TN Division of TennCare

August 30, 2022

Mr. Daniel Tsai
Deputy Administrator and Director
Center for Medicaid and CHIP Services
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop: S2-26-12
Baltimore, Maryland 21244-1850

RE: TennCare III Demonstration, Amendment 4

Dear Mr. Tsai:

Tennessee appreciates CMS' longstanding partnership in the administration of the TennCare demonstration and, specifically, CMS' partnership in implementing the current iteration of the TennCare demonstration, "TennCare III," since January 8, 2021.

We believe that Tennessee and CMS share many of the same goals for Tennessee's Medicaid program and that the TennCare III demonstration is an effective vehicle for advancing these goals. As we have communicated both to you and publicly many times, TennCare III provides a tremendous opportunity to enhance the benefits and services provided to Tennessee's Medicaid beneficiaries as well as serve more Tennesseans in need. In fact, since the approval of TennCare III 18 months ago, Tennessee has significantly expanded the scope of coverage and benefits available under Medicaid in Tennessee, including extending Medicaid postpartum coverage to 12 months, providing dental benefits for pregnant and postpartum beneficiaries, implementing a chiropractic benefit for adults, expanding the scope of HCBS benefits available through the demonstration, and increasing enrollment in HCBS (with the goal of eliminating all waiting lists for HCBS programs). In addition, in the past year Tennessee has submitted a demonstration amendment to CMS to expand TennCare's coverage of adopted children in Tennessee, and we are currently working to implement a dental benefit for all adults enrolled in TennCare. We believe these investments reflect Tennessee's and CMS' shared priorities, will lead to improved health outcomes for Medicaid beneficiaries in Tennessee, and promote the objectives of Medicaid. The opportunity to make investments like these in the health of Medicaid beneficiaries in Tennessee was the driving consideration behind the development and approval of the TennCare III demonstration.

In your letter of June 30, 2022, CMS requested that the state submit a demonstration amendment to revise certain parts of the TennCare demonstration. After careful consideration and in confidence that

the requested changes and attached submission maintain the goals and objectives of TennCare III, we are submitting the attached amendment ("Amendment 4"). We believe this amendment addresses the areas of concern noted by CMS. Each of these areas is further discussed below.

Financing of the Demonstration and Limitations on Reductions in Benefits and Coverage

As CMS is aware, it is longstanding federal policy that all Medicaid 1115 demonstration projects be subject to budget neutrality caps. We note that the aggregate cap to which CMS is now objecting is explicitly permitted by CMS policy[1], and demonstrations with similar aggregate caps have been approved in multiple other states. Nonetheless, Tennessee is confident that the TennCare III demonstration is in fact budget neutral for the federal government and can be demonstrated to be so via any number of methodologies. As such, consistent with CMS' request, the state is including in Amendment 4 a proposal to assess budget neutrality for the TennCare demonstration using a per member per month (PMPM) cap.

To provide additional clarity in this area, we recommend that CMS engage in efforts to educate stakeholders about the role that budget neutrality plays in the administration of Medicaid 1115 demonstration projects. Since its inception, the TennCare III demonstration has been the subject of the misperception that its budget neutrality framework represents a unique constraint on Medicaid expenditures in Tennessee rather than a feature that is common to all 1115 demonstrations. This misperception has been the cause of unnecessary distress for Medicaid beneficiaries and other stakeholders in Tennessee for the past two years (even as the state made historic new investments in maternal health benefits, HCBS, and other Medicaid benefits in Tennessee). To the extent that CMS continues to require that Medicaid 1115 projects demonstrate budget neutrality, CMS should strive to help stakeholders better understand the purpose of the budget neutrality framework and how it functions.

As it relates to benefit reductions, we agree with CMS that the approval of TennCare III and the accompanying Special Terms and Conditions already make clear that nothing in the demonstration authorizes the state to reduce coverage or benefits below the levels that were in place on December 31, 2020. Any such reductions, should they be necessary, would be subject to the standard amendment process. We have no objections to stating this even more explicitly in the demonstration.

Demonstration Expenditure Authorities

A key component of the TennCare III demonstration is the new expenditure authority approved for the state. This expenditure authority represents a significant new opportunity for the state to expand the coverage and benefits available under TennCare and otherwise invest in the health of Medicaid beneficiaries in Tennessee—a key goal of the TennCare III demonstration. Under the TennCare demonstration, these expenditure authorities are coupled with the demonstration's budget neutrality

[1] See for example State Medicaid Director Letter #18-009 (August 22, 2018) regarding budget neutrality policies for Section 1115(a) Medicaid demonstration projects.

framework in recognition that under the demonstration, the state is producing savings for the federal government.

The ability to make new investments in Medicaid coverage and benefits remains the state's primary goal for the TennCare III demonstration, and it is the state's expectation that this authority will be preserved in any amended version of the demonstration. However, to the extent that the demonstration's budget neutrality framework will be modified consistent with CMS's recommendation above, then it will also be necessary to revise the methodology by which these new expenditure authorities are operationalized. In Amendment 4, the state has proposed a revised framework for recognizing savings achieved under the demonstration and reinvesting those savings in the TennCare program in a manner that will advance CMS' and the state's policy goals.

Closed Formulary

In your letter of June 30, 2022, CMS requested that Tennessee submit an amendment to the TennCare III demonstration to remove the expenditure authority for pharmacy and associated pharmacy flexibilities from the demonstration. As CMS is aware, the cost of prescription drugs represents a significant area of concern for Medicaid, and absent the tools commonly available to other payers such as Medicare and commercial insurers, it is a cost that states have limited ability to control. In recent years, a growing number of states have sought to use 1115 demonstration authority to allow for the exclusion of certain drugs from their prescription drug formularies.

In light of these considerations, we believe the flexibility that CMS approved for TennCare is a permissible and reasonable use of the Secretary's authority under Section 1115 to test novel approaches to the financing and delivery of Medicaid benefits. However, maintaining this flexibility does not outweigh the larger benefits of the TennCare demonstration to Tennessee and to TennCare beneficiaries, and so consistent with CMS' request, Amendment 4 proposes to remove this expenditure authority from the demonstration. The inclusion of this proposed change in Amendment 4 is not an indication that Tennessee's concerns with the rising cost of prescription drugs or the lack of mechanisms to meaningfully control drug costs within the existing Medicaid policy framework have been alleviated. We urge CMS to use the tools at its disposal—including both its regulatory powers under Title XIX and its authority to waive rules and statute under Section 1115—to implement strategies to address this critical issue.

Other Pending Demonstration Amendments

Since the approval of TennCare III on January 8, 2021, the state has submitted two demonstration amendment requests to CMS. On March 31, 2021, the state submitted proposed Amendment 1 to CMS. Among other things, Amendment 1 requested to integrate certain services for persons with intellectual disabilities into the state's existing managed care program under the demonstration. On April 8, 2022, the state submitted Amendment 2 to CMS. Amendment 2 requests expenditure authority to extend TennCare coverage to children adopted from state custody who are not otherwise eligible for Medicaid. CMS has yet to act on either of these amendment requests.

The length of time needed by the federal government to review and approve even simple demonstration requests from states (e.g., carving particular Medicaid benefits into or out of managed care, extending already approved demonstrations even when no changes have been requested) continues to be a source of frustration for states and was one of the reasons that led Tennessee to request additional administrative flexibilities under TennCare III. We continue to urge CMS and its federal partners to make improvements to the process for reviewing and approving 1115 demonstration requests from states.

As it pertains to TennCare III and the attached amendment request, we request that in approving Amendment 4, CMS also include approval of the changes requested by the state in Amendment 1 and Amendment 2. Both of these amendment requests propose changes that are clearly permissible, advance the objectives of Medicaid, and have been before CMS long enough for CMS and its federal partners to have sufficient opportunity to review them.

Year 1 Shared Savings

While Tennessee is open to discussing the proposed changes in the attached amendment with CMS, we also note that Tennessee has been operating the TennCare III demonstration for more than a year and a half. It is our expectation that shared savings earned under Year 1 of the demonstration will be determined and approved in the immediate future pursuant to the terms and conditions currently in place.

We appreciate CMS' ongoing partnership in the administration of Tennessee's Medicaid program. Thank you for your attention to this important matter.

