December 20, 2019

The Honorable Alex Azar  
Secretary  
U.S. Department of Health and Human Services  
Hubert H. Humphrey Building  
200 Independence Avenue, S.W.  
Washington, D.C. 20201

Dear Secretary Azar:

Thank you for providing an opportunity to submit comments on Tennessee’s proposal to amend TennCare II, the state’s ongoing Medicaid 1115 demonstration (Project No. 11-W-00151/4). This proposal, identified as Amendment #42, would enable the state to operate its experiment as a block grant for nearly all populations and services covered under its state Medicaid plan. The Robert Wood Johnson Foundation (RWJF) is pleased to have the opportunity to respond to this request for comments. In brief, we request that the Secretary reject the Tennessee proposal.

RWJF is the nation’s largest philanthropy dedicated to improving health and health care in the United States. Since 1972, we have worked with public and private-sector partners to advance the science of disease prevention and health promotion; train the next generation of health leaders; and support the development and implementation of policies and programs to foster better health across the country, including high-quality health care coverage for all. We are working with others to build a Culture of Health, in which everyone has the opportunity to live the healthiest life possible, which includes removing barriers to good health like poverty and discrimination.

Access to comprehensive, quality health care is central to our mission of good health and well-being. Accordingly, health care coverage expansion is critical to our mission and has been an essential component of our work for more than four decades.

RWJF’s commitment to coverage is established in the following principles:

- Good health is necessary for everyone in America to participate fully in society, and a healthy population is vital to the productivity and economic and social well-being of our nation.
- Health care is critical to good health and should be available to all regardless of race/ethnicity, age, gender, geography, or income.
- Health insurance coverage is essential for access to necessary and appropriate health care and should be available to everyone in America.
Therefore, we believe that:

- Health insurance coverage should be affordable. Individuals should contribute to the cost of their care, however, the cost of health insurance and the out-of-pocket costs incurred in accessing care should not force individuals to choose between health care and other basic necessities of life.
- Health insurance coverage should include necessary, appropriate, and effective health care services.
- Health insurance coverage should be continuous and portable, bridging life span, employment, and geographic relocation.
- Health insurance coverage should promote high-quality and cost-effective health care.
- Health insurance coverage should be based on shared responsibilities between the public and private sectors and individuals. These responsibilities include the oversight, management, and financing of the health care system.

Medicaid provides more than 65 million people in America, including children, the elderly, and people with disabilities, with access to critically important health services. Our strong commitment to health care coverage and its important role in promoting good health compels us to provide comments on this latest proposal regarding TennCare. That is why as noted previously, we recommend that the Secretary reject the state’s application.

This proposal represents a significant risk to hundreds of thousands of Tennessee’s poorest and most vulnerable residents. Rather than promoting Medicaid’s core purpose—the standard that governs the Secretary’s decision to use his 1115 power—this proposal would contravene it by placing what Medicaid provides to states and communities through coverage and population health efforts directly at risk. From the point of view of the very people whom Medicaid was designed to help, there are no benefits to be gained by depriving the state of the funding it needs to operate its program over time.

Tennessee is proposing a complete transformation of Medicaid by replacing its historic federal financing structure with an aggregate federal spending cap. If approved, this proposal would abandon the aspect of Medicaid which makes it possible for states to respond to emerging health needs and manage high or unpredictable health care costs. Tennessee proposes to eliminate this safeguard in exchange for the power and flexibility to make non-reviewable decisions about policies and complex matters of state administration. Many of the matters over which the state seeks the power to disregard federal standards and make non-reviewable decisions, such as prescription drug coverage and managed care access and quality standards, involve crucial program safeguards. The purpose of these safeguards is to improve performance and strengthen Medicaid’s role as the nation’s largest funder of health and health care interventions to promote greater health equity for the nation’s most vulnerable populations. The state offers only the most general idea of how it intends to use its flexibility, what benefits and public health investments might be added, where spending efficiencies will come, and what, exactly, the program will do if costs outstrip projections.
Past research points to the risk of serious consequences for health and health care raised by a block grant experiment

The state’s experiment would forgo open-ended Medicaid funding, which helps states address costs. These costs are driven by numerous unpredictable factors: unexpected population growth; technology breakthroughs that increase care intensity and cost; pricing surges even for common procedures and treatments in a rapidly changing health care market; changes in service utilization; and emerging population and patient health needs such as rising maternal mortality rates, communicable disease epidemics, or public health crises such as the opioid epidemic.

