



**BILL HASLAM**  
GOVERNOR  
STATE OF TENNESSEE

January 6, 2017

The Honorable Kevin McCarthy  
U.S. House Majority Leader  
H-107, The Capitol  
Washington, DC 20515

Dear Leader McCarthy and Committee Leadership:

Thank you for your December 2<sup>nd</sup> letter and the invitation to provide feedback regarding the health insurance and Medicaid challenges and opportunities in Tennessee.

Tennessee has a history of finding innovations and efficiencies in our health care system. We have long advocated for more flexibility in TennCare, our Medicaid program, and we believe states must receive meaningful relief from the federal constraints that exist today in order to be successful in the management of our health care systems. Further, we know costs must be addressed and reduced within the market so that a sustainable health care system may emerge for Tennesseans and all Americans. We hope Tennessee's proven track record of efficient and effective management will be recognized as you consider new funding models and approaches.

Enclosed, please find our responses to your questions as well as additional information related to Medicaid that should be helpful to you. We look forward to working with you as you seek to address necessary and important challenges in our country's health care system.

Sincerely,

A handwritten signature in black ink that reads "Bill Haslam".

Bill Haslam

Cc: Senator Lamar Alexander  
Senator Bob Corker  
Congressman Phil Roe  
Congressman John Duncan  
Congressman Chuck Fleischmann  
Congressman Scott DesJarlais  
Congressman Jim Cooper  
Congressman Diane Black  
Congressman Marsha Blackburn  
Congressman David Kustoff  
Congressman Steve Cohen  
Commissioner Julie McPeak, Tennessee Department of Commerce and Insurance  
Dr. Wendy Long, Director of TennCare, Tennessee Department of Finance and Administration

**1. What changes should Congress consider to grant more flexibility to states to provide insurance options that expand choices and lower premiums?**

The Affordable Care Act (ACA) provided a generally federal-centric approach to reforming the regulation of health insurance. While there are areas where Congress authorized flexibility for the states, including in the structure of exchanges, the law in large part either imposed new regulatory requirements on the states or deferred to the U.S. Department of Health and Human Services (HHS) to develop and implement new regulations to apply uniformly across the states.

As you and your colleagues consider enacting health insurance reforms, the Tennessee Department of Commerce and Insurance (TDCI) would strongly encourage you to reconsider the premise that health insurance public policy should be directed from Washington, D.C. Instead and as further described below, Congress and the Administration should consider returning to the states as much flexibility as possible to address the unique needs of our respective markets. That flexibility may extend to policy benefits (Essential Health Benefits under the ACA), rating rules and rating bands, and timelines for the development of policies and rates, among other things.

**2. What legislative and regulatory reforms should Congress and the incoming administration consider to stabilize your individual, small group, and large group health insurance markets?**

The individual insurance market by volume (when compared to employer provided coverage, Medicare and Medicaid) has by far the smallest population but is the market that is discussed most frequently because individuals in this insurance pool tend to have higher medical costs resulting in higher rate increases than other insurance markets and programs. The next Congress and Administration may want to consider the following items when developing comprehensive reform proposals:

- **Essential Health Benefits (EHB):** EHB prescribes benefits that must be offered in individual insurance market plans. Though EHB is defined to an extent in the ACA, the U.S. Department of Health and Human Services (HHS) controlled the process of identifying state EHB benchmark plans, providing states only limited flexibility in selecting such benchmarks. The states may be better positioned to work with insurance carriers to bring innovative products to market if we had more flexibility on how EHB is defined. Two or three standard plans should be considered, with other more flexible plan designs available in the marketplace.
- **Rating Factors:** The ACA severely limited an insurance carrier's ability to underwrite a policy of insurance, permitting only age, location, and smoking status to be used when determining an individual's premium price. Going further, the differentiation in rate based on age could not extend beyond a 3:1 ratio. Providing more flexibility to insurance regulators and carriers in how individuals are rated, even while keeping prohibitions against discrimination based on preexisting conditions, may help stabilize insurance markets.
- **Special Enrollment Periods (SEPs):** Special enrollment periods are an absolute necessity for individuals who experience a change in life circumstance (e.g. childbirth, employment change). However, reports suggest that SEPs are so broadly defined that they are almost akin to a permanent open enrollment period, allowing individuals to access health insurance benefits only when health care is an immediate necessity. The implementation of SEPs should be restricted to focus on the more commonly recognized special conditions for enrollment.

