STATE OF TENNESSEE
OFFICE OF THE ATTORNEY GENERAL

January 26, 2015

Opinion No. 15-06

Insure Tennessee

QUESTIONS

Contingent upon authorization by joint resolution of the Tennessee General Assembly, as required by Tenn. Code Ann. §71-5-126, Tennessee will request that the Centers for Medicare and Medicaid Services ("CMS") approve an amendment to Tennessee's current TennCare II Medicaid demonstration program, also referred to as the TennCare Waiver, for the purpose of adding a new component to be called "Insure Tennessee." The target population for this amendment is the optional Medicaid eligibility category described in 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII).[1] The amendment reflects the expectation that program expenditures for Insure Tennessee will be funded with 100 percent federal dollars through December 31, 2016, and with a combination of federal dollars and revenues from a state assessment on hospitals when the federal match rate declines, beginning January 1, 2017.

1. Can the federal government or CMS unilaterally change provisions within the agreement between the State and CMS, which agreement defines the terms, conditions, and eligibility criteria of the TennCare waiver as approved by the United States Department of Health and Human Services?

2. Can the federal government or CMS adopt one interpretation of a provision in the agreement and subsequently reinterpret that same provision and adopt a different and contrary interpretation, resulting in the State incurring additional costs?

3. If legislation is enacted to create the two-year Insure Tennessee pilot program, then:

   (a) Without additional legislative authority, under current statutes imposing the Annual Coverage Assessment can the State use the revenue generated from these fees to assist in funding the pilot program?[2]

[1] This category includes persons between the ages of 19 and 64 who are not otherwise eligible for Medicaid and who have family incomes not in excess of 138% of the Federal Poverty Level.

[2] This opinion request, which posed a series of questions relating to both the Annual Coverage Assessment on hospitals and the Annual Nursing Home Assessment, was submitted before the release

(b) Without additional legislative authority, under current statutes imposing the Annual Coverage Assessment can the State increase the rate of these fees to cover excess costs incurred by the State for the pilot program?

(c) Can the current statutes that authorize this assessment be amended, by legislative enactment, to permit the re-direction of those revenues for the purpose of funding the pilot program? Stated differently, is there any constitutional or other provision of law, such as the Due Process Clause, Contract Clause, or federal regulation, prohibiting an amendment to those current statutes to change or divert the use of the revenue to fund the pilot program?

(d) Can the current statutes that authorize this assessment be amended, by legislative enactment, to increase the rate of the fees to fund excess costs incurred by the State for the pilot program? Stated differently, is there any constitutional or other provision of law, such as the Due Process Clause, Contract Clause, or federal regulation, prohibiting an amendment to those current statutes to increase the rates for the purpose of funding the excess costs?

(e) Is legislation required to permit the use of the Annual Coverage Assessment for the purpose of funding the pilot program?

(f) Is legislation required in order to increase the rate of the Annual Coverage Assessment for the purpose of funding the pilot program?

4. If legislation is enacted to create the two-year Insure Tennessee pilot program and to permit the use of the Annual Coverage Assessment to fund the program, then:

(a) If federal and state funds, including revenues from the assessment, terminate, or otherwise become insufficient to continuing funding [of] Insure Tennessee, then could the State unilaterally discontinue coverage for the Insure Tennessee population?
(b) If the answer to Question (4)(a) is no, then, alternatively, could the State unilaterally expand its TennCare program under the Affordable Care Act to cover the Insure Tennessee population?

---

of the Waiver Amendment Request to add the Insure Tennessee component. Because the Insure Tennessee proposal submitted to the General Assembly expressly contemplates the use of state assessments on hospitals, and makes no mention of nursing home assessments, we have limited our discussion and opinions to assessments imposed on hospitals.

(c) If the answer to Question (4)(b) is no, then, alternatively, could the State unilaterally terminate that part of the TennCare waiver that was revised and approved by the Secretary of DHHS to operate Insure Tennessee and return to the original TennCare waiver as it existed prior to those revisions?

(d) If the answer to Question (4)(c) is no, then, alternatively, could the State unilaterally discontinue the entire TennCare program?

