National Urban League | Empowering Communities. Changing Lives.

Urban League of Middle Tennessee

Knoxville Area Urban League

National Urban League Comments on TennCare III Project

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

Re: TennCare III Project Approved Special Terms and Conditions

Dear Secretary Becerra:

On behalf of the National Urban League, an organization with a 111 year history of advocating for policies that promote economic empowerment for African Americans and other historically underserved communities, and our Urban League affiliates in Nashville and Knoxville, we write to express serious concerns regarding the state of Tennessee's Medicaid waiver project, TennCare III.

The National Urban League has serious concerns that TennCare III does not meet the requirements of section 1115 of the Social Security Act, restricts low-income Tennesseans' access to Medicaid coverage and services, and exacerbates existing racial health disparities in the State. We have described below our specific objections to the core features of the project.

Racial Equity

Due to the ongoing effects of structural racism and inequality, the poverty rate among Black and Hispanic Tennesseans is roughly twice as high as the poverty rate among white Tennesseans.[i] As a result, nonwhite individuals are much more likely than white individuals to rely on Medicaid for their health care.[ii] By restricting access to Medicaid coverage and services, TennCare III disproportionately harms people of color.

TennCare III will also perpetuate and exacerbate existing racial health disparities throughout the State.[iii] Currently, the infant mortality rate in Tennessee is almost twice as high for Black infants as for white infants. Additionally, COVID-19 has disproportionately sickened and killed Black Tennesseans – while Black residents make up 17% of the population, they account for 20% of cases and 36% of deaths.[iv] Instead of granting Tennessee waivers that would assuredly promote racial health disparities and inequities, CMS should encourage the State to reduce these gaps through Medicaid expansion.

Tennessee is one of only twelve states that still deny their residents access to Medicaid under broadened eligibility rules established by the Affordable Care Act, despite research conclusively demonstrating that Medicaid expansion has reduced mortality and morbidity.[v] Furthermore, Medicaid enhances families' financial security, contributing to their ability to address social determinants of health.

No Retroactive Coverage

CMS should withdraw the waiver permitting Tennessee to eliminate retroactive coverage for Medicaid beneficiaries. There is nothing experimental about waiving retroactive coverage, in fact, several states have been allowed to ignore the requirement since at least the 1990s. Tennessee itself has had a waiver of retroactive coverage since the TennCare project began in 1994. Allowing the State to continue the waiver would, at this point, simply be giving Tennessee permission to evade a federal requirement, and numerous courts have said that would be improper use of section 1115.[vi]

The elimination of retroactive coverage subverts the objectives of the Medicaid Act because it "by definition, reduce[s] coverage" for people not currently enrolled in Medicaid.[vii] Without retroactive coverage, Medicaid beneficiaries forgo vital health care and/or incur significant medical expenses.

Data from states with retroactive coverage confirms its vital role for Medicaid beneficiaries. 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.[viii] Low-income individuals cannot afford this, in fact, only 39 percent of Americans can afford an unexpected expense of $1000.[ix] Individuals who are denied retroactive coverage become saddled with medical debt—an outcome that is antithetical to the Biden administration's focus on shoring up and building up the middle class.

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

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.[xii] This is unconscionable at any time, but especially as we are still grappling with dangerous variants of the COVID-19 pandemic.

In the approved STCs, CMS 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 completely 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.

Retroactive coverage is vitally important to the communities our Urban League affiliates serve – communities who, due to the racialized wealth gap, racialized gaps in access to health-promoting resources, faced disproportionate harm long before and as a result of the COVID-19 pandemic.

Aggregate Cap and Shared Savings

CMS should rescind its approval of the "aggregate cap" and shared savings financing structure because it conflicts with section 1396b and it does not promote the objectives of Medicaid.

Section 1396b establishes how the federal government must fund Medicaid programs in the states, and as previous administrations have pointed out, it is not waivable under section 1115. While the TennCare III approval did not grant a waiver of section 1396b, in effect, it permits CMS to deviate from the financing scheme set forth in that provision. For example, if Tennessee spends more than the aggregate cap, it will not receive federal reimbursement for its excess costs. That means that the State will receive an FMAP for its total expenditures on medical assistance that is lower than the FMAP Congress has required in section 1396b. Section 1115 does not give the Secretary the authority to make that change.

In addition, the aggregate cap and shared savings financing structure rewards Tennessee for reducing its Medicaid spending, placing beneficiaries' access to health care services at serious risk. If Tennessee spends less than the aggregate cap in any given year, it can earn up to 55% of the federal savings achieved. While the STCs require Tennessee to spend the savings on Designated State Investment Programs, they do not prevent the State from using the savings to supplant current state funding for DSIPs. In other words, the savings will free up state funding for Tennessee to use for any purpose.