Sincerely,

[redacted]

Stephen Smith
Director, Division of TennCare

cc: Judith Cash, Director, State Demonstrations Group, Center for Medicaid and CHIP Services
April Wiley, Project Officer, State Demonstrations Group, Center for Medicaid and CHIP Services

Division of TennCare

TennCare III Demonstration

Project No. 11-W-00369/4

Amendment 4

Program Modifications

August 30, 2022

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Amendment 4 to the TennCare III Demonstration

Since 1994, Tennessee has operated its Medicaid program under the authority of an 1115 demonstration program known as TennCare. TennCare is a comprehensive Medicaid reform project, consisting of innovations in multiple aspects of the Medicaid program, including eligibility, benefits, and service delivery systems. Tennessee currently provides Medicaid coverage to more than 1.6 million Tennesseans under the authority of the TennCare demonstration.

The current iteration of the TennCare demonstration, known as "TennCare III," began operating on January 8, 2021. From August to September of 2021, the Centers for Medicare & Medicaid Services (CMS) held a public comment period on the TennCare III demonstration, and on June 30, 2022, CMS sent a letter to Tennessee identifying a limited number of issues based on the public comments received. CMS requested that Tennessee submit a demonstration amendment to address these considerations.

We believe that Tennessee and CMS share the same primary goals for Tennessee's Medicaid program, and like CMS, the state values public input on all aspects of its Medicaid program. Out of consideration of these comments and to mitigate the issues identified by CMS, Tennessee proposes the changes outlined below to the TennCare demonstration. These changes will be referred to as "Amendment 4."

I. Description of the Amendment

In its June 30, 2022, letter, CMS requested the state submit a demonstration amendment to address the following areas:

- Financing of the demonstration and limitation on reductions in benefits and coverage,
- Demonstration expenditure authorities, and
- Closed formulary.

Each of these areas is addressed below.

Financing of the Demonstration and Limitations on Reductions in Benefits and Coverage

As with all Medicaid 1115 demonstration projects, CMS requires that Tennessee be able to demonstrate that the TennCare demonstration is budget neutral for the federal government (i.e., the demonstration does not result in Medicaid costs to the federal government that are greater than what the federal government's Medicaid costs would have been absent the demonstration). CMS policy provides a number of ways in which states can demonstrate budget neutrality. Budget neutrality is most commonly demonstrated through either an "aggregate cap" framework or a "per capita cap" framework.[1]

[1] See for example State Medicaid Director Letter #18-009 (August 22, 2018) regarding budget neutrality policies for Section 1115(a) Medicaid demonstration projects.

The TennCare demonstration's budget neutrality framework is currently calculated on an aggregate cap basis.[2] In its June 30, 2022, letter, CMS requested that the state submit an amendment in which the demonstration's budget neutrality would instead be calculated on a per capita cap basis. The state believes that the TennCare demonstration is budget neutral for the federal government and that it can be demonstrated to be so via any number of methodologies. Therefore, consistent with CMS' request, the state proposes in this amendment to assess budget neutrality for the TennCare demonstration via a "per member per month cap" framework and requests that the demonstration's special terms and conditions be modified accordingly.

In proposing this modification, the state is requesting only that the basis by which the demonstration's budget neutrality is calculated be changed (i.e., from an aggregate basis to a per capita basis). The state is requesting no changes to any other elements of the demonstration's budget neutrality framework, including (but not limited to):

- The baseline PMPM costs associated with each beneficiary category,
- The trend rates for each beneficiary category,
- The methodology for rebasing the demonstration's budget neutrality for Years 6 through 10 of the demonstration, and
- The state's ability to carry forward savings from the last five years of the preceding iteration of the TennCare demonstration (TennCare II).

As such, the demonstration's proposed per capita cap budget neutrality model will be calculated based on the following parameters:

	Base Year	Trend Rate	DY 1	DY 2	DY 3	DY 4	DY 5
EG 1 Disabled	$1,515.31	5.4%	$1,728.83	$1,822.19	$1,920.59	$2,024.30	$2,133.61
EG 2 Over 65	$1,182.01	4.5%	$1,319.83	$1,379.22	$1,441.28	$1,506.14	$1,573.92
EG 3 Children	$253.67	5.5%	$290.11	$306.06	$322.89	$340.65	$359.39
EG 4 Adults	$442.62	5.3%	$503.79	$530.49	$558.60	$588.21	$619.38
EG 5 Duals	$890.18	5.5%	$1,018.04	$1,074.03	$1,133.10	$1,195.42	$1,261.17

The above PMPMs will be multiplied by the applicable member months for each beneficiary category based on actual TennCare enrollment, and the resulting values will be added together to calculate a portion of the TennCare budget neutrality cap. Additionally, the TennCare demonstration authorizes

[2] In actuality, the TennCare III demonstration's current budget neutrality cap was only initially an aggregate cap. Under the terms of the demonstration, the aggregate cap became a *de facto* per capita cap once TennCare enrollment grew by more than 1 percentage point above the baseline enrollment level established for the demonstration in 2019.

certain supplemental payments to hospitals and other safety net providers in Tennessee totaling $622,384,474 annually. These expenditures will be added to the expenditures attributable to beneficiary member months described above to derive the total budget neutrality cap for the demonstration.

Tennessee agrees with CMS that the approval of TennCare III and the accompanying special terms and conditions make clear that nothing in the demonstration authorizes the state to reduce coverage or benefits below the levels that were in place on December 31, 2020. Any such reductions, should they be necessary, would be subject to the standard amendment process. The state has no objections to stating this even more explicitly in the demonstration's special terms and conditions.

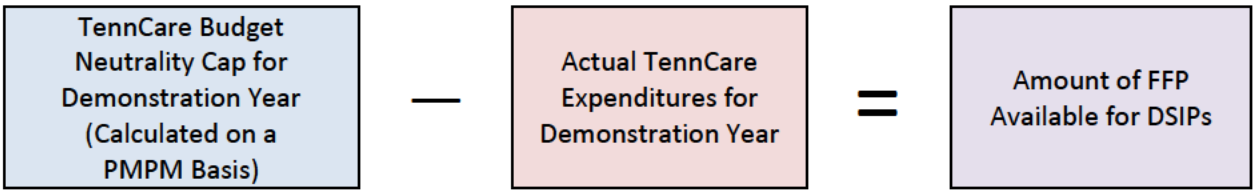
Demonstration Expenditure Authorities

Consistent with CMS' request of June 30, 2022, and the proposed change to TennCare's budget neutrality framework described above, the state proposes corresponding changes to the framework governing the state's expenditure authorities under the demonstration. This component of the demonstration recognizes savings produced to the federal government by the state under the demonstration and provides a mechanism for the state to reinvest a portion of those savings in initiatives to improve the health of Medicaid beneficiaries.

In this amendment, Tennessee requests federal financial participation (FFP) for designated state investment programs (DSIPs). These federal expenditures would be authorized by Section 1115(a) as costs not otherwise matchable (CNOMs). A list of identified and approved programs is included as Attachment O of the TennCare demonstration. These programs support access to healthcare across a variety of domains, spanning mental health, public health, community services, and child health services. Currently, state funds support these services and programs to meet health needs that Medicaid, as it is currently structured, does not. Many of the individuals served by these programs receive services alongside of people who are Medicaid-eligible, and many of them are individuals who churn in and out of Medicaid eligibility, creating a confusing and inefficient system for consumers and communities to navigate.

In order to ensure the budget neutrality of these additional federal expenditures, the state requests that the amount of DSIP expenditure authority each year be based on the extent (if any) to which the state's expenditures for that year are below its budget neutrality cap (now calculated on a per member per month basis), up to a maximum amount equivalent to the federal share of the designated state investment programs specified in the demonstration. This arrangement recognizes the role that these programs play in improving the health of Medicaid enrollees and the communities in which they live and will support the state's efforts to make investments in improving the health of Medicaid beneficiaries over the life of the demonstration (e.g., adult dental services, expanded 12-month postpartum coverage, enhancements to home- and community-based services, etc.).

This new framework for the demonstration's DSIP expenditure authority is illustrated in the figure below.



Closed Formulary

The TennCare III demonstration includes expenditure authority for pharmacy and related flexibilities that allow Tennessee to exclude certain drugs from the state's Medicaid prescription drug formulary (subject to a number of conditions and protections). This flexibility was requested by the state and approved by CMS in recognition of the growing costs of prescription drugs—an increasing number of which are accelerated approval drugs with limited or inadequate evidence of clinical efficacy—and the lack of tools available to states to meaningfully manage these costs within the existing Medicaid policy framework.

