September 9, 2021

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

Submitted via Online Portal

RE: DREDF Comments on Approved TennCare III Demonstration

Dear Secretary Becerra:

The Disability Rights Education and Defense Fund ("DREDF") appreciate the opportunity to provide comment on the approved special terms and conditions ("STCs") of the TennCare III Demonstration. DREDF has serious concerns that TennCare III does not meet the requirements of Section 1115 of the Social Security Act and it will have a devastating impact on access to health care for and health outcomes experienced by low-income Tennesseans with disabilities.

DREDF is a national cross-disability law and policy center that protects and advances the civil and human rights of people with disabilities through legal advocacy, training, education, and development of legislation and public policy. We are committed to increasing accessible and equally effective healthcare for people with disabilities and eliminating persistent health disparities that affect the length and quality of their lives. DREDF's work is based on the knowledge that people with disabilities of varying racial and ethnic backgrounds, ages, genders, and sexual orientations are fully capable of achieving self-sufficiency and contributing to their communities with access to needed services and supports and the reasonable accommodations and modifications enshrined in U.S. law. In particular, DREDF has significant experience in Medicaid law and policy, given that disabled individuals disproportionately live in poverty and depend on health care services and supports. Medicaid is by far the largest publicly-funded provider of long-term services and supports, and thus is a very significant or sole source of essential health care for many people with disabilities.

DREDF unequivocally opposes the approved TennCare III Demonstration, which permitted TennCare to change its financial structure to an inflexible block grant. The approval creates new barriers to health care for hundreds of thousands of low-income people, including people with disabilities. It will result in large health coverage losses, thus undermining the express purposes of the Medicaid program. Under Section 1115 of the Social Security Act ("SSA"), which only

permits the HHS Secretary to approve waiver applications that promote the objectives of Medicaid, the approval will not stand. We urge you to rescind the approval in order to avoid the harms that the program changes will inflict on low-income Tennesseans.

I. The TennCare III Demonstration Is Unlawful Under Section 1115 of the Social Security Act

Section 1115 of the SSA gives the HHS Secretary authority to waive a State's compliance with certain requirements of the Medicaid Act, but only for an "experimental, pilot, or demonstration project which . . . is likely to assist in promoting the objectives" of the Medicaid Act. 42 U.S.C. § 1315(a). The express purpose of the Medicaid Act is to enable each State "to furnish [] medical assistance on behalf of [individuals] whose income and resources are insufficient to meet the costs of necessary medical services" and to provide "rehabilitation and other services to help such families and individuals attain or retain capability for independence or self-care." *Id.* § 1396-1.

By its own terms, the TennCare III Demonstration applies to its "core population," which includes the children, adults, elderly, and blind and disabled eligibility categories. These categories encompass nearly all of the 1.4 million TennCare enrollees. Permanent changes that affect such a significant number of low-income Tennesseans cannot be called a "pilot," nor "experimental"—except in the euphemistic sense of lacking any documented connection between the waiver's proposed actions and achieving the Medicaid Act's stated purpose.

The TennCare III Demonstration does not promote, and indeed undermines, the objectives of the Medicaid program by decreasing access to "medical assistance" and "other services" that individuals, and in particular people with disabilities, depend on "for independence and self-care." *See* 42 U.S.C. § 1396-1. By definition, TennCare III's block grant caps the amount of funding that the State of Tennessee receives from the federal government. Under the prior federal matching structure, the federal funding that TennCare received fluctuated to meet the needs of TennCare enrollees and the program's correlated expenditures. By foregoing this financing structure in favor of a block grant, the State is artificially and unnecessarily limiting the federal contributions that it needs to respond to unpredictable expenditures—meaning that the State will be forced to either raise taxes to cover those additional costs by itself (a scenario that seems unlikely), or restrict access to TennCare services.

