



11 DUPONT CIRCLE NW
SUITE 800
WASHINGTON, DC 20036
202-588-5180
NWLC.ORG

Seema Verma, MPH
Administrator, Centers for Medicare and Medicaid Services
200 Independence Avenue, SW
Washington, DC 20201

December 27, 2019

Re: TennCare II Demonstration (No. 11-W-00151/4), Amendment 42

Dear Administrator Verma,

The National Women's Law Center (the Law Center) is writing to comment on the TennCare II Demonstration (No. 11-W-00151/4), Amendment 42. Since 1972, the Law Center has worked to protect and advance the progress of women and their families in core aspects of their lives, including employment, income security, education, and health and reproductive rights, with an emphasis on the needs of low-income women and those who face multiple and intersecting forms of discrimination.

The Department of Health and Human Services must reject the Tennessee demonstration application. Amendment 42 is vague and lacks necessary description of the policies and processes proposed. Tennessee itself stated, "it is not the intention of the state to enumerate in detail in this document every innovation, reform, or policy change that might take place over the life of the demonstration, since the purpose of the block grant is precisely to give the state a range of autonomy within which it can make decisions about its Medicaid program." However, without the requisite detail of *how* Tennessee plans to use its requested authority, it is impossible to determine the full potential impact and effectively comment.

However, as submitted, this proposal lacks legal authority and impermissibly seeks to radically change the financing, federal oversight, and administrative operation of Tennessee's Medicaid program. Tennessee's proposal would harm those who need Medicaid coverage to obtain critical health care services, including reproductive health services, and who rely on that coverage to stay healthy and care for their families. Accordingly, the Law Center calls on the Centers for Medicare and Medicaid Services ("CMS") to reject Tennessee's 1115 waiver request in its entirety.

I. Medicaid Coverage is Critically Important to Women's Health and Economic Security

Women make up the majority of Medicaid beneficiaries.¹ In Tennessee, Medicaid is an essential source of health coverage for women; according to the Law Center's calculations, in 2015, 345,420

¹ Kaiser Family Found., Medicaid's Role for Women, (June 22, 2017) available at <http://www.kff.org/womens-health-policy/fact-sheet/medicaids-role-for-women/>.

women ages 18-64 were covered by Medicaid.² Nearly 35,000 of these women gained coverage between 2013 and 2015, despite the fact that Tennessee had not expanded Medicaid – and still has not.³

Tennessee women who are able to enroll in Medicaid receive coverage for services critical to their health – including birth control services, maternity care, treatment for chronic conditions, and long-term care services and support.⁴ Imposing barriers to coverage and care—as Tennessee’s proposals would do—would be extremely harmful to women’s health, and specifically to reproductive health. This is especially true given that, among all sources of coverage, Medicaid disproportionately covers the poorest and sickest population of women, so any additional obstacles or burdens that would cause them to lose coverage or access to care will be especially harmful.

Medicaid is an essential source of health coverage for women of reproductive age, covering 21% of U.S. women ages 15–44 in 2017 and 22% in Tennessee.⁵ Moreover, Medicaid is particularly important for reproductive age women who are low-wage workers or struggling to make ends meet. Medicaid ensures that people who otherwise could not afford private insurance have coverage for and access to family planning, pregnancy-related care, STI testing and treatment, and other reproductive health services. For example:

- Federal Medicaid law and regulations include strong protections for coverage of family planning services and supplies, without cost-sharing and free of coercion. As a result of these protections and expanded eligibility, Medicaid accounts for 75% of all public dollars spent on family planning in the United States.⁶
- Federal Medicaid law includes long-standing protections for coverage of maternity care, including prenatal care, labor and delivery, and postpartum care. Many states, including Tennessee, provide Medicaid coverage for pregnancy-related care for many women who are otherwise ineligible – up to 200% of poverty in Tennessee.⁷ With this extensive coverage, Medicaid covers roughly half of all U.S. births, including 50%⁸ of births in Tennessee, for women who would find it difficult if not impossible to pay out of pocket for pregnancy-related care and infant care.⁹

² Nat'l Women's L. Ctr., *Affordable Care Act Repeal and Changes to Medicaid Threaten the Health and Economic Security of 3.9 Million Women Who Recently Gained Medicaid Coverage* (Feb. 2017), available at <https://nwlc.org/wp-content/uploads/2017/02/Medicaid-Coverage-by-State-2.pdf>.