While we regard this flexibility as a permissible and reasonable use of the Secretary's authority under Section 1115 to test novel approaches to the financing and delivery of Medicaid benefits, at CMS' request, the state is proposing to remove this expenditure authority and its associated flexibilities from the TennCare demonstration. In lieu of this flexibility, the state requests that the demonstration's STCs be modified to provide for an adjustment to the demonstration's PMPM caps in instances when prescription drug costs materially affect the average per-member cost of care.

Other Waiver and Expenditure Authorities

The state is requesting no changes to the waiver and expenditure authorities of the demonstration other than those described above. All other waiver and expenditure authorities approved for the TennCare demonstration will continue to be in effect under this amendment. This includes (but is not limited to) waiver and expenditure authorities related to eligibility for individuals not eligible for Medicaid under the State Plan, benefits not covered under the State Plan, use of a statewide managed care service delivery system, the CHOICES program, the Employment and Community First CHOICES program, Tennessee's Katie Beckett/Medicaid Diversion program, retroactive eligibility, and supplemental payments to hospitals and other safety net providers.

II. Expected Impact on Budget Neutrality

Implementation of this amendment will not result in any changes in enrollment or expenditures under the TennCare demonstration. This amendment will result in changes to the way that the demonstration's budget neutrality is calculated, as described in Section I above.

III. Expected Impact on CHIP Allotment Neutrality

This amendment will not result in any changes to Tennessee's CHIP allotment neutrality.

IV. Updates to Monitoring and Evaluation Processes

The state's evaluation design for the demonstration (currently under CMS review) will be modified to reflect that the expenditure authority related to pharmacy and its associated flexibilities are no longer part of the demonstration. Research questions and hypotheses related to the implementation of a closed formulary will be removed from the evaluation design.

In addition, the tools used by CMS and the state to monitor budget neutrality for the demonstration will be modified to reflect the changes to the budget neutrality framework described above (i.e., to reflect the change from an aggregate cap budget neutrality framework to a per member per month cap budget neutrality framework).

V. Demonstration of Public Notice and Input

The state has used multiple mechanisms for notifying the public about this amendment and for soliciting public input on the amendment. These public notice and input procedures are informed by—and comply with—the requirements specified in STC 12 of the TennCare demonstration and 59 Fed. Reg. 49249.

Public Notice

The state held a formal notice and comment period on this proposed demonstration amendment from July 19, 2022, through August 19, 2022. During this time, a comprehensive description of the amendment to be submitted to CMS was available for public review and comment on an amendment-specific webpage on the TennCare website. In addition, a notice of the state's intent to submit a demonstration amendment was published in newspapers of general circulation in Tennessee communities with 50,000 or more residents. This newspaper notice described the major elements of the proposed amendment and provided instructions for how to access the proposal on the TennCare website. The newspaper notice also provided instructions for submitting comments on the proposed amendment to the state during the notice and comment period. In addition, the state notified the public of its intent to submit a demonstration amendment via social media (i.e., Facebook, Twitter) with links to the comprehensive notice on the state's website. The state made copies of its notice available in county health departments throughout the state. TennCare also notified the members of the Tennessee General Assembly of this amendment via an electronically transmitted letter.

Documentation of the state's public notice process is attached as Appendix B.

Public Input

The state received 16 comments on behalf of 30 individuals and organizations in response to its public notice. All comments were reviewed and considered by the state prior to the submission of this amendment to CMS. The comments received, along with the state's responses, are summarized below.

The comments received by the state are also appended to this amendment in their entirety as Appendix C.

Most commenters supported the state's proposal to remove the expenditure authority related to pharmacy and associated flexibilities from the demonstration.

The state thanks these commenters for their support. No changes were made to the amendment based on these comments.

Many commenters supported the state's proposal to assess budget neutrality for the TennCare demonstration using a "per member per month" cap method rather than an aggregate cap method.

The state thanks these commenters for their support. No changes were made to the amendment based on these comments.

Several commenters expressed concern about the TennCare demonstration's waiver of retroactive eligibility for certain populations; these commenters generally believed this waiver creates challenges for beneficiaries and providers. These commenters recommended that the state remove this waiver from the demonstration.

The state respectfully disagrees with these commenters' recommendation. The state's policy of beginning coverage on the day of an individual's application is reasonable and necessary in order for the state to meaningfully manage the care of beneficiaries (a key goal of the TennCare demonstration). In the decades that the state's policy has been in place, the state has adopted a number of strategies to help ensure that individuals applying for care can in fact access such care quickly; these include the use of presumptive eligibility processes for a number of populations, as well as partnerships with nursing facilities, hospitals, and other medical institutions to facilitate the timely submission of applications when needed. No changes were made to the amendment based on these comments.

Some commenters expressed support for stating more explicitly in the demonstration's special terms and conditions that nothing in the demonstration permits the state to reduce coverage or benefits below the levels that were in place on December 31, 2020.

The state thanks these commenters for their support. No changes were made to the amendment based on these comments.

A few commenters expressed concern about the 10-year approval period of the TennCare III demonstration. These commenters generally felt that 1115 demonstrations should be subject to more frequent evaluation and re-authorization. Two of these commenters recommended that the state request a 5-year approval of the demonstration instead of the current 10-year approval.

The state respectfully disagrees with these commenters' concern. The state does not agree that more frequent demonstration approvals add value for the federal government, the state, Medicaid beneficiaries, or providers. The state also notes that the special terms and conditions of the TennCare demonstration require the state to produce and make publicly available a number of interim evaluation reports over the life of the demonstration. To the extent that either the state or CMS determines that the demonstration is failing to meet its objectives, the demonstration's special terms and conditions allow either the state or CMS to discontinue the demonstration at any time. No changes were made to the amendment based on these comments.

A few commenters requested that the state expand TennCare eligibility to low-income adults described in Section 1902(a)(10)(A)(i)(VIII) of the Social Security Act as a means to expand access to coverage among low-income Tennesseans.

These comments are outside the scope of the amendment. Amendment 4 proposes modifications to the existing TennCare demonstration. Under Tennessee state law, any expansion of TennCare under Section 1902(a)(10)(A)(i)(VIII) of the Social Security Act must be authorized by the Tennessee General Assembly, which has not occurred as of the submission date of this amendment. No changes were made to the amendment based on these comments.

Two commenters requested a commitment on the part of the state for transparency and public reporting regarding how funds resulting from the implementation of the TennCare III demonstration are used.

The state thanks these commenters for their comments and reiterates its commitment to public transparency regarding all aspects of the TennCare demonstration, including the use of any funds realized through the demonstration. This commitment to transparency is reflected in the periodic forums, monitoring reports, and interim evaluation reports that are built in to the demonstration, as well as less formal forms of engagement and communication with stakeholders. The state always welcomes input and suggestions from interested stakeholders on how to make its communication efforts more effective.

Two commenters requested that the state include a commitment in the amendment that funds realized through the TennCare III demonstration will be directed to benefit the disability community. Specific recommendations included increasing the wages of workers who support individuals with disabilities, adjusting the expenditure caps in the HCBS programs authorized under the demonstration, and continuing to enroll new persons in HCBS.

The state thanks these commenters for their suggestions. The state reiterates its commitment that funds realized through the TennCare III demonstration will be used for the benefit of TennCare beneficiaries, including TennCare beneficiaries with disabilities. The state notes that since the implementation of the TennCare III demonstration in January 2021, the state has increased reimbursement rates for HCBS providers, increased the expenditure caps on services provided through CHOICES Group 3 and Employment and Community First CHOICES, and increased enrollment in Employment and Community

First CHOICES, with plans to re-open CHOICES Group 3 to new enrollment in fall 2022. The state expects that improvements like these will continue to be possible over the life of the TennCare III demonstration.

Two commenters supported the state's request that the demonstration's budget neutrality framework be adjusted if prescription drug costs materially impact the average per-member cost of care during the time the demonstration is in effect.

The state thanks these commenters for their support. No changes were made to the amendment based on these comments.

Two commenters recommended certain restrictions or "guardrails" be placed around the state's use of DSIP funding. These commenters' suggestions included capping the state's amount of DSIP funding at a fixed amount and the inclusion of "supplement, not supplant" language in the special terms and conditions governing the use of DSIP funding.

The state disagrees with these comments and believes the commenters may not understand the policy objectives of the DSIP component of the demonstration. No changes were made to the amendment based on these comments.

