LWV-TN Comments on TennCare Amendment 42

The following remarks and recommendations are submitted on behalf of the League of Women Voters of Tennessee (LWV-TN) in response to the request for public comment by the Division of TennCare regarding the TennCare II Demonstration, Project No. 11-W-00151/4, Amendment 42, also known as the Block Grant Waiver.[1]

SUMMARY

The LWV-TN believes that Waiver Amendment 42 has the potential to harm current and future TennCare recipients and threatens the financial viability of Tennessee's Medicaid program. While the current waiver amendment addresses previous concerns about federal funding elasticity to accommodate future growth in TennCare enrollment, it raises new concerns about overbroad state flexibility to limit scope, amount, and duration of existing benefits and to restrict the cost and choice of covered medications. As currently written, the waiver amendment fails to describe acceptable mechanisms for public oversight and accountability and creates significant financial risk for the state. Moreover, features of Amendment 42 conflict with federal law and policy and if approved would trigger prolonged litigation, at high cost to both federal and state governments.[2] Most importantly, this amendment does not address Tennessee's most urgent health issues: (1) rising numbers of Tennesseans without health coverage or comprehensive health care access resulting in catastrophic problems for individual and public health; and (2) ongoing rural hospital closures due in part to high rates of uncompensated care and bad debt.

The League of Women Voters opposes changes to federal financing of TennCare proposed in Amendment 42 for the following reasons:

- **Unnecessarily risky and complex policy changes that focus on program financing rather than program outcomes**

Changing federal financing of Tennessee's Medicaid program from a guaranteed entitlement to a capped allotment (block grant) would incur potentially higher costs to our state government, while creating health risks for vulnerable people who currently qualify for TennCare (children, custodial adults, people with disabilities, and elderly nursing home residents).[2,3,4]

Under the proposed block grant waiver, if TennCare expenditures were to exceed baseline costs for core Medicaid services calculated under the proposed new formula, the state would be responsible for the full excess amount. This could result in cuts to current benefit levels, or the appropriation of additional state funding unmatched by the federal government. It could also

have spillover effects for populations or services not initially included in the block grant (e.g., individuals with intellectual disabilities, children in foster care, dual Medicaid-Medicare eligibles, DSH payments to hospitals for uncompensated care, outpatient pharmacy benefits). Any year in which the state does not spend the entire federal block grant, the state would retain 50 percent of unspent federal funds provided by the block grant that could be reinvested in health-related supports for unspecified target populations. This funding arrangement creates a perverse incentive for seeking reductions in the scope, amount and duration of current TennCare services with minimal, if any, oversight from the federal government. Despite the waiver proposal's assurance that there will be "no reductions in who is eligible for or what benefits are currently provided in TennCare," it is likely that significant savings would be realized only by tightening current benefits or reimbursements for MCOs or providers.

The block grant request is based on the premise that TennCare is an extremely efficient program in comparison to other state Medicaid programs and the "savings" TennCare provides to the federal government are due to that greater "efficiency," which has been accomplished over many years through managed care instead of fee-for-service health care financing. TennCare delegates responsibility for care coordination to managed care organizations and often relies on non-profit organizations across the state to supplement case management and wrap-around services that many other state Medicaid agencies themselves provide. Other states offer broader health services than Tennessee and cover additional populations. Tennessee this year became the last state in the union to provide Katie Beckett waiver supports to medically fragile children with complex health problems who would otherwise not meet state Medicaid income eligibility criteria, and Tennessee remains one of only a handful of states that does not provide dental coverage to adults.

While the Amendment funding formula makes allowances for changes in numbers of Tennesseans eligible for the program and indexes the per capita block grant amount to inflation, TennCare acknowledges that in order to maintain budget neutrality, current benefits may need to be restricted and has requested broad flexibility to limit services "in scope, amount, or duration" as well as the flexibility to reduce pharmacy costs by limiting prescription drug options on the TennCare formulary.

Meanwhile Tennessee remains in the lowest quartile of states in the USA with respect to significant population health indicators, including maternal mortality, low birth weight babies, adult obesity, incidence and prevalence of diabetes and cardiovascular disease, and cancer mortality rates.[5] Although TennCare is not solely responsible for these poor public health outcomes, our state's persistently low health rankings call into question whether Tennessee is actually spending enough on caring for low-income people. While Amendment 42 characterizes the state's retention of 50% of the amount it "saves" the federal government as a plus, it could also be argued that instead the Amendment leaves our state's Medicaid funding glass half empty.