(e) If the answer to Question (4)(a) is yes, then:

(i) What procedures would be required to afford the discontinued enrollees procedural due process protections that comport with federal Medicaid and any other fair hearing regulations?

(ii) What is the maximum amount of time necessary to provide due process protections for a population of 200,000 enrollees?

OPINIONS

1. Neither the federal government nor CMS could unilaterally change a provision of Tennessee's State Medicaid plan or the TennCare II Demonstration documents.[3] However, it is possible that Congress through legislation or CMS through regulation or policy statement could require the State to make changes to those agreements, just as Congress and CMS could now do, regardless of the addition of the Insure Tennessee component.

2. Yes; as a general matter, the federal government or CMS could change or clarify a policy or modify a regulation or law that would affect a provision in the TennCare Waiver.

3.(a), (b), (e), (f). Tennessee Code Annotated § 71-5-805(d) authorizes the use of funds generated by the Annual Coverage Assessment on covered hospitals for purposes of funding expenditures in the TennCare program, including any required state share of expenditures for Insure Tennessee. However, without additional legislative authority, the rate of the assessment, now fixed by Tenn. Code Ann. § 71-5-804(a), cannot be increased. Because the Annual Coverage Assessment Act of 2014 expires by its terms on June 30, 2015, new legislation, effective beyond state fiscal year 2014-15, will be required in order to impose an annual coverage assessment on hospitals, set a rate for that assessment, and identify the purposes for use of those

[3] Technically, the TennCare program is governed by two agreements: the Tennessee State Medicaid plan and the TennCare II Section 1115 Demonstration. *See* 42 U.S.C. § 1396 (State Medicaid plans); 42 U.S.C. § 1315(f) (Medicaid demonstration projects, also referred to as waiver projects).

revenues, as required to fund any necessary state share of expenditures for Insure Tennessee.

(c) and (d). Since Tenn. Code Ann. § 71-5-805(d) currently permits the use of funds generated by the Annual Coverage Assessment for the purpose of funding the state share of expenditures for Insure Tennessee, no amendment of that statute would be necessary for that purpose. While an amendment of Tenn. Code Ann. § 71-5-804(a) to prospectively increase the assessment rate for the already permitted purpose of covering the state share of Insure Tennessee expenditures would be necessary, we are aware of no legal impediment to such legislation.

4.(a) The State may unilaterally decide to discontinue coverage for the Insure Tennessee population, as long as implementation satisfies certain notice and phase-out procedures set out in the TennCare Waiver.

(b) The State could unilaterally decide to expand its TennCare program under the Affordable Care Act, but implementation would be accomplished by means of a TennCare Waiver amendment and/or State Medicaid plan amendment that would be subject to review and approval by CMS.

(c) The State has the discretion to terminate that part of the TennCare Waiver governing Insure Tennessee, without affecting the rest of the Waiver, but this change would have to be implemented by means of an amendment to the TennCare demonstration program approved by CMS.

(d) The State retains the ability to decide to withdraw from the Medicaid program entirely, but that would be accomplished by means of amendments to the TennCare Waiver and State plan, to be reviewed and approved by CMS.

(e)(i) The Standard Terms and Conditions of the TennCare Waiver include the requirements for affording due process protections to individuals in a discontinued Insure Tennessee program.

(ii) We lack sufficiently specific information to enable us to determine the maximum amount of time necessary to provide due process protections to a population of 200,000 enrollees.

ANALYSIS

The Medicaid program was created in 1965 when Congress added Title XIX to the Social Security Act, 42 U.S.C. §§ 1396 to 1396W-5. Medicaid provides federal financial assistance to states that choose to reimburse certain costs of medical treatment for needy persons. State participation in Medicaid is purely voluntary, and all states have chosen to participate. *See Harris v. McRae*, 448 U.S. 297, 301 (1980). The program is a joint financing partnership in which the federal government and participating states share the costs of providing covered health care services to

persons meeting Medicaid eligibility requirements. *See generally* 42 U.S.C. § 1396b. The federal medical assistance percentage ("FMAP") rate that the United States Department of Health and Human Services ("HHS") uses in determining the amount of federal matching funds for most state Medicaid service expenditures is determined by a formula set in federal statute, 42 U.S.C. § 1396d(b), and varies by state. Because the level of federal financial participation in the Medicaid program is the creation of Congress, that level is subject to change only through Congressional action.[4]