³ *Id.*

⁴ Although Medicaid covers a range of services women need, it is important to note that federal law restricts federal Medicaid coverage of abortion except if the pregnancy is the result of rape or incest, or if the woman's life is in danger. See, e.g., Consolidated Appropriations Act, 2016, Pub. L. No. 114-113, § 202, 129 Stat. 2242, 2311 (2015).

⁵ *News in Context: Gains in Insurance Coverage for Reproductive Age Women at a Crossroads*, Guttmacher Inst. (Dec. 4, 2018), <https://www.guttmacher.org/article/2018/12/gains-insurance-coverage-reproductive-age-women-crossroads>.

⁶ Kinsey Hasstedt, Adam Sonfield, & Rachel Benson Gold, Guttmacher Inst., *Public Funding for Family Planning and Abortion Services, FY 1980–2015* (2017), <https://www.guttmacher.org/report/public-funding-family-planning-abortion-services-fy-1980-2015>.

⁷ *Medicaid and CHIP income eligibility limits for pregnant women as a percent of the federal poverty level, 2017*, *State Health Facts*, KAISER FAMILY FOUNDATION (Jan. 1, 2017), <http://kff.org/state-category/medicaid-chip/medicaidchip-eligibility-limits/>.

⁸ 50-State Medicaid Budget Survey Archives, KAISER FAMILY FOUNDATION, (Oct. 18, 2019) <https://www.kff.org/medicaid/report/medicaid-budget-survey-archives/>

⁹ Adam Sonfield & Kathryn Kost, Guttmacher Inst., *Public Costs from Unintended Pregnancies and the Role of Public Insurance Programs in Paying for Pregnancy-Related Care: National and State Estimates for 2010*, (2015), <https://www.guttmacher.org/report/public-costs-unintended-pregnancies-and-role-public-insurance-programs-paying-pregnancy>

- Medicaid helps patients address HIV and other STIs, breast and cervical cancer, intimate partner violence, and other reproductive health–related issues. That includes vaccinations (such as for the human papillomavirus), screening and testing services (such as Pap tests and STI tests), treatment services (ranging from antibiotics for chlamydia to radiation therapy for cancer), and counseling and referral (including for non-medical support services).

At the same time, Medicaid has played a critically important role in advancing women’s economic security.¹⁰ It keeps women and their families from medical debt and bankruptcy. By providing health coverage to women and their families that is not tied to employment, Medicaid allows women to seek positions that may offer higher wages or better opportunities, and it also has improved the economic security of future generations. Medicaid’s coverage of birth control allows women to determine whether and when to start a family, expanding their educational and career opportunities. And according to the Law Center’s calculations, Medicaid payments to health care providers directly support nearly 4.4 million health sector jobs held by women nationwide, including 71,747 held by women in Tennessee.¹¹

The importance of Medicaid to women’s health and economic security sets a high bar for any proposed waivers or changes to the Medicaid program. And any review of such proposal must take the effect on women into account.

II. CMS Must Reject Tennessee’s Radical Section 1115 Waiver

The scope of Tennessee’s request is unprecedented. As explained in further detail below, Tennessee’s request violates existing federal law, and would harm women who disproportionately rely on Medicaid coverage.

A. Tennessee’s Proposed Financing Structure Violates Existing Federal Law

Tennessee seeks to “transform” its current Medicaid financing into a “modified block” grant. Instead of utilizing the federal financing methodology codified in section 1903 of the Social Security Act, Tennessee would receive a lump sum of federal funds based on the state’s projected costs of covering children, adults, elderly and those who are blind or disabled without its waiver (“without waiver” costs). Tennessee then proposes to “share” with the federal government the difference between its actual spending and the “without waiver” spending projected by Centers for Medicare and Medicaid Services (“CMS”) under its current demonstration. However, any increase in the *actual* cost of care over the per capita amount must be absorbed by the state because no additional adjustment is available if per enrollee costs rise faster than anticipated funding projections.