The League of Women Voters of Tennessee believes that the Amendment's emphasis on cost savings is sadly misplaced and even creates a perverse incentive to restrict important services

and options. TennCare should be focused instead on demonstrating the value or *cost-effectiveness* of the services provided to covered populations based on health outcomes, and rewarded for outcome improvements. Before launching this experimental waiver, there needs to be a thorough analysis of where TennCare "efficiencies" are currently being achieved in comparison with other state Medicaid programs, as well as an assessment of how health outcomes of TennCare recipients compare with health outcomes of Medicaid recipients in states with higher per-capita costs. This is the only way that Tennessee, and CMS, can fully determine if this block grant proposal has the potential for being a better deal.

- **Unspecified metrics to assess impact of policy changes on TennCare recipients**

Amendment 42 asserts that the State's evaluation will focus on "1) the extent to which TennCare expenditures grow under the block grant, as compared to the growth of Medicaid expenditures nationally, and 2) the extent to which the interventions implemented by the State under the block grant are successful in improving access to care and health outcomes for members." However, no measures are currently specified for monitoring changes in health outcomes or health care access. The waiver proposal notes only that the state intends to contract with an independent evaluator to develop a plan for evaluating these goals and will identify appropriate performance measures to assess the impact of the demonstration in consultation with this evaluator and CMS (p. 23).

The League of Women Voters of Tennessee contends that, at a minimum, TennCare should provide CMS with baseline data on the TennCare population, using both process measures and outcome measures, during the same three-year period (2016-2018) on which average TennCare expenditures are based in the block grant waiver proposal. TennCare should also articulate the metrics it plans to use to evaluate the impact of the proposed demonstration project before any approval is considered. Metrics proposed should enable comparison of TennCare performance and outcomes under the block grant (if approved) with performance and outcomes before implementation of this block grant waiver. And, as noted earlier, the metrics proposed and approved should allow for ongoing comparison of performance and outcomes between TennCare and other state Medicaid programs, both those that continue traditional Medicaid funding and those that have expanded Medicaid services and covered populations.

Performance or process measures might include tracking the percentage of those eligible who are enrolled in TennCare and who maintain the continuity of their coverage; frequency of claim denials and rates of appeals; attainment of maternity and pediatric care benchmarks; attainment of benchmarks tied to current and future episodes of care payments; utilization of preventive care, primary care, specialty care, and mental/behavioral health care including treatment for substance use disorders. Monitoring of the state's ability to maintain adequate provider networks is also important. Many providers have expressed concern about returning to a TennCare system in which patients face arbitrary limits on duration and scope of services and bare-bones formularies requiring the initiation of more frequent appeals for medically warranted exceptions.

Outcome measures might include birth outcomes, rates of preventable hospitalizations, and treatment outcomes for certain health conditions, including not only those tied to episodes of

care but also outcomes clinically related to any benefit adjustments or formulary changes made under the block grant funding scheme.

- **Insufficient provision for oversight of program administration and clinical decision-making related to alterations in benefits and formularies**

Amendment 42 requests broad flexibility and relief from CMS regulations but specifies no mechanisms for clinical or administrative oversight by entities other than the state TennCare bureaucracy or the state legislature. This amounts to a lack of state accountability for the use of taxpayer dollars allotted to TennCare. It is vital not only to retain a significant level of federal oversight but also for the Amendment to specify a transparent process for independent and expedited clinical review of cases involving enrollees whose medical needs might require exemption from formulary limitations or benefit adjustments triggered under a block grant framework. There also needs to an objective independent process for reviewing how such appeals for exemption are resolved.

One projected source of additional "savings" discussed in the Amendment would be achieved by limiting the current Medicaid formulary to the least expensive medications in a given therapeutic class. The prospect of new formulary restrictions has raised a great deal of public concern, particularly for those with chronic conditions. There is considerable genetic variation in the ability to metabolize and tolerate medications, and the least expensive medications are not always the most cost-effective. Some individuals may even experience serious side effects from medications that are considered safe for the general population. For example, persons with latent long QT syndrome—a potentially fatal congenital cardiac condition which requires diagnosis through EKG and stress testing or genetic testing—are unable to tolerate medications that impact heart rate or conductivity in even subtle ways. Over 270 medications on most formularies are contraindicated for patients diagnosed with long QT syndrome, including generic antibiotics, antihistamines, antidepressants, antivirals, antacids, anticancer drugs and asthma medications. Though not a common condition, this condition is not rare. Applying current estimates of prevalence, there are 500-600 current TennCare recipients with this condition. How would their medication needs be handled with a limited formulary? Other chronic conditions require progressively staged treatment through a changing medication regimen because the effectiveness of initial drugs is known to wane over time. Would each step up to a more effective but more expensive medication require a lengthy appeal process?

