CLASP
The Center for Law and Social Policy

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

September 9, 2021

**Re: TennCare III Project Approved Special Terms and Conditions**

Dear Secretary Becerra:

The Center for Law and Social Policy appreciates the opportunity to comment on the approved special terms and conditions (STCs) of the TennCare III project. These comments draw on CLASP's deep experience with Temporary Assistance for Needy Families (TANF) and the Supplemental Nutrition Assistance Program (SNAP), two programs where many of the policies proposed in this proposal have already been implemented – and been shown to be significant barriers to low-income people getting and retaining benefits. These comments also draw on CLASP's experience in working with six states under the Work Support Strategies (WSS) project, where these states sought to dramatically improve the delivery of key work support benefits to low-income families, including health coverage, nutrition benefits, and child care subsidies through more effective, streamlined, and integrated approaches. From this work, we learned that reducing unnecessary steps in the application and renewal process both reduced burden on caseworkers and made it easier for families to access and retain the full package of supports that they need to thrive in work and school.

The Medicaid statute is clear that the purpose of the program is to furnish medical assistance to individuals whose incomes are not enough to meet the costs of necessary medical care and furnish such assistance and services to help these individuals attain or retain the capacity for independence and selfcare. States are allowed in limited circumstances to request to "waive" provisions of the rule but the Secretary of Health and Human Services (HHS) may only approve a project which is "likely to assist in promoting the objectives" of the Medicaid Act.[1] A waiver that does not promote the provision of affordable health care would not be permissible.

This waiver proposal's attempt to transform Medicaid and reverse its core function will result in parents losing needed coverage, poor health outcomes, and higher administrative costs. There is extensive and strong literature that shows, as a New England Journal of Medicine review concludes, "Insurance coverage increases access to care and improves a wide range of health outcomes."[2] Moreover, losing health coverage will also make achieving work and education goals significantly more difficult for beneficiaries. The approval of this amendment is therefore inconsistent with the Medicaid purpose of providing medical assistance and should be reevaluated and rejected.

**Aggregate Cap on Funding Perpetuates Systemic Racism**

Capped funding has historically diluted the strength of programs by eroding total funding over the years.[3] Other federal programs that have undergone such drastic restructuring— particularly the change with 1996's "welfare reform" from Aid to Families with Dependent Children (AFDC) to the Temporary Assistance for Needy Families (TANF) block grant—demonstrate that services are greatly diminished, funding fails to keep up with need, and the block grant is unresponsive in times of recession. All of these consequences leave states with untenable choices. The Child Care and Development Block Grant (CCDBG)—which is comprised of both a discretionary funding stream, subject to the annual federal appropriations process, and a mandatory funding stream—similarly demonstrates shortcomings and has been challenged to provide adequate child care assistance to eligible families.[4] Per capita caps would also undermine the core guarantee of comprehensive medical insurance. The current COVID-19 crisis highlights the dangers of such shifts.

The block grant structure of TANF and CCDBG has led to increased racial disparities about who accesses benefits and the value of the benefits.[5] It's reasonable to expect the same if a state's Medicaid program is allowed to operate under a capped funding model. Due to the ongoing effects of structural racism and inequality, the poverty rate among Black and Hispanic Tennesseans is roughly twice as high as the poverty rate among white Tennesseans.[6] As a result, nonwhite individuals are much more likely than white individuals to rely on Medicaid for their health care.[7] By restricting access to Medicaid coverage and services, TennCare III disproportionately harms people of color.

In so doing, the project will also perpetuate and exacerbate existing racial health disparities in the State.[8] For example, the infant mortality rate in Tennessee is almost twice as high for Black infants as for white infants. And critically, Black Tennesseans have been disproportionately affected by COVID-19, accounting for 20% of cases and 36% of deaths even though they are only 17% of the population.[9] Instead of granting Tennessee waivers that promote racial health disparities and inequities, CMS should encourage the State to reduce these gaps through Medicaid expansion. Tennessee is one of only twelve states that still deny their residents access to Medicaid under broadened eligibility rules established by the Affordable Care Act. Empirical research establishes conclusively that Medicaid expansion has reduced mortality and morbidity.[10] It also enhances families' financial security, thereby contributing to their ability to address social determinants of health.

Furthermore, the STCs incentivize Tennessee to underspend Medicaid dollars because the state will receive 55 percent of "unspent" money as essentially a refund. Although the STC state that any "savings" must be spent on Designated State Investment Programs, the reality is that this money will likely supplant something else in the state budget. The end result will be fewer dollars spent on Medicaid and other health care for people with low incomes.

In its review of the STC, the Centers for Medicare and Medicaid services (CMS) should rescind the approval of the aggregate cap in Tennessee.

