



The Honorable Sylvia Mathews Burwell, Secretary
U.S. Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

February 6, 2016

Dear Secretary Burwell,

Families USA is non-profit, nonpartisan organization dedicated to the achievement of high-quality, affordable health coverage and care for all. We appreciate the opportunity to comment on TennCare II's application for extension, whose original application is set to expire on June 30, 2016. Our comments focus on several elements of Tennessee's request that create cause for concern. We urge HHS to address these concerns in order to better achieve Medicaid's goal of providing health care to low-income individuals. Our comments will focus on retroactive eligibility, the current status of eligibility and enrollment systems, and evaluation of enrollment processes.

We appreciate your consideration of our recommendations on this proposal. Throughout our comments we will refer to "TennCare II" as "TennCare." Should you have any questions, please contact Elizabeth Hagan at ehagan@familiesusa.org or Kara Nester at knester@familiesusa.org.

Sincerely,

Elizabeth Hagan
Senior Policy Analyst

Kara Nester
Policy Analyst

Retroactive eligibility:

The state's waiver extension request seeks a five year continuation to waive the state's compliance with the retroactive eligibility requirements of Section 1902(a)(34) of the Social Security Act and 42 C.F.R. §435.914. We believe the arguments that Tennessee has made to waive retroactive eligibility are flawed and we urge HHS to deny the continuation of this waiver for several reasons. Most notably, we are concerned that TennCare has experienced significant delays in processing, which can lead to enrollees facing a significant medical costs and providers facing increased uncompensated care costs when waiting for enrollment.

Tennessee's extension request contends that the waiver of retroactive eligibility has been in place since TennCare's inception, that it is fundamental to the state's ability to attract enrollees before they incur significant health care needs, and that it prepares enrollees for future qualified health plan enrollment. There are several problems with these presented arguments. First, TennCare initially received the waiver of retroactive eligibility when managed care was still a novel system for Medicaid. The waiver argued that retroactive eligibility was needed to operate a successful, continuous managed care system. Today, Medicaid is primarily administered by managed care¹ and many other states have programs that successfully operate a managed care system while offering retroactive eligibility. Therefore, a reference to the historical significance of retroactive eligibility is no longer a valid argument given the different nature of the Medicaid system today.

Second, the notion that retroactive eligibility deters enrollees from seeking coverage when they get sick and encourages them to enroll when they are healthy lacks evidence. Many enrollees are unaware that retroactive eligibility is a component of the program until they actually enroll into Medicaid coverage, so it unlikely that they are influenced to enroll because of this. In addition, TennCare has failed to produce a study of TennCare eligibility determination processes and the relationship of these processes to retroactive eligibility as required by STC #68. There is lack of evidence that the waiver of this component is necessary and producing positive outcomes for the program, despite the long history of the waiver to have retroactive eligibility.

Third, qualified health plan coverage varies from Medicaid coverage in several distinct ways, not limited to retroactive eligibility. These differences are important because Medicaid is structured to fit the needs of the population it serves. Individuals enrolled in Medicaid may eventually enroll in qualified health plan coverage, but that should not be the goal of the program. Rather, the goal should be to best serve the Medicaid population that is enrolled in coverage, and to ease their transition to qualified health plan coverage should they make that transition. Putting forth an argument that a Medicaid program without retroactive eligibility prepares an individual for QHP-coverage is not reasonable given the different nature of the programs. If this component of the waiver is granted, this same argument could be made to waive other important Medicaid components, which raises major concerns.