¹⁰ Nat’l Women’s Law Ctr., *Medicaid at 50: Celebrating Medicaid’s Contributions to Women’s Economic Security* (July 2015) available at <https://nwlc.org/resources/medicaid-50-celebrating-medicaid%E2%80%99s-contributions-women%E2%80%99s-economic-security/>.

¹¹ Nat’l Women’s Law Ctr., *Medicaid Is Vital for Women’s Jobs in Every Community* (June 2017), available at <https://nwlc.org/resources/medicaid-is-vital-for-womens-jobs-in-every-community/>.

This proposal lacks legal sufficiency under section 1115 of the Social Security Act¹² and will harm TennCare recipients. Tennessee’s financing structure provides a perverse incentive to eliminate eligibility, reduce benefits, shrink enrollment and cut costs; all in order to draw down any unspent federal funds. This is especially concerning as Tennessee additionally requested to spend at least a portion of federal Medicaid funds on anything that the state determines would improve beneficiaries’ health, which could include social services or public health infrastructure that the state already funds with state dollars. Ultimately, the “flexibility” Tennessee would get from this proposal is the ability to effectively provide less and pocket more.

B. Tennessee’s Application is Contrary to the Purposes of Medicaid and Harmful to Individuals Enrolled in the Program, Especially Women

CMS must reject Tennessee’s waiver request because it will not promote Medicaid’s objectives. At its core, Medicaid exists to provide health coverage to low-income people who cannot otherwise afford it, which helps individuals attain or retain the capacity for independence and self-care.¹³ Tennessee’s unprecedented request to bypass federal oversight will, as described below, do the opposite. Granting Tennessee total autonomy over changes to enrollment, delivery systems and Managed Care Organization (“MCO”) management is a radical shift away from accountability and will put vulnerable Tennesseans at risk.

A Waiver of Federal Oversight of Enrollment Processes Will Harm Women

Last year, Tennessee saw one of the largest increases in the rate of uninsured residents in the nation.¹⁴ This rise in uninsurance was due in part to the disenrollment of more than 120,000 TennCare recipients over the span of two years.¹⁵ This staggering drop in Medicaid enrollment was not attributable to increased employer coverage or ineligibility.¹⁶ Instead, TennCare members lost coverage as a result of cumbersome paperwork requirements. This is not the first time TennCare created bureaucratic barriers to enrollment and abdicated its duties to Medicaid-eligible Tennesseans. In 2016, the United States Court of Appeals for the Sixth Circuit affirmed a lower court’s preliminary injunction against Tennessee asserting violations of federal law in TennCare’s eligibility determinations and fair hearings.¹⁷ To this day, Medicaid-eligible Tennesseans face administrative barriers to enrollment and renewal. Less federal oversight would result in a proliferation of manufactured barriers to Medicaid enrollment and coverage.

Denial of health coverage due to barriers is especially harmful to women. Uninsured low-income women are more likely than men to go without care because of cost, and are less likely to

¹² 42 U.S.C.A. § 1315

¹³ 42 U.S.C. §1396 et seq.

¹⁴ Berchick, Edward R., Jessica C. Barnett, and Rachel D. Upton, Current Population Reports, P60-267(RV), Health Insurance Coverage in the United States: 2018, U.S. Government Printing Office, Washington, DC, 2019. f

¹⁵ Brett Kelman, *Tennessee suffered third-largest increase of uninsured people in the nation, Census reports*, Nashville Tennessean, (September 11, 2019) available at <https://www.tennessean.com/story/news/health/2019/09/11/tennessee-uninsured-residents-tenncare-census-report/2276127001/>.

¹⁶ Brett Kelman & Mike Reicher, *At least 220,000 Tennessee kids faced loss of health insurance due to lacking paperwork*, Nashville Tennessean, (July 14, 2019) available at <https://www.tennessean.com/story/news/investigations/2019/07/14/tenncare-coverkids-medicaid-children-application-insurance-denied/1387769001/>.

