STATE OF TENNESSEE
BUREAU OF TENNCARE
DEPARTMENT OF FINANCE AND ADMINISTRATION
310 Great Circle Road
NASHVILLE, TENNESSEE 37243

May 8, 2014

Eliot Fishman, Ph.D., Director
Family and Children's Health Programs Group
Centers for Medicare and Medicaid Services
Center for Medicaid, CHIP, and Survey & Certification
Mail Stop S2-01-16
7500 Security Boulevard
Baltimore, Maryland 23244-1850

RE: TennCare II demonstration (No. 11-W-00151/4), Amendment #22

Dear Dr. Fishman:

We are requesting two program changes and two technical corrections in the TennCare Demonstration. Both of the program changes are necessary because of budget issues facing our state.

Proposal #1: Implement maximum allowable medical copays.

We are proposing to implement the copays outlined in the July 15, 2013, regulations for inpatient stays, outpatient visits, and non-emergency use of the Emergency Room. According to 42 CFR § 447.52(b)(3), the maximum medical copays for a managed care state that does not have fee-for-service payment rates are as follows:

- $75 for an inpatient hospital stay
- $4 for an outpatient service
- $8 for non-emergency use of the Emergency Department

In order to effectuate this change in the current Special Terms and Conditions, we propose that the title of Table 5 ("TennCare Non-Pharmacy Copays") be amended to read "TennCare Non-Pharmacy Copays for TennCare Standard Children." We could then add a new Table 5a as shown below:

Table 5a
TennCare Non-Pharmacy Copays

Applicability	Copayment Amounts
Non-exempt services for non-exempt TennCare Medicaid and TennCare Standard adults, all poverty levels	$75 Inpatient Hospital Stay $4 Outpatient Visits, excluding visits from a home health aide, home health nurse, or private duty nurse and excluding visits to a community mental health center or outpatient substance abuse treatment facility
All enrollees	$8 Non-emergency Use of the Hospital Emergency Department (no more than one copay per day)

"Exempt services" will be those defined at 42 CFR §447.56(a)(2).

"Exempt enrollees" will be defined as all children under the age of 21 and adults in the groups identified at 42 CFR §447.56(a)(1).

In accordance with 42 CFR § 447.54(c), no persons will be exempt from the $8 copay on non-emergency use of the Emergency Department. The procedure to be used by hospitals prior to collecting the copay is outlined at 42 CFR § 447.54(d). Recognizing the additional support that is available to enrollees in a managed care system, CMS approved an alternative procedure for TennCare in correspondence dated April 18, 2012. This procedure is as follows: "[B]efore providing non-emergency care subject to co-payment, emergency department staff [will] recommend that the patient or the patient's caretaker call the 24/7 nurse staffed call center for the patient's MCO to obtain help in locating an available provider in the community, and [will] offer to assist with placing a call to the call center." It is our intent to continue using this procedure.

In accordance with 42 CFR § 447.52(e), we will allow providers to require an enrollee to pay cost-sharing as a condition of receiving the service if the individual has a family income that exceeds 100 percent of the Federal Poverty Level.

We are requesting two waivers in accordance with implementation of these copays.

a. First, we are requesting a waiver of the requirement at 42 CFR § 447.56(f)(1) that the annual aggregate limit be applied on either a monthly or a quarterly basis. The monthly or quarterly calculation process will be confusing and disruptive to both enrollees and providers, not to mention administratively burdensome for the Medicaid agency. Given ordinary claims lag and given the fact that TennCare enrollees are being served by multiple contractors simultaneously, computing the exact point when an enrollee reaches the monthly or quarterly limit is a process that carries with it an unacceptable risk of error. Lengthening the time horizon from a month or a quarter to a year will reduce the likelihood of errors considerably and will make the process much more understandable for enrollees and providers. Under our proposal, once the enrollee has reached his or her annual aggregate cap, there will be no more cost-sharing for the remainder of the calendar year. This approach will be especially favorable to the lowest income enrollees, since they will likely reach their aggregate limit quickly and then will not have to deal with copays again for an entire year. This approach is also more consistent with how commercial insurance programs work. We believe there is value in aligning certain elements of

the Medicaid copay experience with copay policies used by commercial insurance, so that we can help prepare the enrollee for the time when he or she no longer needs Medicaid. We are not aware of any commercial insurance product that calculates annual aggregate limits on a monthly or quarterly basis.

b. Second, we are requesting a waiver of the requirement at 42 CFR § 447.54(f)(2) that the state use a process for tracking cost-sharing that "does not rely on beneficiary documentation." We think beneficiary documentation is the most efficient way to track cost-sharing, since beneficiaries are the ones with the greatest motivation for ensuring that their cost-sharing obligations end at the appropriate time. We believe their motivation will be enhanced when they understand that reaching the annual aggregate limit means no more copays for the remainder of the calendar year, as proposed in the paragraph above. Once we have the data that an enrollee has reached his annual aggregate cap, we can modify our enrollment information so that providers can easily determine that the enrollee should not be charged a copay, unless the service in question is non-emergency use of the Emergency Department.

Proposal #2: Limitation on diapers furnished on an outpatient basis to adults. We are proposing to place a limit on diapers of 200 per month for adults aged 21 and older who receive these items on an outpatient basis and who need them for medical reasons. This limit is estimated to affect about 4,000 people, which is less than 5 percent of the number of non-institutionalized, non-dual individuals who require services in the home and who are therefore at greatest risk of requiring diapers.

Public Notice. These changes have been published for public comment in newspapers of general circulation, in accordance with the public notice requirements of paragraph 15 of the Special Terms and Conditions. Information about the proposals has been posted on the state's website, with a vehicle for comments included. We have received no comments.

Technical Corrections. There are two technical corrections In the existing STCs that we would like to propose.

- Table 1a. In the row that starts with the phrase "Deemed categorically eligible newborns," there are several corrections needed to be consistent with CHIPRA. Those corrections are illustrated below:

Description	Income Limit	Provisions of the Act Waived or Made Not Applicable (see Waiver List
Deemed categorically eligible newborns: Born to ~~& living with~~ a woman who was eligible for and received Medicaid on the date of the child's birth	Eligible for 1 year ~~as long as mother is eligible or would be if pregnant~~	1, 2, 5, 8, 10

- Attachment A. In the Enrollment Counts for Quarter table, the row for "EG4 Adults, Type 2" should be deleted. There are no longer any EG4 Type 2 Adults. This group was removed from STC #53 during the most recent waiver extension.

CHIP Allotment Neutrality Worksheet. We do not believe that these changes will have a significant effect on CHIP allotment neutrality.

Evaluation Design. We do not anticipate modifying the Evaluation Design at this time.

Data Analysis. We are forwarding the worksheet electronically.

We will be glad to work with you and your staff as you review Amendment #22. We are requesting an expedited implementation date of July 1, 2014, in order to avoid the need for additional program reductions. We will need to secure approval in time to provide notice to beneficiaries in accordance with Section XIII, Part II, of the Special Terms and Conditions.

Thank you for your attention to this important matter.

Sincerely,

[redacted]

Darin J. Gordon
Director, Bureau of TennCare

cc: Jessica Woodard, TennCare Project Officer, Center for Medicaid, CHIP and Survey & Certification, Baltimore
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