- **Grace Periods:** Grace periods should be shortened to 30 days. Allowing 90 days for a grace period allows gaming of the system and adds administrative cost to the plan.
- **Third-Party Payors:** HHS has been wrestling with market rules that have allegedly permitted certain third-party payors, sometimes for their own direct financial benefit, to divert consumers from public programs like Medicare to commercial insurance plans. Insurance regulators and markets need additional clarity in this area or the authority to fully address such issues at the state level to ensure that commercial markets are not inappropriately taking on insurance risks that are otherwise intended for public programs.

**3. What are key administrative, regulatory, or legislative changes you believe would help you reduce costs and improve health outcomes in your Medicaid program, while still delivering high quality care for the most vulnerable?**

The chart that follows these questions outlines a number of constraints that currently exist in federal law and regulation that we believe if removed would provide important flexibility to states in operating their Medicaid programs. Some of these requirements are contained in or receive their authority from the ACA. However, many others have been around much longer and/or receive their authority from other statutes. As Congress considers returning control to states, and especially as a new funding model is contemplated, addressing these issues will be important.

**4. What can Congress do to preserve employer-sponsored insurance coverage and reduce costs for the millions of Americans who receive health coverage through their jobs?**

The ACA imposed numerous requirements on employers, small and large alike, that Congress and the Administration may wish to reconsider in an effort to strengthen health insurance options available to individuals through their employers. It is important to note that the employer-sponsored insurance market worked well before the ACA was enacted, and that rates faced by small businesses, though they have increased, have increased at relatively stable levels over the past several years, particularly when compared against rate increases absorbed by individual health insurance policyholders. Additional changes could include:

- **Employer Mandate:** TDCI is concerned that at times the employer mandate may have overwhelmed business owners, particularly small business owners, into not providing employees with access to coverage, instead leaving employees to search the individual marketplace for affordable options. Small and large business owners should be encouraged to provide coverage for employees, not penalized for not offering coverage that meets federal requirements. Regulation of the employer group market, specifically the small group market consisting of 2-100 enrollees, should be returned entirely to the states.
- **Cadillac Tax:** The so-called “Cadillac Tax,” as you know, penalizes companies for providing employer-sponsored health coverage that exceeds certain federally defined thresholds. This tax may have a negative impact on employer innovation and on a company’s efforts to tailor products for its employees if such employers are required to pay a federal tax for providing benefits that are deemed to be too beneficial for the employees. On a related note, wellness programs offered by employers for the benefit of employees, including on-site health clinics, gym memberships and other related benefits, should not be counted against an employer for

purposes of calculating employee health benefits. Employers should be encouraged, not discouraged, from offering such creative wellness benefits to employees.

**5. What key long-term reforms would improve affordability for patients?**

No conversation about health insurance costs or reform is complete without an acknowledgement that health insurance is inevitably tied to health care—the actual medical treatment of our insured populations. This direct connection has, at times, seemed neglected in media coverage of insurance company rate requests or the number of uninsured and insured individuals across our states, but it is not one that should be passed over in any consideration of fundamental industry reforms. In Tennessee, and we suspect across the country, regulators have identified two cost drivers that seem to disproportionately impact insurance rates. First, the lack of regulation of air ambulance services and charges has left many Tennesseans with phenomenal “balance bills” that have gotten as high as \$30,000 and \$40,000 for unsuspecting policyholders who have had to be air-lifted to medical facilities. The states are preempted under federal aviation statutes from regulating the services and charges of air ambulance companies. With only limited regulation, the costs of these charges are often passed along to insurance carriers who have little ability to negotiate reduced rates and, therefore, end up passing costs along to consumers in the form of rate increases.

Second, Congress and the Administration may consider reviewing the impact of the prescription drug industry on health care and health insurance. Insurance regulators, insurance carriers, and the American public at large have recognized steep increases in drug prices in recent years. Anecdotally, we seemingly observe companies entering into consent agreements with federal agencies and paying huge fines only after a public outcry and Congressional response to hikes in the cost of prescription medication. As drug prices continue to climb, insurance carriers will have to respond in kind in terms of premium rates to respond to the higher cost of medical care.

