October 6, 2022

Secretary Xavier Becerra
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, DC 20201

Re: TennCare III Amendment 4

Dear Secretary Becerra,

The undersigned organizations appreciate the opportunity to comment on Tennessee's proposed "Amendment 4" to its TennCare III Demonstration. We commend you for reconsidering portions of the demonstration that were erroneously approved and we urge you to revise the demonstration so that, as directed by section 1115 of the Social Security Act, it promotes the objectives of the Medicaid statute.

As we indicated in our September 9, 2021 comments on TennCare III, the demonstration contains a number of provisions that undermine the Medicaid program in Tennessee, including an aggregate cap on federal funding with a provision for "shared savings," a closed prescription drug formulary, a waiver of 3-month retroactive coverage, and a 10-year duration that is not permitted under federal law.[1] TennCare III also undermines Medicaid by paying providers for uncompensated care delivered to uninsured adults who have a statutory pathway to coverage through Medicaid expansion. Finally, TennCare III would do nothing to address systemic barriers to Medicaid access for underserved communities. We reaffirm these comments and incorporate them here.

In its June 30 letter, the Centers for Medicare & Medicaid Services identified some of the most problematic elements of TennCare III: the closed formulary; the aggregate cap; lack of clarity on limitations on reductions in benefits or coverage; and the "shared savings" framework.[2] CMS asked the state to make changes to address its concerns. In response, the State has submitted Amendment 4. We believe Amendment 4 is only partially responsive to the CMS request and in some respects would make the demonstration even more problematic. *Additional changes are needed in order for the demonstration to meet the requirements of section 1115 and promote the objectives of Medicaid.*

The Closed Prescription Drug Formulary Restricts Access to Needed Prescription Drugs

Currently, TennCare III allows Tennessee to sharply restrict what drugs are covered for adults age 21 and over by permitting the state to cover only one drug per class, with exceptions for six "protected" classes, subject to an undefined appeals process. CMS requested that the state remove this expenditure authority for pharmacy and related flexibilities from the demonstration. In this amendment, the state proposes to do so. We strongly support this request. Restricting beneficiary access to prescription drugs by imposing a closed formulary does not promote the objectives of

[1] Sign-on Letter to Secretary Becerra on "TennCare III" Demonstration Standard Terms and Conditions, September 9, 2021, https://ccf.georgetown.edu/wp-content/uploads/2017/10/Tennessee_STC_Sign_On_Letter_FINAL.pdf.
[2] Letter from Deputy Administrator and CMCS Director Daniel Tsai to TennCare Director Stephen Smith, June 30, 2022, https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/tn-tenncare-iii-cms-ltr-06302022.pdf.

Medicaid; rather, it undermines the program. In particular, a closed formulary has no legitimate experimental purpose. The potential benefits of leveraging lower prescription drug prices—which is highly implausible in a state with a relatively small Medicaid program—is greatly outweighed by the potential harm to beneficiaries with serious medical conditions who need high-cost drugs.

The Aggregate Cap Risks Beneficiaries' Coverage and Care

Currently, TennCare III operates under an "aggregate cap" budget neutrality model that has similarities to the way Medicaid would be financed if it were a block grant. In its June 30 letter, CMS requested that the state submit a new financing and budget neutrality model based on a traditional per member per month cap. Under the traditional model, which is used in all other comprehensive section 1115 demonstrations, states are at risk for increases in per capita costs but not for costs attributable to increases in enrollment. In Amendment 4, the state proposes that budget neutrality be determined using a per member per month cap rather than an aggregate cap, but that other elements of the current methodology, such as baseline PMPM costs, trend rates, and rebasing methodology for years 6 through 10, remain unchanged.

We support the proposed change in budget neutrality model to a per member per month cap. Placing Tennessee at risk for 100% of the additional costs attributable to increases in enrollment incentivizes the state to increase disenrollment and limit new enrollment, undermining the Medicaid program. We also urge CMS to carefully examine the remaining elements of the aggregate cap model to ensure that they promote the objectives of Medicaid. In particular, the Secretary should discard the rebasing methodology for years 6 through 10 in the course of revising the demonstration's term to five years (see below).

