Re: TennCare III demonstration approved January 8, 2021
Attn: Andrea Casart, Director of the Division of Eligibility and Coverage Demonstrations

The following comments are submitted on behalf of the League of Women Voters of Tennessee to the Centers for Medicare and Medicaid Services, U.S. Department of Human Services, in response to the August 10, 2021 request for public comment on the special terms and conditions of the TennCare III demonstration approved on January 8, 2021 (Project Number 11-W-00369/4).[1] We thank CMS for this opportunity to provide comments on the TennCare III demonstration.

SUMMARY

The League of Women Voters of Tennessee remains seriously concerned that TennCare III threatens the long-term financial viability of Tennessee's Medicaid program, TennCare, and has the potential to harm current and future TennCare beneficiaries. Our primary concerns are summarized below:

- *Lack of transparency and public input in the approval and implementation of TennCare III resulting in confusion and anxiety among TennCare recipients and individuals hoping to qualify for coverage*
- *Unnecessarily risky and complex changes to program financing with perverse incentives to decrease per person expenditures for Medicaid recipients*
- *Inappropriate application of an experimental health care financing model without sufficient safeguards for Medicaid waiver populations with special health care needs*
- *Overly broad state flexibility to limit scope, amount, and duration of current benefits and to restrict cost and choice of covered medications without sufficient public oversight or accountability*
- *Inadequately defined or implemented metrics to determine the impact of the TennCare III experiment on beneficiaries with special health care needs and the shifting of quality assessment responsibilities from the state agency to managed care contractors*
- *Failure to meet a core objective of the Medicaid program: to serve the health and long-term care needs of vulnerable and low-income individuals and families*

The League of Women Voters Tennessee (LWV-TN) strongly opposes fundamental changes in federal financing of Tennessee's Medicaid program, TennCare, specified in the January 8, 2021 agreement between the Centers for Medicare and Medicaid Services (CMS) and the Division of TennCare, for reasons explained more fully below.

- **Lack of transparency and public input in the approval and implementation of TennCare IIIresulting in confusion and anxiety among TennCare recipients and individuals hoping to qualify for coverage**

Tennesseans had limited opportunity to review and comment on negotiated changes made after Amendment 42 to TennCare II was submitted to CMS in December 2019. This lack of process was especially alarming given the unprecedented 10-year approval period for TennCare III and the significant changes in design of the aggregate cap from those originally proposed.

The LWV-TN does not fully understand why, after promising ongoing engagement, the Bureau of TennCare negotiated such major changes between December 2019 and January 2021 without giving notification to stakeholders, but this lack of transparency and engagement was again demonstrated by the Bureau when the first Notice of Change in TennCare III Demonstration: Amendment 1 was released. That notice was available only in English. It was posted only on the website. There were no announcements as far as we are aware that were covered by the media. Opportunities for public comment were truncated to 30 days. Opportunities for oral comment on this proposed change were limited to in-person comments for those able to travel to Nashville. This was during the ongoing COVID-19 delta variant pandemic at a time when vaccines were not available for many of the impacted recipients.

Many of the questions asked by the few individuals representing disabled beneficiaries who were able to attend the oral hearing in Nashville on July 6, 2021 could not be answered by the staff in attendance and there did not seem to be any effort to arrange for follow-up with those questioners. Nor were provisions made to video record or stream the proceedings so that other beneficiaries and advocates could observe the process. This does not bode well for future public accountability as additional changes are proposed.

In collaboration with other nonpartisan, nonprofit organizations that advocate for affordable access to health care for all Tennesseans, the LWV-TN encourages open and ongoing engagement of TennCare with all stakeholders in discussions regarding the development of future TennCare priorities and procedures. Should CMS uphold approval of the TennCare III waiver, we urge CMS to require TennCare to establish a TennCare III Advocacy Council inclusive of MCOs, providers, beneficiaries, and the advocacy organizations that represent them. This Advocacy Council would meet at least quarterly with TennCare throughout the planning and implementation of this waiver. Today, technology is available to enable participation in such discussions statewide without necessitating long-distance travel and virtual access should be provided.

- **Unnecessarily risky and complex changes to federal financing of TennCare with perverse incentives to decrease per person expenditures for Medicaid recipients**

