DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

June 21, 2024

Stephen Smith
Director of TennCare
Tennessee Department of Finance and Administration
310 Great Circle Road
Nashville, TN 37243

Dear Director Smith:

On April 23, 2024, the United States District Court for the District of Columbia in the case *McCutchen v. Becerra* granted the Centers for Medicare & Medicaid Services's (CMS) request for a voluntary remand to revisit the challenged approval of Tennessee's section 1115 demonstration, "TennCare III" (project number 11-W-00369/4), as modified by CMS's August 4, 2023, amendment approval. As detailed below, CMS reaffirms its prior decision of August 4, 2023, to approve the requests Tennessee included in its August 30, 2022, proposal for an amended section 1115 demonstration. This letter addresses concerns raised by interested parties to the challenged approval and provides additional explanation for the decision to approve TennCare III, as amended.

The TennCare III section 1115 demonstration, among other things, grants Tennessee the authority to operate a statewide, comprehensive managed care program. Additionally, through the currently approved demonstration, the state has expanded coverage beyond the already expanded coverage provided under the previous TennCare II demonstration. Moreover, TennCare III seeks to strengthen its Medicaid program by: (1) establishing new, expanded eligibility for "Katie Beckett" beneficiaries, who are children through age 18 with disabilities and complex medical needs who are not otherwise Medicaid eligible due to parent income and assets; (2) providing federal financial participation for expenditures for state health programs consistent with Medicaid demonstration objectives that enable the state to continue to improve health outcomes and increase the efficiency and quality of care; and (3) utilizing demonstration authority to add benefits and coverage without seeking prior approval from CMS that would otherwise be required, consistent with what is allowable under other Medicaid authorities. The state has used this last flexibility in recent years to add adult dental coverage, extend postpartum eligibility coverage up to 12 months, as aligned with the state plan option provided by the American Rescue Plan Act, extend the income limits for the pregnancy-related eligibility group, and increase expenditure caps for beneficiaries in home and community-based services (HCBS)

programs. The TennCare III demonstration also allows the state to waive retroactive eligibility for most Medicaid beneficiaries and authorizes the demonstration for a 10-year period.

While the authorities currently approved within the TennCare III section 1115 demonstration are not precedent setting and do not represent new policy, CMS has concerns with waiving retroactive eligibility and 10-year demonstration periods for section 1115 demonstrations, discussed below. However, at this time, CMS is not taking any action to withdraw waivers of retroactive eligibility or 10-year demonstration approval periods that have already been granted, such as those at issue here, or to withdraw any other authority currently provided for in the modified TennCare III demonstration. In light of the amendments approved on August 4, 2023, and taking into consideration the demonstration features described above as well as the demonstration project as a whole, CMS has concluded that the overall TennCare III demonstration, as modified, is likely to assist in promoting the objectives of Medicaid. In our view, specific authorities within the demonstration, such as the waiver of retroactive eligibility, the managed care authority which applies in some form to the majority of Medicaid beneficiaries in Tennessee, and the 10-year demonstration period, must be considered within the overall context of the demonstration as a whole and the state's ability to offer and continue these expanded benefits and services. The TennCare III demonstration includes robust monitoring and evaluation requirements, and CMS reserves its authority to take appropriate action, up to and including suspension or withdrawal of demonstration authorities in the future if monitoring or evaluation data raise concerning evidence.

Ten Year Demonstration Period

CMS approves section 1115 demonstrations for a limited period of time after which the waiver or expenditure authority approved under the demonstration expires unless it is extended. CMS has discretion under the statute to determine the length of the period for which a section 1115 demonstration is approved without being extended. It has been suggested that this longer approval period would reduce administrative burdens and allow the state sufficient time to test its innovative approach. However, CMS has policy concerns with approving section 1115 demonstrations for a 10-year period. These relatively long approval periods provide fewer opportunities for the Secretary of Health and Human Services to receive state and national-level feedback on the scope of the overall demonstration and reduces the opportunities for the Secretary to make policy decisions and adjustments to a demonstration's authorities and special terms and conditions (STCs) based on this feedback and available evidence on policy effectiveness. By comparison, 3-year and 5-year durations for section 1115 demonstrations allow for more frequent state and national public input on a demonstration's merits, in addition to the state-level annual public forums that are required. These state and national public comment periods at a demonstration's extension enhance agency understanding of whether a demonstration may be promoting the objectives of Medicaid and help inform decision-making at a demonstration's extension. Given these concerns, while CMS is not taking any action at this time to withdraw or modify the authority for TennCare III's 10-year demonstration period (which now has fewer than 7 years remaining), CMS does not currently support 10-year demonstration periods and does not plan to approve future section 1115 demonstrations for periods of 10 years. We note, moreover, that unlike cases in which CMS reviewed a 10-year

approval period for the first time, here CMS has already twice reevaluated its approval of TennCare III and the project's end date is less than 7 years away.