One commenter wrote to express appreciation for enhancements to TennCare coverage and benefits that have occurred since the implementation of the TennCare III demonstration. Specifically, this commenter supported coverage of dental services for adults enrolled in TennCare (implementation currently in process) and noted the importance of dental care for both health and quality of life.

The state thanks this commenter for their support. The state agrees about the importance of oral health as a component of overall health and well-being. More broadly, the state is also pleased with the enhancements to TennCare coverage and benefits that have occurred since the implementation of TennCare III and expects additional enhancements to be possible over the life of the demonstration. No changes were made to the amendment based on this comment.

One commenter opposed the provision of the TennCare demonstration that permits the state to suspend eligibility of persons convicted of TennCare fraud. This commenter noted that disruptions in coverage may negatively impact persons receiving ongoing treatment for conditions such as cancer.

The state thanks this commenter for their input. TennCare beneficiaries are recipients of a public benefit, and the state does not believe it is unreasonable that some meaningful accountability should be in place for individuals who abuse that benefit. In fact, such policies strengthen the overall integrity of the Medicaid program. No changes were made to the amendment based on this comment.

One commenter recommended that the supplemental payments authorized under the TennCare demonstration be excluded from the calculation of budget neutrality for the demonstration. This commenter suggested that including these payments within the budget neutrality calculation forces the

state and federal government to scrutinize provider payment arrangements primarily based on their fiscal impact rather than their impact on maintenance of provider networks or achieving high-quality care.

The state thanks this commenter for their input. Because the supplemental payments in question are authorized by the demonstration, it is the state's understanding of CMS policy that these payments must be accounted for within the demonstration's budget neutrality framework. In finalizing the demonstration's new budget neutrality framework, the state will seek to clarify this issue with CMS and determine what flexibility (if any) is available in accounting for supplemental payments to providers within federal budget neutrality policy.

One commenter noted that the cost of prescription drugs is a challenge for Medicaid programs and requested that the state continue to monitor the cost-effectiveness of high-cost medications. This commenter recommended that the state not remove any pharmacy-related hypotheses or research questions from the demonstration evaluation design.

The state shares the commenter's concern about the high cost of certain prescription drugs. If CMS approves the state's proposed amendment, the expenditure authorities for pharmacy and related flexibilities will no longer be part of the TennCare demonstration. Thus, it would not be appropriate to include these authorities and flexibilities within the demonstration's evaluation design. However, the state is committed to continuing to monitor the cost and cost-effectiveness of prescription drugs through mechanisms other than the TennCare evaluation design. No changes were made to the amendment based on this comment.

One commenter requested that the state provide the public an opportunity to comment on future changes to the TennCare evaluation design.

The state and CMS are currently finalizing the evaluation design for the TennCare III demonstration. Once approved by CMS, the approved evaluation design will be posted to TennCare's website in accordance with the demonstration's special terms and conditions. Any future amendments to the TennCare demonstration will include corresponding proposed changes to the demonstration's evaluation design. This process will allow for members of the public to comment on these proposed changes. No changes were made to the amendment based on this comment.

One commenter expressed appreciation for the state's commitment not to reduce the scope of coverage and benefits available under the TennCare demonstration and requested a similar commitment not to reduce provider reimbursement rates.

Provider reimbursement rates are not the subject of Amendment 4 and are outside the scope of the TennCare demonstration generally. However, the state is committed to continuing to work with providers to ensure that provider reimbursement is appropriate, equitable, and sufficient to ensure meaningful

access to care, high quality of care, strong provider networks, and positive health outcomes. No changes were made to the amendment based on this comment.

One commenter recommended that the state establish a managed quality incentive arrangement to support efforts by providers to improve the quality of care and promote positive health outcomes. This commenter requested that the demonstration's budget neutrality framework be modified to allow for adjustments to the budget neutrality cap to accommodate the cost of such an incentive payment arrangement.

The state appreciates this commenter's suggestion and is open to discussing any payment arrangements that will lead to improvements in the cost or quality of care and/or improvements in health equity or health outcomes. In finalizing the demonstration's new budget neutrality framework with CMS, the state will seek to clarify how CMS budget neutrality policy accommodates such incentive payment arrangements and if such an accommodation can be applied to TennCare's budget neutrality framework.

One commenter recommended that states institute policies to protect open access to antiretroviral drugs in Medicaid, similar to the protections found in Medicare Part D, and also to support extension of this protection to antiretroviral drugs utilized for HIV prevention, specifically HIV pre-exposure prophalaxis (PrEP). This commenter also recommended that state Medicaid programs participate in federal efforts to end the HIV epidemic.

The state thanks the commenter for their recommendations and will consider these recommendations when planning HIV prevention initiatives or planning for how to improve care for TennCare beneficiaries living with HIV.

One commenter requested more communication from the state regarding the implementation of the TennCare III demonstration and the impact of implementation on TennCare beneficiaries, particularly those in the disability community.

The state is committed to communicating openly with all stakeholders about the implementation of the TennCare III demonstration and its impact on beneficiaries. A number of communication mechanisms are already in place; however, the state is always open to input and suggestions on how to make its communication efforts more effective. The state will continue to work with interested stakeholders to develop and refine effective communication strategies.

One commenter requested more information about the process for adding new Designated State Investment Programs (DSIPs) to the demonstration over the life of the demonstration. In particular, this commenter recommended that the state and CMS explore opportunities to support other programs that contribute to stable provider networks and increase access to care, such as charity care payments for Critical Access Hospitals (CAHs).

The state agrees that there are programs beyond the DSIPs identified in Attachment O of the demonstration that support access to care for low-income persons or otherwise promote the objectives of Medicaid. Further, like any other part of the demonstration, the list of DSIPs in the TennCare demonstration may be modified through mutual agreement by the state and CMS. The state will work with CMS to determine if additional clarity concerning this aspect of the demonstration is needed.

One commenter recommended that the state increase the expenditure caps for HCBS benefits provided through CHOICES Group 3 and Employment and Community First CHOICES. This commenter also articulated a need to improve reimbursement rates for HCBS providers to ensure providers are adequately compensated for these services.

The state thanks this commenter for their recommendation. Although not the subject of Amendment 4, the state recognizes the critical role that HCBS providers play in supporting individuals with disabilities and their families. The state notes that TennCare adjusted the expenditure caps for CHOICES Group 3 and Employment and Community First CHOICES in fall 2021. The state intends to monitor the impact of these adjustments to determine if additional expenditure cap adjustments are needed in the future. The state is also committed to working with providers to ensure that reimbursement rates are sufficient so support broad access to high-quality care.

Appendix A

Redline Special Terms and Conditions

EXPENDITURE AUTHORITIES

The following expenditure authorities shall enable Tennessee to implement the Medicaid Section 1115 demonstration (TennCare III):

3. Expenditures for Hospital and Clinic Payments.

Expenditures for hospital and clinic payments to the extent specified in STC ~~67~~ 66 (*Permissible Uncompensated Care Payments*).

~~**27. Pharmacy**~~
~~Expenditures for coverage of outpatient drugs as provided in STC 45.~~

SPECIAL TERMS AND CONDITIONS

The STCs have been arranged into the following subject areas:

I. PREFACE
II. PROGRAM DESCRIPTION AND OBJECTIVES
III. GENERAL PROGRAM REQUIREMENTS
IV. ELIGIBILITY
V. BENEFITS
VI. CHOICES, ECF CHOICES, KATIE BECKETT (Part A), MEDICAID DIVERSION (Part B) and CONTINUED ELIGIBILITY (Part C) ENROLLMENT
VII. COST SHARING
VIII. DELIVERY SYSTEMS
IX. GENERAL REPORTING REQUIREMENTS
X. GENERAL FINANCIAL REQUIREMENTS
XI. MONITORING BUDGET NEUTRALITY FOR THE DEMONSTRATION
XII. EVALUATION OF THE DEMONSTRATION

Additional attachments have been included to provide supplementary information and guidance for specific STCs.

