September 9, 2021

The Honorable Xavier Becerra
Secretary
U.S. Department of Health and Human Services
200 Independence Ave, SW
Washington, DC 20201

Re: TennCare III - Approval Special Terms and Conditions

Dear Secretary Becerra:

Thank you for the opportunity to provide comments on the Special Terms and Conditions approved on January 8, 2021 for the TennCare III demonstration waiver.

The undersigned organizations represent millions of individuals facing serious, acute and chronic health conditions across the country. Our organizations have a unique perspective on what individuals need to prevent disease, cure illness and manage chronic health conditions. The diversity of our groups and the patients and consumers we represent enables us to draw upon a wealth of knowledge and expertise and serve as an invaluable resource regarding any decisions affecting the Medicaid program and the people

that it serves. We urge the Department of Health and Human Services (HHS) to make the best use of the recommendations, knowledge and experience our organizations offer here.

The purpose of the Medicaid program is to provide healthcare coverage for low-income individuals and families, and our organizations are committed to ensuring that TennCare provides quality and affordable healthcare coverage. Many of our organizations filed detailed comments (attached) on pieces of the TennCare III waiver in December 2019 expressing our strong opposition to changing the financing structure of TennCare, which jeopardizes access to quality and affordable care for patients with serious and chronic health conditions. The application, and ultimately the approval, contained unprecedented changes that make it harder for patients to get the treatments and services that they need.

As many of our organizations expressed in our May 2021 letter to Centers for Medicare and Medicaid (CMS) Administrator Brooks-LaSure (attached), there were material errors in the public comment period for the TennCare III waiver. Our organizations therefore appreciate your decision to open a 30-day comment period on the special terms and conditions.

As outlined in our previous communications and our comments below, our organizations remain extremely concerned with several components of the TennCare III approval. We urge you to rescind the January 8, 2021 approval as soon as possible and work with the state on a new waiver that ensures quality and affordable coverage in the TennCare program.

Funding Structure

Our organizations have repeatedly voiced our deep concerns with changes to TennCare's financing structure, and we urge you to review the comments that many of our organizations submitted in December 2019.[1,2] Block grants and per capita caps are designed to cap or limit the amount of federal funding provided to states, forcing them to either make up the difference with their own funds or make cuts to their programs reducing access to care for the patients we represent. Program cuts will likely result in enrollment limits, benefit reductions, reductions in provider payments or increased out-of-pocket cost-sharing for Medicaid enrollees.

With the arrival of the COVID-19 pandemic in 2020, our concerns about how Tennessee's project will harm patients have only intensified. This project will limit Tennessee's flexibility in responding to recessions, pandemics, new treatments and natural disasters – and as a consequence, moves in the opposite direction of the lessons learned from 2020. Our organizations urge CMS to revoke approval for the changes to TennCare's financing structure in the special terms and conditions.

Closed Formulary

Our organizations have serious concerns with the new TennCare policy to implement a closed formulary including as few as one drug per class. Diseases present differently in different patients. Prescription drugs have different indications, different mechanisms of action and different side effects, depending on the person's diagnosis and comorbidities. A closed formulary limits the ability of providers to make the best medical decisions for the care of their patients, effectively taking the clinical care decisions away from the doctor and patient and giving them to the state. A robust, open formulary needs to be part of TennCare so that patients can fully benefit from advancements in treatments and access the medications their doctor believes are best for them.

An appeals process is not sufficient to protect patients' access to care. Research shows that administrative hurdles such as prior authorization for drugs can lead patients to delay or abandon

treatment altogether.[3] For a patient with a chronic health condition, a pause or delay in treatment could result in their disease worsening irreversibly. Our organizations encourage CMS to revoke approval for the closed formulary in the special terms and conditions.

10-Year Approval
TennCare III was approved for 10 years. Federal statute limits Section 1115 demonstration extensions to three or five years, depending on the populations covered under the demonstration. Our organizations believe it is important to evaluate the evidence of a waiver's impact on the patients we represent and whether policies should be continued at least that often and value the opportunity to regularly comment on the waiver proposals during the extension process. Additionally, the final TennCare III approval includes a number of vulnerable populations including children with special healthcare needs and people with disabilities. Approving a waiver for ten years is particularly inappropriate without additional protections for vulnerable populations.