Waiver of Retroactive Eligibility

While evidence on the impact of waivers of retroactive eligibility is limited, CMS has concerns with waivers of retroactive eligibility. More generally, we believe they could potentially lead to increased beneficiary medical debt and adverse health outcomes for low-income individuals.[1] Waivers of retroactive eligibility may also impact hospital revenues[2] and result in higher rates of uncompensated care for hospitals,[3] which could threaten the financial stability of safety net providers and ultimately, access to care for beneficiaries. However, data related to the effects of the waiver of retroactive eligibility were not previously collected by Tennessee under TennCare II, since such requirements were not distinctly stipulated in the demonstration's STCs. Tennessee is now required to evaluate how the waiver of retroactive eligibility affects outcomes such as enrollment and enrollment continuity, whether it encourages individuals to enroll in Medicaid while they are healthy rather than doing so when they are sick or need care, and whether the waiver is linked to changes in individuals' medical debt and financial wellbeing. The evaluation is expected to examine changes in provider uncompensated care costs and utilization of services from providers receiving uncompensated care funding. Tennessee is also required to assess potential barriers to enrollment and timely renewal. The TennCare III monitoring reports in alignment with the STC requirements are not yet due to CMS, and the first draft Interim Evaluation Report is under CMS review.[4] Because data are limited, and because CMS finds that TennCare III, as a whole, is likely to assist in promoting the objectives of Medicaid, CMS is not taking any action at this time to withdraw the waiver of retroactive eligibility in the TennCare III demonstration. However, while we continue to work with states, including Tennessee, to collect data and evidence on the impact of this policy, we are not currently inclined to support waivers of retroactive eligibility and have no plans to approve new requests for waivers of retroactive eligibility.

---

[1] **Sommers, B.D., Chen, L., Blendon, R.J., Orav, E.J., & Epstein, A.M. (2020).** Medicaid Work Requirements in Arkansas: Two-Year Impacts on Coverage, Employment, and Affordability of Care. Health Affairs, 39(9), 1522-1530. Retrieved from https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2020.00538; **Kean, N. (2019).** Medicaid Retroactive Coverage: What's at Stake for Older Adults When States Eliminate this Protection? Justice in Aging. Retrieved from https://www.justiceinaging.org/wp-content/uploads/2019/09/Medicaid-Retroactive-Coverage-Issue-Brief.pdf; and **Miller, S., Johnson, N. & Wherry, L.R. (2021).** Medicaid and Mortality: New Evidence From Linked Survey and Administrative Data. Working Paper 26081. Retrieved from https://www.nber.org/papers/w26081.

[2] **Dobson, A.l, DaVanzo, J., & Haught, R. (2017).** The Financial Impact of the American Health Care Act's Medicaid Provisions on Safety-Net Hospitals. The Commonwealth Fund. Retrieved from https://www.commonwealthfund.org/sites/default/files/documents/___media_files_publications_fund_report_2017_jun_dobson_ahca_impact_safety_net_hosps_v2.pdf.

[3] **Dickson, V. (2016).** Providers, Patients Say Ohio Medicaid Overhaul Proposal Needs Revisions. Modern Healthcare. Retrieved from https://www.proquest.com/docview/1789844765?accountid=12786&sourcetype=Trade%20Journals.

[4] The state's current approval period Monitoring Protocol and Evaluation Design are under CMS review, and the draft Interim Evaluation Report includes limited data on the waiver of retroactive eligibility but is pending CMS review.