**No Retroactive Coverage**

CMS should also withdraw the waiver permitting Tennessee to eliminate retroactive coverage for Medicaid beneficiaries. There is nothing experimental about waiving retroactive coverage. Numerous states have been allowed to ignore the requirement since at least the 1990s. Tennessee itself has had a waiver of retroactive coverage since the TennCare project began in 1994. To the extent that the waiver had any experimental value at that time, that is not the case now. Allowing the State to continue the waiver would, at this point, simply be giving Tennessee permission to evade a federal requirement, and numerous courts have said that would be an improper use of section 1115.[11]

In addition, eliminating retroactive coverage subverts the objectives of the Medicaid Act because it "by definition,

reduce[s] coverage" for people not currently enrolled in Medicaid.[12] Without retroactive coverage, Medicaid beneficiaries forgo vital health care and/or incur significant medical expenses.

Data from other states confirms that retroactive coverage is critical for Medicaid beneficiaries. For example, when Indiana received permission to waive retroactive coverage in 2015, CMS required the State to continue to provide some retroactive coverage to parents and caretaker relatives, and almost 14% of that population used the coverage, with the amount paid averaging $1,561 per person.[13] Low-income individuals cannot afford $1500 in unexpected medical expenses. They become saddled with medical debt—an outcome that is antithetical to the Biden administration's focus on shoring up and building up the middle class.

Waiving retroactive coverage also raises uncompensated care costs for hospitals and other safety-net health care providers. When Iowa proposed to eliminate retroactive coverage, the Iowa Hospital Association warned that the waiver would "place a significant financial burden on hospitals and safety-net providers and reduce their ability to serve Medicaid patients . . . translate into increased bad debt and charity care for Iowa's hospitals and . . . affect the financial stability of Iowa's hospitals, especially in rural communities"[14] Tennessee cannot afford to lose additional hospitals. Since 2010, 16 hospitals – 13 of them in rural areas – have closed their doors.[15]

Eliminating retroactive coverage also causes providers that manage to stay open to stop providing care to individuals who are eligible for Medicaid but have not enrolled. As a result, low-income individuals experience a substantial delay in receiving necessary services.[16]

In the approved STCs, CMS appears to suggest that the waiver of retroactive coverage could lead people to enroll in Medicaid earlier, when they are healthy, and to maintain their enrollment. However, low-income individuals do not actively delay seeking Medicaid coverage until they become sick or injured. Medicaid eligibility rules are complicated, and individuals often do not know that they qualify for Medicaid coverage, much less understand that Medicaid has a retroactive coverage policy and what that means. The theory is particularly nonsensical in a non-expansion state like Tennessee, where most low-income adults cannot enroll in Medicaid until they become sick or injured and qualify for the program due to a disability.

**Length of Approval**

If CMS does allow TennCare III to move forward in whole or in part, it should not permit the project to last for 10 years. 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.[17] Congress did not enact section 1115 to allow CMS to make long-term policy changes. As described in detail above, TennCare III is not a valid experiment. Even if it were, there is simply no reason that Tennessee would need 10 years to conduct its experiment.

We acknowledge that, in 2017, CMS issued an Informational Bulletin announcing its intent "[w]here possible, . . . [to] approve the extension of routine, successful, non-complex" section 1115(a) waivers for a period of up to 10 years. Because the policy is contrary to section 1115, it should be reversed. In any event, the policy does not permit approving TennCare III for 10 years. TennCare III contains several new features (e.g., the financing structure and the closed prescription drug formulary), as well as old features that Tennessee has not proven to be successful (e.g., retroactive coverage).

**Conclusion**

Thank you for the opportunity to comment on the TennCare III project. Please contact Suzanne Wikle at swikle@clasp.org if you have further questions. We have included numerous citations to supporting research,

including direct links to the research. We direct CMS to each of the materials we have cited and made available through active links and we request that the full text of each of the studies and article cited, along with the full text of our comment, be considered part of the formal administrative record for purposes of the Administrative Procedures Act.

[1] Jane Perkins, "Section 1115 Demonstration Authority: Medicaid Act Provisions That Prohibit a Waiver," National Health Law Program, 2017, https://9kqpw4dcaw91s37kozm5jx17-wpengine.netdna-ssl.com/wpcontent/uploads/2017/07/Section1115_1396a-limits-1.pdf.

[2] Benjamin D. Sommers, M.D., Ph.D., Atul A. Gawande, M.D., M.P.H., and Katherine Baicker, Ph.D., Health Insurance Coverage and Health — What the Recent Evidence Tells Us, New England Journal of Medicine, July 21, 2017. http://www.nejm.org/doi/full/10.1056/NEJMsb1706645.