In addition, we believe that consumers should have the benefit of additional transparency in health care costs. Prices and quality benchmarks should be published to allow consumers to make informed choices on health care.

**6. Does your state currently have or plan to enact authority to utilize a Section 1332 Waivers for State innovation beginning January 1, 2017?**

We do not currently have plans to utilize a Section 1332 waiver. However, if the guidance around 1332 waivers changes significantly with the next administration, we would review those changes to determine if the circumstances warranted reconsidering that decision.

- a. If allowed, would your state utilize a coordinated waiver application process for both 1115 Medicaid and 1332 State Innovation Waivers for benefit year 2017?**

Not applicable

- b. If allowed, would your state utilize a model waiver for expedited review and approval similar to the Medicare Part D transition and assistance for Hurricane Katrina evacuees?**

Not applicable

- c. **If allowed, which requirements would your state seek to waive under a 1332 waiver?**

Not applicable

- d. **If allowed – and if applicable – what changes would be necessary to current guidance to accelerate your state’s ability to pursue a 1332 waiver?**

Not applicable

- 7. As part of returning more choice, control and access to the states and your constituents, would your state pursue the establishment of a high-risk pool if federal law were changed to allow one?**

We may consider recreating a high-risk pool but would need to see Congressional legislative language that would authorize or require the creation of high-risk pools. We may be challenged to create a high-risk pool absent additional resources from the federal government as we wound down our high-risk pool following the enactment and extended implementation of the ACA. We would be hesitant to stand up a new high-risk pool with only state resources and without assistance from the federal government.

- 8. What timing issues, such as budget deadlines, your legislative calendar, and any consumer notification and insurance rate and form review requirements should we consider while making changes?**

We will likely present a recommended budget at the end of January for State Fiscal Year 2018 (July 1, 2017 to June 30, 2018), with passage of the final budget by the General Assembly anticipated around April 2017. In addition to budget timing, there were a number of operational changes that occurred as a result of the ACA that we are currently implementing or redesigning systems to implement. Appropriate lead time for things like changes to Medicaid eligibility requirements and processes will be important as will the recognition that as of today, we and insurance carriers expect to make product and rate filings for 2018 in early June 2017, with rate and policy development beginning several months ahead of that date. Added uncertainty in insurance markets may have the effect of deterring carriers from participating in the market for 2018. Therefore, we would encourage Congress and the Administration to be flexible in the timing of any new reforms or revisions to health insurance statutes.

- 9. Has your state adopted any of the 2010 federal reforms into state law? If so, which ones? What impact would repeal have on these state law changes?**

We have not enacted substantial legislative changes following enactment of the ACA that would be particularly problematic should the ACA be repealed or significantly reformed. We made changes to address small group filings and otherwise addressed rate filing deadlines, but those changes should not pose significant challenges to us in the event the ACA is revised or repealed.

**List of Medicaid Issues/Constraints/Limitations**

<b>Topic</b>	<b>Citation/Source</b>	<b>Key Questions/Considerations</b>
<p><b>Eligibility and Related Issues</b></p> <p><i>Mandatory Coverage Populations</i></p> <p>Medicaid is currently required to cover certain mandatory populations, including:</p> <ul style="list-style-type: none"> <li>● Low-income children</li> <li>● Low-income pregnant women</li> <li>● Low-income parents/caretaker relatives</li> <li>● Individuals receiving SSI</li> </ul>	<p>Mandatory coverage populations are listed at Section 1902(a)(10)(A)(i) of the Social Security Act.</p> <p><i>The ACA included some changes to Medicaid coverage requirements.</i></p>	<p>If federal contributions to states are set at fixed amounts, will states have additional flexibility to determine what populations they will or will not cover?</p>
<p><i>Enrollment Caps and Waiting Lists</i></p> <p>States are generally prohibited from limiting enrollment or establishing waiting lists, outside of certain optional waiver populations (e.g., HCBS).</p>	<p>Section 1902(a)(8) of the Social Security Act.</p>	<p>If federal contributions to states are set at fixed amounts, will states be given flexibility to set enrollment caps and/or waiting lists for certain populations?</p>
<p><i>Flexibility In Setting Income Standards</i></p> <p>States set income standards for most eligibility categories. However, state flexibility in setting these standards is usually constrained by requirements in federal statute and/or regulation. For example, for parents/caretaker relatives, states are required to set an income standard that is no less than the income standard used by the state's AFDC program on May 1, 1988.</p>	<p>Parameters for each eligibility category are set forth in 42 CFR Part 435.</p>	<p>Could states be allowed to have more flexibility to set income standards for their various eligibility categories?</p> <p>Instead of basing eligibility around specific, discrete categories, could states be allowed to set a single “across the board” income threshold, set as a percentage of the FPL?</p>