In addition to the lack of evidence and insubstantial argument presented by the state for the waiver of retroactive eligibility to continue, there are several reasons to restore retroactive

¹ Paradise, Julia. Kaiser Family Foundation, 2014. Key Findings on Medicaid Managed Care. <http://kff.org/medicaid/report/key-findings-on-medicaid-managed-care-highlights-from-the-medicaid-managed-care-market-tracker/>

eligibility. Enrollees with retroactive eligibility can be relieved of substantial medical debt incurred while waiting for their eligibility determination. Uninsured adults are more likely than other adults with insurance to be unable to pay for basic necessities, such as housing or food, due to medical bills,² underscoring the critical importance of protecting consumers from high medical costs. In addition, retroactive coverage can benefit providers by reducing uncompensated care costs. Retroactive coverage allows providers to treat patients who are eligible for Medicaid when they are sick and be assured they can get paid after the patient enrolls. Both of these advantages of retroactive eligibility are magnified by the fact that TennCare has experienced significant delays in processing applications beyond the 45-day required timeframe. TennCare has claimed responsibility for this failure to process applications in a timely manner. Retroactive eligibility would provide protections for consumers and relieve some fears from consumers that have so far experienced a faulty system.

For all these reasons, Families USA recommends that the request to waive retroactive eligibility be denied.

Current state of eligibility and enrollment systems

TennCare has experienced issues over the past three years in conjunction with bringing its systems up to compliance with Title XIX and the requirements of the Affordable Care Act (ACA) that ensure seamless coverage transitions between Medicaid and the health insurance marketplace. The state failed in its effort to develop the TennCare Eligibility Determination System (TEDS) to meet the ACA's 2013 deadline for reform of state IT systems. Tennessee still lacks an automated eligibility determination system and does not expect to have a functioning system in the near future.

In addition to an inadequate eligibility system, there have been a number of policies that obstruct and delay TennCare enrollment and prevent seamless coverage transitions between TennCare and the Exchange. TennCare has instructed all applications to go through Healthcare.gov for enrollment in Medicaid or qualified health plans and is not accepting applications in-person, by phone, mail, online, or by other means. Tennessee is the only state not in compliance with the federal requirement of allowing individuals to apply for Medicaid online through the state Medicaid agency.³ Because of these interactions with healthcare.gov, TennCare cannot determine whether applicants found ineligible for TennCare are eligible for other insurance affordability programs. Further, TennCare does not authorize hospitals to presumptively enroll MAGI-eligible individuals in Medicaid.

In its waiver extension proposal, TennCare does not recognize its failure to administer a Medicaid eligibility and enrollment process that complies with standards. TennCare should not

² Kaiser Family Foundation, 2015. Key Facts about the Uninsured Population. <http://kff.org/uninsured/fact-sheet/key-facts-about-the-uninsured-population/>

³ Kaiser Family Foundation, 2016. Medicaid and CHIP Eligibility, Enrollment, Renewal, and Cost-Sharing Policies as of January 2016. <http://files.kff.org/attachment/report-medicare-and-chip-eligibility-enrollment-renewal-and-cost-sharing-policies-as-of-january-2016-findings-from-a-50-state-survey>

only address its past obstacles and failures but come up with a plan to fix the current problems prior to focusing on any other initiatives.

We recommend that TennCare be held responsible for the current state of their eligibility and enrollment systems and that CMS works with TennCare to implement a plan to ensure that these systems are brought up to standard.

Evaluation of enrollment processes

TennCare's performance measures, which have been established and regularly updated in the state's Quality Improvement Strategy (QIS), lack a measurement of enrollment and eligibility systems and processes. While we are pleased Tennessee is taking steps to assess Medicaid care, TennCare should also be required to evaluate enrollment systems and the experience of beneficiaries applying for and enrolling coverage. A beneficiary's experience during the eligibility and enrollment process is important because it can play a significant role in the decision to receive and maintain coverage.

Additionally, this is an opportune time for TennCare to implement these metrics given the amount of improvements needed. Performance measures that track progress towards specified goals will allow the state to monitor progress of the system and prioritize fixes. The collection and analysis of eligibility and enrollment quality metrics can also be used to evaluate whether TennCare is effectively carrying out improvement activities.

We recommend that TennCare implement eligibility, enrollment, and renewal standards into their quality reporting.