The New "Shared Savings" Framework Exacerbates Some of the Problems in the Current Demonstration

In conjunction with the aggregate cap, the TennCare III demonstration in its current form includes a so-called "shared savings" element. If in a given year the state's demonstration expenditures are less than the aggregate cap amount, the state would be able to draw down up to 55 percent of the federal government's savings depending on its performance on quality metrics that it selects. (The quality metrics would be drawn from the Medicaid Adult, Child, and Maternity Core Sets, but have yet to be defined by the state). The state may use these so-called "shared savings" to fund certain programs that are currently paid for with state dollars. The federal dollars free up those state dollars to be used for whatever purpose the state decides.

CMS requested that the state propose an alternative to this aggregate cap/"shared savings" structure that would use budget neutrality savings to fund "state reinvestments for initiatives that the state would like to support." In Amendment 4, the state proposes to retain the "shared savings" structure but tie it to the per member per month cap rather than the aggregate cap. If in any year total spending under the demonstration is less than the per member per month cap, the state would draw down not 55 percent but the entire amount --*100 percent* -- of the federal government's share of the savings and spend those federal funds on existing state-funded programs. Moreover, under its proposal, the state would not have to meet any quality metrics in order to draw down these funds.

We urge CMS to reject the state's proposal. The state has not proposed to replace the "shared savings" construct, as CMS requested. In fact, it is proposing to *increase* its share of any federal

savings and *eliminate altogether* the requirement that it meet the Core Set quality metrics in order to qualify for the federal funds. These changes would further incentivize the state to reduce its Medicaid spending in order to generate federal funds which it could then use to invest in health programs serving people who are not eligible for Medicaid or, just as likely, to pave highways or give tax cuts. Assuming that the state would not cut eligibility or benefits (see below), the primary way in which the state could reduce its overall spending in order to generate savings under the cap would be to freeze or cut payments to providers, further discouraging provider participation and jeopardizing beneficiary access to care.

On its face, creating a windfall of federal funds to Tennessee to enable it to refinance existing state-funded programs does not promote the objectives of the Medicaid program and should not be approved. CMS has requested that, instead of "shared savings," Tennessee seek expenditure authority for state reinvestments for initiatives that the state would like to support with budget neutrality savings. This is consistent with CMS's historic use of Designated State Health Program (DSHP) expenditure authority. By comparison, Amendment 4 would continue to improperly incentivize Tennessee to make programmatic cuts to access "savings." Given that CMS has recently indicated it will approve DSHPs in other states, CMS should work with Tennessee to ensure that the amended demonstration does not have a significant negative impact on Medicaid fiscal integrity or alter the underlying financing structure of the Medicaid program. This means replacing the "shared savings" approach with the conventional budget neutrality framework by which CMS establishes a limit on DSHP spending that does not grow if the state spends under its budget neutrality cap.

CMS Should Make Clear that The State Cannot Reduce Benefits or Coverage Without Its Approval

Currently, Special Term and Condition #6 provides that if the state wants to make changes in TennCare III it must submit an amendment to CMS, but only "to the extent that such changes reduce benefits and/or coverage in place as of December 31, 2020." In other words, the STCs allow the state to cut benefits or coverage so long as it submits an amendment and CMS approves it. CMS requested that the state "modify the STCs to more explicitly state that Tennessee cannot cut benefits or coverage in effect December 31, 2021 without an amendment to the demonstration, subject to additional public comment period and CMS approval." In its cover letter, the state indicates that it has no objection to making more explicit in the STCs that reductions in coverage or benefits would be subject to "the standard amendment process" (which does not include a robust public comment opportunity) but did not propose any specific changes to its existing STCs to bolster the process.

Reducing benefits or coverage does not promote the objectives of the Medicaid program. We urge CMS to revise the STCs #6, #7, and #12 to make explicit that if the state wishes to reduce eligibility or benefits below the levels in effect on December 31, 2021, it must submit an amendment to CMS that specifies the reductions the state proposes to make and estimates the number of applicants and beneficiaries that would be affected by the reductions in each year of the demonstration. The amendment should be subject to a public notice and comment period of at least 30 days at the state level and a public notice and comment period of at least 30 days at the federal level.