Topic	Citation/Source	Key Questions/Considerations
<p><i>Retroactive Eligibility</i></p> <p>Medicaid law requires states to provide payment for services received in the three months prior to an individual's Medicaid application. (Tennessee and a limited number of other states have been granted waivers of the requirement.)</p>	<p>Section 1902(a)(34) of the Social Security Act.</p>	<p>Could states choose not to cover services prior to the date of an individual's Medicaid application (without needing a waiver)?</p> <p>Could states choose to cover retroactive services for a shorter period of time (one month), or only for certain populations?</p>
<p><i>Disenrolling Individuals Guilty of Medicaid Fraud and Abuse</i></p> <p>States are generally not allowed to disenroll individuals from Medicaid who have been determined to be guilty of program fraud or abuse. Conditions for eligibility are set forth in Medicaid statute, and CMS and the courts have generally not allowed states to impose additional restrictions on eligibility.</p>	<p>Medicaid eligibility requirements are set forth in Sections 1902(a)(10)(A) and (B) of the Social Security Act.</p>	<p>Would states be allowed to disenroll individuals who have been determined to have committed fraud or abuse against the Medicaid program, and to prevent them from re-enrolling for a specified period of time ("lock out")?</p>
<p><i>Reasonable Opportunity Period</i></p> <p>States are required to provide Medicaid coverage to individuals having satisfactory immigration status during a reasonable period of time while their immigration status is being verified, if they are otherwise eligible for Medicaid. This "reasonable opportunity period" is 90 days. A significant number of persons who receive coverage during the reasonable opportunity period are subsequently determined ineligible.</p>	<p>Sections 1902(ee), 1903(x), 1137(d)(4) of the Social Security Act, and implementing regulations at 42 CFR 435.407.</p>	<p>Would states be allowed to eliminate or to shorten the reasonable opportunity period? Or could states offer a shorter reasonable opportunity period and extend it for good cause at the state's discretion?</p> <p>Would states be allowed to limit the number of reasonable opportunity periods an individual can receive to no more than one per year?</p>

<b>Topic</b>	<b>Citation/Source</b>	<b>Key Questions/Considerations</b>
<p><i>Expedited Eligibility Hearings</i></p> <p>On November 30, 2016, CMS issued a final rule that requires “expedited” fair hearings for individuals who have been determined ineligible for Medicaid. CMS intends to set a timeframe of seven working days for resolving these expedited eligibility appeals.</p>	<p>42 CFR 431.224.</p>	<p>States should not be required to implement expedited fair hearings for eligibility issues.</p>
<p><i>Hospital-Based Presumptive Eligibility</i></p> <p>States are required to implement “hospital presumptive eligibility” programs, whereby hospitals are authorized to make preliminary Medicaid eligibility determinations for most populations.</p>	<p>Section 1902(a)(47)(B) of the Social Security Act, and implementing regulations at 42 CFR 435.1110.</p> <p><i>This is an ACA requirement.</i></p>	<p>Hospital presumptive eligibility should be implemented at the option of the state, and in a way that allows states to ensure the accuracy of eligibility determinations made by participating hospitals.</p>
<p><b>Benefits and Related Issues</b></p> <p><i>Mandatory Benefits</i></p> <p>States are currently required to cover a specified set of benefits (and may choose to offer additional optional benefits).</p>	<p>Medicaid benefits are specified in Section 1905(a) of the Social Security Act.</p>	<p>If federal contributions to states are set at fixed amounts, will states have additional flexibility to determine what benefits they will or will not cover?</p> <p>Could states choose not to cover non-emergency medical transportation services? FQHC/RHC services?</p>



