Georgetown University
Health Policy Institute
CENTER FOR CHILDREN
AND FAMILIES

December 20, 2019

VIA ELECTRONIC SUBMISSION

The Honorable Alex Azar, Secretary
U.S. Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

RE: TennCare II Demonstration Amendment 42 (November 20, 2019)

Dear Secretary Azar:

We are writing to urge you to disapprove "Amendment 42" to the TennCare II Demonstration.

The Georgetown University Center for Children and Families (CCF) is an independent, nonpartisan policy and research center founded in 2005. Its mission is to expand and improve high-quality, affordable health coverage for America's children and families. As part of the McCourt School of Public Policy, Georgetown CCF conducts research, develops strategies, and offer solutions to improve the health of America's children and families, especially those with low and moderate incomes. In particular. CCF examines policy development and implementation efforts related to Medicaid, the Children's Health Insurance Program (CHIP), and the Affordable Care Act.

In "Amendment 42," the state of Tennessee "proposes to convert the federal share of its Medicaid funding relating to providing its core medical services to its core population to a block grant." (p. iii). As we explain below, the Secretary does not have the authority under section 1115 of the Social Security Act to approve this proposal. The proposal asks that the Secretary waive requirements of the Medicaid statute that are outside of section 1902, authority that the Secretary simply does not have. In addition, the proposal would jeopardize coverage for "core populations," including children and families, and it would compromise access to "core medical services," including Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services for children under 21. *The proposal therefore fails the basic test for a demonstration under section 1115, because it is "not likely to assist in promoting the objectives of" Medicaid for children (or any other "core population"). It should be rejected in its entirety.*

Tennessee's Proposal Would Further Undermine Medicaid Coverage for Children

Children have a huge stake in this proposal. Tennessee's Medicaid program, TennCare, currently covers 783,723 children; they account for 55.4% of all TennCare enrollees.[1] In FY2014, the most recent year for which data are available, the state spent $2.4 billion paying for EPSDT and other services for these children.[2] At the time, 65 percent of that amount was paid by the federal government.

We recently issued two reports that bear directly on "Amendment 42"; these are attached to, and incorporated, into this comment letter for purposes of the administrative record.

The first, "The Number of Uninsured Children is on the Rise," finds that the number of uninsured children in Tennessee increased by 25,000 between 2016 and 2018, causing the child uninsured rate to increase from 3.7% to 5.2%. [3] The second, "Nation's Youngest Children Lose Health Coverage at an Alarming Rate," finds that Tennessee is one of 13 states with a statistically significant increase in the rate of uninsured children under age 6 between 2016 to 2018, from 2.9 to 4.3%, with the number of uninsured children under 6 increasing by 6,552. [4]

In both cases, a major driver of the increase in uninsurance among children in Tennessee is the decline in Medicaid and CHIP enrollment, as your agency's own enrollment data show. Between December 2016 and December 2018, over 103,000 fewer children were enrolled in Tennessee's Medicaid program;[5] from January 2018 to December 2018, there was a decline of over 30,000 children and pregnant women enrolled in Tennessee's CHIP program. [6]

"Amendment 42" would do nothing to address this decline in Medicaid and CHIP enrollment by children or the resulting increase in the number of uninsured children in Tennessee. To the contrary, by creating strong fiscal incentives for the state to reduce its general fund Medicaid spending in order to draw down federal funds that the proposal

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[1] TennCare, "TennCare Enrollment Report for Nov 2019", https://www.tn.gov/content/dam/tn/tenncare/documents2/fte_201911.pdf.
[2] Kaiser Family Foundation, "Medicaid Spending by Enrollment Group: FY2014," https://www.kff.org/medicaid/state-indicator/medicaid-spending-by-enrollment-group/?currentTimeframe=0&selectedDistributions=children&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.
[3] Alker, J and Roygardner, L. "The Number of Uninsured Children Is On the Rise," Georgetown University Center for Children and Families, October 2019 https://ccf.georgetown.edu/wp-content/uploads/2019/10/Uninsured-Kids-Report.pdf.
[4] Burak, E.W., Clark, M, and Roygardner, L. "Nation's Youngest Children Lose Health Coverage at an Alarming Rate," Georgetown University Center for Children and Families, December 2019, https://ccf.georgetown.edu/wp-content/uploads/2019/12/Uninsured-Kids-under-6-final-1.pdf
[5] TennCare, "Enrollment Data," https://www.tn.gov/tenncare/information-statistics/enrollment-data.html
[6] CoverKids, "Enrollment Data," https://www.tn.gov/coverkids/enrollment-data-.html (CoverKids enrollment data for 2016 and 2017 is not available on TennCare's website).

characterizes as "shared savings," the proposed block grant will almost certainly make matters worse. Yet the state's proposal does not mention, much less discuss, the increase in uninsured children that is hidden in plain sight, or the implications of the proposed block grant for these children.