Indeed, with the COVID-19 pandemic, we witnessed firsthand the State of Tennessee's response to rising Medicaid costs. In 2020, faced with increased Medicaid enrollment and care utilization in light of the pandemic, Tennessee covered costs by "revers[ing] plans to seek a federal waiver to provide Medicaid coverage for a full year after a woman gives birth (instead of 60 days)" and "revers[ing] plans to extend dental coverage for pregnant and postpartum women,

and to expand access to services for people with intellectual and developmental disabilities."[1] Tennessee's rollbacks during the pandemic both reveal its approach to rising Medicaid costs, and emphasize the reality of health care expenditures: public health emergencies and other unpredictable events happen, and Medicaid programs need flexibility to account for and properly respond to such occurrences. A block grant is antithetical to this reality.

The predictable outcome of the TennCare III Demonstration is not what Congress intended in creating the Medicaid program. It will surely serve to decrease access to health care for low-income Tennesseans and thus should never have been approved via a Section 1115 waiver. *See* 42 U.S.C. §§ 1315(a), 1396-1. We urge you to rescind its approval immediately.

II. Disabled Enrollees Will Be Disproportionately Harmed by the TennCare III Demonstration

A. TennCare III Will Restrict Access to Healthcare Services for Disabled Enrollees

The TennCare III Demonstration applies its block grant restructuring to the "core population" of TennCare enrollees, which explicitly includes people who are eligible for TennCare on the basis of being blind or disabled. While the State has attempted to carve out individuals who are dually eligible for both Medicaid and Medicare (which would include many people with disabilities) and people with intellectual disabilities covered by Tennessee's separate 1915(c) waiver,[2] even these carved-out populations cannot be shielded from the harms that will result when TennCare can no longer afford to fund its entire program. Regardless, there are many people with disabilities who are not dually enrolled or covered by the separate 1915(c) waiver, who are explicitly included within this financial restructuring. And for these individuals, many of whom utilize more health care and thus produce higher expenditures for TennCare, their eligibility and access to services will be at risk.

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[1] Aviva Aron-Dine et al., *With Need Rising, Medicaid Is at Risk for Cuts*, CENTER ON BUDGET & POLICY PRIORITIES (July 22, 2020), https://www.cbpp.org/research/health/with-need-rising-medicaid-is-at-risk-for-cuts (citing STATE OF TENNESSEE, Conference Committee Report on House Bill No. 2922 / Senate Bill No. 2931 / CC0023, http://www.capitol.tn.gov/Bills/111/CCRReports/CC0023.pdf; Shannon Smith, *TennCare PostPartum Care Expansion Cut from Revised State Budget*, WBIR (June 8, 2020), https://www.wbir.com/article/life/tenncare-postpartum-care-expansion-cut-from-revised-state-budget/51-8587612b-7c73-4566-b5e2-be7f524ace0d).

[2] For further discussion on the impact of this proposal on these populations, *see infra* Section II.B.

There are approximately 300,000 individuals who qualify for TennCare on the basis of disability.[3] For these individuals, equal and sufficient access to TennCare's health care services and supports is crucial to ensuring that they can maintain employment, pursue education, raise their families, and participate in their communities. Benefits as simple as a wheelchair, physical therapy, prescription medications, cognitive behavioral therapy, or an accurate glucose monitor are essential to ensuring that people with chronic conditions and disabilities can live and function independently. Without sufficient access to these benefits, or eligibility for the health program that covers them, many individuals will be denied equal access to society.

Take, for example, coverage of mobility devices such as a wheelchair. For people with mobility disabilities, access to a working and properly fitted wheelchair can be a gateway to full participation in their communities. Without health insurance coverage of appropriate equipment, people are often homebound—unable to work, go to school, or even get out of bed. Others may be forced to obtain lesser devices than what they medically need, putting their health and safety at risk. Still others face institutionalization because they cannot function in their own homes.

The health care benefits that TennCare offers to people with disabilities are critical. However, they are also sometimes expensive, which places disabled TennCare enrollees in a precarious position—they may be a prime target for a reduction of services *when* the State of Tennessee exceeds the block grant cap. TennCare's "disabled" enrollment category encompasses approximately 19 percent of all TennCare enrollees,[4] yet accounts for approximately 38 percent of all expenditures.[5] As the highest cost group of all of the enrollment categories, it is easy to see how their eligibility and coverage would be an early target for the State when they are forced to make cuts to TennCare or modify their spending priorities. Perversely then, the group of individuals that most needs access to health care services for daily functioning will be put at the highest risk for reduction of services.