A ten-year approval is also concerning given Tennessee's history with coverage losses. In 2005, Tennessee changed its eligibility rules to disenroll 170,000 individuals from its Medicaid program due to budgetary pressures, one of only two states to ever go through a large-scale disenrollment of this nature.[4] Subsequent research found that after this loss of coverage, individuals' self-reported health and access to care declined, visits to doctors and dentists decreased and the use of public and free clinics increased.[5] Additionally, Tennessee is among the states with the largest increases in uninsured children between 2016 and 2019, with many children losing coverage without a finding that they were ineligible.[6] Our organizations continue to urge CMS to rescind this 10-year approval.

Retroactive Coverage
Our organizations oppose Tennessee's request to continue to waive retroactive coverage in TennCare. Retroactive eligibility in Medicaid prevents gaps in coverage by covering individuals for up to 90 days prior to the month of application, assuming the individual is eligible for Medicaid coverage during that time frame. It is common that individuals are unaware they are eligible for Medicaid until a medical event or diagnosis occurs. Retroactive eligibility allows patients who have been diagnosed with a serious illness to begin treatment without being burdened by medical debt incurred prior to their official eligibility determination.

Medicaid paperwork can be burdensome and often confusing. A Medicaid enrollee may not have understood or received a notice of Medicaid renewal and only discovered the coverage lapse when picking up a prescription or going to see their doctor. Without retroactive eligibility, Medicaid enrollees could then face substantial costs at their doctor's office or pharmacy. Health systems could also end up providing more uncompensated care. For example, in Indiana, Medicaid recipients were responsible for an average of $1,561 in medical costs with the elimination of retroactive eligibility.[7] Additionally, when Ohio was considering a similar provision in 2016, a consulting firm advised the state that hospitals could accrue as much as $2.5 billion more in uncompensated care as a result of the waiver.[8] Increased uncompensated care costs are especially concerning as safety net hospitals and other providers continue to deal with the COVID-19 pandemic. Our organizations urge CMS to rescind approval for the waiver of retroactive eligibility.

Conclusion
Our organizations are committed to working with you to expand affordable, accessible, and adequate healthcare coverage in TennCare. Thank you for the opportunity to provide these comments.

Sincerely,

American Lung Association
American Cancer Society Cancer Action Network
American Heart Association
Arthritis Foundation
Asthma and Allergy Foundation of America
Cancer Support Community
Cystic Fibrosis Foundation
Epilepsy Foundation
Hemophilia Federation of America
Lutheran Services in America
March of Dimes
National Hemophilia Foundation
National Multiple Sclerosis Society
National Organization for Rare Disorders
National Patient Advocate Foundation
National Psoriasis Foundation
Pulmonary Hypertension Association
Susan G. Komen
The AIDS Institute
The Leukemia & Lymphoma Society
United Way Worldwide

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[1] Patient Groups Oppose Tennessee Medicaid Block Grant Proposal. December 18, 2019. https://www.lung.org/media/press-releases/patient-groups-oppose-medicaid-block-grant
[2] Patient Groups Comments to HHS re TennCare II Demonstration Amendment 42. December 18, 2019. https://www.lung.org/getmedia/4b0b487a-8a65-4461-acc9-8e7a739e7d16/health-partner-comments-to-12.pdf
[3] American Medical Association, 2017 AMA Prior Authorization Physician Survey. https://www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/public/arc/prior-auth-2017.pdf
[4] Melinda B. Buntin, Ph.D. "Tennessee's Opening Bid for a Medicaid Block Grant." (October 31, 2019) New England Journal of Medicine. Accessed at: https://www.nejm.org/doi/full/10.1056/NEJMp1913356?query=TOC
[5] Thomas DeLeire, "The Effect of Disenrollment from Medicaid on Employment, Insurance Coverage, Health and health Care Utilization," (August 2018). NBER Working Paper No. 24899. Accessed at: https://www.nber.org/papers/w24899
[6] Joan Alker and Alexandra Corcoran, "Children's Uninsured Rate Rises by Largest Annual Jump n More Than a Decade," Georgetown University Health Policy Institute, Center for Children and Families. October 2020. https://ccf.georgetown.edu/wp-content/uploads/2020/10/ACS-Uninsured-Kids-2020_10-06-edit-3.pdf
[7] Healthy Indiana Plan 2.0 CMS Redetermination Letter. July 29, 2016. Available at: 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
[8] Virgil Dickson, "Ohio Medicaid waiver could cost hospitals $2.5 billion", Modern Healthcare, April 22, 2016. (http://www.modernhealthcare.com/article/20160422/NEWS/160429965)