Notably, Tennessee has a history of redirecting federal funding intended to benefit low-income individuals.[xiii] During the Great Recession, the State improperly diverted hundreds of millions of additional federal Medicaid funding provided by the American Recovery and Reinvestment Act of 2009 away from Medicaid and into its reserve fund.[xiv] Similarly, instead of using federal TANF funding to assist low-income families with children, Tennessee has hoarded the money.[xv] It has continued to grow its TANF reserve while more than 22% of children – and a shocking 40% of Black children – continue to live in poverty in the State.[xvi] There is nothing to prevent Tennessee from using the TennCare III shared savings as a slush fund to pay for policy priorities that are unrelated to improving health care coverage for low-income and underserved individuals and communities. Given the State's recent history, there is every reason to fear that it will do so.

In an effort to maximize its shared savings, Tennessee will reduce its Medicaid spending. Under the approval, Tennessee cannot reduce the populations or services covered without amending the

project and triggering a change in the aggregate cap. So, to reduce its spending, the State will have to reduce the capitated rates paid to managed care plans, leaving it to the plans to figure out how to cut their costs (while also fulfilling their fiduciary duty to maximize their profits). TennCare III approval will disproportionately harm beneficiaries who have the greatest medical need – children and adults with chronic, complex conditions.

Conclusion

Thank you for the opportunity to comment on the TennCare III project. If you have further questions, please contact Lydia Isaac (lisaac@nul.org) or Morgan Polk (mpolk@nul.org) at the National Urban League.

Sincerely,

Marc H. Morial
President and CEO
National Urban League

Clifton E. Harris
President and CEO
Urban League of Middle Tennessee

Phyllis Nichols
President and CEO
Knoxville Area Urban League

---

[i] *State Health Facts, Poverty Rate by Race/Ethnicity, 2019*, KAISER FAMILY FOUND., https://www.kff.org/other/state-indicator/poverty-rate-by-raceethnicity/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D (last visited August 16, 2021).

[ii] *The TennCare Block Grant Makes Health Disparities Worse*, TENN. JUSTICE CTR., https://www.tnjustice.org/blockgrant/ (last visited Aug. 19, 2021) (showing that at least 29.6% of Black Tennesseans are enrolled in TennCare, compared to 13.9% of white Tennesseans).

[iii] *See, e.g.*, Kinika Young, Tenn. Justice Ctr., *Rooted in Racism: An Analysis of Health Disparities in Tennessee* (2020), https://www.tnjustice.org/wp-content/uploads/2020/07/Rooted-in-Racism-An-Analysis-of-Health-Disparities-in-Tennessee.pdf ; Bill Frist & Andre L. Churchwell, *Discrimination and Disparities in Health: Examination of Racial Inequality in Nashville*, TENNESSEAN (July 31, 2020), https://www.tennessean.com/story/opinion/2020/07/31/examination-racial-inequality-nashvilles-healthcare/5540680002/.

[iv] Kinika Young, *supra* note iii, at 2.

[v] Matt Broaddus, et al., *Medicaid Expansion Has Saved at Least 19,000 Lives, New Research Finds; State Decisions Not to Expand Have Led to 15,000 Premature Deaths* (2019); https://www.cbpp.org/research/health/medicaid-expansion-has-saved-at-least-19000-lives-new-research-finds.
[vi] *See, e.g., Beno v. Shalala*, 30 F.3d 1057, 1069 (9th Cir. 1994).
[vii] *Stewart v. Azar*, 313 F. Supp. 3d 237, 265 (D.D.C. 2019).
[viii] 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.
[ix] Konish, Lorie. 2021. *Just 39% of Americans Could Pay for a $1,000 Emergency Expense.* CNBC. https://www.cnbc.com/2021/01/11/just-39percent-of-americans-could-pay-for-a-1000-emergency-expense.html (Aug. 26, 2021).
[x] 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.
[xi] *Rural Hospital Viability*, TENN. HOSPITAL ASS'N, https://tha.com/focus-areas/small-and-rural/rural-hospital-viability/ (last visited August 15, 2021).
[xii] *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.
[xiii] *See* Tenn. Justice Ctr., *Tennessee's Misuse of Federal Funds Makes it a Poor Candidate for a Medicaid Block Grant*, https://www.tnjustice.org/tenncare-misuse-federal-funds/.
[xiv] *Id*. (citing Declaration of David L. Manning, *Crabtree v. Goetz*, No. 3-08-939, (M.D. Tenn. May 15, 2009)).
[xv] *Id*.
[xvi] *Id.*; *The State of America's Children 2020, Table 2: Poor Children in America in 2018 – A Portrait* (2021), CHILDREN'S DEFENSE FUND, https://www.childrensdefense.org/policy/resources/soac-2020-child-poverty-tables/.