

December 24, 2019

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: Modified Block Grant and Accountability

Dear Secretary Azar:

Justice in Aging, The Center for Medicare Advocacy, the Medicare Rights Center, and the National Academy of Elder Law Attorneys appreciate the opportunity to comment on Tennessee's proposed Amendment 42 to the TennCare II Demonstration under section 1115 of the Social Security Act. For the reasons discussed below, we strongly oppose the proposal which would eliminate critical accountability elements and convert TennCare's federal funding for its core populations and services to a modified block grant; we urge the Department of Health & Human Services (HHS) to reject it.

Justice in Aging is an advocacy organization with the mission of improving the lives of low-income older Tennesseans and older adults nationwide. We use the power of law to fight senior poverty by securing access to affordable health care, economic security and the courts for older adults with limited resources, particularly populations that have traditionally lacked legal protection such as women, people of color, LGBTQ individuals, and people with limited English proficiency. We have decades of experience with Medicare and Medicaid and have worked extensively with advocates who represent low-income older Tennesseans. Justice in Aging conducts trainings and engages in advocacy regarding Medicare and Medicaid, provides technical assistance to attorneys in Tennessee and across the country on how to address problems that arise under these programs, and advocates for strong consumer protections at both the state and federal level.

The Center for Medicare Advocacy, founded in 1986, is a national, non-partisan education and advocacy organization that works to ensure fair access to Medicare and to quality healthcare. At the Center, we educate older people and people with disabilities to help secure fair access to necessary health care services. We draw upon our direct experience with thousands of individuals to educate policy makers about how their decisions affect the lives of real people. At the Center, we focus on matters regarding access to health care for lower-income people, including the rights of those dually eligible for Medicare and Medicaid. Additionally, we provide legal representation to ensure that people receive the health care benefits to which they are legally entitled, and to the quality health care they need.

Medicare Rights Center is a national, nonprofit organization that works to ensure access to affordable health care for older adults and people with disabilities through counseling and advocacy, educational programs, and public policy initiatives. Medicare Rights provides services and resources to three million people with Medicare, family caregivers, and professionals each year. Through our National Helpline, we hear daily from people who are dually eligible for Medicare and Medicaid and help them overcome enrollment issues and barriers in access to care, including bureaucratic hurdles.

The National Academy of Elder Law Attorneys (NAELA) is a national, non-profit association comprised of 4,500 attorneys who concentrate on legal issues affecting seniors, people with disabilities, and their families. The mission of NAELA is to establish NAELA members as the premier providers of legal advocacy, guidance, and services to enhance the lives of individuals with disabilities and people as they age. NAELA has chapters in 32 states, including Tennessee. NAELA's Tennessee members counsel individuals on issues of TennCare eligibility and services.

We urge HHS to reject this proposal because of the harms it would cause to Tennesseans who rely on Medicaid to access health care and long-term services and supports, including older adults and people with disabilities who are dually eligible for Medicare and Medicaid. Tennessee is requesting broad, unchecked authority and federal funding to fundamentally alter its Medicaid program. As a threshold matter, HHS should not consider this proposal as an amendment to the state's existing 1115 TennCare demonstration program because it would not simply amend but completely overhaul that demonstration and therefore virtually the state's entire Medicaid program. Rather, HHS should treat this application as a new demonstration program, which would be in line with the Government Accountability Office's recent recommendations on ensuring transparency of proposals for Medicaid demonstrations.<sup>1</sup>

We also urge HHS to reject the proposal because it is too vague to allow for our organizations to meaningfully comment on the proposal's impact on older Tennesseans and individuals dually eligible for Medicaid and Medicare. Finally, we request that HHS extend the public comment period because the Centers for Medicare & Medicaid comment site has been blocking/deterring comments from the public for several days during an already limited comment period interrupted by two federal holidays. The remainder of our comments address our opposition to the waiver amendment as impermissible under federal law, not promoting the objectives of the Medicaid program, and harmful to older adults and people with disabilities.

