December 19, 2023

VIA ELECTRONIC SUBMISSION

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

Re: TennCare III Demonstration Amendment 5

Dear Secretary Becerra,

The Center on Budget and Policy Priorities and the Georgetown University Center for Children and Families appreciate the opportunity to comment on Tennessee's proposed amendment to its "TennCare III" section 1115 demonstration project.[1]

The Center on Budget and Policy Priorities (CBPP) is a nonpartisan research and policy organization based in Washington, D.C. Founded in 1981, CBPP conducts research and analysis to inform public debates and policymakers about a range of budget, tax and programmatic issues affecting individuals and families with low or moderate incomes. The Georgetown University Center for Children and Families (CCF) is an independent, nonpartisan policy and research center founded in 2005 with a mission 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 offers solutions to improve the health of America's children and families, particularly those with low and moderate incomes.

Tennessee is seeking to adjust its eligibility threshold for section 1931 parents/caretaker relatives (PCRs) to align with the federal poverty level (100 percent of the FPL), effectively increasing the eligibility level for this population. Additionally, the state is requesting expenditure authority to provide a fixed monthly supply of diapers to children under age 2 enrolled in Medicaid. We support both of these proposed policy changes, with the additional considerations noted below.

As we explained in our October 6, 2022 comments on a prior amendment[2], the underlying TennCare III demonstration that these proposals would amend is seriously flawed. While many of our concerns have been addressed, two remain. TennCare III has a ten-year term; federal law does not permit ten-year extensions of section 1115 demonstration projects. TennCare III includes a waiver of 3-month retroactive eligibility except for pregnant women, infants, and children under age 21; the waiver of 3-month retroactive coverage for the non-exempt adult populations undermines Medicaid in Tennessee. Our support for the policy proposals in Amendment 5 should not be construed as support for these flaws in TennCare III.

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[1] Division of TennCare, "Amendment 5: Supporting Strong Families," November 13, 2023, https://www.medicaid.gov/sites/default/files/2023-11/tn-tenncare-iii-pa-11132023.pdf.
[2] Letter from 17 organizations on Tennessee's Amendment 4 to the TennCare III Demonstration, October 6, 2022, https://ccf.georgetown.edu/wp-content/uploads/2023/01/Tennessee_Amendment4_SignOn_Comment_Letter_FINAL-1.pdf.

Aligning the Eligibility Threshold for Parent/Caretaker Relatives with the Federal Poverty Level Would Increase Coverage, But Coverage Gaps Remain

Eligibility for the section 1931 Medicaid population in Tennessee is currently established based on a fixed dollar threshold ($1,611 per month for a family of three in 2023). The proposal would change the eligibility level for this group by setting the threshold at 100 percent of the federal poverty level (FPL) ($2,072 per month for a family of three in 2023), increasing the number of parents and caretaker relatives eligible for TennCare. We support this proposed change.

Since the state currently uses a dollar threshold that *is not* regularly adjusted, inflation has resulted in declining eligibility for the section 1931 group over time. For example, between 2020 and 2023, the section 1931 limit decreased by over ten percentage points, from 94 percent FPL to 82 percent FPL, when the dollar value is calculated to represent the FPL equivalents.[3] According to the state's estimates, the proposal would provide coverage to an additional 8,100 parents and caretakers. We encourage CMS to act quickly on this proposal so parents who would be eligible to maintain coverage under the new threshold do not experience coverage disruptions during the remainder of the state's unwinding of the Medicaid continuous enrollment protection.