Managed Care Authority

Managed care is the predominant delivery system in state Medicaid programs, with most beneficiaries receiving some or all Medicaid benefits through a managed care delivery system. Congress has expressly granted states broad flexibility to require Medicaid beneficiaries to be enrolled in managed care arrangements to receive Medicaid state plan benefits and gave states the option to determine the scope of its managed care program. States can utilize Medicaid managed care authority through both a state plan option, and program waiver authority that has been in effect for over 40 years (see discussion below). For example, a state may decide to utilize a risk-based managed care program to provide comprehensive coverage (i.e., acute, primary care, and specialty care), or a risk-based or non-risk limited benefit program, or a state may choose to utilize a primary care case management program. The type of managed care program a state utilizes determines the type of managed care plan(s) [(i.e., managed care organizations MCOs), prepaid inpatient health plans (PIHPs), prepaid ambulatory health plans (PAHPs), primary care case managers (PCCMs) or primary care case management entities (PCCM entities)] that deliver care to its enrollees.

In 2021, approximately 77 million Medicaid beneficiaries (approximately 85 percent of all such beneficiaries) received some care from a managed care program (to receive all or some benefits) across 49 states and territories while approximately 68 million of those Medicaid beneficiaries (approximately 75 percent of all Medicaid beneficiaries) received comprehensive care (i.e., acute, primary care, and specialty care) in a managed care program across 46 states and territories.[5, 6] Medicaid managed care is the predominant delivery system not only for Medicaid beneficiaries, but also Medicaid spending. Medicaid managed care spending totaled almost $459 billion in Federal fiscal year 2022 accounting for over 57 percent of all Medicaid expenditures.[7]

States have flexibility to determine the design of its managed care program, including the benefits covered, eligibility groups to be enrolled, and whether enrollment will be voluntary or mandatory. As noted above, states have several different authorities they can utilize to require Medicaid beneficiaries to receive Medicaid benefits through a managed care delivery system, including state plan authority under section 1932(a) of the Social Security Act (hereafter referred to as "the Act"), a waiver under section 1915(b) of the Act, and section 1115 demonstration authority. Section 1915(a) also authorizes voluntary enrollment managed care options. The Medicaid managed care authority(ies) that a state utilizes will vary based on the design and objectives of their managed care program as the requirements under each authority vary, including whether the authority can be utilized for voluntary or mandatory enrollment, the populations that can be mandatorily enrolled, what types of managed care plans can be authorized, and the length of approval. For example, under section 1915(a) of the Act, states can implement a voluntary managed care program by executing a contract with managed care plans that the state has procured using a competitive procurement process.

To require Medicaid beneficiaries to enroll in a managed care program to receive services, a state must obtain approval from CMS. Through a state plan amendment (SPA) authorized under

---

[5] Medicaid Managed Care Enrollment and Program Characteristics, 2021; Table 4. KFF Total Medicaid MCOs:
[6] The data is the Medicaid Managed Care Enrollment and Program Characteristics report is self-reported by states.
[7] Medicaid and CHIP Scorecard: Medicaid and CHIP Expenditures by Service Category.

section 1932(a) of the Act, states can implement a mandatory managed care delivery system; however, this authority does not allow states to require beneficiaries who are dually eligible for Medicare and Medicaid (dually eligible beneficiaries), American Indians/Alaska Natives,[8] or children with special health care needs, to enroll in managed care. This SPA authority can only be utilized for MCOs, PCCMs and PCCM entities, and once approved, SPAs remain in effect until modified by the state and approved by CMS. Through a waiver under section 1915(b) of the Act, a state could require all Medicaid beneficiaries, including dually eligible beneficiaries, American Indians/Alaska Natives, or children with special health care needs, to enroll in a managed care delivery system. This authority can be utilized for all managed care plan types, and these arrangements may remain in place indefinitely as long as the waiver is approved every two years (certain waivers can be operated for up to five years if they include dually eligible beneficiaries).

States may also choose to request authorization of managed care programs as part of demonstration projects under section 1115 of the Act to implement innovative designs in their Medicaid programs. As part of such a demonstration, a state might be permitted to require all Medicaid beneficiaries to enroll in a managed care delivery system, including additional populations that are authorized under the section 1115 demonstration, and who are not otherwise eligible for Medicaid under the Medicaid state plan. Section 1115 authority is an important and distinct pathway for authorizing managed care delivery systems that states may use to broaden the scope of coverage to include populations, benefits, or administrative procedures (such as changes to the enrollment process, payment models, or plan models) not otherwise included under other Medicaid managed care authorities. For example, under section 1115 authority, states may seek additional flexibility to demonstrate and evaluate innovative policy approaches for delivering Medicaid benefits, as well as the option to provide services not typically covered by Medicaid or to modify the number of managed care plans that participate. CMS believes it is critical to continue to allow states the option to utilize section 1115 authority for managed care programs to allow states to implement innovative delivery models that meet the states' goals and objectives for the Medicaid program.