TennCare is a demonstration program operating under a section 1115 waiver approved by CMS. *See* section 1115 of the Social Security Act, 42 U.S.C. § 1315. Medicaid waiver programs are time-limited and include an expiration date in the waiver's special terms and conditions. The waiver under which TennCare is operating, granted under authority of section 1115(f) of the Act, extends through June 30, 2016. *See* TennCare II Medicaid Section 1115 Demonstration, *located at* http://www.tn.gov/tenncare/forms/tenncarewaiver.pdf.

Enacted in 2010 as part of the Affordable Care Act ("ACA"), 42 U.S.C. §1396a(a)(10)(A)(i)(VIII) added a new eligibility category to the Medicaid program. Under the Supreme Court's decision in *National Federation of Independent Business v. Sebelius* ("*NFIB*"), 132 S.Ct. 2566 (2012), this new eligibility category may be covered at the option of the state. *See NFIB*, 132 S.Ct. at 2607.

On January 8, 2015, Governor Bill Haslam announced his intention to request CMS approval of a TennCare Waiver amendment to add a new component called "Insure Tennessee." As reflected in the Waiver Amendment Request, TennCare Demonstration Amendment # 25, *located at* http://www.tn.gov/tenncare/forms/InsureTennesseeWaiverAmendment.pdf, Insure Tennessee is an alternative plan for providing services to persons in the optional Medicaid eligibility category described in 42 U.S.C. §1396a(a)(10)(A)(i)(VIII). Individuals in this category, often referred to as "Newly Eligibles," are between the ages of 19 and 64, are not otherwise eligible for Medicaid, and have family incomes that do not exceed 138 percent of the federal poverty level.

As reflected in Amendment #25, it is expected that expenditures for Insure Tennessee will be 100 percent paid with federal dollars through December 31, 2016. On January 1, 2017, the federal amount paid will adjust to 95 percent.[5] Amendment

[4] Congress, through the Appropriations Clause of the Constitution, U.S. Const., art. I, § 9, cl. 7, is vested with exclusive power over the federal purse.

[5] The federal matching rates applicable to the new eligibility category are set out in the Social Security Act, at 42 U.S.C. § 1396d(y)(1), which provides that the federal medical assistance percentage shall be equal to (A) 100 percent for calendar quarters in 2014, 2015, and 2016; (B) 95 percent for calendar quarters in 2017; (C) 94 percent for calendar quarters in 2018; (D) 93 percent for calendar quarters in 2019; and (E) 90 percent for calendar quarters in 2020 and each year thereafter.

#25 recites that Tennessee hospitals have committed to financially supporting Insure Tennessee through an increase in a state assessment on hospitals, so there will be no adverse impact on the state's budget even when the federal match rate declines. Waiver Amendment Request, at section IX. The proposed waiver amendment expressly provides that "Insure Tennessee will end if either of the following events occurs: (1) the federal match rate available for the program is reduced below the amount available under [the] ACA as it exists on January 1, 2015, or (2) revenues available from the assessment on hospitals fails [sic] to cover any remaining state share of expenditures in the event of a reduction in the federal match rate." *Id.*

1. The United States Supreme Court has long recognized that under the Spending Clause of the Constitution, U.S. Const. Art. 1, § 8, cl. 1, "Congress may fix the terms on which it shall disburse federal money to the States." *Pennhurst State School and Hospital v. Halderman*, 451 U.S. 1, 17 (1981). However, that Court has repeatedly characterized Spending Clause legislation, such as Medicaid, as "much in the nature of a contract," in which the legitimacy of federal action "rests on whether the State voluntarily and knowingly accepts the terms of the 'contract.'" *Id.*; *see also NFIB*, 132 S.Ct. at 2602; *Barnes v. Gorman*, 536 U.S. 181, 186 (2002). Consistent with that characterization and contract-law analogy, the federal government or CMS should not be able to unilaterally change a provision of Tennessee's State Medicaid plan or the TennCare II Waiver program, and we are not aware of any instance in which the federal government or CMS has sought to do so.