As the state's proposal rightly notes, children would benefit from the proposed change to eligibility standards as well. Research has shown that when parents are insured, their children are more likely to be insured.[4] Similarly, children whose parents have coverage have been found to be more likely to receive recommended care like regular well child visits.[5]

Tennessee indicates that this proposal would fix "*a* coverage gap" that exists in the state (emphasis added). While it would close the coverage gap for many parents and caretaker relatives of dependent children, the state's continued refusal to expand Medicaid coverage to non-elderly adults with incomes up to 138 percent of FPL leaves significant gaps for the rest of the uninsured population. According to the state's own estimates over 300,000 uninsured Tennesseans would be eligible for coverage after the first year of implementation if the state expanded Medicaid.[6] Additionally, the state would receive federal matching dollars for 90 percent of all expenditures for this population in addition to an estimated $1.1 billion in federal funding from the ARPA expansion incentives.[7]

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[3] Tricia Brooks, *et. al.*, "Medicaid and CHIP Eligibility, Enrollment, and Cost Sharing Policies as of January 2020: Findings from a 50-State Survey, March 26, 2020, Kaiser Family Foundation, https://www.kff.org/medicaid/report/medicaid-and-chip-eligibility-enrollment-and-cost-sharing-policies-as-of-january-2020-findings-from-a-50-state-survey/; Tricia Brooks, *et. al.,* "Medicaid and CHIP Eligibility, Enrollment, and Renewal Policies as States Prepare for the Unwinding of the Pandemic-Era Continuous Enrollment Provision," Kaiser Family Foundation, April 4, 2023, https://www.kff.org/medicaid/report/medicaid-and-chip-eligibility-enrollment-and-renewal-policies-as-states-prepare-for-the-unwinding-of-the-pandemic-era-continuous-enrollment-provision/.

[4] Julie L. Hudson and Asako S. Moriya, "Medicaid Expansion for Adults Had Measurable 'Welcome Mat' Effects on Their Children," *Health Affairs,* September 2017, https://www.healthaffairs.org/doi/10.1377/hlthaff.2017.0347.

[5] Maya Venkataramani, Craig Evan Pollack, & Eric T. Roberts, "Spillover Effects of Adult Medicaid Expansions on Children's Use of Preventive Services," *Pediatrics*, December 2017, https://publications.aap.org/pediatrics/article-abstract/140/6/e20170953/38165/Spillover-Effects-of-Adult-Medicaid-Expansions-on?redirectedFrom=fulltext.

[6] Tennessee General Assembly Fiscal Review Committee, Fiscal Note: SJR 466, January 23, 2018.

[7] Breanna Sharer, "With North Carolina Adopting Medicaid Expansion, a Dwindling Number of States Are Missing Out on Its Economic and Health Benefits," Center on Budget and Policy Priorities, September 27, 2023, https://www.cbpp.org/research/health/with-north-carolina-adopting-medicaid-expansion-a-dwindling-number-of-states-are.

As Tennessee recognized with its extension of postpartum Medicaid coverage to twelve months, the state faces a maternal health crisis. But by failing to cover Medicaid expansion adults, the state has left prospective mothers without access to coverage before pregnancy, which can affect maternal outcomes. In 2019, the uninsured rate among reproductive age women in Tennessee was 13.6 percent, or over 165,000 uninsured individuals.[8] Having health coverage prior to becoming pregnant allows individuals to receive necessary treatments to manage chronic conditions that may be aggravated during pregnancy and begin their pregnancy in better health.

Providing Diaper Supplies to Infants and Toddlers Would Address a Key Health-Related Social Need for Families with Low Incomes

The state is proposing to cover a supply of diapers, 100 per month, for each child under age 2 enrolled in TennCare. We support the goals of Tennessee's request, but as written, improvements are needed, given the proposal's important implications for children in Tennessee and, potentially, across the country.

Diapers are a necessity and an unavoidable expense for families with very young children, regardless of income. But for low-income families, the cost of diapers can be extremely challenging. According to the National Diaper Bank, the average cost of diapers for an infant is $70 to $80 per month.[9] This can account for an upwards of 17 percent of household income for the poorest 20 percent of families. Almost half of the nation's families in 2023 reported diaper need – struggling to provide enough diapers for their child.[10] Inadequate supplies of diapers can result in children going longer than recommended between diaper changes, which can result in diaper dermatitis (i.e., diaper rash), urinary tract infections, and other health conditions that necessitate clinical treatment to resolve. The state's proposal would provide roughly a third to half of the diaper supply families with infants and toddlers need each month in the first two years of life, making an important difference in the wellbeing of those children and families.