- Attachment A: Developing the Evaluation Design
- Attachment B: Preparing the Interim and Summative Evaluation Reports
- Attachment C: Limitations on Home Health Services
- Attachment D: Limitations on Private Duty Nursing Services
- Attachment E: Glossary of Terms of TennCare CHOICES
- Attachment F: Best Practices Guidance Regarding Consumer Direction of HCBS
- Attachment G: Certified Public Expenditures Protocol
- Attachment H: Employment and Community First CHOICES Service Definitions
- Attachment I: Reconciliation of Uncompensated Care Payments (reserved)
- Attachment J: Evaluation Design (reserved)
- Attachment K: COVID-19 Emergency HCBS Flexibilities
- Attachment L: Glossary of Terms for Katie Beckett Program

- Attachment M: Implementation Plan (reserved)
- Attachment N: Monitoring Protocol (reserved)
- Attachment O: Designated State Investment Programs
- Attachment P: ~~Shared Savings Quality Measures Protocol~~ (reserved)
- Attachment Q: DSIP Claiming Protocol (reserved)
- Attachment R: Maternal Health Enhancements
- Attachment S: COVID-19 Emergency HCBS Flexibilities 2

V. BENEFITS

29. TennCare Benefits. With the implementation of the CHOICES program, TennCare covers physical, behavioral, and long-term care benefits provided through managed care delivery systems.

g. Medication Therapy Management (MTM) Benefit.
Individuals enrolled in the state's patient-centered medical home (PCMH) and health home programs are eligible to receive MTM, regardless of which eligibility group the individual qualifies under. This benefit will expire three years after the implementation date of the state's MTM pilot program, not to exceed June 30, 2021, unless amended in accordance with the requirements of STC 7. The state must notify CMS in the subsequent quarterly monitoring report, as required by STC ~~56~~ 55, when the benefit has been implemented.

30. Benefits for TennCare Medicaid Population Only that are Not Included in the TennCare Standard Benefit package.

b. Medicare Parts A and B Buy-In Premiums. Medicare beneficiaries who are members of the CHOICES 217-Like HCBS Group, the CHOICES At Risk Demonstration Group, the ECF CHOICES 217-Like HCBS Group, the Interim ECF CHOICES At-Risk Group, and upon implementation of Phase 2 of ECF CHOICES, the ECF CHOICES Working Disabled Group and ECF CHOICES At- Risk Group; the Standard Spend Down group, the CHOICES 1 and 2 Carryover Group and the PACE Carryover Group, but not described in Section 1902(a)(10)(E) of the Act, are referred to as "Demo Duals."

ii. Medicare premiums paid on behalf of Demo Duals are demonstration expenditures, and must be reported on an appropriate Form CMS-64.9 or 9p Waiver, as described in STC ~~63~~ 62 (*Reporting Expenditures and Member Months*).

32. Designated State Investment Programs. The state may claim FFP for health programs, funded as of December 31, 2020 identified in Attachment O, subject to the restrictions described below unless otherwise specified. Expenditures are limited to costs not otherwise covered under the state plan, but consistent with Medicaid demonstration objectives that enable the state to continue to improve health outcomes and increase the efficiency and quality of care.

a. The DSIPs must meet one or more of the criteria for promoting the objectives of title XIX. These criteria include:
   i. increase and strengthen overall coverage of low-income individuals in the state;
   ii. increase access to, stabilize, and strengthen providers and provider networks available to serve Medicaid and low-income populations in the state;
   iii. improve health outcomes for Medicaid and other low-income populations in the state; or
   iv. increase the efficiency and quality of care for Medicaid and other low-income populations through initiatives to transform service delivery networks.

b. Allowable Expenditures
   i. Medicaid services for non-Medicaid eligible people.
   ii. Non-Medicaid services for Medicaid eligible people.
   iii. Medicaid provider stabilization payments for current Medicaid services for people at-risk for Medicaid if services are not received.

c. Prohibited Expenditures**.** Allowable expenditures do not include the following.
   i. Capital investments;
   ii. Expenditures that are not health-related; and
   iii. Any expenditure that is otherwise prohibited by statute or regulation.

d. Savings achieved under the demonstration are calculated as the total computable difference between the ~~aggregate~~ PMPM budget neutrality cap in a given year and actual demonstration expenditures for that year. ~~Up to 55 percent~~ Up to the federal share of newly accrued savings during the TennCare III demonstration period may be used as federal expenditure authority to fund DSIP ~~contingent on meeting quality performance targets~~. For example, if the state's ~~federal~~ total demonstration expenditures are $100 million less than the aggregate budget neutrality cap for a demonstration year, the state ~~may be~~ is eligible to draw down up to ~~$55 million~~ the federal share of that $100 million ~~in~~ as federal funding for approved DSIPs ~~(provided the state has the requisite quality improvements to achieve the full 55 percent level)~~. The total amount of federal match available to the state for approved DSIPs in a given year may be equal to, but will not exceed, the federal match on identified CNOMs.

e. Qualifying for Savings to use on DSIP. Tennessee will be eligible to qualify for shared savings on an annual basis when it underspends the "without waiver" ~~aggregate~~ budget neutrality cap ~~and meets quality targets~~. These shared savings will be available as federal funding to be used as DSIP-like CNOMs on a number of existing programs that are currently being funded with state dollars. These shared savings are available to the state for the year in which they ~~qualify~~ are earned or during any subsequent year of the demonstration. Any available savings will be made available to: overages of current programs funded in the Tenncare II demonstration; expenditure

authorities 8 and 9 and increased UC above the December 31, 2020 expenditure amount; and then DSIP.

~~f. Shared Savings Quality Measures Protocol. No later than 60 calendar days after the demonstration approval, the state will submit for CMS approval, a protocol that includes the following:~~

~~i. At least 10 quality metrics from the Medicaid Adult, Child, and Maternity Core Sets (at least 3 applicable to each population impacted by the demonstration) to be monitored for performance measurement in order to access shared savings. These metrics will be called the Shared Savings Metric Set. The state will use CY 2019 as the baseline year, and the baseline will be recalculated in DY5. At the rebasing that occurs at DY5, the state may select a different set of 10 quality metrics from the Medicaid Adult, Child, and Maternity Core Sets (at least 3 applicable to each population impacted by the demonstration) to be monitored for the remainder of the demonstration.~~

~~ii. Any deviations from national measure steward technical specifications.~~

~~iii. A mathematical representation by which to document how shared savings are earned and spent, and commensurate with STC 32.h. Upon approving the Shared Savings Quality Measures Protocol, CMS will attach the deliverable to the STCs as Attachment P.~~

~~iv. Any revisions to the Shared Savings Quality Measures Protocol will submitted to CMS for approval.~~

~~g. Reporting on Shared Savings Quality Measures. Progress on the shared savings metric set will be documented in the quarterly and annual monitoring reports, and will capture the calculation of shared savings for that year as well as how savings are spent in each demonstration year. All quality measures will be calculated based on the demonstration population as the denominator. The quality measures will represent a segment of the overall metrics reported to CMS for monitoring of the demonstration. The measures for shared savings must be reported to CMS annually, upon completion of measure validation, and in accordance with CMS' process.~~

~~h. To be eligible to expend savings on DSIP:~~

~~i. If Tennessee underspends the aggregate cap and demonstrates performance maintenance and improvement it will qualify for up to 45 percent of the savings for maintenance of performance, and for an additional ten percentage points up to 55 percent of the savings for improvement. There are further requirements related to underperformance and its effect on qualifying for these savings opportunities in (ii) below.~~

ii. Performance maintenance and determining the shared savings amount for the first 45 percent opportunity. To determine performance maintenance, the state will assess the value of each Shared Savings Metric for the demonstration year compared to the baseline year. The initial baseline year is 2019, and the baseline will be rebased in the 5th demonstration year. If the value for any of the Shared Savings Metrics for the demonstration year is lower than that of the baseline year, the state will follow the process outlined below:

1. To be eligible for 45 percent of shared savings for performance maintenance, the observed percent change between the demonstration year and the baseline for each Shared Savings Metric must either improve or not significantly decline as defined by a minimum effect size change relative to the starting baseline performance. This minimum effect size change is defined as:

Baseline Metric Performance	**Annual Minimum Effect Size Change**
0-59	At least a 6 percentage point change
60-74	At least a 5 percentage point change
75-84	At least a 4 percentage point change
85-92	At least a 3 percentage point change
93-96	At least a 2 percentage point change
97-99	At least a 1 percentage point change

For any shared savings metric where the trend of national performance has declined, any measurement of Tennessee's performance on the shared savings metric will account for the decline in national trend in order to ensure there is no inconsistency with this decline. Inconsistent with the decline in national trend is defined to mean that any decline that Tennessee has experienced on the shared savings metrics must be more than aggregate total decline of the decline in the national trend and the minimum effect size change for that shared savings metric.

2. If performance in any of the Shared Savings Metrics exhibits a statistically significant decline as described in the bullet above, the state will be required to submit a performance improvement plan to CMS.