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<p><i>Mandatory Benefits - EPSDT</i></p> <p>For children under 21, Medicaid currently requires coverage of early and periodic screening, diagnostic, and treatment services. The federal government defines this benefit expansively, which makes it difficult to manage services available to children under 21.</p>	<p>Section 1905(a)(4) and Section 1905(r) of the Social Security Act.</p>	<p>Could states limit certain services for children as they currently may for adults?</p> <p>Could states exclude services which are optional for adults from the definition of EPSDT?</p> <p>Could EPSDT be limited to children under 18?</p>
<p><i>Comparability of Services</i></p> <p>Generally, the benefits package covered by the state must be made available in the same amount, duration, and scope to all individuals enrolled in the program. (There are certain exceptions to this rule, such as the requirement to provide EPSDT to children.)</p>	<p>Section 1902(a)(17) of the Social Security Act.</p>	<p>Could states be allowed to develop different benefits packages targeted more narrowly to address the needs of specific populations (e.g., elderly and disabled SSI recipients versus pregnant women)?</p> <p>(There is currently some flexibility to do this through the use of “alternative benefit plans.” However, the ABP development and approval process is extremely cumbersome, and certain populations must be allowed to opt out of ABP coverage. See entry on ABPs below.)</p>
<p><i>Pharmacy – Mandatory Coverage</i></p> <p>Pharmacy is classified as an optional Medicaid benefit; but, states that elect to cover pharmacy services are not permitted to manage their formularies in any meaningful way. States are required to cover all drugs produced by manufacturers that have entered into a rebate agreement with the federal government.</p>	<p>Sections 1902(a)(54) and 1927(d)(4) of the Social Security Act.</p>	<p>States should have more flexibility to manage their formularies, including flexibility to cover or not cover specific drugs based on factors such as cost and clinical efficacy.</p>

Topic	Citation/Source	Key Questions/Considerations
<p><i>Pharmacy – Mandatory Coverage</i></p> <p>When new drugs are approved by the FDA, states are required to begin covering them immediately if the drug in question is covered by the Medicaid drug rebate program. There is no opportunity for the state to review the relevant clinical evidence in order to make decisions about the drug's preferred/non-preferred status, appropriate authorization requirements, and use among special populations (e.g., children, pregnant women). Although Medicare requires its Pharmacy &amp; Therapeutics Committee to review new drugs before coverage can begin, CMS does not allow the same process to be used in Medicaid.</p>	<p>Sections 1902(a)(54) and 1927(d)(4) of the Social Security Act.</p>	<p>When new drugs are approved for coverage by the FDA, states should have an opportunity to review the clinical evidence on which the drug's approval is based in order to decide how the drug should be covered and to ensure appropriate prescribing and authorization practices.</p>
<p><i>ACA-Related Coverage Mandates</i></p> <p>Section 2502 of the ACA prohibited states from excluding barbiturates, benzodiazepines, and tobacco cessation drugs from coverage.</p>	<p>Section 1927(d)(7) of the Social Security Act.</p> <p><i>This mandate is a part of the ACA.</i></p>	<p>Coverage of barbiturates, benzodiazepines, and tobacco cessation products should be optional for states.</p>

Topic	Citation/Source	Key Questions/Considerations
<p><i>Benefit Reductions and Limitations</i></p> <p>When states reduce or limit the amount, duration, and scope of a covered service, CMS requires the state to demonstrate that the reduced benefit is still sufficient to reasonably achieve its purpose. In its review process, CMS has interpreted this to mean that the reduced or limited benefit would continue to meet the needs of at least 90 percent of beneficiaries. (No such restriction exists when states choose to eliminate a benefit entirely.)</p>	<p>Subregulatory guidance from CMS Region IV (Atlanta), based on 42 CFR 440.230.</p>	<p>States should have flexibility to manage the scope of their covered benefits, including reducing benefits and setting limits when necessary. CMS should not require states to go through an exercise of demonstrating that 90 percent of enrollees will be unaffected by a new limit.</p>
<p><i>Alternative Benefit Plans</i></p> <p>Medicaid statute provides some flexibility for states to develop “alternative benefit plans” for certain populations. However, this flexibility is almost unusable because of the process established by CMS for development and approval of “ABPs.” This process requires detailed, exhaustive comparisons to a set of “benchmark” benefit plans, including various substitutions and supplementations of benefits, with little if any flexibility. In addition, CMS maintains that ABPs must cover all “essential health benefits,” which involves a separate set of detailed comparisons and demonstrations. When Tennessee has explored the possibility of ABPs with CMS in the past, CMS’s interpretation of the ABP authority would have only allowed benefit designs that were more generous than traditional Medicaid.</p>	<p>Section 1937 of the Social Security Act, with implementing regulations at 42 CFR Part 440, Subpart C.</p> <p><i>Much of the current guidance around ABPs, including the requirement that they must cover certain “essential” health benefits, stems from the ACA.</i></p>	<p>States should be given genuine flexibility to design alternative benefits packages for certain populations. The requirements for developing and approving ABPs should be significantly simplified.</p>

