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24 Hour Crisis & Support Helpline 1-800-334-4628

October 16, 2019

Mr. Gabe Roberts
Director, Division of TennCare
310 Great Circle Road
Nashville, TN 37243

Dear Mr. Roberts,

YWCA Nashville & Middle Tennessee appreciates the opportunity to comment on the proposed Medicaid block grant. We have been a part of the Nashville community for over 120 years. The YW operates the largest emergency domestic violence shelter in the state of Tennessee. The 65-bed Weaver Domestic Violence Center serves more than 500 women and children each year who flee their homes and uproot their lives to escape domestic violence. We also offer trauma informed counseling services and transitional housing support. The women and children we serve access our services after calling the 24-hour Crisis and Support Helpline. We received more than 7,500 calls to this number last year.

Only a handful of survivors come to the YWCA Weaver Center with private insurance. About forty percent of the women we serve have no insurance at all. That means nearly half of the survivors trying to heal from the physical and emotional wounds of domestic violence receive their insurance through TennCare.

All of the women and children we serve have experienced trauma. Many have lived with and through the abuse for months and even years. Their wounds are both visible and, in many cases, invisible. The women and children we serve need consistent, reliable, comprehensive health care coverage.

Please see attached our concerns and ideas for improving health outcomes for the vulnerable people we serve.

Regards,

Sharon K. Roberson

Sharon K. Roberson
President & CEO

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Comments on Proposed Medicaid Block Grant
October 16, 2019

1. On Page 9 of the Draft Amendment 42, under "Per Capita Adjustments for Member Growth", TennCare attempts to answer how newly eligible applicants for TennCare who are excluded from receiving TennCare coverage due to expenditure of all of the block grant will receive services since the concept of block grants is that when the funds for the program go to zero, no further services can be offered to those who would be eligible until the next block grant cycle is entered.

   Currently, once an applicant is determined eligible, services are immediately available and retroactive to the date of application.

   The original block grant is to be based on "TennCare's average enrollment in four member categories during a specified base period (State Fiscal Years 2016-2018)".

   TennCare proposes that there will be a "per capita adjustment for member growth" and that:

   > If while the demonstration, TennCare's actual enrollment in any of these categories exceeds the category's average enrollment during the base period [Fiscal Years 2016-2018], then the state's block grant will be adjusted on a per capita basis to reflect the increase in membership. The per capita adjustment will be equivalent to the federal portion of the appropriate "Without Waiver" expenditure amount (the same number used to calculate the initial block grant amount for the member category in which enrollment has increased), trended forward by, the inflation factor, and multiplied by the number of additional members above the average base period enrollment.
   >
   > The per capita adjustment ensures the state will continue to be able to provide medical assistance to all eligible individuals, regardless of changes in the economy or other factors outside the state's control that may result in an increase in TennCare enrollment.

   What is not addressed is:

   a. How much of an increase in enrollment would be needed to trigger the adjustment, one person or one hundred persons? and

   b. How long will it take TennCare and the Centers for Medicare and Medicaid Services (CMS) to agree on the funding change and make this adjustment to the block grant?

   Federal reviews on program changes and new funding proposals are not known for their timeliness.

   In the meantime, persons needing medical care and who are otherwise eligible, could be on the outside looking in on services for which they are eligible, but for which there is no available funding, pending agreement by TennCare and CMS on the numbers of eligibles in each affected category and the per capita

amount for that category and the receipt of CMS' blessing on TennCare's proposed funding adjustment. It could be that those persons may be unable to obtain medical treatment during the interim.

Will, then, TennCare hold these eligibles harmless and provide state funding via a supplemental state appropriation for medical care during this waiting period?

This should be clarified by TennCare in its proposal to CMS.

2. On Page 15 of the Draft Amendment 42, under "Delivering the Right Care to the Right Members", TennCare advocates the change in federal policy that currently requires the same services be offered to all recipients, and wants to be allowed to offer services directed toward the needs of a specific population. If approved by CMS, this offers the opportunity for the YWCA to advocate for TennCare services to be made available to victims of domestic violence who are without insurance or the means to obtain insurance because they have lost their means of support and, presumably would need to be certified to be a DV victim by the YWCA and/or law enforcement.

   It would be appropriate to raise this possible new category at each level of comment, i.e., during this initial period ending on October 18, then, during the federal comment period as CMS considers the State's proposal, as well as with legislators who must approve by resolution the plan agreed to by CMS and TennCare. There is still another opportunity again with the legislators who, later in the Joint Government Operations Rules Review hearings will be reviewing TennCare's proposed rules implementing the block grant program, and testimony could be provided by the Y and other interested groups in support of this category.