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<sup>1</sup> Government Accountability Office, "Medicaid Demonstrations: Approvals of Major Changes Need Increased Transparency" GAO 19-315 (April 2019), <https://www.gao.gov/assets/700/698608.pdf>.

I. The Proposal Is Impermissible under Federal Law and Would Not Promote the Medicaid Program’s Objectives.

Section 1115 of the Social Security Act requires an “experimental, pilot, or demonstration project ... [that] is likely to assist in promoting the objectives” of the Medicaid program.<sup>2</sup> “Reconceiv[ing] the partnership between the state and federal government” as the proposal states is simply not permissible under this standard. First, Medicaid demonstration waivers cannot be used to alter the basic funding structure of the program because the sections of the law governing funding cannot be waived.<sup>3</sup> Changes to how Medicaid is financed must be made by Congress. Yet Congress recently voted against legislation that would have provided states with capped funding instead of the existing federal matching funds. Tennessee should not be allowed to bypass Congress and federal law. Second, the state’s request for a waiver of all managed care regulations is not allowed under Section 1115 authority because it both exceeds the language limiting waivers “to the extent . . . [the Secretary] finds necessary” to enable the state to carry out the project, and because the managed care regulations are not among the provisions that can be waived. Similarly, Section 1115 does not allow waiver of the provision that would allow the state to create a closed prescription drug formulary.<sup>4</sup>

Furthermore, demonstration waivers are allowed only if they are “likely to assist in promoting the objectives” of the Medicaid program.<sup>5</sup> The Amendment 42 proposal fails to meet this standard. As confirmed by the court multiple times,<sup>6</sup> Medicaid’s primary objective is to furnish medical assistance to low-income persons.<sup>7</sup> Yet the state’s application does not address how block granting the bulk of the program will advance providing coverage to Tennesseans who cannot otherwise afford coverage. In fact, as discussed more fully below, capping funding and eliminating managed care regulations would lead to cuts in coverage and therefore undermine Medicaid’s main objective. Much of the discussion of the purpose of the Amendment is around saving the state money, which is not an objective of the Medicaid program. Moreover, there are no guardrails to ensure that any potential “savings” from

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<sup>2</sup> 42 U.S.C. § 1315(a).

<sup>3</sup> 42 U.S.C. § 1315(a) specifies which requirements can be waived. The list does not include 42 U.S.C. 1392b, which governs financing of Medicaid. In addition, CMS recently acknowledged that it lacks the legal authority to change a state’s federal Medicaid matching rate in a letter to North Carolina: “Section 1115(a)(i) waiver authority extends only to provisions of section 1902 of the Act, and does not extend to provisions of section 1905 of the Act, such as section 1905(b). Nor is CMS able to grant the state’s request by providing expenditure authority under section 1115(a)(2)(A) of the Act. Section 1115(a)(2)(A) only permits state expenditures to be regarded as federally matchable. It does not allow applicable federal match rates to be altered.” Centers for Medicare & Medicaid Services, North Carolina Medicaid Reform Demonstration Approval (Oct. 19, 2018), [www.medicare.gov/Medicare-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/nc/Medicaid-Reform/nc-medicare-reform-demo-demo-appvl-20181019.pdf](http://www.medicare.gov/Medicare-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/nc/Medicaid-Reform/nc-medicare-reform-demo-demo-appvl-20181019.pdf).

<sup>4</sup> Section 1927 is not waivable under Section 1115. See *PhRMA .v. Thompson*, 251 F.3d 219, 222 (D.C. Cir. 2001). CMS has also rejected a closed formulary proposal in Massachusetts and should do the same here.

<sup>5</sup> 42 U.S.C. § 1315(a).

<sup>6</sup> See, e.g., Memorandum Opinion, *Stewart v. Azar*, Civil Action No. 1:18-cv-152 (JEB) (June 29, 2018).

<sup>7</sup> See 42 U.S.C. § 1396-1.

cutting federal funding through a block grant would be used to provide coverage to low-income Tennesseans.