CMS defines a health-related social need (HRSN) as an individual-level adverse social condition that when left unmet, can contribute to "higher downstream medical costs [and] worse health outcomes."[11] The need for diapers falls squarely into the HRSN framework. Diaper dermatitis and urinary tract infections resulting from an insufficient supply of diapers are demonstrably worse (and considerably painful) health outcomes for the infants and toddlers. And the cost of visits to primary care providers or emergency rooms to treat these avoidable conditions clearly increases downstream medical costs.

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[8] Maggie Clark, Emma Bargeron, and Alexandra Corcoran, "Medicaid Expansion Narrows Maternal Health Coverage Gaps, But Racial Disparities Persist," Georgetown University Center for Children and Families, September 2021, https://ccf.georgetown.edu/wp-content/uploads/2021/09/maternal-health-and-medex-final.pdf.

[9] National Diaper Bank Network, "What is diaper need?" February 2020, https://nationaldiaperbanknetwork.org/wp-content/uploads/2022/02/NDBN_DiaperNeed_Overview_February_2020.docx.pdf.

[10] National Diaper Bank Network, "The NDBN Diaper Check 2023: Diaper Insecurity among U.S. Children and Families," June 15, 2023, https://nationaldiaperbanknetwork.org/wp-content/uploads/2023/06/NDBN-Diaper-Check-2023_Executive-Summary-FINAL.pdf.

[11] Deputy Administrator Daniel Tsai, "Coverage of Services and Supports to Address Health-Related Social Needs in Medicaid and the Children's Health Insurance Program, Center for Medicaid and CHIP Services Informational Bulletin, November 16, 2023, https://www.medicaid.gov/sites/default/files/2023-11/cib11162023.pdf.

Unanswered Questions about the Design and Operation of the Proposed Demonstration

The state's proposal indicates that "Tennessee will work with CMS to develop policies and procedures for administration and oversight of the proposed diaper benefit." It goes on to say that the benefit will be "operationalized through TennCare's pharmacy benefit" and that TennCare "will work with its Pharmacy Benefit Manager to operationalize this benefit and establish needed processes with appropriate controls." This cursory description leaves many important policy and operational questions unanswered:

1.) The proposal appears to limit points of access to diapers to pharmacies. While pharmacies are one potential source of diapers for low-income Tennessee families, they are not the only sources. Diaper banks (Tennessee has five) and many FQHCs and RHCs are currently operating as the sources of free diapers for many low-income families in Tennessee. Does the state intend that this proposed diaper benefit supplement the efforts of these diaper banks and primary care clinics or supplant them? If the intent is to supplant them, what is the rationale?

2.) Some rural areas in the state may be "pharmacy deserts." Nationally, pharmacy deserts are becoming increasing prevalent, especially in rural areas and low-income neighborhoods where pharmacies have closed.[12] If the state intends to limit access points to pharmacies, how will Medicaid beneficiaries in these desert communities access the diapers that they need? Will these families be effectively excluded from the demonstration altogether by virtue of the area in which they live?

3.) Will children require a prescription for the diaper benefit? If so, how frequently will the prescription need to be refilled? What practitioners will be authorized to prescribe? Will the prescriptions be subject to prior authorization by the managed care organizations (MCOs) with which the state contracts? If so, will the standard for medical necessity be the broad standard that applies to EPSDT benefits to which these children are currently entitled? Will the state require the MCOs to pay for the practitioner visit (whether in person or by telemedicine) necessary for the child to obtain the prescription?

4.) Under the state's proposal, the number of diapers a child may receive in a month from TennCare is limited to 100. How will TennCare track this amount for each beneficiary? Will that amount be reduced in the case of those Medicaid beneficiaries who now obtain free diapers from one of the diaper banks (or one of the FQHCs or RHCs that the diaper banks supply)?