The proposal is crystal clear in explaining that the financing of services to all Tennessee children enrolled in Medicaid would be subject to the block grant and the associated waivers. That, however, is where the clarity stops. Despite the critical importance of Medicaid to these children and their families, the proposal does not explain how the different elements of the proposal would affect Medicaid coverage for children as well as the other "core populations," such as parents/caretaker relatives.

A proposal of this scope and complexity, which by its own account would "transform the traditional Medicaid financing structure in Tennessee to a block grant," (p. 4), should at a minimum give reasons why the single largest beneficiary group in the program (children) would not be worse off as a result of this "transformation." The proposal contains optical statements such as "no reductions in who is eligible for or what benefits are currently provided," (p. iii), but as we discuss below, these assertions are contradicted by the waivers the proposal is seeking. As such, the proposal is fundamentally defective and should be rejected.

Tennessee's proposal requests waivers of section 1903 of the Social Security Act that the Secretary does not have the authority to approve.

The proposal requests six new waiver authorities (pp. 25-26). A number of these requests are so vague as to be almost unintelligible; your certification that the proposal was complete and ready for public comment was plainly erroneous. Nonetheless, in these comments we address three proposed waiver authorities that are most likely to harm children enrolled in Medicaid, thereby undermining rather than promoting the objectives of the Medicaid program. This focus is consistent with our expertise and should not be construed as an implicit approval of the state's remaining requests for new waiver authorities.

In two of these proposed waivers, the Secretary is being asked to waive requirements of section 1903 of the Social Security Act. Under section 1115, the Secretary only has the authority to waive requirements of section 1902. Even if the Secretary had the authority to waive the requirements of section 1903, which the Secretary clearly does not have, the proposal fails to explain, much less justify, how the waivers would be likely to assist in promoting the objectives of Medicaid with respect to low-income children in Tennessee.

The Secretary does not have the authority to cap the state's Medicaid expenditures at the annual block grant amount.

The proposal "seeks to move away from a system where federal funds are made available based simply on state spending, and instead replace it with one where Tennessee

earns federal funds based on quality, efficient, and responsible stewardship of the TennCare program." (p. 11) Specifically, instead of receiving federal matching payments for its Medicaid spending on "core services" for "core populations" at its current 65 percent FMAP, the state requests an annual amount of federal funds in a block that does not decline if state spending declines (p. 6). In addition, it requests one half of what it characterizes as any federal "savings" attributable to the state spending less than the block grant amount in any given year (p. 10).

In short, Tennessee wants to change the current open-ended federal-state matching arrangement codified in section 1903 of the Social Security Act since the enactment of Medicaid in 1965. Under section 1115(a)(1) of the Social Security Act, the Secretary is authorized only to waive requirements of section 1902, and only for purposes of a demonstration that is "likely to assist in promoting the objectives of" Medicaid. *The Secretary has no authority to waive the federal-state matching provisions of section 1903(a).* And even if section 1115(a)(1) waiver authority reached section 1903, which by its plain text it does not, waiving the open-ended federal-state matching requirement would undermine, not promote, the central objective of Medicaid: to make coverage available to low-income Americans. To achieve its vision, Tennessee needs a fundamental policy change in Medicaid, a change that only Congress can effectuate by amending section 1903(a).

By breaking the link between spending state funds and receiving federal matching dollars, Tennessee's proposal would effectively raise its federal matching rate above its current 65.21 percent. The formula for determining a state's matching rate is prescribed by section 1905(b); state matching rates are promulgated each year in accordance with section 1101(a)(8)(B). Neither of these provisions is within reach of the Secretary's waiver authority under section 1115, which extends only to the requirements of section 1902 of the Social Security Act. The reason is obvious: Congress did not want the Secretary to use section 1115 authority to change the effective federal Medicaid matching rate for any individual state, or for states as a whole. Again, if Tennessee wants a higher federal matching rate, it needs to obtain a statutory change from Congress.

The Secretary does not have the authority to allow the state to operate a managed care program that does not comply with the requirements of 42 CFR Part 438.

