



October 6, 2022

The Honorable Xavier Becerra
Secretary
U.S. Department of Health and Human Services
200 Independence Ave, SW
Washington, DC 20201

Re: Amendment 4 to the TennCare Demonstration

Dear Secretary Becerra:

Thank you for the opportunity to submit comments on Tennessee's TennCare Program Amendment.

The undersigned organizations represent millions of individuals facing serious, acute and chronic health conditions. We have a unique perspective on what individuals and families need to prevent disease, cure illness and manage chronic health conditions. The diversity of our organizations and the populations we serve enable us to draw upon a wealth of knowledge and expertise that is an invaluable resource regarding any decisions affecting the Medicaid program and the people that it serves. We urge the Department of Health and Human Services (HHS) to make the best use of the recommendations, knowledge and experience our organizations offer here.

The purpose of the Medicaid program is to provide healthcare coverage for low-income individuals and families, and our organizations are committed to ensuring that TennCare provides quality and affordable healthcare coverage. Many of our organizations submitted detailed comments to the Department of Health and Human Services (HHS) during the September 2021 comment period on the current TennCare demonstration.¹ We support certain changes that Tennessee has made in response to these comments in Amendment 4, including the removal of the closed formulary and the removal of the aggregate cap.

However, we remain concerned about additional provisions in the TennCare III Demonstration, including the waiver of retroactive coverage and the proposed 10-year approval. Our organizations offer the following comments on these areas of Amendment 4 to the TennCare III Demonstration.

Closed Formulary

Our organizations support the removal of the closed formulary from the demonstration. Diseases present differently in different patients, and prescription drugs have different indications, different mechanisms of action and different side effects, depending on the person's diagnosis and comorbidities. A closed formulary limits the ability of providers to make the best medical decisions for their patients and jeopardizes patients' access to evidence-based care.

TennCare patients include very low-income pregnant women, the elderly, children and the blind and disabled. The Medicaid population does not have the luxury of shopping around for health plans, unlike participants in the commercial insurance market, and so these individuals likely would have lost access to needed medications under the closed formulary proposal. Our organizations appreciate that the closed formulary policy has been removed and believe that Medicaid enrollees in Tennessee will benefit from this change.

Funding Structure

Our organizations support the proposed changes to the budget neutrality model to remove the aggregate funding cap and replace it with a per member per month cap. Aggregate caps that limit the amount of federal funding provided to a state could force the state to either make up the difference with state funds or make cuts to the Medicaid program that would reduce access to care for the patients we represent. Program cuts would likely have resulted in enrollment limits, benefit reductions, reductions in provider payments or increased out-of-pocket cost-sharing for Medicaid enrollees.

We also urge CMS to carefully examine the remaining elements of the aggregate cap model and related shared savings provisions to ensure that they promote the objectives of Medicaid. Our organizations are troubled that Amendment 4 proposes to increase the state's share of any federal savings and eliminate the requirement that the state meet the Core Set quality metrics in order to receive additional funds. As negotiations move forward, we urge CMS to put guardrails in place to ensure that spending meets the needs of beneficiaries. For example, Tennessee should have a fixed demonstration budget for the designated state investment programs (DSIPs) rather than the proposed opened ended structure to ensure that there are not incentives in place to reduce spending on or access to important services for patients with Medicaid coverage. Additionally, the state should be required to report on how any approved DSIP funds are spent to ensure that they are actually spent and used for approved, Medicaid-related programs. It is important that the CMS establish a clear policy for this type of spending that is consistent with recent approvals in states like Oregon, and that any policy does not create incentives for the state to make Medicaid funding cuts that reduce access to care for beneficiaries.

Future Changes to Benefits and Coverage

Our organizations urge CMS to make explicit changes to the Special Terms and Conditions (STCs) to make clear the state cannot reduce coverage or benefits through TennCare III. In its cover letter, the state indicated that it had no objections to this type of change, but did not offer specific revisions. It is critical that CMS approve any future amendments to the demonstration to ensure they meet the objectives of Medicaid, and that any amendments are subject to a public comment process where our organizations and other stakeholders can offer feedback on the impact of proposals on the patients we

represent. Our organizations recommend that the STCs be revised to explicitly protect patients from reductions in coverage and benefits to ensure access to care for Tennesseans.

Retroactive Coverage

Our organizations remain concerned by the continued waiver of retroactive coverage for non-pregnant adults in the TennCare III Demonstration. Retroactive coverage in Medicaid prevents gaps in coverage by covering individuals for up to 90 days prior to the month of application, assuming the individual is eligible for Medicaid coverage during that time frame. It is common that individuals are unaware they are eligible for Medicaid until a medical event or diagnosis occurs, meaning enrollment will only come after incurring costly medical bills.

As President Biden made clear in his recent executive order on strengthening Americans' access to affordable, quality health coverage,² many adults have medical debt, though it is more likely to affect Black and Hispanic families.³ Those living in the South or in states that have not expanded Medicaid were also found to be more likely to have significant medical debt.⁴ Without retroactive eligibility, many patients who are eligible for Medicaid but not enrolled may face substantial costs from providers and subsequent medical debt. In Indiana, Medicaid recipients were responsible for an average of \$1,561 in medical costs with the elimination of retroactive eligibility.⁵ This can also lead to patients that are newly diagnosed with health conditions delaying their treatment. Retroactive coverage allows patients who have been diagnosed with a serious illness to begin treatment without being burdened by medical debt prior to their official eligibility determination, providing crucial financial protections to newly enrolled beneficiaries.