<b>Topic</b>	<b>Citation/Source</b>	<b>Key Questions/Considerations</b>
<p><i>Mental Health Parity</i></p> <p>In general, the Mental Health Parity and Addiction Equity Act (MHPAEA) prevents states from imposing conditions or limitations on behavioral health services (including substance use disorder services) that are more restrictive than those applied to medical/surgical services. This significantly constrains states' ability to manage behavioral health benefits (except by imposing additional restrictions on medical/surgical services). In addition, CMS's new regulation for enforcing parity (March 2016) sets out a complicated and onerous process for states to implement parity requirements. This process involves classifications and sub-classifications of benefits, and detailed analyses of "predominant" quantitative and non-quantitative treatment limits that can be applied to "substantially all" benefits in particular classifications.</p>	<p>Section 2726 of the Public Health Service Act, with implementing regulations for Medicaid at 42 CFR Part 438, Subpart K.</p>	<p>States choosing to cover behavioral health and addiction treatment services for adults should have greater flexibility to manage these benefits.</p> <p>A simpler process needs to be developed for ensuring that states are complying with provisions regarding mental health parity.</p>
<p><b>Enrollee Responsibilities and Expectations</b></p>		

<b>Topic</b>	<b>Citation/Source</b>	<b>Key Questions/Considerations</b>
<p><i>Cost Sharing – General</i></p> <p>States are currently severely restricted in imposing premiums and co-pays on Medicaid enrollees. Co-pays are limited to:</p> <ul style="list-style-type: none"> <li>• Certain enrollee populations, and</li> <li>• Certain services.</li> </ul> <p>Premiums are further limited to enrollees at certain income levels.</p> <p>Permissible premium and co-pay amounts are restricted to nominal amounts specified in regulation.</p>	<p>Sections 1902(a)(14), 1916, and 1916A of the Social Security Act, and implementing regulations at 42 CFR Part 447.</p>	<p>Would states be given more flexibility to design appropriate cost sharing frameworks that impose reasonable levels of enrollee responsibility?</p>
<p><i>Cost Sharing – Aggregate Cap and Tracking</i></p> <p>Enrollees' financial obligations are limited to 5 percent of household income. States are required to develop and maintain systems that track enrollees' incurred cost sharing on a monthly or quarterly basis, and "turn off" cost sharing obligations for the remainder of the month/quarter if the 5 percent limit is reached.</p>	<p>42 CFR 447.56(f).</p>	<p>States should not be required to track enrollee cost sharing.</p> <p>If states are required to track enrollee cost sharing, could they be allowed to track over a longer period of time (i.e., one year)?</p>
<p><i>Cost Sharing – Enforceability</i></p> <p>Medicaid co-pays are generally unenforceable, meaning that providers are required to provide services to enrollees even when the enrollee fails to pay required co-pays.</p>	<p>Section 1916(e) of the Social Security Act.</p>	<p>Would states be allowed to enforce co-pays for non-emergency services for certain populations? (Enforceable co-pays are currently allowable under certain "alternative" cost sharing arrangements, but like the ostensible flexibility for alternative benefit plans, the development and approval process is extremely cumbersome.)</p>