In place of traditional Medicaid funding, Tennessee would receive lump-sum federal funding that, even if initially adequate, could rapidly run up against the types of unanticipated challenges that threaten any state’s health care system and economy. At this point, without federal funding elasticity, state health officials would have no choice but to take drastic steps such as reducing eligibility and benefits, slowing enrollment, cutting provider payment, and eliminating key access and health standards such as those found in federal managed care rules. Whether or not the state can take such steps only with federal clearance is, frankly, beside the point: these are the types of risks that such an experiment poses for program beneficiaries.

In exchange for living under a fixed aggregate federal budget, the state (which already budgets relatively tightly given its reliance on managed care contracts that offer the advantage of predictable premium growth) would receive $7.9 billion in the first experimental year. This amount reflects virtually all federal Medicaid spending other than outpatient prescribed drugs, certain direct payments to hospitals, expenditures made on behalf of dual enrollees, certain discrete services currently carved out of TennCare,1 and state expenditures for plan administration. Base funding would be trended forward according to a Congressional Budget Office (CBO) annual spending adjustment factor, without regard for state-specific, actual changes in price, technology, utilization, service intensity, or enrollment and eligibility among the traditional Medicaid population groups now covered under the state plan. As such, the proposal would lock the state into a hard federal budget that disregards the unpredictable factors that drive U.S. health care spending generally, and Medicaid in particular.2

A considerable body of research points to the complexity of accurately projecting Medicaid growth over time and the risks inherent in an experiment that accounts only for standardized medical inflation. The literature on block grants and the dangers they pose is quite considerable, but nowhere is this literature reflected in the state’s proposal, nor does the state suggest that it has even considered these risks.

For example, Congress’s effort to block grant Medicaid in 1995 generated extensive research on the effects of an aggregate federal spending cap. These analyses showed that over time, an aggregate cap would result in the loss of coverage for 8.8 million beneficiaries including 4 million children.3 Because Congress’s 1995 block grant proposal contained sufficient data to calculate state-by-state impact, researchers were able to identify a 22 percent differential for Tennessee between what was projected
under the legislation and the state’s actual experience by 2002, seven years after the block grant would have taken effect.  

Research examining the 1981 Reagan-era block grant plan (which was somewhat more generous than that proposed in 1995 because it was state-specific) showed that over the 1982-1991 time period, an enormous gap would have occurred between projected spending ($213.7 billion) and actual federal spending ($290.3 billion)—some $76.6 billion dollars or 26 percent.  

The recent legislative debate over whether to block grant Medicaid on a national scale similarly yielded extensive information on the large federal funding losses over time compared to current policy spending levels. One impact estimate concluded that between 2020 and 2026, under the cap envisioned under the House-passed version of the block grant, federal spending would decline by 43 billion dollars nationally for children, with a $1.9 billion decrease for Tennessee alone—by 2026, there would have been a 17 percent decrease in federal funding for traditionally-eligible children. Under the Graham-Cassidy proposal, the same researchers concluded that Tennessee would experience a $1 billion dollar federal funding decrease over the 2020-2027 time period, relative to current law. Between 2020 and 2036, this decrease would grow to $61 billion dollars in Tennessee, and to $4,150 billion nationally. Much of the loss was attributed to Medicaid per-capita spending growth rates that fell well below actual experience.  

Estimates of the impact of other Medicaid block grant proposals show similar results. One estimate by the Urban Institute of the impact of a block grant plan (A Better Way) put forth by House Speaker Paul Ryan found that under his proposal, between 14 and 21 million people eventually would lose Medicaid, on top of those who would lose coverage as a result of repealing the ACA Medicaid expansion itself. This study also found that states would reduce provider payment by over 30 percent to help compensate for the loss of funding. Additional research on A Better Way concluded that the proposal would reduce federal Medicaid spending by $841 billion over ten years, causing state Medicaid spending to increase by 29.7 percent. Were states to choose not to increase their own spending to offset federal losses, total Medicaid spending on beneficiaries would decline by $1.4 trillion. Tennessee alone would see a federal spending decline of $13 billion under A Better Way, that would in turn trigger the need for an estimated 25 percent increase in Tennessee state spending if the state were to attempt to offset the loss. Were the state to try to offset lost funding by cutting benefits and provider payment rates (including payments to managed care plans), its Medicaid program would face a beneficiary spending decline of $21 billion over a decade.  

This substantial body of research underscores the difficulty of projecting Medicaid growth over time and the scale of financial loss that a state could experience if it attempts to hold spending constant. Inevitably, services, access, and enrollment are threatened unless a state chooses to replace the federal funding it loses with state funding. Tennessee’s own proposal makes clear that the state is in no position to do that. Although certain aspects of Tennessee’s plan may distinguish the proposal from prior experience, the body of research to date helps elucidate the magnitude of federal revenue loss that the state could confront, especially since the state asks that its experimental proposal be made a permanent feature of
its Medicaid program. Nowhere does the state explain why its experience under a block grant might be any different from these decades of research.