But, it is possible that Congress through legislation or CMS through regulation or policy statement could require the State to make changes to those agreements. For example, with respect to state Medicaid plans, federal regulation requires that a state plan "provide that it will be amended whenever necessary to reflect . . . changes in Federal law, regulations, policy interpretations, or court decisions" as well as "material changes in State law, organization, or policy, or in the State's operation of the Medicaid program." 42 U.S.C. § 430.12(c). A similar requirement is found in the special terms and conditions (STCs) that govern demonstration projects such as TennCare. The current TennCare II Medicaid Section 1115 Demonstration approval includes a provision, at STC ¶ III(3), that the State "must, within the timeframes specified in law, regulation, or policy statement, come into compliance with any changes in Federal law, regulation, or policy affecting the Medicaid . . . program[ ] that occur during th[e] demonstration approval period, unless the provision being changed is expressly waived or identified as not applicable."[6]

[6] If the State were to refuse to make a required change, it is possible that it would be subject to a noncompliance action under Section 1904 of the Social Security Act, 42 U.S.C. § 1396c, or that CMS would terminate the TennCare demonstration project. Paragraph 13 of the "General Program Requirements" of the Special Terms and Conditions of the current TennCare Waiver provides that CMS reserves the right to withdraw waivers or expenditure authorities if it "determines that continuing the waivers or expenditure authorities would no longer be in the public interest or promote the objectives of Title XIX . . . ." STC ¶ III(13). That same provision in ¶ III(13) provides that the

Under the Supreme Court's decision in *NFIB*, the ability of the federal government or CMS to require that the State make certain changes to programs authorized under the Spending Clause, such as Medicaid, is constrained. The Court recognized that the Medicaid provisions of the Social Security Act contain a clause expressly reserving to Congress "[t]he right to alter, amend, or repeal any provision" of that statute. 132 S.Ct. at 2605, quoting 42 U.S.C. 1304. But, "though Congress' power to legislate under the spending power is broad, it does not include surprising participating States with post-acceptance or 'retroactive' conditions" when those changes represent a "shift in kind, not merely degree." *Id.* at 2605-06. Whether a Congressional change to the Medicaid program would amount to an impermissible "shift in kind" would, of course, depend on a fact-specific exercise in line-drawing, and the Court in *NFIB* expressly declined to fix such a line. *Id.* at 2606.

If the federal government or CMS were to require a change to the TennCare II demonstration project that the State did not wish to implement, the STCs of the demonstration agreement expressly recognize that the State has the right to "suspend or terminate th[e] demonstration in whole, or in part," as long as the State follows certain specified notice and phase-out procedures. STC ¶ III(9).

2. The general rule that applies in disputes between CMS and the states is that a state's interpretation of a provision in its state plan or waiver documents governs, as long as the state's interpretation is reasonable in light of the language of the plan as a whole and the applicable federal requirements. *See, e.g., Missouri Dept. of Social Services*, Department of Health and Human Services, Departmental Appeals Board (DAB) No. 1515 (1995);[7] *California Dept. of Health Services*, Department of Health and Human Services, Departmental Appeals Board (DAB) No. 1474 (1994).[8] However, in disputes involving the meaning of a federal statute or regulation within the purview of HHS, the general rule is that the federal government's interpretation controls, unless that interpretation is arbitrary and capricious or otherwise not in accordance with law. *See Chevron U.S.A., Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837, 843-45 (1984).[9] But in the

---

State would be afforded an opportunity to request a hearing to challenge CMS's determination prior to the effective date.

[7] Located at http://www.hhs.gov/dab/decisions/dab1515.html.

[8] Located at http://www.hhs.gov/dab/decisions/dab1474.html.

