September 9, 2021

The Honorable Xavier Becerra, Secretary
U.S. Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Ave., S.W.
Washington, D.C. 2021

Re: Comments on Pending Tennessee TennCare III 1115 Demonstration

Submitted electronically via Medicaid.gov

Dear Secretary Becerra:

Families USA appreciates the opportunity to provide comments on Tennessee's TennCare III Section 1115 Demonstration Waiver.

Families USA is a national health care advocacy organization that supports policies and programs at the state and federal levels to expand access to high quality, affordable health care, with a particular focus on policies that affect lower-income individuals.

Multiple elements of Tennessee's proposal are both legally problematic and poor policy choices for the state. The objective of Section 1115 waiver programs – to demonstrate and evaluate state-specific policy approaches to better serve Medicaid populations[1]– is not advanced in the proposal for TennCare III. Additionally, President Biden's Executive Order 14009[2] requires federal agencies to examine demonstration and waiver policies that may reduce coverage or undermine Medicaid. The elements of the waiver request that fail to meet these federal requirements are discussed in greater detail below.

Comments on Specific Provisions in the Waiver Request

1. **The "Aggregate Cap" Puts Families at Risk**

Families USA is seriously concerned with Tennessee's aggregate cap financing proposal, which will end the 50-plus year federal guarantee of matching each states' actual Medicaid spending, passing risk and costs onto the state government, taxpayers, and TennCare beneficiaries. Of particular concern is the precedent of setting an aggregate cap for Medicaid and how that precedent may manifest in future administrations.

A basic concept of the Medicaid program through Section 1396b is that it provides federal funds that match a state's needs and spending. Previous administrations have determined that Section 1396b is not waivable under Section 1115 demonstrations such as TennCare III. The ability to match state Medicaid expenditures with federal funds is a crucial function to ensure that states have adequate resources to provide necessary care for children, pregnant people, seniors, people with disabilities, and working families and to protect them from the effects of public health and financial crises like the ones Tennessee and the United States are currently grappling with in COVID-19. Tennessee's proposal that would cap the level of state expenditures that are eligible to receive federal matching funds will impact

[1] Medicaid.gov, *About Section 1115 Demonstrations*, (Centers for Medicare and Medicaid Services, n.d.), https://www.medicaid.gov/medicaid/section-1115-demonstrations/about-section-1115-demonstrations/index.html
[2] Exec Order No. 14009, 86 FR 7793 (2021).

four categories of beneficiaries: children, adults, elderly people, and disabled people. Many people in these categories have been disproportionately harmed by COVID-19, making their access to coverage and care all the more important in the years to come.

In its waiver request, Tennessee's proposal to forgo the protections of a federal matching structure in favor of a defined federal contribution places the state in the position of having to pay any Medicaid expenditures above the cap with state-only funds. If state expenditures exceed this cap, whether because of significant enrollment growth or growth in per capita costs, it would be forced to decide between cutting benefits and coverage or raising taxes to cover the additional cost at high state expense. Tennessee claims the aggregate cap will provide flexibility from unnecessary or excessive federal intervention; however, the aggregate cap would result in serious Medicaid funding shortfalls that have a devastating impact on the people served by TennCare. Our lived experience with COVID-19 demonstrates the critical importance of Medicaid in times of crisis. Without a doubt, if this block grant proposal was in place during the Public Health Emergency, Tennessee would have exceeded its cap and been forced to cut services in the middle of the crisis.

Additionally, the state's proposed "shared savings mechanism" component further incentivizes the state to cut beneficiaries' benefits and coverage even beyond the pressure to stay under the federal funding cap. This proposed incentive would allow the state to recoup up to 55% of all unspent federal dollars below the aggregate cap amount. Essentially, the state is requesting new "flexibilities" to cut enrollment, services, and benefits in order to reduce spending below the capped block grant amount and generate savings that the state could use for other purposes. While the state commits to reinvest the savings in state health programs, the Special Terms and Conditions (STCs) in the waiver proposal do not prevent the state from using the savings to free up other state funding for any purpose. The clear losers here are TennCare beneficiaries, especially since Tennessee has a well-documented history of redirecting federal funding intended for low-income individuals, including diverting federal Medicaid funds to a state reserve fund during the Great Recession and refusing to spend TANF reserves except to fund a Medicaid work requirement.[3]

2. Elimination of Retroactive Coverage Does not Promote Medicaid's Objectives

TennCare III includes a waiver permitting Tennessee to eliminate retroactive Medicaid coverage for thousands of pregnant people, fathers with dependent children, seniors, and people with disabilities. CMS should withdraw the waiver permitting the state to eliminate retroactive coverage so that all TennCare beneficiaries are able to access coverage and afford care during or after undergoing treatment.

Eliminating retroactive coverage is in direct contradiction with Medicaid's stated objective to provide comprehensive health coverage to low-income individuals. TennCare beneficiaries' health and well-being are best served when they can prioritize care and treatment first and obtain coverage at a more convenient or less emergent time. Using existing authority provided by the Biden Administration's Executive Order 14009 to rescind waiver policies that undermine Medicaid, we urge Secretary Becerra and CMS to immediately withdraw this portion of Tennessee's demonstration.

---

[3] Tennessee Justice Center, *Tennessee's Misuse of Federal Funds makes it a Poor Candidate for a Medicaid Block Grant*, https://www.tnjustice.org/tenncare-misuse-federal-funds/.