The proposed focus on cost of medications rather than case-by-case cost-effectiveness is clinically short-sighted and questionable. CMS would be abrogating its mandate to use waivers to innovate in ways that do no harm if this waiver were approved without the specification of mechanisms for the provision of broad clinical oversight and expedited appeals. We are concerned that the costs of these necessary patient protections have not been sufficiently weighed in the preparation of this proposal.

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The League of Women Voters of Tennessee recommends that TennCare articulate how it would convene a non-partisan oversight commission to assure that any decisions to alter the TennCare program are based not only on cost, but also clinical effectiveness for affected populations. In addition, we urge TennCare to allow CMS to retain oversight over benefit changes with potential clinical impact and on overall evaluation of this program.

- **Failure to address the state's health coverage gap, which is contributing to high rates of uncompensated care and hospital closures in rural areas**

Expanding TennCare eligibility to include uninsured low-income adults is more in keeping with the intent of the Medicaid statute than Amendment 42, The federal Medicaid program was designed to help eligible Americans with limited resources obtain health coverage for medically necessary care. The TennCare block grant waiver is more narrowly focused on leveraging billions of dollars in federal funding without strict accountability to taxpayers for how it is used or for whom. Tennesseans are already tired of paying the freight for more generous Medicaid programs in other states; now we are also being asked to tolerate higher risks for an even less generous program. The block grant waiver proposal does not expand TennCare eligibility for *any* uninsured low-income adults.

LWVTN has long supported programs designed to decrease the number of individuals lacking health insurance in Tennessee and to increase access to preventive, primary, and acute health care that is cost-effective for *all* Tennesseans. To that end, our members have been persistent advocates for the expansion of Medicaid to include uninsured, nondisabled adults without dependent children, with income up to 138 percent of the federal poverty level ($17,236 annual income limit in 2019 for one household member in 48 contiguous states including Tennessee and the District of Columbia). The League of Women Voters of Tennessee strongly recommends amending the TennCare waiver to expand eligibility for these uninsured low-income adults.

Expanding TennCare eligibility would:

- Reduce adverse selection and the average per capita cost of TennCare beneficiaries, improving program viability over the long term.
- Reduce the state's uninsured rate and alleviate the burden of uncompensated care which has contributed to more hospital closures in Tennessee than in any other state.
- Improve the health and productivity of approximately 300,000 uninsured Tennesseans who currently delay or forego health care because their incomes are too high for Medicaid but too low to qualify for tax credits to buy marketplace coverage or to afford comprehensive commercial insurance.
- Contribute to the reduction of health care costs in Tennessee over the long term through improvements in individual and public health.
- Significantly increase the federal Medicaid match rate for TennCare enrollees with income up to 138% FPL—from 65.87% in 2019 to 90%. If TennCare eligibility were expanded, the state would be responsible for only 10% of expenditures for the expansion population instead

of 35.13%, amounting to a projected influx of an estimated 26 billion dollars in federal payments over the next decade.[4]

The expansion alternative would not preclude efforts to develop robust wrap-around services for TennCare recipients with chronic health conditions, including mental illness and substance use disorders, but would in fact make these services more accessible to low income Tennesseans at points in their lives when intervention can have more lasting impact (e.g., before pregnancy, before incarceration, before addiction).

The LWV-TN stands ready to assist our state and our TennCare program with constructive and innovative ways to improve the health of *all* Tennesseans. Amendment 42 is not the way to achieve these goals, and in fact puts at risks gains that have been made or could be made through efforts to expand rather than restrict the TennCare program. In its current form we can not support Amendment 42 and will urge CMS to reject it.

References:

1. Division of TennCare TennCare II Demonstration Project No. 11-W-00151/4 Amendment 42 DRAFT. May 24, 2019. Available at https://www.tn.gov/content/dam/tn/tenncare/documents2/TennCareAmendment42.pdf

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