, and/or novel clinical scenarios pursuant to a very stringent exceptions process" (waiver proposal, p. 30).

[9] For example, children would have no benefit limits, premiums, or copays; disabled beneficiaries would not be subject to benefit limits; and premiums would not apply to individuals with incomes below poverty, David Goetz Communication, op. cit.

[10] The state notes that, in its previous waiver, it received a waiver of the EPSDT requirement for children previously assigned to TennCare Standard. To date, the state has provided them with a set of benefits that is identical to that offered to the EPSDT population. In the new waiver proposal, the state seeks reaffirmation from CMS that it can make changes in coverage, including the application of copayments, premiums, or benefit limits, for this population that may be in conflict with EPSDT requirements, Proposed Amendment, op. cit, p. 44. Under the waiver, additional children would be moved to TennCare Standard.

[11] Children and people with disabilities would be exempt from benefit limits; disabled defined as Medically Needy who are aged, blind, or disabled, HCBS recipients, persons receiving SSDI. Other disabled individuals and people with chronic illnesses who do not meet this definition would be subject to the benefit limits. SSI beneficiaries and pregnant women are not subject to the specified benefit limits because they are TennCare Medicaid enrollees.

[12] Tennessee will not grant requests for fair hearings when an enrollee is challenging the state's policy of imposing benefit limits and copayments. Individuals will have the right to a fair hearing for "legitimate factual disputes" relating to benefit limits and copayments; the state retains authority to determine whether factual disputes are legitimate. The state will provide notice of eligibility determinations (including applicable benefit limits, copayments, and premiums); enrollees will have the right to appeal these determinations.

[13] "Future changes will be made through the Advisory Commission process as established in Tennessee statute and rule and under scenarios limited by financial circumstances and CMS," David Goetz Communication, op. cit.

[14] In addition to the specified changes described in this table, the waiver seeks authority to make broad changes in eligibility, benefits and cost sharing to keep program costs within spending target.

[15] Disabled defined as Medically Needy who are aged, blind, or disabled, or persons receiving SSDI; other disabled individuals and people with chronic illnesses who do not meet this definition would be subject to the benefit limits. SSI beneficiaries and individuals who are institutionalized or receiving Home and Community Based waiver services are not subject to the specified benefit limits because they are TennCare Medicaid enrollees.

[16] Also, pregnant women are included in TennCare Medicaid rather than Standard and, thus, are exempt from benefit limits, premiums, and cost sharing.

[17] Screenings required under the Emergency Medical Treatment and Active Labor Act will not count toward the limit.

[18] See footnote 8.

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