[9] Deference to agency interpretation, however, may have limits beyond the arbitrariness standard. Consistent with the contract-law analogy applicable to federal-state spending programs, it appears that the Supreme Court, while acknowledging that modification to such federal-state agreements may be made over time, would recognize certain constraints on the ability of a federal agency to engage in post-agreement interpretations. Federal interpretations "should be informed by the statutory provisions, regulations, and other guidelines" in existence at the time the federal-state agreement was entered into. *Bennett v. Kentucky Dept. of Educ.*, 470 U.S. 656, 670 (1985).

context of litigation, the Supreme Court has observed that the case for judicial deference is less compelling with respect to agency positions that are inconsistent with previously held views, and that the consistency of an agency's position is a factor in assessing the weight that position is due. *See Good Samaritan Hospital v. Shalala*, 508 U.S. 402, 417 (1993); *INS v. Cardozo-Fonseca*, 480 U.S. 421, 446 n. 30 (1987).

In the past, when the federal government has changed regulations or policy interpretations that alter its prior interpretation as applied to state funding issues, it has provided for transition periods of various lengths to implement the changes, recognizing the impact on state budgets.[10] For example, when changes were made affecting the calculation of the "upper payment limit" that could be paid to certain public health care facilities, CMS promulgated a rule reflecting a multi-year transition plan for those states that had been paying above what the new rules would allow. In its rule explaining the transition period, CMS stated that the transitions were justified because it "recognize[d] that immediate implementation of these new upper payment limits could disrupt state budget arrangements for states that have relied on funding obtained from approved rate enhancement State plan amendments." *See* 66 Fed. Reg. 3148, 3160 (Jan. 12, 2001); *see also* 73 Fed. Reg. 77904, 77908 (Dec. 19, 2008) (When CMS enacted a regulation implementing a statutory requirement to conduct audits of disproportionate share hospital (DSH) payments, CMS provided for a five-year transition period for states' development of their audit practices before implementation of recoupment and refunding of any overpayments discovered.)

Were CMS to adopt a different and contrary interpretation of a policy, statute, or regulation that would require a change to the Insure Tennessee program, the State would retain the ability to suspend or terminate the demonstration program, in whole or in part, as long as the State follows certain specified notice and phase-out procedures as provided in STC ¶ III(9) of the TennCare Waiver.

3. The Annual Coverage Assessment Act of 2014, Tenn. Code Ann. §§ 71-5-801 to 71-5-806, imposes a coverage assessment for the fiscal year beginning July 1, 2014, and ending June 30, 2015, on each specifically defined "covered hospital." *See* Tenn. Code Ann. §§ 71-5-802(1) and (6); § 71-5-803. The rate of hospital assessment for fiscal year 2014-15 is set by Tenn. Code Ann. § 71-5-804(a) at 4.52% of a covered hospital's "annual coverage assessment base," as defined at Tenn. Code Ann. § 71-5-802(2). The funds generated thereby must be deposited in the "maintenance of coverage trust fund" initially created by Chapter 909 of the Public Acts of 2010 and continued annually thereafter with similar legislation. *See* Tenn. Code Ann. §71-5-805(a); § 71-5-160(a). The uses for which the funds generated by the annual hospital assessment may be expended are limited as set out in Tenn. Code

[10] Just because the federal government, in its discretion, has provided for such implementation transition periods in the past does not, of course, bind it to do so in the future. The fact that Insure Tennessee will be a time-limited pilot program may diminish any adverse effect of a short transition period.

Ann. § 71-5-805(d). As provided in Tenn. Code Ann. § 71-5-806, the Annual Coverage Assessment Act of 2014 expires on June 30, 2015.

(a), (b), (e), and (f). The paramount rule of statutory construction is to ascertain and give effect to legislative intent without broadening the statute beyond its intended scope. *Carter v. Bell,* 279 S.W.3d 560, 564 (Tenn. 2009); *In re Adoption of A.M.H.*, 215 S.W.3d 793, 808 (Tenn. 2007). If the statutory language is clear and unambiguous, courts will apply its plain meaning. *Brown v. Erachem Comilog, Inc.* 231 S.W.3d 918, 921 (Tenn. 2007); *Calaway v. Schucker*, 193 S.W.3d 509, 514 (Tenn. 2005). If, however, the language of a statute is ambiguous, the court will look beyond the statutory language to determine the legislature's intent. *State v. Strode*, 232 S.W.3d 1, 12 (Tenn. 2007). A statute may be said to be ambiguous when it is susceptible of more than one reasonable interpretation. *Memphis Housing Auth. v. Thompson*, 38 s.W.3d 504, 512 (Tenn. 2001).