Our organizations strongly urge that retroactive coverage be reinstated for all Medicaid eligibility groups in Tennessee to protect patients from devastating medical debt. This is in line with the objectives of Medicaid and would improve the affordability of care for patients in Tennessee.

Ten-Year Approval

Our organizations are strongly opposed to a ten-year approval for the TennCare III Demonstration. Federal statute limits Section 1115 demonstrations to three or five years, depending on who the demonstration covers. Our organizations believe it is important to evaluate a waiver's impact on the patients we represent and whether policies should be continued at least that often, and we value the opportunity to regularly comment on waiver proposals during this process.

A ten-year approval is also concerning given Tennessee's history with coverage losses. In 2005, Tennessee changed its eligibility rules to disenroll 170,000 individuals from its Medicaid program due to budgetary pressures, one of only two states to ever go through a large-scale disenrollment of this nature.⁶ Subsequent research found that after this loss of coverage, individuals' self-reported health and access to care declined, visits to doctors and dentists decreased and the use of public and free clinics increased.⁷ Additionally, Tennessee is among the states with the largest increases in uninsured children between 2016 and 2019, with many children losing coverage without a finding that they were ineligible.⁸ Our organizations continue to urge CMS to limit the length of the TennCare III Demonstration to no more than five years.

Conclusion

Our organizations are pleased by some of the changes that have been proposed for TennCare in Amendment 4 but urge CMS to work with the state to make additional changes to strengthen the waiver and protect patients and consumers before approval. Thank you for the opportunity to provide comments.

Sincerely,

American Cancer Society Cancer Action Network
American Heart Association
American Liver Foundation
American Lung Association
Arthritis Foundation
Asthma and Allergy Foundation of America
CancerCare
Cystic Fibrosis Foundation
Epilepsy Foundation
Hemophilia Federation of America
Lupus Foundation of America
Lutheran Services in America
March of Dimes
National Hemophilia Foundation
National Multiple Sclerosis Society
National Organization for Rare Disorders
National Patient Advocate Foundation
National Psoriasis Foundation
Susan G. Komen
The Leukemia & Lymphoma Society

¹ Health Partners Letter to Secretary Becerra re: TennCare 1115 Waiver. September 9, 2011. Available at: [https://www.lung.org/getmedia/4a6256df-73e6-43ef-9fb6-4aefc979375a/health-partner-letter-re-tenncare-1115-waiver-\(final\).pdf](https://www.lung.org/getmedia/4a6256df-73e6-43ef-9fb6-4aefc979375a/health-partner-letter-re-tenncare-1115-waiver-(final).pdf).

² <https://www.whitehouse.gov/briefing-room/presidential-actions/2022/04/05/executive-order-on-continuing-to-strengthen-americans-access-to-affordable-quality-health-coverage/?msclkid=887ba3d9b67111ec81e80c7ddd11167b>; Fact Sheet: The Biden Administration Announces New Actions to Lessen the Burden of Medical Debt and Increase Consumer Protection, The White House, April 11, 2022. Available at: <https://www.whitehouse.gov/briefing-room/statements-releases/2022/04/11/fact-sheet-the-biden-administration-announces-new-actions-to-lessen-the-burden-of-medical-debt-and-increase-consumer-protection/>.

³ Bennett, Neil et al. 19% of U.S. Households Could Not Afford to Pay for Medical Care Right Away, United States Census Bureau, April 7, 2021. Available at: <https://www.census.gov/library/stories/2021/04/who-had-medical-debt-in-united-states.html>.

⁴ Rae, Matthew, et al. The burden of medical debt in the United States, Peterson-KFF Health System Tracker, March 10, 2022. Available at: <https://www.healthsystemtracker.org/brief/the-burden-of-medical-debt-in-the-united-states>.

⁵ Healthy Indiana Plan 2.0 CMS Redetermination Letter. July 29, 2016. Available at: <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-lockouts-redetermination-07292016.pdf>.

⁶ Melinda B. Buntin, Ph.D. "Tennessee's Opening Bid for a Medicaid Block Grant." (October 31, 2019) New England Journal of Medicine. Accessed at: <https://www.nejm.org/doi/full/10.1056/NEJMp1913356?query=TOC>.

⁷ Thomas DeLeire, "The Effect of Disenrollment from Medicaid on Employment, Insurance Coverage, Health and health Care Utilization," (August 2018). NBER Working Paper No. 24899. Accessed at: <https://www.nber.org/papers/w24899>.

⁸ Joan Alker and Alexandra Corcoran, "Children's Uninsured Rate Rises by Largest Annual Jump in More Than a Decade," Georgetown University Health Policy Institute, Center for Children and Families. October 2020. https://ccf.georgetown.edu/wp-content/uploads/2020/10/ACS-Uninsured-Kids-2020_10-06-edit-3.pdf.