In Tennessee, the TennCare III managed care authority authorizes the managed care delivery system for approximately 1.6 million Medicaid beneficiaries.[9] Tennessee has had authority under various demonstrations since 1994, which has allowed it to mandatorily enroll all state plan populations, as well as demonstration-eligible individuals who are not otherwise eligible for Medicaid, in managed care. Over the span of time during which Tennessee has maintained section 1115 authority for a managed care delivery system, the state has modified and updated this authority to incorporate new services offered through managed care as well as provide managed care coverage to new populations, such as the more than 16,000 beneficiaries covered in demonstration-eligible groups and coverage of more than 4,000 new beneficiaries who received coverage because of the administrative flexibilities authorized through TennCare III.[10]

---

[8] Except as permitted in section 1932 (a)(2)(C) of the Act.

[9] Medicaid Managed Care Enrollment and Program Characteristics, 2021; Table 2.

[10] With the approval of TennCare III, Tennessee added a new demonstration eligible population, the Katie Beckett group, to their Medicaid program and managed care delivery system. TennCare III also maintains demonstration-only coverage for additional populations such as the Medicaid Diversion group and the CHOICES Carryover

TennCare III also provides flexibility they would not otherwise have under other authorities to create a specialized managed care program for TennCare Select. Tennessee is still actively testing the outcomes and benefits of managed care for the TennCare program as a whole, and the program has continued to evolve and change across demonstration periods. Preliminary findings from the draft Interim Evaluation Report submitted to CMS in early 2024 suggest that the demonstration, and its predecessor, have increased access to care. In alignment with demonstration goals, the proportion of TennCare enrollees in Patient-Centered Medical Homes (PCMH) – the primary care delivery system that offers care coordination – continued to significantly increase after the approval of TennCare III, representing 43.7 percent of TennCare enrollees in 2022 compared to 11.4 percent of TennCare enrollees in 2017. Available data through the first year of the TennCare III approval period also show that timeliness of prenatal care increased from 77 percent in 2017 to 83 percent in 2021, just surpassing the national average. The ratios of TennCare enrollees to one behavioral health provider and one intellectual and developmental disabilities (I/DD) provider have also continued to decrease after the approval of TennCare III, demonstrating sustained improvements in access to care – the behavioral health provider ratio decreased from 3,668:1 in 2019 to 3,083:1 in 2021, while the I/DD provider ratio decreased from 49,329:1 in 2017 to 23,272:1 in 2022.

CMS continues to monitor implementation of the TennCare III demonstration to ensure applicable managed care requirements are met. Unless expressly waived or granted expenditure authority, the requirements of 42 CFR 438 apply to the state's managed care programs. For example, the state must comply with managed care requirements related to enrollee rights and protections, grievances and appeals, program integrity, reporting requirements, and quality improvement activities. Additionally, the demonstration specifically requires evaluation of aspects related to managed care authorities, including information on access to services, appeals, and complaints.

While it's true that the TennCare demonstration has evolved over time and the managed care authorities in TennCare have included new populations, benefits or ways of operating managed care which represent new research opportunities under section 1115, CMS underscores that continual innovation and change to a demonstration is not a requirement to allow it to continue to be extended. Not being able to extend demonstrations more than once if a state does not change in some fundamental way could threaten many other policies that are approved under section 1115 authority, not just managed care. These authorities often do not have any other pathway for approval under the state plan or other Medicaid authorities. This includes demonstrations that authorize targeted population expansions or benefits expansions, which provide critical low-income safety net coverage of individuals and services[11] that are not otherwise coverable under any other Medicaid authority, as seen in Family Planning demonstrations or the Flint demonstration. Additionally, a range of initiatives such as those related to Health-Related Social Needs (HRSN), the Substance Use Disorder (SUD) and Serious Mental Illness (SMI) initiatives, or the Reentry initiative, are either required via law to use the section 1115 authority, and/or can only be approved and extended using section 1115 authority. These demonstration projects

groups. The state has also used administrative flexibilities approved in TennCare III to incorporate additional populations and benefits otherwise allowable under the state plan into managed care, such as expanded eligibility for the pregnancy-related eligibility group and adult dental benefits.