II. Elimination of Beneficiary Protections Would Harm Older Adults & People Dually Eligible for Medicare & Medicaid

Tennessee is asking for authority to waive many important federal beneficiary protections that apply across the TennCare program.<sup>8</sup> For example, it requests authority to “operate a managed care program that does not comply with the requirements of 42 [Code of Federal Regulations] Part 438.” Because Tennessee delivers services, including long-term services and supports, to virtually all of its Medicaid enrollees through managed care plans, this deregulation of managed care puts all Medicaid enrollees at serious risk of harm, including more than 260,000 Tennesseans dually eligible for Medicare and Medicaid.<sup>9</sup>

This means that older adults and people with disabilities, including duals, could lose access to covered services because managed care plans could limit their provider networks, or could deny or make it difficult to get authorization for necessary but costly treatments. The state would no longer be required to ensure actuarial soundness and could set plan payment rates that are below what it costs to provide all the necessary care to enrollees. This would force the plans to ration care, which is a particular concern for people needing long-term services and supports who already face challenges getting the full range of services and the number of personal aide hours they need. Yet the state wants to do away with the managed long-term services and supports regulations that are aimed at improving quality through network adequacy standards, care transition and coordination requirements, and other accountability measures. Even more, under Tennessee’s proposal there would be no federal oversight or other mechanism to ensure adequate access to care.

This lack of oversight and standards would be especially problematic for Tennesseans living in rural areas. Some providers in rural areas already do not accept TennCare because of low reimbursement rates—eliminating actuarial soundness standards would exacerbate this problem. Moreover, if services like transportation that Medicare does not cover are cut and provider networks are weakened, older adults and others who rely on TennCare to get to the doctor will not get the care and services they need.<sup>10</sup> When access to care is compromised, so is people’s health and financial well-being. Older

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<sup>8</sup> Despite carving out dually eligible individuals and certain other populations from the block grant funding calculation, the state explicitly acknowledges that its proposals to eliminate many federal regulations and accountability measures are intended to apply to the entire TennCare population. TennCare II Amendment 42 Application at 39-40.

<sup>9</sup> Centers for Medicare & Medicaid Svcs., MMCO Statistical & Analytic Reports: Monthly Enrollment Snapshots, *available at* <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Analytics>.

<sup>10</sup> See 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?eType=EmailBlastContent&eld=443776c8-cb7a-4c89-991a-85ede6f99509>.

adults who are already living on limited fixed incomes cannot afford to pay bills for necessary care and services that the Medicaid plan refused to cover and would be faced with impossible choices like paying their utility bill or paying for transportation to a doctor who may be hundreds of miles away.

Tennessee also requests broad, undefined authority to “modify enrollment processes, service delivery systems, and comparable program elements without the need for a demonstration amendment.” The application does not identify the statutory source of the requested authority or provide adequate information about the scope of the changes it is proposing, making it impossible to assess how enrollees would be impacted. Nonetheless, we know that federal standards that apply to these areas of program administration contain essential enrollee protections and measures to ensure the state uses federal funds appropriately. For example, federal requirements prohibit states from requiring enrollees to submit unnecessary paperwork, in-person interviews, or overly frequent redeterminations. The state should not be given broad, undefined authority to change these requirements without federal review to ensure their processes are not creating red tape that prevents eligible enrollees from getting or maintaining coverage.

In addition, Tennessee requests authority to add benefits without going through the federal approval process. Federal approval ensures that benefits are provided statewide, are of sufficient amount, duration or scope, and are not provided in a way that discriminates based on a person’s illness or diagnosis. Without this review, Tennessee could favor certain providers through geographic restrictions on benefits or put arbitrary limits on the benefits it decides to provide. Once again, this type of unchecked authority would allow Tennessee to make changes that would harm the entire TennCare population, particularly older adults and others with greater healthcare needs.