3. The performance improvement plan will be submitted to CMS 60 calendar days after the Shared Savings Metrics are submitted to CMS, and will describe the state's plan for how it will improve performance on the measures which fall statistically significantly below the percent change of national average.

4. If the state experiences a consecutive year of such a decline in the same Shared Savings Metric, the amount of shared savings eligible for DSIP will be reduced in that demonstration year by 10 percentage points from

~~the maintenance opportunity of 45 percent, not to be less than 20 percent unless the state does not qualify for any share savings as defined below.~~

~~5. If the state experiences a consecutive year of decline in four or more Shared Savings Metrics, the state will not be eligible in that demonstration year for any shared savings, with the exception that the state improves performance as defined in (iii and iv) below on all remaining Shared Savings Metrics~~

~~6. For Shared Savings Metrics for which there is no Medicaid Adult or Child Core Set national average, the state will propose in its Shared Savings Metrics Protocol an alternative comparison for CMS's approval.~~

~~iii. Performance improvement and determining the shared savings amount for the opportunity of an additional ten percentage points up to 55 percent. Only if the state qualifies for any shared savings under the maintenance opportunity, the state is also eligible to qualify for an additional ten percentage points up to 55 percent when the state is successful in achieving improvement on one or more of the shared savings metrics consistent with effect sizes described in STC 32.h.ii.1; the amount of shared savings for improvement within this ten percentage point opportunity will be proportionate to the number of Shared Savings metrics associated with this opportunity to demonstrate improvement.~~

~~iv. Also subject to qualifying for any shared savings under the maintenance opportunity, if in any demonstration year the state performs with sufficient improvement on a shared savings metric to be in the 75th percentile or higher, the state may continue to access shared savings equivalent to the portion allowed for improvement on that metric even if a 2 percentage point improvement was not achieved. Once the state reaches the 90th percentile, the metric will be retired for purposes of achieving shared savings, and the state and CMS will jointly identify a replacement quality metric.~~

~~v. In the event of a public health emergency during a performance measurement period, the state may submit for CMS approval an adjustment to the performance expectation for achieving shared savings.~~

~~i.~~ f. Implementation Plan: All DSIP (including any subsequent changes in programs) will be subject to the Implementation Plan requirements as outlined in STC ~~54~~ 53.

~~j.~~ g. Monitoring Protocol: As outlined in STC ~~55~~ 54, the state is required to submit to CMS a draft or amended Monitoring Protocol no later than ninety (90) calendar days prior to the planned start date of the DSIP.

~~k.~~ h. DSIP Monitoring Reporting: As part of the monitoring reports required under STC ~~56~~ 55, the state will report DSIP claims and expenditures to date, in addition to any metrics reporting applicable for DSIP.

~~l.~~ i. Claiming Process: Documentation of each DSIP's expenditures must be clearly outlined in the state's supporting work papers and be made available to CMS.

i. Federal funds must be claimed within two years after the calendar quarter in which the state disburses expenditures for the DSIPs.

ii. Sources of non-federal funding must be compliant with section 1903(w) of the Act and applicable regulations. To the extent that federal funds from any federal programs are received for the DSIPs, they shall not be used as a source of non-federal share.

iii. The administrative costs associated with DSIPs, (that is not generally part of normal operating costs that would be included in rates) shall not be included in any way as demonstration and/or other Medicaid expenditures.

~~m.~~ j. DSIP Claiming Protocol. The state will develop a DSIP claiming protocol, subject to CMS approval, with which the state will be required to comply in order to draw down DSIP funds. State expenditures for the DSIP must be documented in accordance with the protocols. The state is not eligible to receive FFP until an applicable protocol is approved by CMS. Once approved by CMS, the protocol becomes Attachment Q to these STCs.

VI. CHOICES, ECF CHOICES, KATIE BECKETT, AND MEDICAID DIVERSION ENROLLMENT

33. Operations of the TennCare CHOICES Programs.

d. **Enrollment Targets for TennCare CHOICES**. The state may establish enrollment targets for CHOICES 2 and CHOICES 3. (There will be no enrollment target for CHOICES 1 or Interim CHOICES 3.) The purpose of the targets is to permit the CHOICES program to grow in a controlled manner, while assuring that the persons enrolled in the program are served appropriately, and cost effectively within available state and Federal resources. Information on CHOICES Groups, targets, and enrollment numbers must be supplied to CMS in the Quarterly Monitoring Report as set forth in STCs ~~56~~ 55 (*Monitoring Reports*), ~~57~~ 56 (*Enrollment Report*).

iv. If the enrollment target established by the state for CHOICES 2 or CHOICES 3 is reached or exceeded, the state shall not enroll additional persons in CHOICES 2 or CHOICES 3, except as indicated below. The

state may also establish a waiting list for CHOICES, subject to the following:

A. **Reserve Capacity**. The state may reserve slots in CHOICES 2 for individuals being discharged from a NF and for individuals being discharged from an acute care setting who are in imminent risk of being placed in a nursing facility setting absent the provision of home and community-based services. A copy of the operational procedures for determining individuals for whom the slots will be reserved must be included as an attachment to the Monitoring Report (see STC ~~56~~ 55). The state may establish additional criteria or modify procedures for allocating reserve slots upon 30 day advance written notification to CMS; the operational procedure documents included as attachments to subsequent Annual Monitoring Reports must reflect any such changes. In each Quarterly Monitoring Report, the state must provide an accounting of their management of the reserve capacity, including a summary (as of the last day of the quarter) that states the total enrollment targets for CHOICES 2 and 3, the number enrolled in each CHOICES group, and the numbers of slots being held in reserve for various purposes.

34. Operations of Employment and Community First (ECF) CHOICES.

d. **Enrollment Targets for ECF CHOICES**. The state may establish enrollment targets for ECF CHOICES. The purpose of the targets is to permit ECF CHOICES to grow in a controlled manner, while assuring that the persons enrolled in the program are served appropriately and cost effectively within available state and Federal resources. Information on ECF CHOICES groups, targets, and enrollment numbers must be supplied to CMS in the Quarterly Monitoring Report as set forth in STCs ~~56~~ 55 (*Monitoring Reports*), ~~57~~ 56 (Enrollment Report).

35. Operations of the TennCare Katie Beckett and Medicaid Diversion Programs.

c. **Enrollment Targets for Katie Beckett and Medicaid Diversion groups**. The state may establish enrollment targets for Katie Beckett (Part A) and Medicaid Diversion (Part B) groups. There will be no enrollment target for the continued eligibility group. The purpose of the targets is to permit the Katie Beckett and Medicaid Diversion groups to grow in a controlled manner, while assuring that the persons enrolled in the program are served appropriately, and cost effectively within available state and Federal resources. Information on Katie Beckett and Medicaid Diversion groups, targets, and enrollment numbers must be supplied to CMS in the Quarterly Monitoring Report as set forth in STCs ~~56~~ 55 (*Monitoring Reports*), ~~57~~ 56 (*Enrollment Report*).

ii. If the enrollment target established by the state for the Katie Beckett and Medicaid Diversion groups is reached or exceeded, the state shall not enroll additional persons in Katie Beckett or Medicaid Diversion groups, except as indicated below. The state may also establish a waiting list for Katie Beckett and Medicaid Diversion group, subject to the following:

A. **Reserve Capacity**. The state may reserve slots in Katie Beckett and Medicaid Diversion groups for individuals with the highest level of need, those awaiting discharge from an institution, and for individuals who are in imminent risk of being placed in a facility institutional setting absent the provision of home and community-based services. A copy of the operational procedures for determining individuals for whom the slots will be reserved must be included as an attachment to the Monitoring Report (see STC ~~56~~ 55).