The construction of one statute may be aided by considering the words and legislative intent indicated by the language of another, similar, statute. "When one statute contains a given provision, the omission of the same provision from a similar statute is significant to show a different intention existed." *State v. Lewis*, 958 S.W.2d 736, 739 (Tenn. 1997), quoted in *Howell v. State*, 151 S.W.3d 450, 458-59 (Tenn. 2004).

The Annual Coverage Assessment Act of 2014, at Tenn. Code Ann. § 71-5-805(d), provides that "[m]oneys credited or deposited to the maintenance of coverage trust fund together with all federal matching funds shall be available to and used by the bureau *only for expenditures in the TennCare program and shall include the following purposes . . .*" (emphasis added). The categories of included purposes are enumerated in subdivisions (d)(1) – (d)(4) of § 71-5-805.

The Tennessee Supreme Court has recently reaffirmed that when "including" is used alone in conjunction with a list of items, it serves as a term of enlargement, not one of restriction. "When a statutory definition states that it 'includes' specific items, we have held that the 'enumerated items are illustrative, not exclusive.' *State v. Marshall*, 319 S.W.3d 558, 561 (Tenn. 2010) (quoting *Gragg v. Gragg,* 12 S.W.3d 412, 415 (Tenn. 2000)." *Lovlace v. Copley*, 418 S.W.3d 1, 18 (Tenn. 2013).

Using these principles of statutory construction, we conclude that Tenn. Code Ann. §71-5-805(d) authorizes the use by the TennCare Bureau of funds in the maintenance of coverage trust fund "for expenditures in the TennCare program," but not restricted to the enumerated purposes in subdivisions (d)(1) – (d)(4) of that statute. That interpretation of Tenn. Code Ann. § 71-5-805(d) is supported by a comparison to the language used by the General Assembly with respect to the annual Nursing Home Assessment Trust Fund. Tennessee Code Annotated § 71-5-1002 provides that nursing home annual assessment fees "shall be available to and used by the bureau of TennCare for the sole purpose of providing payment to nursing homes." § 71-5-1002(f). Similarly, it is provided that "no part of the nursing home

annual assessment fee payments made by nursing homes under this section . . . shall be used for any purpose other than providing payment to nursing homes." § 71-5-1002(g). In § 71-5-1002(h), the Legislature set out the purposes for which the nursing home assessment trust fund can be expended and said that the fund "shall be used exclusively" for those enumerated purposes. A comparison of the strikingly different language used in each of the two, related, statutory schemes—both enacted for state fiscal year 2014-15—clearly evidences two differing legislative intents. Where one uses a term of enlargement ("include"), the other uses terms of restriction.

Because we conclude that Tenn. Code Ann. § 71-5-805(d) authorizes the use of funds generated by the annual coverage assessment on covered hospitals for "expenditures in the TennCare program," the State could use those funds to assist in funding Insure Tennessee, if that program is authorized by the General Assembly, it is approved by CMS, and funding of any state share of expenditures were necessary.[11] However, under the current statute imposing the annual coverage assessment the State cannot increase the rate of assessment. That rate is a creation of, and expressly fixed by, the current statute: "The annual coverage assessment established for this part [the Annual Coverage Assessment Act of 2014] shall be four and fifty-two hundredths percent (4.52%) of a covered hospital's annual coverage assessment base." Tenn. Code Ann. § 71-5-804(a).

The Annual Coverage Assessment Act of 2014, enacted to impose an annual coverage assessment on covered hospitals, at a specified rate, to be expended for specified purposes, expires on June 30, 2015, by virtue of Tenn. Code Ann. § 71-5-806. If the General Assembly, by joint resolution, authorizes the Governor to do all that is necessary and appropriate to implement Insure Tennessee substantially as described in TennCare Demonstration Amendment #25, then new legislation, effective beyond state fiscal year 2014-15, will be required in order to impose an annual coverage assessment on hospitals, at a rate to be specified by that legislation, and to be expended for the purposes set out in that new legislation, as required to fund any necessary state share of expenditures for Insure Tennessee.