Finally, the state is requesting authority to implement a closed formulary for its prescription drug benefit as commercial plans do and deny access to new potentially life-saving treatments. While TennCare enrollees who are dually eligible for Medicare get their prescription drug coverage through Part D, we are deeply concerned that older adults who are on TennCare before they become eligible for Medicare would not have access to the full range of prescription drugs they may need. This is unwise policy for several reasons. First, lack of access to treatments leads to poorer health outcomes, which will result in increased costs elsewhere, including unnecessary hospitalizations and other more costly care paid for by the federal government when those individuals become eligible for Medicare. For example, 89% of adults over 65 and 75% of people aged 50-64 report taking prescription drugs, compared to 38% of those aged 18-29.<sup>11</sup> By limiting prescription drug access, the state is likely to reduce compliance with needed medications for people approaching Medicare age, forcing them to jump through administrative hoops to get the drugs they need to support their diagnoses or to go without. Lack of access to medications can, in turn, lead to health risks and increased costs for the

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<sup>11</sup> Ashley Kirzinger, et al., Kaiser Family Foundation, “Data Note: Prescription Drugs and Older Adults,” Kaiser Family Foundation (Aug. 09, 2019), <https://www.kff.org/health-reform/issue-brief/data-note-prescription-drugs-and-older-adults/>.

health care system. Several studies have shown how medication non-adherence leads to death, hospitalization, and cost increases in the tens or hundreds of billions of dollars.<sup>12</sup>

Second, we know from our experience with Part D that limited formularies and exceptions processes do not work well and can delay access to medication. People with chronic and serious health conditions disproportionately rely on Medicaid and often need access to more than one medication per drug class. Under Tennessee’s proposal, these individuals would be forced to navigate a cumbersome exceptions process despite the devastating, even life-threatening, consequences any delay in access might cause.

### III. Capping Federal Medicaid Funding will Harm Older Adults & People Dually Eligible for Medicare and Medicaid

Tennessee’s waiver application and proposed structure of the block grant raise serious concerns that the state has not thought through the impact they would have on every single Medicaid population, including those who are dually eligible for Medicaid and Medicare. The state intends to exclude all *expenditures* on behalf of dually eligible beneficiaries from the block grant. Yet the state would deregulate the managed care organizations that deliver duals’ care and, as discussed below, be highly incentivized to cut spending across the TennCare program under the block grant. This means the decisions the managed care organizations and the state make under capped funding will impact access to necessary care for the entire TennCare population, including dually eligible individuals.

Capping federal Medicaid funding to the state cannot be accomplished without harming all Tennesseans who rely on TennCare currently or may one day need TennCare. Unlike the existing funding structure that responds to need by guaranteeing a federal match for every dollar the state spends, the proposed modified block grant will artificially limit the federal contribution and make it impossible for TennCare to fully respond to future needs, both those that are expected and unexpected. It will inhibit TennCare’s capacity to serve older adults and people with disabilities not included in the block grant, especially as needs increase with the unprecedented growth of the older adult population<sup>13</sup> and the simultaneous increases in senior poverty.<sup>14</sup> Moreover, Tennessee’s proposal provides no way to cover additional unanticipated costs such as public health crises (e.g., the opioid epidemic) or advances in treatment (e.g., new drug therapies). Because the state cannot go into debt

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<sup>12</sup> Meera Viswanathan, et al., “Interventions to Improve Adherence to Self-administered Medications for Chronic Diseases in the United States: A Systematic Review,” *Ann Intern Med.* 2012;157(11):785-795, <https://annals.org/aim/fullarticle/1357338/interventions-improve-adherence-self-administered-medications-chronic-diseases-united-states>.

<sup>13</sup> By 2030, nearly 1 in 5 Tennesseans will be age 65 or older. Univ. of Virginia Weldon Cooper Ctr. for Public Service, *Observed & Projected Population Proportion at 65+ for the U.S. and the States, 2010-2040*, <https://demographics.coopercenter.org/national-population-projections>.