¹⁷ *Wilson v. Gordon*, 822 F.3d 934, 939 (6th Cir. 2016)

have a regular source of care or utilize preventive services than low-income women with health insurance. A growing body of research has demonstrated how important Medicaid coverage is to beneficiaries' access to care, overall health and mortality rates.¹⁸ This is particularly true for the health of mothers and infants, which is inextricably linked to their access to health coverage.¹⁹ Coverage gaps and Tennessee's failure to expand Medicaid contribute to Tennessee's staggering maternal and infant mortality rates, 33rd²⁰ and 38th²¹, respectively. Furthermore, losing Medicaid's guarantee of birth control coverage would be devastating for Tennessee's women of reproductive age. Medicaid coverage removes cost barriers to birth control that otherwise can prevent women from accessing it or make its accessibility inconsistent. Should Tennessee women lose birth control coverage, many will be at greater risk of unintended pregnancy.

As discussed above, Tennessee is not well-suited to implement changes to their enrollment processes without federal oversight. The Law Center is deeply concerned that Tennessee's request will result in administrative barriers and increased disenrollment of eligible women and families. These barriers will have a disproportionate impact on women's coverage, and therefore women's health and well-being, as well as the well-being of their children.

A Waiver of Managed Care Regulations and Federal Oversight of Delivery Systems Will Harm Women

Tennessee further requests "flexibility" to avoid federal oversight of its health care delivery systems and to waive crucial managed care regulations. Loosened standards and reduced oversight will increase disenrollment, reduce access to covered services and lead to serious lapses in care.

Tennessee's Medicaid managed care has grown from a small constellation of "full risk" contracts to a proliferation of MCOs, Prepaid Inpatient Health Plans ("PIHPs"), Prepaid Ambulatory Health Plans ("PAHPs"), and plans offering Managed Long-Term Services and Supports ("MLTSS") – generally known as managed care plans or entities – that now serve all Medicaid beneficiaries. The regulations Tennessee seeks to waive provide a framework for network adequacy requirements, enrollment and disenrollment processes, utilization management, care coordination, member appeals, actuarially sound rates, and many other critical areas.²² Medicaid enrollees already experience more difficulty accessing services and providers than their privately insured counterparts.²³ "Flexibility" will mean worse access to care for over a million Tennesseans from a state which has already demonstrated a lack of interest in holding MCOs accountable.

¹⁸ Benjamin D. Somers et al., *Mortality and Access to Care Among Adults after State Medicaid Expansions*, 367 *New Eng. J. Med.* 1025 (July 2012); Julia Paradise & Rachel Garfield, *What is Medicaid's Impact on Access to Care, Health Outcomes and Quality of Care? Setting the Record Straight on the Evidence*, Kaiser Commission on Medicaid and the Uninsured (Aug. 2013), available at <https://kaiserfamilyfoundation.files.wordpress.com/2013/08/8467-what-is-medicaids-impact-on-access-to-care1.pdf>.

¹⁹ Why are Tennessee moms and babies dying at such a high rate?, (September 26, 2018) available at <https://www.tnjustice.org/wp-content/uploads/2018/09/Infant-and-Maternal-Mortality-Policy-Brief.pdf>.

²⁰ *Id.*

²¹ *Id.*

²² Elizabeth Hinton, MaryBeth Musumeci, and Robin Rudowitz, *Why it Matters: Tennessee's Medicaid Block Grant Waiver Proposal*, Kaiser Family Found., (Dec. 9, 2019) <https://www.kff.org/medicaid/issue-brief/why-it-matters-tennessees-medicaid-block-grant-waiver-proposal>

²³ See, e.g., *Medicaid Access in Brief: Children's Difficulties in Obtaining Medical Care*, Medicaid & CHIP Payment & Access Comm'n, (2016), at 1, ("[C]hildren in Medicaid or CHIP are more likely than those with private coverage to report difficulties accessing medical care; these difficulties include finding a provider who will accept their insurance, obtaining a timely appointment, and obtaining a referral to a specialist."), <https://www.macpac.gov/wp-content/uploads/2016/06/Children%E2%80%99s-difficulties-in-obtaining-medical-care.pdf>.

Tennessee’s waiver will further dismantle managed care enrollee protections and prevent the delivery of appropriate and comprehensive services to all.

