October 17, 2019

Electronically submitted to ***public.notice.tenncare@tn.gov***

Re: Amendment 42

To Gabe Roberts, Director:

The Center for Law and Social Policy (CLASP) appreciates the opportunity to comment on Tennessee's proposed amendment (Amendment 42) to the TennCare II Demonstration waiver. CLASP is a national, nonpartisan, anti-poverty nonprofit advancing policy solutions for low-income people. We work at both the federal and state levels, supporting policy and practice that makes a difference in the lives of people living in conditions of poverty. CLASP has reviewed the proposed amendment to the TennCare II Demonstration waiver and has serious concerns about the proposal's impact on the Medicaid eligible population in Tennessee.

These comments draw on CLASP's experience in working with six states under the Work Support Strategies 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 the processes and practices that states use in the application and renewal processes are as fundamental to enrollment as the eligibility parameters. These comments also draw upon CLASP's deep experience with the Temporary Assistance for Needy Families (TANF) block grant and the Child Care and Development Block Grant (CCDBG), which have demonstrated the effects of capped funding on eligibility, reimbursements, and administrative processes.

Medicaid plays a critical role in supporting the health and well-being of low-income adults and children. Many work in low-wage jobs where employer-sponsored health care is not offered or is prohibitively expensive. In fact, only 16 percent of poor adults receive health insurance through their jobs[1] and, according to a recent survey by the Bureau of Labor Statistics, low-wage workers pay more for employer-provided medical care benefits than higher-wage workers.[2] Others may have health concerns that threaten employment stability, and without Medicaid, would be denied access to the medical supports they need to hold a job, such as access to critical medications.

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 to furnish such assistance and services to help these individuals attain or retain the capacity for independence and self-care. 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.[3] A waiver that does not promote the provision of health care would not be permissible.

In the proposed amendment Tennessee is requesting sweeping changes to both the financing and federal oversight of the Medicaid programs. If approved by CMS, this proposal would negatively affect the Medicaid eligible population in Tennessee. In addition to our specific concerns below, CLASP believes the core content of this waiver proposal is not compatible with the waiver authority granted through Section 1115 waivers. A

complete restructuring of Medicaid financing and a lack of any federal oversight on Medicaid spending and enrollment changes are not allowable through Section 1115 waivers.[4]

Tennessee's proposal to receive fifty percent of any federal dollars that are not spent in a given year provides the state with a clear incentive to underspend the federal block grant. Underspending federal dollars in order for the state to receive half of the unspent federal dollars would likely be achieved in several ways. For example, lowering reimbursement rates for providers, eliminating benefits, or changing application and enrollment processes in ways that lead to reduced enrollment.

Specifically, our concerns include eligibility and enrollment, diverting dollars from health care, member penalties and lock-out periods, and more clarity needed for the dual eligible population.

Eligibility and enrollment

The proposed amendment clearly states that Tennessee is not requesting to change or reduce eligibility for Medicaid, but the provisions requested within the amendment are highly likely to lead to reduced enrollment. The combination of the proposed financing agreements and lack of oversight by CMS to enrollment policies causes CLASP to believe that access to Medicaid will be diminished.

Tennessee's request to have unilateral ability to change enrollment processes, service delivery systems, and comparable program elements without seeking additional CMS approvals via State Plan Amendments or demonstration amendments is highly problematic. Without further understanding of what Tennessee intends to change with regard to enrollment processes and service delivery systems, our concern is that the state will act to make the processes more cumbersome and difficult for beneficiaries. This could be done by increasing verifications, adding paperwork to the process, or requesting more frequent checks of eligibility – all of which make it more likely that someone will either not complete the enrollment process or will become unenrolled due to paperwork barriers during their certification period. There is strong evidence that such processes can have significant impacts on program participation, without any "eligibility" changes.[5]

Furthermore, because Tennessee is proposing to exempt administrative costs from the block grant, the state would not have an incentive to keep administrative costs low, meaning there would be no incentive to keep paperwork and other verifications at a minimum. Under the waiver proposal, Tennessee could spend a dollar in increased administrative costs to save a dollar in medical costs, and claim a share of the "savings." This is both a huge waste of public resources and a clear violation of the cost neutrality requirement for waivers.

Together, the incentive to underspend federal dollars combined with the request to make any changes to enrollment processes without federal oversight is a recipe for the state to make enrollment and renewal more difficult as a means to reducing participation and spending fewer dollars on Medicaid.

Diverting dollars from health care

Tennessee's proposal to use federal Medicaid dollars for services not directly related to health care raises concerns that dollars will be diverted from providing health care – the core purpose of Medicaid – to other unknown expenditures. While CLASP acknowledges that social determinants of health play a large role in a person's well being, previous waivers that have approved Medicaid spending on non-health care services have included specific information on the services that will be offered, the populations targeted, and the evidence that

these services will improve health care outcomes. Moreover, all of the services are proposed to be taken away from the core Medicaid entitlement, not capped expenditures.