Topic	Citation/Source	Key Questions/Considerations
<p><i>Cost Sharing – Disenrollment for Non-Payment</i></p> <p>Enrollees with premium obligations may be disenrolled for failure to pay premiums. However, states are not allowed to impose mandatory disenrollment periods, meaning someone who has been disenrolled may immediately re-enroll.</p>	<p>42 CFR 447.55.</p>	<p>Would states be allowed to disenroll individuals who fail to make required contributions, and “lock them out” for a specified period of time?</p>
<p><i>Work and Training Requirements</i></p> <p>Various states have expressed interest in adding work, work seeking, and/or work training requirements as a condition of Medicaid eligibility, at least for certain populations. Work requirements are not listed as an eligibility criterion in statute, and historically CMS and the courts have not allowed states to add eligibility requirements beyond those contained in federal law.</p>	<p>Medicaid eligibility requirements are set forth in Sections 1902(a)(10)(A) and (B) of the Social Security Act.</p>	<p>Could statute be amended (or would CMS grant a waiver of statute) to allow states to impose work, work seeking, and/or training requirements as a condition of eligibility for certain populations?</p>
<p><i>Circumstances in which Providers May Bill Enrollees</i></p> <p>Medicaid providers are generally not permitted to bill enrollees for services (other than approved cost sharing amounts). This prohibition stems from CMS’ interpretation of the requirement for providers to accept Medicaid payments as “payment in full.” In certain circumstances, this requirement interferes with the ability of providers to provide services to enrollees who are able and willing to pay.</p>	<p>42 CFR 447.15</p>	<p>States should have greater flexibility to allow providers to bill enrollees in certain circumstances.</p>

Topic	Citation/Source	Key Questions/Considerations
<p><i>Reasonable Charges for Missed Appointments</i></p> <p>Longstanding Medicaid policy has been that enrollees cannot be charged for missed or “no show” appointments with Medicaid providers. Cost sharing is only allowed for covered Medicaid services as approved by CMS, and CMS does not regard missed appointments as a distinct reimbursable Medicaid service. CMS views missed appointments as part of a provider’s overall cost of doing business.</p>	<p>Cost sharing for Medicaid enrollees is limited by Section 1902(a)(14) of the Social Security Act and implementing regulations at 42 CFR 447.15.</p>	<p>Could states allow providers to charge enrollees a reasonable charge for missed appointments? Like co-pays, these charges could be set at reasonable levels based on enrollee income.</p>
<p><b>Service Delivery Systems</b></p>		
<p><i>Mandatory Managed Care Enrollment</i></p> <p>States cannot mandate enrollment into managed care for all enrollees. (Certain populations must be allowed to opt out of managed care.)</p>	<p>Section 1932(a) of the Social Security Act.</p>	<p>Could states be allowed to mandate all enrollees into managed care without the need for a waiver?</p>
<p><i>Enrollee Choice of Managed Care Plans</i></p> <p>States that require enrollment into managed care are required to offer enrollees a choice of at least two managed care entities.</p>	<p>42 CFR 438.52.</p>	<p>Could states be allowed to restrict enrollee choice for certain types of managed care entities based on the scope of services provided by the entity (e.g., PBM, DBM)? This currently requires a waiver.</p>

<b>Topic</b>	<b>Citation/Source</b>	<b>Key Questions/Considerations</b>
<p><i>Premium Assistance – Benefit “Wraps”</i></p> <p>States may implement premium assistance programs to buy eligible individuals into private insurance. However, states generally cannot mandate individuals into premium assistance arrangements. And, CMS has required states exercising this option to “wrap” benefits and cost sharing protections not provided by the private insurance plan.</p>	<p>42 CFR 435.1015.</p>	<p>Could states be allowed to mandate certain populations into premium assistance arrangements?</p> <p>When enrollees voluntarily choose to enroll in a premium assistance arrangement, could states be relieved of the obligation to provide them with “wrap around” benefits and protections?</p>
<p><i>Beneficiary Supports and Assistance</i></p> <p>Current regulations require states to provide assistance with applications or renewals in person, over the telephone, and online. In addition, the new managed care rule requires states to establish “beneficiary support systems” beginning in 2018 to provide choice counseling and assistance for enrollees in understanding managed care.</p>	<p>42 CFR 435.908 and 42 CFR 438.71.</p> <p><i>The requirement for states to offer assistance in person, by telephone, and online stems from the ACA.</i></p>	<p>States should have greater flexibility in determining the types of reasonable assistance and supports needed by their applicants and enrollees.</p>
<p><b>Program Administration</b></p> <p><i>Network Adequacy Standards</i></p> <p>The new managed care rule requires states to develop time and distance standards for specified provider types beginning in 2018. Tennessee currently has well-established distance standards; however, in our experience time standards are generally not useful for ensuring network adequacy and access.</p>	<p>42 CFR 438.68.</p>	<p>Could states be allowed to utilize only distance standards?</p>