Under prior 1115 Medicaid waivers, Tennessee received open-ended funding from the federal government to help cover the costs of the TennCare program on a roughly 65% federal: 35% state match rate, as long as the state was able to keep expenditures below a budget neutrality cap based on what CMS would expect to spend if Tennessee were operating a standard (non-waiver based) Medicaid program. It is our understanding that in years when TennCare costs were below the budget neutrality cap the program was allowed to retain the full amount of those savings. The TennCare III waiver changes the financing arrangement by imposing a more stringent aggregate cap on the amount of funding the state will receive from the federal government. In return, CMS allows the state great flexibility to make certain changes in program parameters without seeking permission from CMS. If the state is able to realize additional "savings" for the federal government in any given year, the state could earn back between 45-55% of those savings [depending on its ability to achieve approved outcome targets], in what has been termed a Designated Savings Investment Programs (DSIP). However, if expenditures exceed the aggregate cap in any year, say as a result of accelerated medical inflation or more complex beneficiary health care needs, our state would be responsible for the full excess amount.[2,4] While the state originally proposed under TennCare II Amendment 42 that the aggregate cap continue to be calculated based on expected Medicaid expenditures, TennCare III's aggregate cap is now based on TennCare's own baseline expenses, which are historically below the median of other state programs. Under this revised baseline, TennCare III potentially incurs higher financial risks for the state and curtails any potential "savings" that could be "earned".[7]

The funding formula employed under TennCare III makes allowances in the cap for changes in numbers of Tennesseans eligible for the program, although the state must absorb the full cost of growth below 1% of baseline enrollment. The formula also indexes the per capita grant amount to general inflation, affording some fiscal protection during economic recessions except during periods of higher rates of medical inflation. Even with these modifications, TennCare acknowledges that now, in order to maintain budget neutrality, current benefits and services may need to be modified "in scope, amount, or duration". Tennessee is granted special flexibility to reduce pharmacy costs by limiting prescription drug options on the TennCare formulary.[5,7]

The underlying framework of the DSIP creates what is considered a perverse incentive by linking the state's ability to earn back federal dollars to its ability to find ways to cut spending. While some TennCare savings may be found in administrative "efficiencies", additional "savings" may be possible only through reductions in per member per month expenditures, which are already relatively low compared to other state Medicaid programs. The potential for harmful and disparate impacts from per member per month reductions is always present, and need to be quickly identified and addressed. The LWV-TN is concerned that whether efforts to attain savings are through administrative cuts, limiting the formulary, modifying benefits, or reducing MCO or provider reimbursements, the impacts will fall hardest on the most vulnerable TennCare enrollees (children and custodial adults with complex medical needs, persons with disabilities, and elderly nursing home residents).[2,3,4,5,7]

Should CMS allow this financing experiment to go forward, any and every change resulting in savings should be evaluated for its impact on coverage, service access, and health status of beneficiaries. Robust monitoring and evaluation are necessary to protect beneficiaries and to assess the comparative effectiveness of this aggregate cap financing model versus the standard Medicaid entitlement financing model currently employed in all other states. We do not see evidence that an effective, comprehensive evaluation plan which should be essential for approval has yet been put in place.

- **Inappropriate application of an experimental health care financing model without sufficient safeguards for Medicaid waiver populations with special health care needs**

The LWV-TN does not support experimentation with federal financing of essential services provided to Tennessee's Medicaid beneficiaries, who are among our state's most vulnerable residents, without adequate safeguards that protect their health and access to needed care. Indeed, the populations originally proposed to be part of the experimental block grant financing model in Amendment 42 to TennCare II did not include individuals with intellectual and developmental disabilities, children in foster care, or persons dually eligible for Medicaid and Medicare.

In the past our state has underspent cost projections in part by denying medically necessary services, complicating recertification, requiring an excessive gauntlet of appeals, and suppressing enrollment numbers by failing to do outreach or provide in-person enrollment assistance. Administrative barriers make it difficult for many Medicaid applicants and enrollees, particularly those with limited English proficiency or limited internet access, to document their eligibility and keep their health coverage. Seeking additional administrative "efficiencies" in enrollment and recertification is one way TennCare can generate "shared savings" There is nothing we see in the terms of approval that require monitoring the impacts of administrative process changes on enrollment. We consider such process evaluation metrics essential.

Given TennCare's recent decision to "integrate" persons with intellectual and developmental disabilities and children with special health care needs into MCO networks through Amendment 1, stringent oversight is especially critical. If this experiment is allowed to go forward, it is of paramount importance for CMS to specify and monitor a transparent process for independent and expedited clinical review of cases involving enrollees whose medical needs might require exemption from formulary limitations or benefit adjustments triggered under a capped allotment framework. There should also be an objective, independent process for reviewing over time how appeals for exemption are resolved and the clinical impact of any benefit adjustments.

CMS administrators in January 2021 inexplicably extended this experiment for 10 years and put in place bureaucratic mechanisms that make any interventions to renegotiate or modify TennCare III even more difficult should modifications be needed to prevent inequities or adverse impacts. If TennCare III is allowed to proceed, sentinel metrics should be developed to identify adverse and or disparate impacts that would trigger immediate CMS investigation and early intervention. These metrics should assure that any decisions to alter TennCare program benefits are not based solely on cost, but also on clinical effectiveness.