5.) Shelf-stocked diaper boxes are generally not available in increments of 100. How will the state ensure that families receive their full monthly allotment of diapers? Would a family be limited to a smaller box with a number of diapers that is less than 100? Or would pharmacies be responsible for repacking diapers into packages of 100?

[12] Aaron Gregg and Jacyln Pesier, "Drugstore closures are leaving millions without easy access to a pharmacy," The Washington Post, October 22, 2023, https://www.washingtonpost.com/business/2023/10/22/drugstore-close-pharmacy-deserts/#.

6.) Does the state intend to impose copayments or other forms of cost-sharing on the diapers for some or all eligible children? If so, what amounts of copayments or other cost-sharing will the state impose, and how and by whom will these cost-sharing requirements be administered? Given that copayments and other forms of cost-sharing are prohibited with respect to preventive services for all children under age 18 without regard to income, what is the policy rationale for imposing copayments or other cost-sharing on diapers for children 0 to 2? How could this possibly promote the objectives of Medicaid?

7.) How will the state ensure that the prices at which it purchases the diapers on behalf of eligible families are at least as low as the prices that the nonprofit diaper banks in Tennessee currently pay manufacturers for their bulk purchases of diapers? How will the state ensure that its purchases won't have the effect of raising the prices that manufacturers currently charge the Tennessee diaper banks, thereby disrupting their operations and potentially compromising access to the current supply of free diapers?

8.) What administrative fee or markup, if any, will the state (or its Pharmacy Benefit Manager) pay the pharmacies for dispensing the monthly supply of diapers to eligible children? How will this fee (or markup on the diapers, or both) compare to the amount that the state currently pays pharmacists for filling prescriptions for Medicaid beneficiaries?

9.) How will the state pay the PBM for administering the diaper benefit? If the state pays the PBM a service fee, will it be a flat dollar amount that reflects the fair market value for such services? Will the PBM be prohibited from spread pricing, i.e., paying the pharmacies less than the amount the PBM charges the state? Will the state require the PMB to be transparent about the amount of any service fee it receives, the amounts it pays for diapers and the amount of any dispensing fee or markup that the PMB pays to participating pharmacies?

10.) If the demonstration is successful, and the costs associated with treatment of diaper dermatitis and UTIs in children under age 2 in fact decrease following implementation of the diaper benefit, the savings will be realized by the MCOs that currently pay for the physician office visits and emergency department visits that these children would otherwise need to make. Does the state intend to recover those savings from the MCOs?

Additional Demonstration Hypothesis Concerning Utilization of Primary Care for Well-Child Visits

The central purpose of section 1115 demonstrations is to test hypotheses relating to policy changes in the Medicaid program that will potentially improve outcomes for beneficiaries. The state identifies two such hypotheses in connection with its proposal to cover diapers for children under 2. The first is that costs associated with treatment of diaper rash/diaper dermatitis in children under age 2 will decrease following implementation of the diaper benefit. The second is that costs associated with treatment of UTIs in children under age 2 will decrease following implementation of the diaper benefit. In both cases, costs would include physician office visits, emergency department visits, and prescriptions). We suggest adding a third hypothesis: that utilization of primary care for well-child visits will increase following implementation of the diaper benefit.

This third hypothesis is dependent on inclusion of primary care clinics as well as pharmacies in the system for distribution of the diapers. In our view, the pharmacy network is too narrow in scope

to reach all the children and families who need the diaper benefit. It is our understanding that currently, a number of FQHCs and Rural Health Clinics in Tennessee distribute diapers supplied to them by diaper banks in the state. We believe that this demonstration should build on that existing distribution network rather than ignoring it, not just to reach more children, but also to test whether the availability of diapers at these primary care sites will incentivize parents to bring children in for well-child visits.