VIII. DELIVERY SYSTEMS

~~**45. Pharmacy Flexibilities**~~

~~a. Adults age 21 and over will receive their pharmacy benefit through this demonstration under the expenditure authority in section 1115(a)(2) and will not receive coverage through the state plan under sections 1902(a)(54) and 1905(a)(12) and 42 CFR 440.12 of the Social Security Act and 42 CFR 440.12.~~

~~b. The state must provide drugs to such adults consistent with Essential Health Benefit (EHB) requirements as set forth in section 1937(b) of the Social Security Act, identify the EHB benchmark plan they are using, and should adopt an already approved EHB formulary and drug coverage that meets the EHB standard (i.e., use one that a qualified health plan (QHP) would use in the marketplace). This means the prescription drug coverage formulary already meets the requirements of prescription drug coverage at 45 CFR 156.122 including the greater of 1 drug per United States Pharmacopeia (USP) category and class; or the same number of prescription drugs in each category and class as the EHB benchmark plan. In addition, drugs categories described below in item d. must also be covered.~~

~~c. The state must maintain and publish in print and on a website an up to date, accurate, and complete lists of all covered drugs in their formularies. The state must also provide timely notice to beneficiaries of the changes to the pharmacy benefit in advance of the changes going into effect.~~

~~d. The formulary must comply with: 1) the MAT drug coverage requirements under Section 1905(a)(29) and 1905(ee), 2) the "substantially all" Part D coverage rules for antidepressants, anticonvulsants, antipsychotics, immunosuppressants, antineoplastics, and antiretroviral drugs (including PreP).~~

~~"Substantially all" in this context means that all drugs and unique dosage forms in these categories are expected to be included in the formulary, with the following exceptions:~~

~~i. Multi-source brands of the identical molecular structure;~~

~~ii. Extended release products when the immediate release product is included;~~

~~iii. Products that have the same active ingredient or moiety; and~~

~~iv. Dosage forms that do not provide a unique route of administration (e.g., tablets and capsules versus tablets and transdermals).~~

~~e. A P&T Committee (or use of the state's current DUR Board as the P&T Committee) shall be used to manage the formulary. The responsibility of the P&T Committee is to provide Formulary Management which includes: (1) developing procedures to ensure appropriate review; (2) making clinical decisions based on scientific evidence; (3) considering therapeutic advantages of drugs; (4) reviewing new Food and Drug Administration (FDA) approved drugs and biologicals and new uses for existing drugs; (5) ensuring state's formulary drug list covers a broad range of drugs across therapeutic categories consistent with adopted formulary structure; (6) requiring that the formulary provides appropriate access to drugs included in broadly accepted treatment guidelines and consistent with general best practices; (7) identifying the medical necessity criteria/ clinically appropriate criteria that will be used to determine whether specific drugs will be available to patients; (8) reviewing the utilization management techniques that the state will use in general to manage the pharmacy benefit as well as those for specific drugs.~~

~~f. A state exception process shall be implemented for enrollees to request and gain access to clinically appropriate drugs (clinically appropriate being defined by the state) not on the plan's formulary; the state will publish an explanation of internal and external exceptions process and timeframe to obtain non-formulary drugs when clinically appropriate.~~

~~g. The state ensures that non-discrimination clauses as provided in 45 CFR 156.125 and 45 CFR 156.225, which prevent discrimination on the basis of a number of factors, including health conditions, are applied to the formulary.~~

~~h. Section 1927 DUR provisions: the state will apply their current DUR program, including SUPPORT Act requirements, to the population receiving the covered outpatient drug benefit through this demonstration.~~

~~i. Because under section 1115(a)(2), expenditures under this section on outpatient drugs are "regarded as" expenditures under the State plan, section 1927(b) requirements pertaining to the obligation for a drug manufacturer with a drug rebate agreement to pay rebates will still apply pursuant to section 1115(a)(2) expenditure authority. The state is expected to report utilization data to CMS on a quarterly basis for rebate purposes consistent with current reporting requirements. CMS will work with the state to determine any additional~~

~~information that may be required. The state will also seek approval of any modifications to its Supplemental Rebate Agreements with manufacturers.~~

IX. GENERAL REPORTING REQUIREMENTS

~~46.~~45. **Deferral for Failure to Submit Timely Demonstration Deliverables.**

~~47.~~46. **Submission of Post-Approval Deliverables.**

~~48.~~47. **Compliance with Federal Systems Updates.**

~~49.~~48. **Compliance with Managed Care Reporting Requirements.**

~~50.~~49. **Compliance with Specified HCBS Requirements.** Beneficiaries receiving Medicaid HCBS and LTSS services furnished through the 1115 demonstration, including individuals who derive eligibility through the demonstration must receive services in residential and non-residential settings located in the community, which meet CMS standards for HCBS settings as articulated in current 1915(c) policy and federal regulation. The state shall include a description of the steps taken to ensure compliance with these regulations as part of the Monitoring Report discussed in STC ~~56~~ 55.

~~51.~~50. **Quality Improvement Systems and Strategy for the CHOICES, ECF CHOICES, and Katie Beckett (Part A) Programs.**

~~52.~~51. **Quality Improvement Strategy for 1915(c) or 1915(i)-approvable HCBS Services.** For services that could have been authorized to individuals under a 1915(c) waiver or under 1915(i) authority, the state's Quality Assessment and Performance Improvement Plan must encompass LTSS-specific measures set forth in the federal rule and should also reflect how the state will assess and improve performance to demonstrate compliance with applicable federal waiver assurances set forth in 42 CFR 441.301 and 441.302, as follows:

d. **Health and Welfare**. The state must demonstrate it has designed and implemented an effective system for assuring HCBS participants' health and welfare. Evidence that highlights the health and welfare deficiencies found during the monitoring and evaluation of the HCBS demonstration, with an explanation of how these deficiencies have been or are being corrected, as well as the steps that have been taken to ensure that these deficiencies do not reoccur will be reported to CMS as an attachment to the Monitoring Report detailed in STC ~~56~~ 55.

~~53.~~52. **CHOICES, ECF CHOICES, and Katie Beckett (Part A) Data.**

~~54.~~53. **Implementation Plan.** The state is required to submit an Implementation Plan to cover key policies being tested under this demonstration. The state will be expected to provide additional details not captured in the STCs regarding implementation of

demonstration policies that are outlined in the STCs. For example, the policies covered in the Implementation Plan will include fraud ~~and the pharmacy benefits~~ and additional policies the state may test under the flexibilities provided in this demonstration. Once determined complete by CMS, the Implementation Plan will be incorporated into the STCs, as Attachment M. At a minimum, the Implementation Plan must include definitions and parameters of key policies, and describe the state's strategic approach to implementing the policies, including timelines for meeting milestones associated with these key policies. The state must submit a draft Implementation Plan to CMS for review and comment no later than ninety (90) calendar days after the start date of the demonstration approval period. Likewise, in consultation with CMS, in the event the state chooses to exercise for the first time one of the flexibilities granted in this demonstration or to account for any changes to benefits or coverage (including modifications to DSIP or CNOM programs), the state is required to update this Implementation Plan, or submit a new Implementation Plan, and shall submit for CMS review and comment no later than ninety (90) calendar days prior to the planned implementation date of such changes. The state must submit a revised Implementation Plan within sixty (60) calendar days after receipt of CMS's comments.

~~55.~~54. **Monitoring Protocol.** The state must submit to CMS a draft Monitoring Protocol no later than one hundred and fifty (150) calendar days after the start date of the demonstration approval period. The state must submit a revised Monitoring Protocol within sixty (60) calendar days after receipt of CMS's comments. Once approved, the Monitoring Protocol will be incorporated into the STCs, as Attachment N. In consultation with CMS, the state will be required to update this monitoring protocol based on any changes to benefits or coverage (including modifications to DSIP or CNOM programs) and must submit draft updates no later than ninety (90) calendar days prior to the planned implementation of any such changes.

At a minimum, the Monitoring Protocol will affirm the state's commitment to conduct quarterly and annual monitoring in accordance with CMS's templates and the STCs. For policies that have standard CMS monitoring templates, any proposed deviations from CMS's templates should be documented in the Monitoring Protocol. The Monitoring Protocol will describe the quantitative and qualitative elements on which the state will report through quarterly and annual monitoring reports. For quantitative metrics (e.g., performance metrics as broadly described in STC ~~56~~ 55 below), CMS will provide the state with a set of required metrics and technical specifications for data collection and analysis covering the key policies being tested under this demonstration, including but not limited to, waivers of retroactive eligibility, premiums and suspension/disenrollment/lock-out for nonpayment of premiums for the Katie Beckett program, suspension for fraud, and DSIP or CNOM programs. The Monitoring Protocol will specify the methods of data collection and timeframes for reporting on the state's progress as part of the quarterly and annual monitoring reports. For the qualitative elements (e.g., operational updates as described in STC ~~56~~ 55 below), CMS will provide the state with guidance on narrative and descriptive information which will supplement the quantitative metrics

on key aspects of the demonstration policies. The quantitative and qualitative elements will comprise the state's quarterly and annual monitoring reports.