3. On page 16 of the Draft Amendment 42, under "Delivering the Right Care to the Right Members", TennCare states that it is "not the intent under this proposal to reduce covered benefits for members below their current levels". The proposal strongly suggests that the federal approval process is "unnecessarily limiting and constrains" TennCare's ability to develop new means of providing different packages of services to different groups because of the federal requirement of "comparability" which mandates the same "amount, duration and scope" of services for all eligible populations, and, therefore, limits TennCare's ability to "explore new therapies and treatment modalities" and "develop pilot programs designed to assess their clinical efficacy and potential cost effectiveness" [See page 15].

   While this new flexibility would appear to make possible the provision of TennCare services to DV victims noted in #2 above, on the other hand, it does not explain how TennCare will develop and fund these new/different services without affecting some services in the packages offered currently. Presumably, these new services could be funded by the savings TennCare believes that will result from its greater flexibility in targeting services differently for different groups' medical needs and/or the 50% retention of savings gained in the block grant process as proposed by TennCare, but how these possible sources of funding will become available for these new "therapies and treatment modalities" is not otherwise specifically discussed in this section. We are left to wonder if current service packages, including the types and amounts of prescription drugs offered, will be reduced in order to direct experimental programs or therapies, or, for treatments for health crisis issues such as the opioid problem rather than seeking specific, separate, appropriations to address additional serious chronic or new health crises.

This should also be addressed in the proposal.

4. Finally, the potential illegality of the block grant proposal may cause the state of Tennessee to be embroiled in expensive, protracted litigation. In an article from the *Chattanooga Times Free Press* dated September 18, 2019, the basic legality of the concept of block granting any Medicaid program has been questioned by a University of Michigan law professor, Nicholas Bagley.

   He states:

   > "…setting aside the dubious policy merits of block grants, however, I don't think the proposal is legal.
   > "I don't even think it's close," added Bagley, who posted his views Tuesday on The Incidental Economist, a health policy blog.
   > …
   > Bagley, a former appellate staff attorney in the Civil Division at the U.S. Department of Justice who previously served as a law clerk to U.S. Supreme Court Justice John Paul Stevens, says he sees a problem in the state's concept for the waiver.
   >
   > Under section 1903*[of the Social Security Act, Section 42 United States Code, Section 1396b]* of the Medicaid statute, he says, the federal government "must pay a fixed 'match rate' (known in the statutory lingo as 'the Federal medical assistance percentage') to every state that participates in Medicaid."
   >
   > Tennessee's match rate is now 65.21%, meaning that for every $1 the state spends on TennCare, Uncle Sam provides a little over $2. That, however, would change under a number of different TennCare programs under [Governor] Lee's proposed waiver.
   >
   > "As Tennessee recognizes," Bagley writes, "it'll need a waiver from HHS to make these changes. And section 1115 *[of the Social Security Act; 42 United States Code Section 1315]* of the Medicaid statute does allow HHS to waive lots of the law's restrictions in connection with experimental projects that are likely to assist in promoting Medicaid's objectives."
   >
   > Acknowledging that he's previously written he isn't sure "block granting Medicaid counts as an experiment that serves Medicaid's purposes," the New York University of Law graduate whose writings have appeared in the Harvard Law Review, Columbia Law Review, Georgetown Law Journal and New England Journal of Medicine, goes on to say *"there's a more fundamental problem with Tennessee's proposal.*
   >
   > *"You can't use section 1115 to waive section 1903," he says.* ***"To the contrary, section 1903 is pointedly omitted from the list of statutory provisions that HHS is empowered to waive.*** "So, you can't use Medicaid waivers to change Medicaid's financing structure. And that's exactly what Tennessee is proposing to do," Bagley adds.

He is correct that the financing provisions of the Medicaid law are omitted from Section 1115's waiver authority under subsection (a) paragraph (1). The statute reads:

> **SEC. 1115 [***of the Social Security Act***.] [***42 United States Code Section 1315***]**
>
> **(a) In the case of any experimental, pilot, or *demonstration project* [***TennCare***] which, in the judgment of the Secretary, is likely to assist in promoting the objectives of title I [***Old-Age Assistance***], X [***Aid to the Blind***], XIV [***Aid to the Totally & Permanently Disabled***], XVI[***SSI***], or XIX [*Medicaid*], or part A [***TANF/Families First***]or D[*Child Support*] of title IV [***Grants to States for Aid and Services to Needy Families with Children and for Child-Welfare Services***], in a State or States—**
>
> > (**1) the Secretary may waive compliance with any of the requirements of section** 2 [SSA], 402 [State Plans under Title IV-A/TANF/Families First], 454 [State Plan for Child Support], 1002 [State Plans for Aid to Blind], 1402 [State Plans for Aid to the Totally and Permanently Disabled], 1602 [State Plans for Aid to the Aged, Blind and Disabled/SSI], or ***1902 [State Plans for Medical Assistance*]** **as the case may be, to the extent and for the period he finds necessary to enable such State or States to carry out such project, and**

As stated by Professor Bagley, Section 1903 is clearly not included in the waiver provisions permitted by subsection (a)(1) of Section 1115.