- **Overly broad state flexibility to limit scope, amount, and duration of current benefits and to restrict cost and choice of covered medications without sufficient oversight and public accountability**

As noted above, the TennCare III Demonstration approval allows the state modify services and to restrict coverage of prescription drugs by limiting the current Medicaid formulary to less expensive medications in each therapeutic class. The prospect of new formulary restrictions has raised a great deal of public concern in our state, particularly among individuals with chronic conditions and special health care needs.

TennCare highlights the state's new authority to limit prescription drug coverage as a key means to achieve savings. This option is potentially dangerous for patients who rely on TennCare for care of chronic and complex illnesses that often require trials of several classes of drugs before an effective, well-tolerated medication is identified for individual patients. There is considerable genetic variation in the ability to metabolize and tolerate medications, and the least expensive medications are not always the most cost-effective. Some individuals may even experience serious side effects from medications that are considered safe for the general population. The focus on limiting the cost of medications rather than on promoting cost-effectiveness is clinically and financially short-sighted.

Restricted drug coverage is also risky for patients with complex or rare conditions more effectively managed by newer generations of medications which may be more expensive in the short term, but in the long term achieve better outcomes. Adjustments in the TennCare formulary should not be allowed to proceed until specific safeguards are in place to assure speedy appeal and independent clinical review of individual cases for beneficiaries who would be affected by proposed formulary changes. A "grandfathering" process for patients already being treated with a more expensive but more effective medication after documented failures of less expensive drugs to manage their conditions should also be considered.

TennCare III both modifies and extends a harmful feature of the TennCare program under previous waivers--the denial of 3-months of retroactive coverage for persons qualifying for coverage which began when TennCare I was first instituted 25 years ago. While TennCare III thankfully restores the 3-month retroactive eligibility criterion for pregnant women and children up to age 21, this valuable feature of Medicaid continues to be denied to other adults. The LWV believes this long period of denial has contributed to our state's distinction of having one of the highest rates of medical debt and medically related bankruptcy in the nation. While medical debt can impact even those with qualified health insurance, in Tennessee it especially impacts those with low incomes who are uninsured, a population disproportionately comprised of people of color and those with disabling chronic conditions.[8]

Denial of coverage of recent medical bills to non-pregnant adults nearly guarantees that thousands of Medicaid eligible individuals and their families will face crippling medical debt before they are able to apply. The retention of this parsimonious retroactive eligibility criterion is especially troubling in view of our state's failure to extend Medicaid eligibility to all low-income Tennesseans. In the absence of expanded eligibility, most non-pregnant adults who are not caregivers of minor children cannot qualify for TennCare until they sustain a disabling injury or illness. Medicaid expansion could provide access to care, and expedite detection and provide

management of health problems before they become disabling.

TennCare III also extends more flexibility to develop new provider payment approaches and to adjust Medicaid supplemental payments. Concerns about overall low reimbursement levels, new payment approaches, and inadequate supplemental payments have been heightened in light of the extensive number of rural hospital closures in our state, which also has the highest per capita rural hospital closure rate in the country.[9] It is unclear how CMS will provide oversight over this aspect of the waiver. The LWV-TN believes that TennCare should be required to evaluate whether payment changes implemented under TennCare III authority increase or decrease financial pressures on MCOs, hospitals, and other health providers, as well as how they impact provider participation and network adequacy.

- **Inadequately defined or implemented metrics to determine the impact of the TennCare III experiment on beneficiaries with special health care needs and the shifting of responsibility for quality assessment from the state agency to managed care contractors**

Clearer documentation of Quality Assurance (QA) measures relevant to the health, mental health, and social issues faced by persons with intellectual and developmental disabilities is essential before implementing the inclusion of populations eligible for 1915 waivers, the CHOICES programs, and the Katie Beckett program in managed care (as proposed under TennCare III Amendment 1). QA metrics should be in place prior to implementation of proposed program changes so that any negative consequences for any group of beneficiaries can be promptly identified and addressed to avert poor health outcomes. Quality Improvement metrics targeted to each beneficiary group are also important to determine the effectiveness of this experimental financing policy change.

The 2020 Annual EQRO Technical Report, the Comparative Analysis of Audited Results from TennCare MCOs Following the 2020 National Benchmark Release, and the 2021 Update to the Quality Assessment and Performance Improvement Strategy report results of clinical and utilization outcomes monitoring for populations covered under TennCare II Amendment 42. TennCare has also posted a framework for Shared Savings Metrics for this same population. But process and outcome measures for populations impacted by TennCare III Amendment 1 are still under development by the Division of TennCare. Before Amendment 1 is implemented, we strongly urge that TennCare publicize the final version of these metrics in formats that are accessible and understandable to beneficiaries, their advocates, and the general public.