TennCare's waiver of retroactive coverage is not new, but it no longer has any policy justification. The waiver dates back to a time in the 1990s when Tennessee had the broadest Medicaid eligibility in the country and could plausibly claim to be moving to universal coverage. That meant that a waiver of retroactive coverage was part of a broader approach to seamless Medicaid eligibility in the state. Now Tennessee has one of the narrowest Medicaid eligibility programs in the country with a recent track record of punitive eligibility redetermination practices. There are no grounds for waiving retroactive coverage in Tennessee.

Eliminating retroactive coverage would raise uncompensated care costs for health systems and providers and prevent providers from treating people who are eligible for Medicaid but have yet to be enrolled. After Iowa submitted a demonstration proposal to eliminate retroactive coverage, the Iowa Hospital Association released a statement stating, "This amendment will place a significant financial burden on hospitals and safety-net providers and reduce their ability to serve Medicaid patients."[4] The impact of retroactive coverage elimination on hospitals and providers represents another way in which this proposal does not promote Medicaid's objectives.

3. **10-Year Section 1115 Demonstration Projects are not Permitted Under Federal Law**

Section 1115 demonstration projects are not meant to enact long-term policies. Section 1115 allows the Secretary to waive Medicaid Act requirements only for an experimental, pilot, or demonstration project, and only "to the extent and for the period necessary" to enable the state to carry out its experiment.[5] Demonstrations receive approvals with durations between three and five years with extensions of existing demonstrations also receiving additional five year approvals. TennCare III is an invalid experiment simply based on its length of approval.

While CMS released an Informational Bulletin[6] in 2017 stating it "may approve the extension of routine, successful, non-complex section 1115(a) waiver and expenditure authorities in a state for a period up to 10 years," the drastic financing approach and other provisions within TennCare III do not qualify as non-complex.

4. **Other Concerning Provisions**

Changes Requirements for Hospitals to Receive Uncompensated Care Funds

TennCare III enables the state to control the amount of uncompensated care funding for hospitals and develop the distribution methodology associated with the state's two uncompensated care funds. Importantly, Tennessee will be able to do this without prior approval from CMS. The approval letter states, "The state will have the flexibility to implement a methodology that will align with moving towards a value-based model to promote value over volume of services." Without specifications around that methodology, or requiring further CMS approval, the federal taxpayer as well as uninsured

---

[4] Virgil Dickson, *Hospitals Balk at Iowa's Proposed $37 Million Medicaid Cut*, (Modern Healthcare, August 8, 2017), https://www.modernhealthcare.com/article/20170808/NEWS/170809906/hospitals-balk-at-iowa-s-proposed-37-million-medicaid-cut.

[5] 42 U.S.C. § 1115(a)

[6] Centers for Medicare and Medicaid, *CMCS Informational Bulletin: Section 1115 Demonstration Process Improvements*, November 6, 2017, https://www.medicaid.gov/sites/default/files/federal-policy-guidance/downloads/cib110617.pdf.

Tennesseans are at risk of a re-designed program that serves state budget needs or other non-Medicaid goals rather than actually compensating uncompensated care.

Adoption of a Closed Drug Formulary

TennCare III provides the state with a concerning authority to implement a closed drug formulary, with the exception of drugs for children entitled to Early and Periodic Screening, Diagnostic, and Treatment (EPSDT). Section 1396r-8 of the Medicaid Act outlines the requirements for state Medicaid programs, including those that govern the development and use of a formulary. Since Section 1115 only allows waivers of Medicaid provisions in Section 1396a, HHS cannot waive provisions in 1396r-8 and CMS should therefore withdraw approval of this provision.

Implementation of this closed formulary would exclude certain new drugs and medications where there is at least one drug already available per therapeutic class. This is problematic as there is often therapeutic value in having multiple drugs for a given condition. Two drugs may have essentially the same effectiveness at a population level, but individual consumers may need to take one medication over another due to side effects, interactions with other medications or health conditions, or ease of adherence. Additionally, much of the evidence used to demonstrate a drug's clinical benefit is based on studies with overwhelmingly white participants, and there may be important differences in drug efficacy for people of color.[7]

Implementing a closed formulary does not align with Medicaid's objectives. Restricting access to life-saving medications will not only be harmful to TennCare beneficiaries, it will also affect the Tennessee health care system in the form of higher health care costs.

Conclusion

As detailed above, Families USA is deeply concerned with TennCare III's implications for the Medicaid program in Tennessee and the impact an approval of this demonstration will have on TennCare beneficiaries and the Medicaid program as a whole. The aggregate cap, elimination of retroactive coverage, and other provisions do not serve Medicaid's objectives and actively undermine the coverage Medicaid provides. Additionally, the 10-year duration of the approval is not allowed under Section 1115. We recommend that CMS withdraw approval for TennCare III and encourage Tennessee to improve their Medicaid program through well-established methods such as Medicaid expansion.

Thank you for your consideration of these comments. If you have any questions, please contact Garrett Hall at GHall@familiesusa.org.

Respectfully submitted,

Eliot Fishman
Senior Director of Health Policy at Families USA

[7] Esteban Burchard *et al*., "*Moving toward True Inclusion of Racial/Ethnic Minorities in Federally Funded Studies. A Key Step for Achieving Respiratory Health Equality in the United States*," American Journal of Respiratory and Critical Care Medicine 191, no. 5 (January 2015), available online https://www.atsjournals.org/doi/abs/10.1164/rccm.201410-1944PP?url_ver=Z39.88-2003&rfr_id=ori%3Arid%3Acrossref.org&rfr_dat=cr_pub%3Dpubmed.