[3] Suzanne Wikle, "Medicaid Financing: Dangers of Block Grants and Per Capita Caps, Lessons from TANF and CCDBG", CLASP, June 2020. https://www.clasp.org/sites/default/files/June%202020%20updated%20-%20Medicaid%20Block%20Grants%20brief.pdf

[4] 4 The Child Care and Development Block Grant (CCDBG) is also known as the Child Care and Development Fund or CCDF. CCDBG's structure is unusual because it is comprised of multiple funding streams: mandatory, matching, and discretionary. Each state receives a Mandatory allotment based on a formula set in 1996, and may draw down Matching funds up to a cap if it contributes required state Match and Maintenance of Effort fund. Discretionary funding is subject to the annual federal appropriations process and does not require a state match.

[5] Suzanne Wikle, "Medicaid Financing: Dangers of Block Grants and Per Capita Caps, Lessons from TANF and CCDBG", CLASP, June 2020. https://www.clasp.org/sites/default/files/June%202020%20updated%20-%20Medicaid%20Block%20Grants%20brief.pdf

[6] *State Health Facts, Poverty Rate by Race/Ethnicity, 2019,* KAISER FAMILY FOUND., https://www.kff.org/other/state-indicator/poverty-rate-by-raceethnicity/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D (last visited August 16, 2021).

[7] *The TennCare Block Grant Makes Health Disparities Worse*, TENN. JUSTICE CTR., https://www.tnjustice.org/blockgrant/ (last visited Aug. 19, 2021) (showing that at least 29.6% of Black Tennesseans are enrolled in TennCare, compared to 13.9% of white Tennesseans).

[8] *See, e.g.*, Kinika Young, Tenn. Justice Ctr., *Rooted in Racism: An Analysis of Health Disparities in Tennessee* (2020), https://www.tnjustice.org/wp-content/uploads/2020/07/Rooted-in-Racism-An-Analysis-of-Health-Disparities-in-Tennessee.pdf ; Bill Frist & Andre L. Churchwell, *Discrimination and Disparities in Health: Examination of Racial Inequality in Nashville*, TENNESSEAN (July 31, 2020), https://www.tennessean.com/story/opinion/2020/07/31/examination-racial-inequality-nashvilles-healthcare/5540680002/.

[9] *See, e.g.*, Kinika Young, Tenn. Justice Ctr., *Rooted in Racism: An Analysis of Health Disparities in Tennessee* (2020), https://www.tnjustice.org/wp-content/uploads/2020/07/Rooted-in-Racism-An-Analysis-of-Health-Disparities-in-Tennessee.pdf ; Bill Frist & Andre L. Churchwell, *Discrimination and Disparities in Health: Examination of Racial Inequality in Nashville*, TENNESSEAN (July 31, 2020), https://www.tennessean.com/story/opinion/2020/07/31/examination-racial-inequality-nashvilles-healthcare/5540680002/.

[10] MATT BROADDUS, ET AL., *MEDICAID EXPANSION HAS SAVED AT LEAST 19,000 LIVES, NEW RESEARCH FINDS; STATE DECISIONS NOT TO EXPAND HAVE LED TO 15,000 PREMATURE DEATHS* (2019); HTTPS://WWW.CBPP.ORG/RESEARCH/HEALTH/MEDICAID-EXPANSION-HAS-SAVED-AT-LEAST-19000-LIVES-NEW-RESEARCH-FINDS.

[11] *See, e.g.*, *Beno v. Shalala*, 30 F.3d 1057, 1069 (9th Cir. 1994).

[12] *Stewart v. Azar*, 313 F. Supp. 3d 237, 265 (D.D.C. 2019).

[13] Letter from Vikki Wachino, Dir., Ctr. for Medicaid & CHIP Servs., to Tyler Ann McGuffee, Ins. & Healthcare Policy Dir., Office of Governor Michael R. Pence (July 29, 2016), 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.

[14] Virgil Dickson, *Hospitals Balk at Iowa's Proposed $37 Million Medicaid Cuts*, MODERN HEALTHCARE (Aug. 8, 2017), http://www.modernhealthcare.com/article/20170808/NEWS/170809906.

[15] *Rural Hospital Viability*, TENN. HOSPITAL ASS'N, https://tha.com/focus-areas/small-and-rural/rural-hospital-viability/ (last

visited August 15, 2021).

[16] *See, e.g.,* Jessica Schubel, Ctr. on Budget & Policy Priorities, *Ending Medicaid's Retroactive Coverage Harms Iowa's Medicaid Beneficiaries and Providers*, OFF THE CHARTS (Nov. 9, 2017), https://www.cbpp.org/blog/ending-medicaids-retroactive-coverage-harms-iowas-medicaid-beneficiaries-and-providers.

[17] 42 U.S.C. § 1115(a); *see also id*. § 1115 (d)(2), (f)(6) (limiting the extension of "state-wide, comprehensive demonstration projects" to one initial extension of up to 3 years (5 years, for a waiver involving dual eligible individuals) and one subsequent extension not to exceed 3 years (5 years, for Medicare-Medicaid waivers)).