(c) and (d). As just discussed, it is our view that the current provisions of Tenn. Code Ann. § 71-5-805(d) permit the use by the TennCare Bureau of funds generated by the annual coverage assessment for the purpose of funding the state share of expenditures for Insure Tennessee, if necessary. Therefore, no amendment of that statute would be required for that purpose, nor would such expenditures be an arguably impermissible "change or diver[sion]" of such funds, as question 3(c) assumes. While an amendment of § 71-5-804(a) to prospectively increase the annual coverage assessment rate for the already permitted purpose of covering the state

[11] As previously noted, under the terms of Amendment #25 Insure Tennessee will end if the federal match rate were to be reduced below the amounts currently provided for by federal statute, which specifies federal funding of 100 percent through the end of calendar year 2016. 42 U.S.C. § 1396d(y)(1).

share of Insure Tennessee expenditures would be necessary, we are aware of no legal prohibition of such a legislative enactment.

In any event, whether an unnecessary amendment to Tenn. Code Ann. § 71-5-805(d) or a required amendment to § 71-5-804(a) runs afoul of any conceivable legal impediment is a purely theoretical inquiry in which we must respectfully decline to engage. The current statutory scheme that authorizes the annual hospital assessment, setting out the purposes for which the funds generated by that assessment can be expended and the rate at which the assessment will be imposed—the Annual Coverage Assessment Act of 2014—expires on June 30, 2015. The need to amend that Act for purposes of its remaining five-month lifespan and, even if so amended, the need to draw on the funds generated pursuant to such amendment in order to pay a state share of Insure Tennessee expenditures incurred during that five-month period, are extremely unlikely to arise. To trigger those needs, and the resulting threat of any cognizable injury, all of the following events would have to occur *before* June 30, 2015, in order for the Annual Coverage Assessment Act of 2014 and the funds generated thereunder to be impacted: the General Assembly would have to authorize Insure Tennessee; CMS would have to approve the Waiver amendment request; the Insure Tennessee program would have to be implemented and enrollment of eligible individuals, incurring covered medical expenses, would have to be underway; *and* Congress would have to enact and make effective legislation reducing the federal matching rate applicable to the Insure Tennessee population, dropping below the 100 percent federal funding currently required by 42 U.S.C. § 1396d(y)(1), thereby necessitating expenditure of hospital assessment funds for the state share of expenditures.

4(a). The State may unilaterally decide to discontinue coverage for the Insure Tennessee population, as long as the implementation of that decision satisfies certain notice and phase-out procedures set out in the TennCare Waiver. For those components of Insure Tennessee that are governed by the Section 1115 Demonstration Project, the State would retain the ability, expressly recognized in the special terms and conditions of the demonstration agreement, to "suspend or terminate the demonstration in whole, or in part," subject to following specified notice and phase-out provisions. *See* STC ¶ III(9). The suspension or termination would take the form of an amendment to the TennCare Demonstration to be reviewed and approved by CMS. Similarly, for any components of Insure Tennessee that are governed by the State Medicaid plan, the State would need to submit a State plan amendment to CMS for approval.

CMS has made clear that if a state covers the newly eligible group that will be part of Insure Tennessee, "it may decide later to drop the coverage." CMS, "Frequently Asked Questions on Exchanges, Market Reforms, and Medicaid," at 12. *Located at* http://www.cms.gov/CCII0/Resources/Files/Downloads/exchanges-faqs-12-10-2012.pdf. *See also id.* at 11 ("states have flexibility to start or stop the expansion"). Amendments would be required to discontinue coverage for the Insure Tennessee

population. But CMS, in light of its acknowledgment of states' flexibility in this regard, and in light of the explicit language of section IX of TennCare Demonstration Amendment #25 setting out the financing contingencies under which Insure Tennessee will end, would be expected to approve any waiver and/or state plan amendments stopping that coverage, provided that specified phase-out requirements are met. In the highly unlikely event that CMS did not approve, the Supreme Court's decision in *NFIB* suggests that the State could not be penalized for then acting unilaterally to cease coverage. Finding that the Medicaid expansion provided for in § 1396a(a)(10)(A)(i)(VIII) of the ACA constitutes a "shift in kind" that states cannot be mandated to implement, the *NFIB* decision removed from the Secretary of HHS her ability to apply her enforcement authority under 42 U.S.C. 1396c to require a state to do just that. *See NFIB*, 132 S.Ct. at 2607.