**Public comments to date evidence widespread concern and opposition**

In order to move forward, an experiment as sweeping as the one proposed by the state should have strong public opinion behind it. But the public comment record from state residents to date shows otherwise. According to news accounts, Tennessee received 1800 public comments, 11 of which were supportive. A public record like this demonstrates overwhelming opposition, not just by those directly affected by the proposal but from residents more generally. Although the state made adjustments in its final, submitted proposal, the plan remains fundamentally the same.

Many comments focused on the state’s proposal to eliminate virtually the entire Medicaid managed care rule, including its access and provider network standards, its quality standards, and requirements related to physical and mental health coverage parity. Most fundamentally, perhaps, waiving the rule would threaten the entire regulatory structure on which managed care financing rests, including the assurance of actuarial soundness and robust medical loss ratios.

The state makes much of its desire to invest savings (should they emerge) in health and health care activities. But as commenters pointed out, the state makes no reinvestment guarantee with identified, specific investments according to a proposed time schedule. Indeed, Tennessee has a public record of diverting unspent funding from social welfare programs and retaining these savings unspent. This record includes recent stories pointing to over $700 million in unspent temporary Assistance for Needy Families (TANF) funding, in a state with one of the nation’s poorest populations.

Of particular concern in our view is what happens to people with serious medical conditions such as diabetes, heart disease, serious mental illness, and other severe conditions that threaten health and life but that can effectively be managed with comprehensive, ongoing care. It is in these types of conditions that one sees the nation’s worst health inequities by income and race, and it is these types of conditions that, as research shows, have lent themselves to effective health care management under Medicaid.

The state responded with general assertions that its plan is not to reduce enrollment, access, coverage, or quality. But this response offers no explanation as to why the state and its residents ultimately will not have to confront precisely these choices.

**The state’s proposal must be viewed against the broader backdrop of coverage and access**

Tennessee’s proposal comes from a state that already is experiencing a serious health crisis in terms of coverage and access. Even a cursory review suggests that this is not a state whose health care system can withstand the severe shock of stagnant funding in the face of rising costs. The case for testing a Medicaid block grant in Tennessee weakens still further as facts about the overall state of health care in Tennessee come into view.
United States Census figures released earlier this year\textsuperscript{13} show that between 2017 and 2018, Tennessee experienced the third largest rate of growth nationally in its uninsured population. At a 0.6 percent increase, this represents an additional 46,000 uninsured residents at a time when the national economy is booming. By 2018, some 675,000 state residents—one in 10—were uninsured.\textsuperscript{14} Because Tennessee has not adopted the ACA Medicaid expansion, more than 200,000 adults, an estimated 38 percent of the state’s uninsured nonelderly population, are caught in a coverage gap, because they are too poor to qualify for Marketplace premium tax credits but ineligible for medical assistance.\textsuperscript{15}

Experts have documented the relationship between health system performance and community-wide insurance rates.\textsuperscript{16} This relationship, between the collective ability of communities to support health care systems and the relative strength of those systems, can be seen in Tennessee, in which higher poverty levels and reduced insurance rates have caused broader spillover effects on health system capacity. Since 2012, at least 10 rural hospitals have closed and others have ended all inpatient care, leaving affected communities without readily accessible hospital care. Without hospitals to serve as health care anchors, attracting and retaining physicians grows more challenging; indeed one national estimate of primary care physician shortages shows that 18 percent of the state’s population lives in one of the state’s 111 designated physician shortage areas.\textsuperscript{17} The state’s proposal, by contrast, does not suggest that it has considered the broader public health implications of an experiment that would place arbitrary limits on federal funding.

**Conclusion**

Tennessee’s proposal raises alarms regarding the dangers it poses to the state’s most vulnerable populations and its potential to seriously erode, not advance, the goal of health equity. Research strongly suggests that the proposed demonstration will trigger significant reductions in enrollment, eligibility, and coverage, with risks for population health and health care system stability. For these reasons, we believe that the proposal should be rejected.

Thank you for providing us with this opportunity to comment.

Sincerely,

Richard E. Besser, MD  
President and CEO  
Robert Wood Johnson Foundation
1. According to the state, these are the services provided to individuals with intellectual disabilities under the authority of a separate 1915(c) waiver and targeted case management services provided to children in state custody.


4. Id.