Additionally, Tennessee touts its intent to “maximize program efficiency,” yet their proposed financing structure, driven by the potential for recouping monies not spent, incentivizes Tennessee to reduce spending by any means necessary. This will include abdicating MCO oversight, altering the care delivery system, and reducing optional eligibility and services for high cost beneficiaries. Tennessee’s requests put all TennCare eligible individuals at risk, but particularly those with complex health and social needs. State delivery and payment reforms are often focused on people who have high health care needs and incur high costs.²⁴ Spending for non-dual seniors and persons with disabilities – who on average have high health needs and associated costs – are explicitly included in the modified block grant request. Tennessee spends over 930 million dollars each year on long-term care services²⁵ and 5 billion annually on the aged and disabled.²⁶

Any changes to long-term care services or services for the aged and disabled will hit women hardest. Women experience longer lifespans than men,²⁷ are 80 percent more likely than men to be impoverished at age 65 and older²⁸, have higher rates of physical and cognitive impairments that limit functionality and hinder their ability to live independently,²⁹ and have slightly higher rates of disability than men.³⁰ Federal oversight ensures that any changes are measured, well-reasoned, and do not devastate the most vulnerable TennCare beneficiaries.

Tennessee’s Proposed Closed Formulary is Contrary to Law and Harmful to Women

Finally, Tennessee’s proposed change to prescription drug coverage is contrary to law and harmful to women. Tennessee seeks an unprecedented waiver of the requirement that Medicaid cover approved drugs in accordance with section 1927 of the Social Security Act. Under this section, Tennessee can impose preferred drug lists but is essentially barred from imposing a fully “closed” formulary under which only one drug is required to be provided by therapeutic class

²⁴ MEDICAID: *A Small Share of Enrollees Consistently Accounted for a Large Share of Expenditures*, United States Government Accountability Office, (May 2015), at XX, <https://www.gao.gov/assets/680/670112.pdf>.

²⁵ Urban Institute estimates based on data from CMS (Form 64), as of August 2019; *Distribution of Fee-for-Service Medicaid Spending on Long Term Care*, Kaiser Family Foundation., (last accessed on December 26, 2019) <https://www.kff.org/medicaid/state-indicator/spending-on-long-term-care/>

<https://www.kff.org/medicaid/state-indicator/spending-on-long-term-care/?currentTimeframe=0&selectedRows=%7B%22states%22:%7B%22tennessee%22:%7B%7D%7D%7D&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>

²⁶ KFF estimates based on analysis of data from the 2014 Medicaid Statistical Information System (MSIS) and Urban Institute estimates from CMS-64 reports. MSIS spending was adjusted to CMS-64 spending to account for MSIS undercounts of spending and missing quarters of data; *Medicaid Spending by Enrollment Group: 2014*, Kaiser Family Foundation., (last accessed on December 26, 2019) <https://www.kff.org/medicaid/state-indicator/medicaid-spending-by-enrollment-group/?currentTimeframe=0&selectedRows=%7B%22states%22:%7B%22tennessee%22:%7B%7D%7D%7D&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>

²⁷ Alina Salganicoff, *Women and Medicare: An Unfinished Agenda*, American Society on Aging (2015)

<https://www.asaging.org/blog/women-and-medicare-unfinished-agenda>; *Medicare’s Role for Older Women*, Kaiser Family Foundation, (May 16, 2013) <https://www.kff.org/womens-health-policy/fact-sheet/medicares-role-for-older-women/>

²⁸ Women 80% More Likely to be Impoverished in Retirement, National Institute on Retirement Security, (March 1, 2016) <https://www.nirsonline.org/2016/03/women-80-more-likely-to-be-impoverished-in-retirement/>

²⁹ Alina Salganicoff, *Women and Medicare: An Unfinished Agenda*, American Society on Aging (2015)

<https://www.asaging.org/blog/women-and-medicare-unfinished-agenda>; *Medicare’s Role for Older Women*, Kaiser Family Foundation, (May 16, 2013) <https://www.kff.org/womens-health-policy/fact-sheet/medicares-role-for-older-women/>

³⁰ Matthew W. Brault, *Americans With Disabilities: 2010*, U.S. Census Bureau, (July 2012), at 7,

<https://www.census.gov/content/dam/Census/library/publications/2012/demo/p70-131.pdf>.

and/or certain drugs will not be covered. Tennessee’s proposal requests the Secretary allow the state to exclude FDA-approved drugs entirely “until market prices are consistent with prudent fiscal administration or the state determines that sufficient data exist regarding the cost effectiveness of the drug.” This request is particularly harmful to women.