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[3] *See* KAISER FAMILY FOUND., *Medicaid Enrollees by Enrollment Group* (last visited June 10, 2021), https://www.kff.org/medicaid/state-indicator/distribution-of-medicaid-enrollees-by-enrollment-group/.

[4] For Fiscal Year 2014, there were 284,100 TennCare enrollees who qualified for the program on the basis of disability, out of a total of 1,526,200 enrollees. KAISER FAMILY FOUND., *Medicaid Enrollees by Enrollment Group* (last visited June 10, 2021), https://www.kff.org/medicaid/state-indicator/distribution-of-medicaid-enrollees-by-enrollment-group/.

[5] TennCare enrollees who qualified on the basis of disability account for $3,572,566,300 in spending, out of a total $9,310,791,500 for Fiscal Year 2014. KAISER FAMILY FOUND., *Medicaid Spending by Enrollment Group* (last visited June 10, 2021), https://www.kff.org/medicaid/state-indicator/medicaid-spending-by-enrollment-group/.

The HHS Secretary only has authority to grant a Section 1115 waiver when the program "is likely to assist in promoting the objectives" of the Medicaid Act, which are, in part, "to furnish [] medical assistance" and to provide "services to help [individuals] attain or retain capability for independence or self-care." 42 U.S.C. §§ 1315(a), 1396-1. The approved TennCare III Demonstration does not promote these goals. Instead, it will disproportionately impact disabled enrollees and risk decreasing access to the medical assistance that they rely on to maintain health, independence, and livelihoods. Thus, the approved waiver must be rescinded.

B. TennCare III Will Negatively Impact the Long-Term Services and Supports ("LTSS") That Many People with Disabilities Need

Many people with disabilities rely on long term services and supports to support their independent, community-based living. Within TennCare, LTSS is provided through two programs: CHOICES and Employment and Community First ("ECF") CHOICES. The CHOICES program serves adults with disabilities, while ECF CHOICES serves people with intellectual and developmental disabilities. TennCare III included both CHOICES and ECF CHOICES within its block grant. This will have disastrous effects on people who rely on LTSS for self-sufficiency.

Both CHOICES and ECF CHOICES are projected to grow significantly in the coming years. As the "baby boomer" generation ages, the number of adults who will need LTSS through CHOICES is anticipated to expand considerably. Likewise, there is already a wait list of approximately 7,000 adults and children for the ECF CHOICES program. With TennCare restructured into a block grant, it will make it far more difficult to provide LTSS services to the expanding population of people who need it. Block grant funding makes it extremely difficult for the TennCare program to meet the growing LTSS needs of low-income Tennesseans. All Medicaid enrollees will be subject to quantitative or qualitative service cuts that will place them at greater risk of institutionalization, waiting lists for the growing programs, or both.

C. TennCare III Will Negatively Impact People Dually Eligible for Medicaid and Medicare and People with Intellectual Disabilities Covered Under the Separate 1915(c) Waiver

The TennCare III Demonstration provides for a few exemptions to its restructuring, including "[e]xpenditures 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" and "services provided to individuals with intellectual disabilities under the authority of a separate 1915(c) waiver."

First, this language is vague and does not make clear precisely who or what services are exempt from the proposed financial restructuring. For dual eligibles, the language could be read to

exempt only “partial duals,” i.e., people enrolled in the Medicare Savings Program but not eligible for any other Medicaid benefits, instead of people who also receive full Medicaid benefits. Similarly, the approval uses differing language throughout to describe the 1915(c) population that is exempt. It remains unclear which populations Tennessee is attempting to carve out, and without such necessary specificity, such a structure will produce unpredictable results.