The history of the TANF block grant provides strong evidence that simply stating that any services outside health care being funded with federal dollars will have a "demonstrable connection" to TennCare member health, does not act as a protection. TANF funds may be used for any activity that furthers the four statutory purposes of TANF. States have interpreted this broadly, funding activities from child protective services to college scholarships. In some states, much of this funding has supplanted funding from state general revenues that would otherwise have gone to these purposes, meaning that the total level of investment has not increased. Meanwhile, the share of federal and state TANF funds going to cash assistance has declined to less than a quarter of total spending, even as the overall pool has declined due to inflation.

Tennessee provides a striking example of how TANF funds have been diverted away from the core purposes of TANF. In FY 2018, Tennessee reported that only 13.3 percent of total TANF spending was on cash assistance, and just 5.5 percent on work, education and training activities. Program management – essentially administrative costs – consumed 19 percent of TANF spending, and more than 60 percent went to pre-K and Head Start activities.[6]

The core purpose of Medicaid is to alleviate the burden of accessing essential health services. In the context of a block grant, allowing the state to spend Medicaid dollars on undefined and ambiguous services as long as they have a connection, however tenuous, to health care threatens beneficiaries' access to core health services. Additionally, it perpetuates and increases existing health inequities.

Member penalties and lock out periods

CLASP has significant concerns about Tennessee's proposal regarding penalizing member fraud. First, the state provides no information that member fraud is problematic enough that such actions are necessary. Second, the proposed penalties and their implementation raises many concerns and questions.

A lock out period of 12 months is both immoral and damaging to beneficiaries' health. Once suspended from Medicaid coverage, beneficiaries will likely become uninsured. Needed medical services and prescription drugs, including those needed to maintain positive health outcomes, may be deferred or skipped. Because people without health coverage are less likely to have regular care, they are more likely to be hospitalized for avoidable health problems and to experience declines in their overall health.[7] Further, during the lock out period, these now-uninsured patients present as uncompensated care to emergency departments, with high levels of need and cost—stretching already overburdened hospitals and clinics. This will only lead to poorer health outcomes and higher uncompensated costs for providers.

The impact of even short-term gaps in health insurance coverage has been well documented. In a 2003 analysis, researchers from the Urban Institute found that people who are uninsured for less than 6 months are less likely to have a usual source of care that is not an emergency room, more likely to lack confidence in their ability to get care and more likely to have unmet medical or prescription drug needs.[8] A 2006 analysis of Medicaid enrollees in Oregon found that those who lost Medicaid coverage but experienced a coverage gap of fewer than 10 months were less likely to have a primary care visit and more likely to report unmet health care needs and medical debt when compared with those continuously insured.[9]

The consequences of disruptions in coverage are even more concerning for consumers with high health needs. A 2008 analysis of Medicaid enrollees in California found that interruptions in Medicaid coverage were associated with a higher risk of hospitalization for conditions such as heart failure, diabetes, and chronic obstructive disorders. In addition to the poorer health outcomes for patients, these avoidable hospitalizations are also costly for the state.[10] Similarly, a separate 2008 study of Medicaid enrollees with diabetes who experienced disruptions in coverage found that the per member per month cost following reenrollment after a coverage gap rose by an average of $239, and enrollees were more likely to incur inpatient and emergency room expenses following reenrollment compared to the period of time before the enrollee lost coverage.[11]

Lastly, Tennessee's proposal that member penalties could be individualized, such as suspending only a portion of a member's benefits (such as prescription coverage) is extremely administratively complex, and therefore likely expensive. This level of complexity is likely to lead to administrative mistakes and a lack of understanding among members who are penalized.

More clarity needed regarding dual eligible population

The proposal says that "Expenditures on behalf of individuals who are enrolled in Medicare, including cost sharing and premium assistance (including Medicare Part D "claw back" payments) paid on behalf of individuals who are dually enrolled in Medicare and TennCare" are not included. This language does not make it clear whether all people who are dually eligible for Medicaid and Medicare, including those who are eligible for full Medicaid benefits, are excluded. It could be read to only exclude so-called "partial duals" who are eligible for the Medicare Savings Programs but not for any other Medicaid benefits.

Adding to the confusion is the fact that the block grant is calculated using 64,679 "elderly" for the base period enrollment. While the proposal says this number excludes "Medicare members," we question that it excludes all dually eligible adults age 65 and older. This is because of multiple data sources that show both nationwide and in Tennessee specifically, nearly all seniors enrolled in Medicaid are also enrolled in Medicare. For example, the Census Bureau's American Community Survey data shows that in 2018, there were 138,000 individuals dually in Medicare and Medicaid in Tennessee who were age 65+. There were also 138,000 Medicaid enrollees age 65+ in Tennessee. This aligns with the Kaiser Family Foundation's data for 2013: 152,200 Tennessee seniors age 65+ were enrolled in Medicaid 156,000 and 99% of Tennessee Medicaid enrollees age 65+ that year were dual enrolled. In other words, it is impossible that the 64,679 "elderly" that Tennessee is using to calculate its base block grant amount excludes seniors on Medicare. Either this number is a mistake or the state is not intending to exclude all persons dually eligible.