<b>Topic</b>	<b>Citation/Source</b>	<b>Key Questions/Considerations</b>
<p><i>Access Monitoring Review Plans</i></p> <p>Federal regulations require states to develop extensive “access monitoring review plans” when states intend to reduce or restructure provider payments. The purpose of this exercise is to ensure that changes to payment methodologies do not result in reduced access. However, the access monitoring review plan required by regulation is overly complicated and cumbersome.</p>	<p>42 CFR 447.203.</p>	<p>States should not be required to submit access monitoring review plans in order to make adjustments to provider payments. There should be a simpler way for states to demonstrate adequate access to services.</p>
<p><i>“Pay and Chase”</i></p> <p>In instances when Medicaid enrollees have other insurance (third party liability), states may sometimes deny payment and instruct providers to bill the enrollee’s third party insurance instead of Medicaid. However, for certain claims (EPSDT and prenatal services), states are required to pay provider claims themselves and “chase” the third party payment.</p>	<p>42 CFR 433.139(b).</p>	<p>Could “pay and chase” requirements be eliminated so that states could choose to reject claims when other coverage is available?</p>
<p><i>Fraud Control</i></p> <p>Under current regulation, states are subject to a number of mandated fraud control requirements (e.g., the Medicaid Fraud Control Unit requirement). These requirements could be streamlined and simplified.</p>	<p>42 CFR Part 455 and 42 CFR Part 1007.</p>	<p>Could states be given some relief from mandatory fraud control activities, or additional flexibility in fraud control activities, while bearing the risk of failure to control fraud effectively?</p>

<b>Topic</b>	<b>Citation/Source</b>	<b>Key Questions/Considerations</b>
<p><i>Section 1115 Waivers</i></p> <p>Section 1115 demonstration waivers are an important source of flexibility utilized by virtually all states. These waivers expire periodically and are subject to an extensive set of renewal processes. This is the case even for successful, longstanding waivers, and even when no substantive programmatic changes are being requested.</p>	<p>Section 1115 of the Social Security Act and implementing regulations at 42 CFR Part 431, Subpart G.</p>	<p>When existing (already approved) waivers are due for renewal and no substantive programmatic changes are being requested, the application for renewal should be subject to an expedited review and approval process.</p> <p>There should be a mechanism in place for waivers that have been renewed multiple times to remain in effect without requiring re-approval every three to five years.</p>
<p><i>Cost-Based Reimbursement for FQHC/RHC Services</i></p> <p>Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) are unique among Medicaid providers in that federal law specifies the way they are to be reimbursed and sets a floor for payment. This required cost-based reimbursement/prospective payment system is inefficient and creates inequities among providers.</p>	<p>Section 1902(bb) of the Social Security Act</p>	<p>States should be allowed to set or negotiate appropriate rates with FQHCs and RHCs as they do with all other providers.</p>

<b>Topic</b>	<b>Citation/Source</b>	<b>Key Questions/Considerations</b>
<p><i>Services for Dually Eligible Enrollees</i></p> <p>Medicaid provides assistance with Medicare premiums and cost sharing for certain low-income Medicare beneficiaries, as well as funding for Medicare Part D in the form of required contributions (“clawback”). Medicare Part B and Part D costs represent one of the most significant factors driving growth in state Medicaid spending, and states have no means by which to influence or manage these costs. In addition, certain individuals qualify for full coverage under both Medicare and Medicaid, meaning they receive health care services from two different programs simultaneously, often with little coordination.</p>	<p>Section 1902(a)(10)(E), Section 1905(p), and Section 1935(c) of the Social Security Act</p>	<p>States should not continue to be responsible for rising Medicare Part B and Part D costs over which they have no control. Medicare is managed by the federal government, and the federal government should be responsible for growth in program costs.</p> <p>Is it an efficient use of resources for individuals to be covered by two separate health care assistance programs simultaneously? If state Medicaid programs are going to continue to be responsible for certain costs for such enrollees (e.g., LTSS), states should have the flexibility to choose to cover and administer the full range of services, with appropriate transfer of funds from Medicare to Medicaid for such an arrangement.</p>