(b) The State could unilaterally decide to expand its TennCare program under the Affordable Care Act, but implementation would be accomplished by means of a Waiver amendment and/or State plan amendment that would be subject to review and approval by CMS.

(c) The State has the discretion to terminate that part of the TennCare Waiver that governs Insure Tennessee, without affecting the rest of the TennCare Waiver, but this would be implemented by means of a CMS-approved amendment to the demonstration project. In light of the *NFIB* decision, and CMS's statements that states may drop coverage for the optional Medicaid eligibility category in 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII), CMS should not be able to legally withhold approval of such an amendment to the Waiver, provided that the request complied with the demonstration phase-out requirements of the TennCare Demonstration STCs, at ¶ III(9).

(d) The State retains the ability to decide to withdraw from the Medicaid program entirely, but that would be accomplished by means of amendments to the TennCare Waiver and State plan, to be reviewed and approved by CMS. We do not believe that there is any valid basis on which CMS could withhold approval, provided that the demonstration phase-out requirements of the TennCare Demonstration STCs, to the extent applicable to a complete withdrawal, were met.

(e)(i) The TennCare STCs, at ¶ III(9), include requirements for the suspension or termination of the demonstration project, in whole or in part, that would, in the absence of contrary action by CMS on the Insure Tennessee proposed amendment, be applicable in the case of discontinued coverage for the Insure Tennessee population. The State must obtain CMS approval of the phase-out plan prior to the implementation of phase-out activities. With respect to the procedural due process protections to be afforded individuals in a discontinued Insure Tennessee population, the TennCare Waiver STCs ¶ III(9) provide for notice to affected enrollees, including information on the enrollee's appeal rights, in accordance with all notice requirements found in 42 CFR §§ 431.206, 431.210, and 431.213. The State must

assure that appeal and hearing rights are afforded to these enrollees, as outlined in 42 CFR §§ 431.220 and 431.221. If an individual requests a hearing before the date of disenrollment, the State must maintain benefits as required in 42 CFR § 431.230. Importantly, however, federal regulations provide that "[t]he agency need not grant a hearing if the sole issue is a Federal or State law requiring an automatic change adversely affecting some or all beneficiaries." 42 CFR § 431.220(b). So, for example, an Insure Tennessee enrollee whose appeal challenges only the discontinuation of that program would not be entitled to a hearing. *See Rosen v. Goetz*, 410 F.3d 919, 926-27 (6th Cir. 2005). The State must also conduct reviews of affected Insure Tennessee enrollees in order to determine whether they qualify for a remaining Medicaid eligibility category.

The TennCare Waiver's STCs include federally-approved procedures for redetermining eligibility of enrollees whose eligibility is ending when the category in which they have been enrolled is being closed. Unless modified by an approved demonstration amendment, those procedures include a notice to the individual 30 days before the termination of eligibility to request additional information that may establish eligibility in another category, an expiration notice if eligibility is not established in another category, and an appeals process limited to valid factual disputes. STC ¶ XIII. These procedures have been part of the TennCare Waiver since 2005 and were upheld by the Sixth Circuit Court of Appeals in *Rosen* as consistent with due process.

(e)(ii) We lack sufficiently specific information to enable us to determine the maximum amount of time necessary to provide due process protections to a population of 200,000 enrollees.

HERBERT H. SLATERY III
Attorney General and Reporter

ANDRÉE SOPHIA BLUMSTEIN
Solicitor General

LINDA A. ROSS
Deputy Attorney General

Requested by:

The Honorable Randy McNally
State Senator
307 War Memorial Building
Nashville, Tennessee 37243-0205