[11] Section 1115(e) of the Social Security Act.

represent critical and innovative initiatives and provide beneficiaries with important benefits and services that are otherwise not allowed under the state plan or other Medicaid authority and are not intended to be short-term approvals that states can eventually move to other authorities.

Moreover, as allowable under statute and regulation, states may choose to extend demonstrations and approved authorities at the end of that demonstration period. However, the specific limitations on number of extensions and length of demonstration period mentioned in section 1115 of the Act apply only to extensions approved under section 1115(e) and 1115(f) of the Act. Specifically, 1115(e) may only be granted if it is first preceded by an approval under section 1115(a). Further, an extension approved under section 1115(e) must not make any changes to the previous demonstration period's authorities or special terms and conditions and may generally only be approved for a period of up to three years. A demonstration that seeks approval under section 1115(f) must first receive approval under section 1115(e) and may only generally be approved for a period of up to three years (though the state may make changes to the authorities and the special terms and conditions).[12] TennCare III, along with the majority of section 1115 extension approvals, is authorized under section 1115(a) of the Act, which does not outline any specific number of extensions allowable or specific duration of time for the demonstration period.

As discussed above, TennCare III seeks to strengthen the Tennessee Medicaid program in various ways—including through the expansion of coverage. More than 16,278 beneficiaries receive Medicaid coverage solely through TennCare III demonstration authority and cannot be covered under any other state plan or waiver authority available.[13] Further, administrative flexibilities approved in TennCare III allow the state to add benefits and coverage without seeking prior approval from CMS that would otherwise be required, consistent with what is allowable under other Medicaid authorities. This has enabled the state to quickly expand coverage and benefits in the past few years to add adult dental coverage, extend postpartum eligibility coverage up to 12 months, as aligned with the state plan option provided by the American Rescue Plan Act, extend the income limits for the pregnancy-related eligibility group, and increase expenditure caps for beneficiaries in HCBS programs, which has impacted over 4,000 TennCare III beneficiaries to date.[14] The demonstration also provides federal financial participation for expenditures for state health programs consistent with Medicaid demonstration objectives that enable the state to continue to improve health outcomes and increase the efficiency and quality of care. Finally, the state also uses managed care authority to deliver benefits to approximately 1.6 million TennCare Medicaid beneficiaries.[15] The state is required to continue evaluating the TennCare III demonstration, inclusive of the managed care component, in particular assessing the impacts of expanding the benefits and coverage in its dental, ppostpartum,and maternal health, and HCBS programs on improving healthcare access and health outcomes for the state's Medicaid beneficiaries.

---

[12] Section 1115(f) of the Social Security Act.
[13] https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/tn-tenncare-iii-qtrly-rpt-jan-dec-2023.pdf
[14] https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/tn-cms-aknldgmnt-pre-grup-incm-thrsd-incrse-12192023.pdf
[15] Medicaid Managed Care Enrollment and Program Characteristics, 2021; Table 2.

We note that the amendment to TennCare III that we approved on August 4, 2023, has addressed many of our concerns about TennCare III, as originally approved, and we now reinforce our conclusion that TennCare III, as a whole, is likely to assist in promoting the objectives of Medicaid. First, the modification of the aggregate cap budget neutrality and shared savings structure were aimed to alleviate concerns raised in the comments, including concerns about state reductions in benefits for the accrual of savings. Second, the removal of the closed drug formulary was similarly targeted to address comments and concerns regarding access to prescription drugs, which contributed to our prior concerns about whether the project as a whole was likely to assist in promoting the objectives of Medicaid.

Therefore, taking into account the totality of the TennCare III demonstration described above, CMS has concluded that the overall TennCare III demonstration, as modified by the August 4, 2023 amendment approval, is likely to assist in promoting the objectives of Medicaid. CMS reaffirms its approval of the TennCare III demonstration, as modified by the August 4, 2023 amendment, and will not be withdrawing or modifying any authorities currently approved therein. It is our expectation that CMS and Tennessee will continue working in close collaboration to ensure that the state conducts systematic monitoring and comprehensive evaluation of the effects of the demonstration on the state's Medicaid beneficiaries, which may in turn support undertaking future actions to continue ensuring Tennessee's program is in the best interest of the populations Medicaid is designed to serve.

If you have any questions, please contact Jacey Cooper, Director, CMS State Demonstrations Group, at (410) 786-9686.

Sincerely,

Daniel Tsai
Deputy Administrator and Director