Almost all Tennessee Medicaid beneficiaries, including children, are enrolled in managed care organizations (MCOs). The payment for, and delivery of services through managed care is governed by federal regulations at 42 CFR Part 438. The state's proposal seeks "relief" from these regulations, arguing that freedom from "unnecessary federal interference is essential to the ability to operate within a capped funding structure." (p. 21). The federal government currently pays two thirds of the costs of Medicaid in Tennessee. The federal regulations at 42 CFR Part 438 are the mechanism for the federal government to ensure that Medicaid funds purchase accessible, high quality care from MCOs and that the rates paid for those services are actuarially sound.

As noted above, the Secretary does not have the authority under section 1115(a)(1) to waive section 1903(a) or section 1905(b) of the Act. Similarly, the Secretary does not have the authority to waive sections 1903(m), 1905(t), or 1932 of the Act or their implementing regulations at 42 CFR Part 438. As explained in the Department's own regulations, 42 CFR 438.1, these statutory sections are the basis for all of the provisions of 42 CFR Part 438 except the application of requirements to PIHPs and PAHPs that do not meet the statutory definition of an MCO or PCCM (the statutory basis for that exception is section 1902(a)(4)).

Even if the Secretary had the authority under section 1115 to waive provisions in section 1903(m), 1905(t), and 1932 and the implementing regulations at Part 438—authority the Secretary plainly does not have—waiving the implementing regulations at Part 438 is not "likely to assist in promoting the objectives of" the Medicaid program. The central objective of the Medicaid program is to provide coverage to low-income Americans, including children. Coverage for Medicaid beneficiaries is not meaningful or effective if the MCOs in which those beneficiaries are enrolled do not have adequate provider networks through which covered services are accessible and of high quality.

This is particularly true for the EPSDT benefit for children under 21. It's not sufficient to assert that "no changes would be made to the scope of" the EPSDT benefit on paper (p. 22). As CMS recognizes in its "EPSDT Guide for States:" "Managed care entities must demonstrate to the state that they have adequate provider capacity in the plan to serve enrolled children including an appropriate range of pediatric and specialty services; access to primary and preventive care; and a sufficient number, mix and geographic distribution of providers. Monitoring managed care entities' compliance with EPSDT requirements is essential; a strong oversight framework ensures that states are meeting their responsibilities to children as well as Federal monitoring requirements."[7]

The regulations at Part 438 implement the statutory provisions designed to protect children and other MCO enrollees in Tennessee and other states from underservicing and substandard care, including the requirement that capitation rates be actuarially sound. Allowing Tennessee to suspend this and other beneficiary protections in Part 438 would not promote the objectives of Medicaid, especially when the state is requesting the waiver in order to "operate within a capped funding structure," presumably by reducing capitation rates and allowing MCOs to deny services to high-need enrollees. The proposal does not explain why this waiver would not result in the loss of EPSDT benefits for medically fragile children, among others.

[7] CMS, "EPSDT: A Guide for States: Coverage in the Medicaid Benefit for Children and Adolescents" (June 2014), p. 31, https://www.medicaid.gov/medicaid/benefits/downloads/epsdt_coverage_guide.pdf

Tennessee's proposal requests waivers that are not likely to promote the objectives of the Medicaid program.

Allowing Tennessee to operate a closed formulary that does not comply with section 1927(d)(4) would not be likely to promote the objectives of the Medicaid program.

The state proposes that the Secretary waive the requirements of section 1927(d)(4) of the Act to enable it to adopt a "commercial-style closed formulary with only at least one drug available per therapeutic class." (p. 14). Among the drugs the state seeks to exclude from the formulary are new drugs coming to market through FDA's accelerated approval pathway "until market prices are consistent with prudent fiscal administration" or it determines that "sufficient data exist regarding the cost effectiveness of the drug." (p. 15) The proposal asserts that the state will maintain "an exceptions process to cover drugs that are not on the formulary when medically necessary;" presumably this would apply both to drugs already on the market as well as new drugs. (p. 16).

The proposal is internally contradictory. For example, in the case of new drugs, the criteria for exclusion are inconsistent with the criteria for the exceptions process; either a new drug is "medically necessary" for a beneficiary or it is not, regardless of its market price or cost effectiveness data. The fiscal incentive for the state will be to exclude costly drugs, whether new or already on the market, even when the drug is medically necessary. (This fiscal incentive would operate even though the state proposes to exclude prescription drug spending from the block grant, since such spending would still include a state share). The incentive to reduce state spending, combined with the ability to exclude high-cost drugs, could directly undercut EPSDT coverage for children with a medical need for these drugs.