Pediatricians and family practitioners should have frequent touchpoints with children in their first two years of life. The American Academy of Pediatrics periodicity schedule currently recommends ten well-child visits before a child turns two.[13] Based on data from the Child Core Set reflecting calendar year 2021, only 61 percent of children in Tennessee received six or more well-child visits within the first 15 months of life (the AAP recommendation is nine visits during this period).[14] Our hypothesis is that the diaper benefit, if implemented through FQHCs and Rural Health Clinics among other venues, could improve the state's performance on that metric for children enrolled in Medicaid. We believe this hypothesis is well worth testing, given the known benefits of access to care for children in Medicaid.[15]

Expanding Diaper Benefit to Fully Address Diaper Need-Related Conditions

Tennessee's proposal for a diaper benefit has potential implications for national Medicaid policy for children 0 to 3. As such, demonstrating the value of the benefit needs to be done under conditions that enable an effective evaluation. To this end, CMS and the state should consider whether the diaper benefit should be coupled with a supply of wipes and diaper cream.

Having a sanitary material to clean after soiled diapers is needed to prevent diaper rash and other diaper-related illnesses. Additionally, like diapers, parents are often required to provide wipes for their child to participate in childcare programs, as they are part of the recommended diapering process for childcare settings.[16] And when a child does experience diaper rash (an inevitable occurrence for most young children), diaper cream protects the skin from irritation and can prevent it from worsening to where medical interventions are needed. Without these additional supplies, the result of the experiment may be difficult to evaluate, since diapers may be necessary (and thus helpful) but not *sufficient* to achieve the hypothesized benefits.

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[13] "Recommendations for Preventative Pediatric Health Care," American Academy of Pediatrics and Bright Futures, April 2023, https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf.

[14] "2022 Child and Adult Health Care Quality Measures" Center for Medicare and Medicaid Services, September 2023, https://data.medicaid.gov/dataset/dfd13757-d763-4f7a-9641-3f06ce21b4c6.

[15] Edwin Park, Joan Alker, and Alexandra Corcoran, "Jeopardizing a Sound Investment: Why Short-Term Cuts to Medicaid Coverage During Pregnancy and Childhood Could Result in Long-Term Harm," The Commonwealth Fund, December 8, 2020, https://www.commonwealthfund.org/publications/issue-briefs/2020/dec/short-term-cuts-medicaid-long-term-harm.

[16] Center for Disease Control, "Diaper Changing Steps for Childcare Settings," July 5, 2022, https://www.cdc.gov/hygiene/childcare/childcare.html; Tennessee Department of Human Services, "Tennessee Diapering Process," August 1, 2012, https://www.tn.gov/content/dam/tn/human-services/documents/Tennessee%20Diapering%20Process%20Handout%20revised.pdf.

Medical Care Advisory Committee Review

In other states, the Medicaid agency would have submitted an important initiative like the proposed diaper benefit to its Medical Care Advisory Committee, which would have provided valuable input that would have enabled the agency to anticipate and address the operational concerns we have raised here. Tennessee did not do so, because it does not maintain a MCAC, as it is required to by federal regulation at 42 CFR 431.12. The TennCare demonstration, as approved by CMS, does not waive this requirement (nor would it promote the objectives of Medicaid to do so), and the state does not request a waiver of this requirement in this proposed amendment. It has simply chosen not to comply, and has successfully done so with no apparent consequence. We urge that CMS, in approving this amendment, require the state to come into compliance with the requirement for standing up an MCAC within six months.

Conclusion

Our comments include numerous citations to supporting research, including direct links to the research, for HHS's benefit in reviewing our comments. We direct HHS to each of the studies cited and made available to the agency through active hyperlinks, and we request that the full text of each of the studies cited, along with the full text of our comments, be considered part of the administrative record in this matter for purposes of the Administrative Procedure Act.

Thank you for the consideration of our comments. If you would like any additional information, please contact Joan Alker (jca25@georgetown.edu) or Allison Orris (aorris@cbpp.org).