Second, even reading the exemptions broadly, purportedly “exempt” individuals will still be negatively impacted by the block grant restructuring. While TennCare III may not directly limit eligibility and coverage for these specific populations of seniors and people with disabilities, reduced spending to the overall TennCare program (which will inevitably happen when the program hits the cap) will still impact these populations. For example, if the State reduces provider reimbursement rates (or even if its unable to make an annual adjustment to increase them), then fewer health care providers will accept TennCare, meaning decreased access for all enrollees.[6]

D. TennCare III Will Decrease Access to Needed Prescription Drugs

The TennCare III Demonstration additionally adopts a commercial-style closed formulary, whereby as few as only one drug may be available per therapeutic class. This is a departure from TennCare’s traditional alliance with the federal Medicaid drug rebate program, and it should be immediately rescinded.

Many people with chronic conditions or disabilities rely on prescription drugs to manage symptoms associated with their disability or health conditions that they may have. A formulary that allows for only one drug per class is simply insufficient to meet the needs of many TennCare enrollees with disabilities. Prescription drugs in the same therapeutic class can still have different mechanisms of action, drug interactions, or side effects depending on the individual, their condition(s), and their other necessary medications. Take, for example, prescription medications used to treat disabling depression, anxiety, or other mental health conditions. One antidepressant, for example, may actually exacerbate an individual’s condition or cause suicidal thoughts; while a different antidepressant in the same class may reduce the symptoms of their disabling mental health condition, thus allowing them to better function. Limiting a formulary to only one option is shortsighted and against all generally accepted clinical guidelines.

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[6] JUSTICE IN AGING, *Medicaid Funding Caps Would Harm Older Americans* (Feb. 2017), https://www.justiceinaging.org/wp-content/uploads/2017/02/Medicaid-Funding-Caps-Would-Harm-Older-Americans.pdf.

Further, there is no mechanism of appeal built into the TennCare III formulary structure, should an enrollee need or their treating physician determine that an alternative prescription medication is required for the individual. Thus, for example, if an individual has relied on a specific medication for years, yet that medication is no longer covered under the new formulary, they would have no mechanism of recourse. This lack of attention to detail highlights, yet again, how ill-conceived the TennCare III Demonstration was.

E. Eliminating Retroactive Coverage Will Decrease Access to Health Care and Increase Medical Debt for Vulnerable Tennesseans

HHS should also withdraw the waiver permitting Tennessee to eliminate retroactive coverage for Medicaid beneficiaries. There is nothing experimental about waiving retroactive coverage. Numerous states, including Tennessee, have been allowed to ignore the requirement since the 1990s. 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 federal courts have said that would be improper use of Section 1115.[7]

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.[8] Without retroactive coverage, Medicaid beneficiaries forgo vital health care and/or incur significant medical expenses. This is especially true for Tennesseans with disabilities, many of whom rely on costly health care services and devices in order to function, go to work, pursue education, and raise their families.

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.[9] 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 rebuilding a strong middle class.

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

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

[9] 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.

Waiving retroactive coverage also raises uncompensated care costs for hospitals and other safety-net health care providers. For example, 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"[10] Tennessee cannot afford to lose additional hospitals. Since 2010, 16 hospitals – 13 of them in rural areas – have closed their doors.[11]

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.[12]

In the approved TennCare III Demonstration, HHS 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 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.

III. Length of Approval

If HHS does allow the TennCare III Demonstration 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

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[10] 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.

[11] *Rural Hospital Viability*, TENN. HOSPITAL ASS'N, https://tha.com/focus-areas/small-and-rural/rural-hospital-viability/ (last visited August 15, 2021).

[12] *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.

and for the period necessary" to enable the state to carry out its experiment.[13] Congress did not enact Section 1115 to allow for 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).

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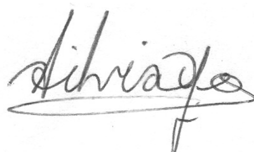
The TennCare III Demonstration will disproportionately harm the health and livelihood of people with disabilities. For this reason, as described in detail above, strongly urge HHS to immediately rescind its approval.

Thank you for considering our comments. Please do not hesitate to contact us if you have any questions about the above.

Sincerely,



Carly A. Myers
Staff Attorney

Silvia Yee
Senior Staff Attorney

[13] 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 dual-eligibles)).