Despite this obvious risk, the proposal does not identify which drugs, new or otherwise, would be excluded, which of those drugs are designed for children, or how children who are determined by their physicians to need those drugs would have payment made for them. Moreover, the proposal does not provide any detail about when specific clinical needs of a child (or other beneficiary) would justify access to drugs excluded from the formulary (it only says that the procedures for seeking an exemption would be similar to the existing prior authorization process for non-preferred drugs). In short, the state has failed to explain its closed formulary proposal as it would affect children, much less justify it. Waiving the current formulary protections at section 1927(d)(4) would not be "likely to assist in promoting the objectives" of the Medicaid program. For these reasons, this proposal warrants the same result as a similar proposal from Massachusetts: disapproval.[8]

[8] https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ma/MassHealth/ma-masshealth-demo-amndmnt-appvl-jun-2018.pdf

Allowing Tennessee to modify enrollment processes, service delivery system, and comparable program elements without the need for a demonstration amendment would not be likely to promote the objectives of the Medicaid program.

Tennessee seeks a waiver to "modify enrollment processes, service delivery system, and comparable program elements without the need for a demonstration amendment" subject to approval by CMS. The state does not describe what it means by "modifying enrollment processes," what it means by "modify… service delivery system," or what it means by "modify… comparable program elements." Nor does it specify the provisions of section 1902 that it seeks to have waived to enable these modifications without CMS approval. Finally, the state does not explain how these modifications will affect children enrolled in its Medicaid program or why these modifications are warranted.

This lack of specificity in this request, as well as the lack of a justification, makes it impossible to comment. The request could expand coverage or reduce it; the lack of information about the request means neither those commenting on the proposal nor the Secretary considering it can know. That fact alone makes it impossible for the Secretary to determine that a demonstration containing this waiver (of whatever provision is sought to be waived) is "likely to assist in promoting the objectives" of the Medicaid program. Under these circumstances, the Secretary does not have the authority to approve this waiver request.

Tennessee's proposal requests expenditure authorities that are not likely to promote the objectives of the Medicaid program.

Tennessee requests four new expenditure authorities under section 1115(a)(2). Consistent with our primary focus, our comments address one that is particularly problematic for children covered by Medicaid now or in the future. This focus should not be construed as implicit approval of the state's remaining requests for new expenditure authorities.

Tennessee's request to spend federal block grant dollars on items or services not otherwise reimbursable under Title XIX but which have an impact on enrollee health would not be likely to promote the objectives of the Medicaid program.

The proposal seeks authority under section 1115(a)(2) to receive federal funds for costs it incurs that are not otherwise matchable under Title XIX but that have "an impact on enrollee health." The proposal does not specify what amount of its federal block grant dollars it intends to spend on these not otherwise matchable costs. Nor does the proposal specify what these items or services will be; instead, it provides only an "illustrative" list of such services, such as nutritional assistance and housing supports. The state emphasizes that "it is not committing to spend block grant dollars on the services listed in this paragraph, or to limit its potential use of block grant funds to only these services." (p. 14, ftn. 3).

Under section 1115(a)(2), the Secretary may approve federal Medicaid matching funds for costs not otherwise matchable in connection with a demonstration that "is likely to assist in promoting the objectives of" the Medicaid statute. As we have explained above, the demonstration that the state is seeking—"to convert the federal share of its Medicaid funding relating to providing its core medical services to its core population to a block grant"—does not meet this standard. Similarly, the request to spend federal block grant dollars from this unapprovable demonstration for unspecified items and services that are not matchable under Title XIX is not "likely to promote the objectives of" Medicaid.

Over 780,000 children in Tennessee depend on Medicaid for their health care. The proposal offers no evidence that the state's Medicaid program is currently meeting the medical needs of those children by fully funding EPSDT services, which are mandatory benefits for a mandatory coverage group and are eminently matchable. Nor does the state commit that it will fully fund EPSDT services under the block grant. Instead, the proposal requests permission to use limited federal block grant dollars to pay for unspecified items and services the costs of which are not otherwise matchable.

Under the proposal, Tennessee Medicaid would operate under a "capped funding structure"—i.e., federal block grant dollars would be limited. Limited federal block grant dollars that are spent on costs not otherwise matchable are block grant dollars that are not available to be spent on costs that are matchable for services that the state is required to provide to populations it is required to cover. The central objective of Medicaid is to make coverage available to low-income Americans. In the case of children, a mandatory coverage group, EPSDT services, a mandatory benefit, are integral to that coverage. Diverting federal dollars from paying for those matchable services to paying for unspecified services that do not benefit children and are otherwise unmatchable is likely to undermine the objectives of the Medicaid program, not promote it.

Thank you for your consideration of our comments. If you need any additional information, please contact Andy Schneider (Andy.Schneider@georgetown.edu) or Joan Alker (jca25@georgetown.edu).

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