Furthermore, the enrollment number the state provides for the "disabled" category does not indicate that it excludes "Medicare members," which it should if the state is intending to exclude all duals.

Should Tennessee choose to move forward with this proposal, we ask that the state to clarify whether it is excluding all dually eligible beneficiaries, regardless of age or type of Medicaid coverage. If this is the case, then the state should acknowledge that it is excluding virtually all of its 65+ Medicaid beneficiaries and not include them in the base calculation.

Given these apparent inconsistencies and lack of clarity as to which populations are included in the block grant and which are carved out, we are concerned that the state has not fully thought through the impacts of its proposal. It is critical that the state fully understands the probable impact of capped funding on every single Medicaid population.

Conclusion

For all the reasons detailed above, CLASP strongly opposes Amendment 42 to the TennCare waiver. The policies outlined in Amendment 42 would harm Medicaid enrollees in Tennessee by incentivizing federal underspending, increased bureaucracy and red tape, and diverting dollars away from health care. As such, we urge the state to reconsider its approach by withdrawing this waiver amendment and instead focusing on proven ways to increase access to health care and improve health outcomes, such as implementing Medicaid expansion as intended by the Affordable Care Act.

Thank you for the opportunity to comment and your review of CLASP's comments. Please contact Elizabeth Lower-Basch (**elowerbasch@clasp.org**) with any questions.

All sources accessed October 2019.

[1] Kaiser Family Foundation, "Health Insurance Coverage of the Total Population," 2017, **https://www.kff.org/other/state-indicator/total-population/?currentTimeframe=0&sortModel= percent7B percent22colId percent22: percent22Location percent22, percent22sort percent22: percent22asc percent22 percent7D**; Kaiser Family Foundation, "Health Insurance Coverage of Adults 19-64 Living in Poverty (under 100 percent FPL)," 2017, **https://www.kff.org/other/state-indicator/poor-adults**.

[2] Bureau of Labor Statistics, "Lower-wage Workers Pay More Than Higher-wage Workers for Employer-provided Medical Care Benefits," U.S. Department of Labor, January 2019, **https://www.bls.gov/opub/ted/2019/lower-wage-workers-pay-more-than-higher-wage-workers-for-employer-provided-medical-care-benefits.htm**.

[3] Jane Perkins, "Section 1115 Demonstration Authority: Medicaid Act Provisions That Prohibit a Waiver," National Health Law Program, 2017, **http://www.healthlaw.org/issues/medicaid/waivers/sec-1115-demonstration-authority-medicaid-provisions-that-prohibit-waiver#.WhRlBFWnHIU**.

[4] Rachel Sachs Nicole Huberfeld, "The Problematic Law and Policy of Medicaid Block Grants," Health Affairs, July 2019, **https://www.healthaffairs.org/do/10.1377/hblog20190722.62519/full/**.

[5] Tricia Brooks, Edwin Park, and Lauren Roygardner, *Medicaid and CHIP Enrollment Decline Suggests the Child Uninsured Rate May Rise Again*, Center for Children & Families of the Georgetown University Health Policy Institute, May 2019, **https://ccf.georgetown.edu/wp-content/uploads/2019/06/Enrollment-Decline.pdf**.

[6] Office of Family Assiatnce, *TANF and MOE Spending and Transfers by Activity, FY 2018 by State*, U.S. Department of Health & Human Services, Spetember 2019, **https://www.acf.hhs.gov/sites/default/files/ofa/fy2018_tanf_and_moe_state_piecharts_b508.pdf**.

[7] Kaiser Family Foundation, "Key Facts About the Uninsured Population" September 2017, **http://kff.org/uninsured/fact-sheet/key-facts-about-the-uninsured-population/**.

[8] Jennifer Haley and Stephen Zuckerman, "Is Lack of Coverage A Short or Long-Term Condition?," Kaiser Family Foundation, June 2003, **http://kff.org/uninsured/issue-brief/is-lack-of-coverage-a-short-or/**.

[9] Matthew J. Carlson, Jennifer DeVoe, and Bill J. Wright, *Short-Term Impacts of Coverage Loss in a Medicaid Population: Early Results From a Prospective Cohort Study of the Oregon Health Plan*, Annals of Family Medicine, 2006, **http://www.annfammed.org/content/4/5/391.short**.

[10] Andrew Bindman, Amitabha Chattopadhyay, and G. M. Auerback, "Interruptions in Medicaid Coverage and Risk for Hospitalization for Ambulatory Care-sensitive Conditions," *Annals of Internal Medicine*, 2008, **https://www.ncbi.nlm.nih.gov/pubmed/19075204?dopt=Abstract**.

[11] Allyson G. Hall, Jeffrey S. Harman and Jianyi Zhang, "Lapses in Medicaid Coverage: Impact on Cost and Utilization Among Individuals With Diabetes Enrolled in Medicaid," *Medical Care*, Vol. 46, No. 12, December 2008, **https://www.ncbi.nlm.nih.gov/pubmed/19300311?dopt=Abstract**.