Ten-Year Section 1115 Demonstration Project Extensions are Not Permitted Under Federal Law

Currently, TennCare III has a 10-year approval period that began on January 8, 2021 and ends on December 31, 2030. We urge you to limit the length of the demonstration to December 31, 2025.

Section 1115 demonstrations can only be approved "for the period...necessary" for the state to carry out the project and are generally approved for no more than five years. Subsections (e) and (f) of section 1115 of the Social Security Act are clear that initial and subsequent extensions of an approved demonstration are limited to three or five-year periods depending on the type of demonstration project. Nonetheless, CMS issued guidance in November 2017, stating that 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."

As our comments make crystal clear, TennCare III is far from a "routine, successful, non-complex" demonstration, so it would not qualify for a ten-year approval even in the absence of a statutory prohibition on extensions longer than three or five years. There is certainly no reason to extend the demonstration for more than five years. If, by the end of year four, the evaluation of TennCare III shows that the demonstration should be extended, Tennessee can request another five-year extension. Nor has Tennessee shown that 10-year approval is *necessary* to this experiment.

The Waiver of 3-Month Retroactive Coverage Undermines Medicaid in Tennessee

Under TennCare III, Medicaid beneficiaries except for infants and children under 21 and pregnant and postpartum women do not have the financial protection of retroactive coverage for three months prior to a determination of eligibility. Waiving retroactive coverage by definition reduces coverage for most adult Medicaid beneficiaries and thereby fails to promote the principal objective of the program, as required for approval under section 1115. We urge you in revising TennCare III to eliminate the waiver of retroactive coverage altogether. Doing so would be consistent with the principles that this Administration has articulated in Executive Orders 13985, 14009, 14070, addressing health equity, health coverage, and reduction of medical debt, respectively.[3]

Rejection of the waiver is particularly compelling in the case of Tennessee, which has been allowed to eliminate 3-month retroactive coverage since the first TennCare demonstration in 1994. Even if the waiver initially had a legitimate experimental purpose, that purpose has been accomplished during the past 27 years. Whatever lessons the waiver of 3-month retroactive coverage in Tennessee was to have taught policymakers have been learned. Removal of coverage leaves beneficiaries exposed to medical debt and bankruptcy and creates uncompensated care for hospitals.

At this point, the waiver of retroactive coverage functions as an end-run around the Medicaid statute for Tennessee and the 13 other states that have been granted waivers of 3-month retroactive

[3] Executive Order No. 13985, 86 FR 7009 (2021), https://www.federalregister.gov/documents/2021/01/25/2021-01753/advancing-racial-equity-and-support-for-underserved-communities-through-the-federal-government; Executive Order No. 14009, 86 FR 7793 (2021), https://www.federalregister.gov/documents/2021/02/02/2021-02252/strengthening-medicaid-and-the-affordable-care-act; Executive Order No. 14070, 87 FR 20689 (2022), https://www.federalregister.gov/documents/2022/04/08/2022-07716/continuing-to-strengthen-americans-access-to-affordable-quality-health-coverage.

coverage for traditional and expansion populations. That policy choice is one for the Congress to make; section 1115 does not give the Secretary the authority to make it.

Thank you for your willingness to consider our comments. If you need additional information, please contact Joan Alker (jca25@georgetown.edu) or Allison Orris (aorris@cbpp.org).

ACNM Tennessee Affiliate
American College of Obstetricians and Gynecologists (ACOG)
American Lung Association
Autistic Self Advocacy Network
Center for Law and Social Policy
Center on Budget and Policy Priorities
Cystic Fibrosis Foundation
Families USA
First Focus on Children
Georgetown University Center for Children and Families
Justice in Aging
March of Dimes
Medicare Rights Center
National Alliance on Mental Illness
National Multiple Sclerosis Society
National Partnership for Women & Families
Tennessee Academy of Family Physicians