<sup>14</sup> Justice in Aging, *Senior Poverty*, <https://www.justiceinaging.org/senior-poverty/>

to cover growing and changing needs of its TennCare population, it will be forced to cut services, restrict eligibility, or both.<sup>15</sup>

In addition, the proposed structure would nearly double the amount of money the state gets to keep if it reduces spending. So, although all states have a financial incentive to make their Medicaid programs efficient, Tennessee is proposing to create a windfall for itself and illegally shift costs onto the federal government. This structure is certain to push the state to spend less. In addition, Tennessee says it needs a waiver from the federal standards discussed above to mitigate the financial risk of the block grant—indicating that it would offset financial risk by cutting services and restricting eligibility.

We disagree with the state’s assertion that the block grant is not expected to have a material impact on enrollment. While the proposal itself may have few provisions directly addressing eligibility—making it difficult to assess and comment on the impact—we know that capped funding in combination with growing needs and the state’s ability to collect savings if it spends under the capped allotment will necessitate limiting eligibility in the future across the program. As discussed above, Tennessee is requesting broad authority to change eligibility standards and processes without federal review and has provided no guarantee that these inevitable restrictions on eligibility will not impact populations the state is asserting are carved out from the proposed block grant. In fact, because dually eligible individuals, who comprise 99% of the over 65 TennCare population,<sup>16</sup> utilize more care and require higher spending, restricting eligibility for these populations would be the easiest way to make up for funding shortfalls from the block grant. So, while the state is intending to carve out individuals dually eligible for Medicare and Medicaid and therefore the vast majority of seniors and many people with disabilities from the capped funding, these populations cannot be carved out from the harm that will result when TennCare can no longer afford to provide coverage and services to its entire Medicaid population.

Finally, although Tennessee suggests various improvements it could make to TennCare, it makes no commitment to implementing any of them. There would be no federal oversight of how it spends the “savings” from spending less than the caps and the application indicates it could use this federal money to pay for state-funded benefits that are outside of the Medicaid program. Moreover,

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<sup>15</sup> 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?eType=EmailBlastContent&eld=443776c8-cb7a-4c89-991a-85ede6f99509>.

<sup>16</sup> Multiple data sources show both nationwide and in Tennessee specifically, nearly all seniors are enrolled in Medicare as are an even higher percentage of seniors who are enrolled in Medicaid. 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: 99% of Tennessee Medicaid enrollees age 65+ that year were dually enrolled in Medicare. Kaiser Family Foundation, Aged and Disabled Dual Eligibles as a Percent of Total Medicaid Beneficiaries, <https://www.kff.org/medicaid/state-indicator/ageddisabled-medicaid-beneficiaries/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>

Tennessee’s “intention” to maintain current benefits and enrollment is meaningless when coupled with the elimination of any accountability. In short, this proposal will neither improve care nor expand coverage, and puts the health and well-being of 1.4 million TennCare enrollees, especially older adults and people with disabilities who have greater care needs, at risk.

IV. Conclusion

For these reasons, we urge HHS to reject this proposal. The state should focus on improving and expanding TennCare coverage for low-income Tennesseans, including older adults and people with disabilities.

We have cited research demonstrating the harms of these proposals and we respectfully request that HHS review each of the sources cited and made available to the agency through active hyperlinks. We further request that the full text of each of the sources 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.

If any questions arise concerning this submission, please contact: Natalie Kean, Senior Staff Attorney with Justice in Aging, at [nkean@justiceinaging.org](mailto:nkean@justiceinaging.org); Julie Carter, Senior Federal Policy Associate with the Medicare Rights Center, at [jcarter@medicarerights.org](mailto:jcarter@medicarerights.org); Kata Kertesz, Policy Attorney with Center for Medicare Advocacy, at [kkertesz@MedicareAdvocacy.org](mailto:kkertesz@MedicareAdvocacy.org); or Erica Asbell, Public Policy Associate with NAELA, at [easbell@naela.org](mailto:easbell@naela.org).

Sincerely,

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National Academy of Elder Law Attorneys