In addition, the October 01, 2019 edition of *The Tennessean* also now reports its own interview with Professor Bagley, that essentially confirms his earlier statement to the *Free Press*.

Noting that the 2017 attempt to repeal the Affordable Care Act which included requiring block granting of State Medicaid programs failed, there appears in the article an additional, perhaps more problematic, issue involving legality of implementing Medicaid block grants.

The article notes that among those now opposing the attempts by States to use block granting is U.S. Rep. Frank Pallone Jr., D-N.J., chairman of the House Energy and Commerce Committee whose committee has jurisdiction over Medicaid program provisions, and the article quotes Rep. Pallone saying:

> "Block granting Medicaid through a waiver is illegal, and the Trump administration does not have the authority to approve Tennessee's request," Pallone said Wednesday in a statement to the USA TODAY Network, declaring that "Tennessee and the Trump administration are attempting to bypass Congress and the American people."

The article continues:

> Pallone in June sent a letter to U.S. Department of Health and Human Services Secretary Alex Azar explaining that he believes federal law does not currently permit him to approve such a measure.

The article does not say what statutory provisions of the law, or lack thereof, Rep. Pallone states render block grants illegal for the Medicaid program.

Though the waiver of provisions of the financing law of Section 1903 does not appear in Section 1115(a)(1) of the Social Security Act] [42 U.S.C. Section 1315] which permits waiver by HHS of certain statutory provisions governing a State Medicaid Plan (among several others programs), Section 1903(a)(2) of the Social Security Act [42 U.S.C. Section 1396a(a)(2)] regarding requirements for State Plans for Medical Assistance does contain the following language relative to funding requirements:

> 1902(a)(2)
>
> A State plan for medical assistance must—
>
> (a)
> …
> (2) provide for financial participation by the State equal to not less than 40 per centum of the non-Federal share of the expenditures under the plan with respect to which payments under section [42 U.S.C, Section 1396b [Section 1903 of the Social Security Act][42 U.S.C. 1396b] of this title are authorized by this subchapter; and, effective July 1, 1969, provide for financial participation by the State equal to all of such non-Federal share or provide for distribution of funds from Federal or State sources, for carrying out the State plan, on an equalization or other basis which will assure that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope, or quality of care and services available under the plan;

This is one of literally dozens of operating standards to which a State Medicaid program must adhere unless waived pursuant to Section 1115.

But subsection (a)(2) of Section 1115 has language relating to funding of State Plans for which waivers are granted.

Section 1115 of the Social Security Act/42 U.S.C. 1315(a)(1) & (2) states:

(a) In the case of any experimental, pilot, or *demonstration project* *[TennCare's program]* which, in the judgment of the Secretary, is likely to assist in promoting the objectives of title I [*Old-Age Assistance***], X [***Aid to the Blind***], XIV [***Aid to the Totally & Permanently Disabled***], XVI[***SSI***],** or **XIX[*Medicaid*], or part A [***TANF/Families First***]or D[*Child Support*] of title IV [***Grants to States for Aid and Services to Needy Families with Children and for Child-Welfare Services***], to enable such State or States to carry out such project. and**

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(**1)** ***the Secretary may waive compliance with any of the requirements of section*** 2 [SSA], 402 [State Plans under Title IV-A/TANF/Families First], 454 {State Plan for Child Support], 1002 [State Plans for Aid to Blind], 1402 [State Plans for Aid to the Totally and Permanently, Disable], 1602 [State Plans for Aid to the Aged, Blind and Disabled/SSI], or ***1902[State Plans for Medical Assistance*****] as the case may be, to the extent and for the period he finds necessary to enable such State or States to carry out such project,** ***and***

(2)(A) costs of such project which would not otherwise be included as expenditures under section 3, 1003, 1403, 1603**,** or ***1903[Medicaid],*** **as the case may be, and which are not included as part of the costs of projects under section** 1110, **shall, to the extent and for the period prescribed by the Secretary, be regarded as expenditures under the State plan or plans approved under such title, or for administration of such State plan or plans, as may be appropriate, and…**

Although no specific waiver authority from the standard match financing requirement process in Section 1903 is provided in Section 1115(a)(1), it could be argued that under paragraph (2) of subsection (a) of Section 1115 that if a waiver from the Medicaid State plan requirements is made for Tennessee under subsection (a), paragraph (1) of Section 1115 to carry out a demonstration project, then paragraph (2)(A) of subsection (a) of Section 1115 states that any state Medicaid plan that is normally subject to Section 1903's funding requirements, could have the costs of the demonstration project be treated as if they satisfied the funding requirements for Tennessee's Medicaid State Plan under Section 1903(a)(2).

Although Amendment 42 does not address the explicit justification for block grant funding versus the match process, this may be what TennCare is basing the waiver of current funding requirements that would then permit the use of a block grant for Tennessee's TennCare program.

The specific basis under Section 1115 for the block grant funding mechanism should be clearly explained by TennCare.