- **Failure to meet a core objective of the Medicaid program: to serve the health and long-term care needs of vulnerable and low-income individuals and families**

TennCare III fails to address Tennessee's most urgent health issues: (1) Rising numbers of low-income residents without health coverage or access to comprehensive health care (an estimated 360,000 adults pre-pandemic) resulting in catastrophic problems for individual and public health; and (2) Ongoing rural hospital closures (15 rural hospital shuttered since 2010) due in part to high rates of uncompensated care, bad debt, and inadequate government reimbursement and support.[9]

The initial rationale for "shared savings" proposed in TennCare II Amendment 42 was to provide a source of new revenue for TennCare to expand eligibility categories or benefits. Under TennCare III, however, there is no commitment to cover anyone who did not already qualify for TennCare II. Changes to the baseline for calculating shared savings (DSIP) guarantee that any additional savings will be much more limited than anticipated under proposed TennCare II Amendment 42.[7] The maximum savings that could be realized are just a fraction of the funding offered for Medicaid expansion at the 90:10 FMAP proposed by the Patient Protection and Affordable Care Act and the over one billion dollars in new incentives in the American Rescue Plan.

Many of TennCare III's priority areas could also be addressed more cost-effectively by Medicaid expansion than through the DSIP scheme alone. For example, maternal and infant health outcomes are greatly influenced by pre-pregnancy health status, but low-income single women only become eligible for TennCare after pregnancy is confirmed and many of the key fetal developmental phases have already occurred. Severe health and mental health consequences related to opioid and other substance use disorders among low-income adults could be addressed at earlier stages of their illness if they had full access to treatment and support sooner. While Tennessee continues to invest in expansion of its behavioral health safety net for the uninsured, those state funds could be multiplied nine-fold if Medicaid expansion were enacted.

In summary, the LWV-TN has long supported programs designed to decrease the number of individuals lacking health insurance in Tennessee and to increase access to preventive, primary, and acute health care that is cost-effective for *all* Tennesseans. To that end, our members have been persistent advocates for the expansion of Medicaid to include uninsured, nondisabled adults without dependent children, with income up to 138 percent of the federal poverty level. The LWV-TN strongly recommends expanding eligibility for these uninsured low-income adults, particularly given the increased federal incentives to do so. These new CMS incentives would provide our state with much greater and more immediate "savings" than can be realistically generated by TennCare III in the foreseeable future—funds that could be quickly re-invested in expansion of benefits as well as coverage and used to stabilize Tennessee's vulnerable rural health systems.

The League of Women Voters of Tennessee remains committed to assisting our state and the TennCare program in developing constructive and innovative ways to improve the health of *all* Tennesseans. We do not, however, believe that TennCare III will enable our state to achieve this goal without significant revision. Indeed, what we see as a perversely incentivized foundation for financing may jeopardize program improvements that have already been made or could be made through efforts toexpand rather than restrict the TennCare program.

REFERENCES

1. Division of TennCare. TennCare III Demonstration (Project Number 11-W-00369/4), approval period: January 8, 2021 – December 31, 2020. Available at: https://www.tn.gov/content/dam/tn/tenncare/documents/tenncarewaiver.pdf

2. Kaiser Family Foundation. Why It Matters: Tennessee's Medicaid Block Grant Waiver Proposal. December 9, 2019. Available at: https://www.kff.org/medicaid/issue-brief/why-it-matters-tennessees-medicaid-block-grant-waiver-proposal/

3. Center on Budget and Policy Priorities. Tennessee Block Grant Proposal Threatens Care for Medicaid Beneficiaries. September 25, 2019. Available at: https://www.cbpp.org/research/health/tennessee-block-grant- proposal-threatens-care-for-medicaid-beneficiaries

4. Health Affairs. Looking Inside Tennessee's Block Grant Proposal. October 4, 2019. Available at: https://www.healthaffairs.org/do/10.1377/hblog20191002.734156/full/

5. Health Affairs. Inside Tennessee's Final 1115 Medicaid Block Grant Proposals. December 6, 2019. Available at: https://www.healthaffairs.org/do/10.1377/hblog20191205.927228/full/

6. Sycamore Institute Tennessee. TennCare III: Unpacking Tennessee's New "Block Grant". January 14, 2021. Available at: https://www.healthaffairs.org/do/10.1377/hblog20191002.734156/full/

7. Health Affairs. McCutchen V Becerra Underscores the Need for Section 1115 Reforms as a Matter of Health Equity. July 1, 2021. Available at: https://www.healthaffairs.org/do/10.1377/hblog20210628.723391/full/

8. Sycamore Institute Tennessee. Medical Debt in Tennessee: Who Has It and Why It Matters. May 8, 2019. Available at: https://www.sycamoreinstitutetn.org/medical-debt-tennessee/

9. Tennessee Health Care Campaign. *Rural Hospital Closures*: "The ambulance is our emergency room"-- the voices of rural Tennessee. March 2021. Available at: https://tnhealthcarecampaign.org/rural-equity-report/