STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: TENNESSEE

Citation	Condition of Requirement
1906 of the Act	State Method on Cost Effectiveness of Employer-Based Group Health Plans

I. The State of Tennessee uses two (2) methods to determine the likely cost effectiveness of a group health plan:

(1) Cost effectiveness based on average expenditure projection

The likely cost effectiveness of a health insurance policy to Medicaid may be determined by comparing the annualized premium, deductible, and copayments, plus the administrative cost of analysis and processing by the State against the average Medicaid expenditure for a recipient in the recipient's eligibility classification for types of service(s) covered under the policy. The premium shall be paid even if the policy covers other non-Medicaid person(s).

(2) Cost effectiveness based on actual expenditures

The likely cost effectiveness of health insurance may be established by documentation of actual expenditures (Explanation of Benefits) from the insuror which, based upon a recipient's existing condition, are likely to continue and that exceed the annualized cost of the policy as described in (1) above.

II. Policies with coverage limitations

Health insurance policies which are not considered to be cost effective, based upon the limited nature of their coverage, are accident, indemnity, Medicare supplemental and surgical policies. These policies therefore will not be evaluated. Dread disease and cancer policies may be cost effective if documented by insurance benefits which can be expected to be ongoing and when determined to be cost effective as described in I.

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III. Payment of Premiums For Cost Effective Health Insurance Policies Where Federal Financial Participation (FFP) is available at the Medical Services Rate

(1) Medicaid shall pay health insurance premiums (policyholder portion only if it is an employment related policy) for Medicaid recipients with policies likely to be cost effective to the Medicaid program. Payments shall be made directly to the employer or health insuror providing the coverage.

(2) Medicaid shall pay all deductibles, coinsurance and other cost sharing obligations under the group plan, not to exceed the Medicaid allowable, for Medicaid recipients enrolled in the group health plan for items and services under the state plan.

(3) Medicaid will pay the Medicaid allowable amount for all items and services provided to Medicaid recipients under the state plan that are not covered in the group health plan.

(4) Medicaid will provide for payment of premiums for non Medicaid eligible family members only in order to enroll a Medicaid eligible family member in the group health plan and it is likely to be cost effective to Medicaid based on the recipient policy cost evaluation.

(5) Medicaid will treat the group health plan as a third party resource in accordance with Tennessee Medicaid TPL cost avoidance policies.

(6) Federal financial participation shall be available at the medical services rate for these state plan criteria to be operational.

(7) Medicaid shall require, as a condition of eligibility (except for an individual who is unable to enroll on his/her behalf), enrollment in a group health plan of individuals otherwise entitled to Medicaid, where enrollment is likely to be cost effective.

(8) The recipient shall immediately notify the Department of Human Services in the event of any change of status which might affect the cost effectiveness of the health insurance policy.

(9) The employer or insurance company receiving Medicaid payment for premiums shall immediately notify Medicaid in the event of a policyholder status change, as in (4), and any applicable policy enrollment premium information.

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