Medicaid covers 22% of women ages 15–44 in Tennessee. Access to contraception is essential. In fact, federal law recognizes the need to provide unimpeded access to family planning care, requiring states to cover family planning services and supplies.³¹ Medicaid enrollees have a right to guaranteed coverage of family planning, including freedom of choice, free of coercion.³² To the extent that Tennessee’s closed formulary proposal infringes on this right or amounts coercion in choice of family planning, it is unlawful.

Moreover, closed formularies ignore the specific experience of women. Historically, inclusion of men in clinical research outpaced women in both design and conduct.³³ Men, mostly white men, were considered to be the standard study population.³⁴ Even recent studies evaluating federally-funded randomized clinical trials in nine major medical journals found most studies that were not sex-specific had an average enrollment of only 37% women.³⁵ Moreover, 64% of those studies *did not specify their results by sex*.³⁶ Ultimately, a drug that effectively manages a white man’s condition or diagnosis may not be as effective, or effective at all, for women of any race. Excluding FDA approved prescriptions “until market prices are consistent with prudent fiscal administration or the state determines that sufficient data exist regarding the cost effectiveness of the drug,” would harm women.

Additionally, Tennessee’s prioritization of cost over care would deny medically necessary medications to women who otherwise cannot afford them. This is particularly concerning for the Law Center, as women are more likely to use several classes of medications than men³⁷ and prescription medication is ubiquitous. Nearly 1 in 2 non-pregnant women between 15-44 years of age reported using prescription medication in the last 30 days and almost 1 in 4 pregnant women.³⁸ The use of medications for chronic conditions only *increases* as women age. Ultimately, Tennessee’s proposal would severely limit access to prescription medication, prevent women and their physicians from pursuing the most effective treatment plans and frustrate the purpose of Medicaid.

³¹ The Medicaid Act guarantees that family planning services must be “furnished (directly or under arrangements with others) to individuals of child-bearing age (including minors who can be considered to be sexually active) who are eligible under the State plan and who desire such services and supplies.” 42 U.S.C. § 1396d(a)(4)(C). States must ensure that “each beneficiary is free from coercion or mental pressure and free to choose the method of family planning to be used.” 42 C.F.R. § 441.20.

³² *Id.*

³³ Vivian W. Pinn, *Sex and gender factors in medical studies: implications for health and clinical practice*, JAMA, (Jan 22, 2003) <https://doi.org/10.1001/jama.289.4.397>

³⁴ Theresa M. Wizemann, *Exploring the biological contributions to human health: does sex matter?*, National Academy of Sciences (2001) <http://www.nationalacademies.org/hmd/~media/Files/Report%20Files/2003/Exploring-the-Biological-Contributions-to-Human-Health-Does-Sex-Matter/DoesSexMatter8pager.pdf>

³⁵ Stacie E. Geller et al., *Inclusion, analysis, and reporting of sex and race/ethnicity in clinical trials: have we made progress?* J Womens Health, (2011) <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3058895/>

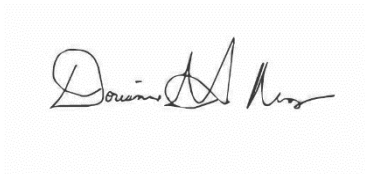
³⁶ *Id.*

³⁷ Catherine M Roe et al., *Gender- and age-related prescription drug use patterns*, Ann. Pharmacother., (Jan 2002), at 9, <https://www.ncbi.nlm.nih.gov/pubmed/11816254>

³⁸ *Key Findings: Prescription Medication Use among Women in the United States, 1999-2006*, Centers for Disease Control and Prevention, (last accessed on December 26, 2019) <https://www.cdc.gov/pregnancy/meds/treatingfortwo/features/keyfinding-prescription-med.html>

Tennessee's Application 42 violates Medicaid law and will harm women's health and economic security. CMS must reject it in its entirety.

Sincerely,



Dorianne G. Mason, Director of Health Equity
National Women's Law Center