~~56.~~55. **Monitoring Reports.** The state must submit three (3) Quarterly Monitoring Reports and one (1) Annual Monitoring Report each DY. The fourth quarter information that would ordinarily be provided in a separate report should be reported as distinct information within the Annual Monitoring Report. The Quarterly Monitoring Reports are due no later than sixty (60) calendar days following the end of each demonstration quarter. The Annual Monitoring Report is due no later than ninety (90) calendar days following the end of the DY. The reports will include all required elements as per 42 CFR 431.428, and should not direct readers to links outside the report. Additional links not referenced in the document may be listed in a Reference/Bibliography section. The Monitoring Reports must follow the framework provided by CMS, which is subject to change as monitoring systems are developed/evolve, and be provided in a structured manner that supports federal tracking and analysis. These monitoring reports must include, but are not be limited to:

c. Budget Neutrality and Financial Reporting Requirements – Per 42 CFR 431.428, the Monitoring Reports must document the financial performance of the demonstration. The state must provide an updated budget neutrality workbook with every Monitoring Report that meets all the reporting requirements for monitoring budget neutrality set forth in the General Financial Requirements section of these STCs, including the submission of corrected budget neutrality data upon request. In addition, the state must report quarterly and annual expenditures associated with the populations affected by this demonstration on the Form CMS-64. Administrative costs for this demonstration should be reported separately on the CMS-64. The state will report all expenditures for DSIP payments on the forms CMS-64.9 Waiver and/or 64.9P Waiver under the waiver name "DSIP" as well as on the appropriate forms CMS-64.9I and CMS-64PI. The reported DSIP claims and expenditures will be reconciled at the end of the demonstration with the state's CMS-64 submissions. Any ~~DHSP~~ DSIP repayment required under this subparagraph will be accomplished by the state making an adjustment for its excessive claim for FFP on the CMS-64 by entering an amount in line 10(b) of the Summary sheet equal to the amount that equals the difference between claimed DSIP and actual expenditures made for these initiatives during the demonstration period.

~~57.~~56. **Enrollment Report.**

~~58.~~57. **Corrective Action Plan Related to Monitoring.**

~~59.~~58. **Close Out Report.** Within 120 days after expiration of the demonstration, the state must submit a draft Close Out Report to CMS for comments.

e. A delay in submitting the draft or final version of the Close Out Report may subject the state to penalties as described in STC ~~46~~ 45.

~~60.~~59. Monitoring Calls.

~~61.~~60. Post Award Forum.

X. GENERAL FINANCIAL REQUIREMENTS

~~62.~~61. Expenditure Groups (MEG).

~~63.~~62. Reporting Expenditures and Member Months. The state must report all demonstration expenditures claimed under the authority of title XIX of the Act and subject to budget neutrality each quarter on separate forms CMS-64.9 WAIVER and/or 64.9P WAIVER, identified by the demonstration project number assigned by CMS (11-W-00369/4). Separate reports must be submitted by MEG (identified by Waiver Name) and Demonstration Year (identified by the two digit project number extension). Unless specified otherwise, expenditures must be reported by DY according to the dates of service associated with the expenditure. All MEGs identified in the Master MEG Chart as WW must be reported for expenditures, as further detailed in the MEG Detail for Expenditure and Member Month Reporting table below. To enable calculation of the budget neutrality expenditure limits, the state also must report member months of eligibility for specified MEGs.

f. Budget Neutrality Specifications Manual. The state will create and maintain a Budget Neutrality Specifications Manual that describes in detail how the state will compile data on actual expenditures related to budget neutrality, including methods used to extract and compile data from the state's Medicaid Management Information System, eligibility system, and accounting systems for reporting on the CMS-64, consistent with the terms of the demonstration. The Budget Neutrality Specifications Manual will also describe how the state compiles counts of Medicaid member months and how the state tracks both carryover savings and newly accrued savings through the demonstration. The Budget Neutrality Specifications Manual must be made available to CMS on request.

Table 9: MEG Detail for Expenditure and Member Month Reporting								
MEG (Waiver Name)	**Detailed Description**	**Exclusions**	**CMS-64.9 Line(s) To Use**	**How Expend. Are Assigned to DY**	**MAP or ADM**	**Report Member Months (Y/N)**	**MEG Start Date**	**MEG End Date**
EG16 MEC Additions	Described in expenditure authority 8 and defined as Type 2 in STC ~~83.b~~ 82.b	None	Follow CMS-64.9 Base Category of Service Definitions	Date of Service	MAP	No	1/8/21	12/31/30
EG17E Less Than MEC Additions	Described in expenditure authority 8 and defined as Type 2 in STC ~~83.b~~ 82.c	None	Follow CMS-64.9 Base Category of Service Definitions	Date of Service	MAP	No	1/8/21	12/31/30
Virtual DSH	Described in STC ~~67.a~~ 66.a	None	Use Line 1B Inpatient Hospital - DSH for actual DSH, Line 1C Inpatient Hospital - Sup. Payments for Virtual DSH	Date of Payment	MAP	No	1/8/21	12/31/30
UC Pool	Described in STC ~~67.b~~ 66.b	None	Use Line 1C Inpatient Hospital - Sup. Payments, or Line 10 Clinic Services	Date of Payment	MAP	No	1/8/21	12/31/30

g. Title XIX Expenditures Subject to the Budget Neutrality Expenditure Limit. For the purpose of this section, the term "expenditures subject to the budget neutrality expenditure limit" refers to:

i. All TennCare title XIX expenditures on behalf of individuals who are enrolled in this demonstration (excluding the services specified in STC 30, *Benefits for TennCare Medicaid Population Only that Are Not*

Included in the TennCare Standard Benefit Package), including all service expenditures and applicable administrative costs (see subparagraph ~~h. below~~ d. above) net of premium collections and other offsetting collections (e.g., pharmacy rebates, fraud and abuse), and

ii. All expenditures described in STCs ~~66.d.~~ 65.d (*Extent of Federal Financial Participation for the Demonstration*) and ~~67~~ 66 (*Permissible Uncompensated Care Payments*).

iii. All title XIX expenditures that are subject to the budget neutrality expenditure limit are considered demonstration expenditures and must be reported on Forms CMS 64.9 Waiver and/or CMS-64.9P Waiver, with the exception of those described in ~~h. below~~ d. above.

~~64.~~63. Demonstration Years.

~~65.~~64. Standard Funding Process.

~~66.~~65. Extent of Federal Financial Participation for the Demonstration. Subject to CMS approval of the source(s) of the non-Federal share of funding (see STC ~~70~~ 69 *Sources of Non-Federal Share*), CMS will provide FFP at the applicable federal matching rate for the demonstration as a whole for the following, subject to the budget neutrality limits described in Section XI~~:~~. When referenced, actual cash disbursements is intended to signify that certified public expenditures may not be used to establish expenditures for these pools.

~~67.~~66. Permissible Uncompensated Care Payments.

~~68.~~67. Distribution of Uncompensated Care Payments.

~~69.~~68. Reconciliation of Uncompensated Care Payments. Upon ~~approval~~ implementation of the distribution methodology described in paragraph ~~65~~ 67 (Distribution of Uncompensated Care Payments), the state will develop an annual reconciliation process for each uncompensated care fund. The state must submit a draft of its proposed reconciliation processes for approval by CMS no later than 60 days after approval of the state's uncompensated care payments distribution methodology. The reconciliation processes will be included as an attachment to these STCs (Attachment I) and are subject to the amendment provisions in STC 7 (Amendment Process) should the state need to make changes to the reconciliation process.

~~70.~~69. Sources of Non-Federal Share.

~~71.~~70. Financial Integrity for Managed Care and Other Delivery Systems.

~~72.~~71. Program Integrity.

~~73.~~72. **Budget Neutrality Monitoring Tool.**

~~74.~~73. **Claiming Period.**

~~75.~~74. **Future Adjustments to Budget Neutrality.** CMS reserves the right to adjust the budget neutrality expenditure limit:

a. To be consistent with enforcement of laws and policy statements, including regulations and letters, regarding impermissible provider payments, health care related taxes, or other payments, CMS reserves the right to make adjustments to the budget neutrality limit if any health care related tax that was in effect during the base year, or provider-related donation that occurred during the base year, is determined by CMS to be in violation of the provider donation and health care related tax provisions of section 1903(w) of the Act. Adjustments to annual budget targets will reflect the phase out of impermissible provider payments by law or regulation, where applicable.

b. To the extent that a change in federal law, regulation, or policy requires either a reduction or an increase in FFP for expenditures made under this demonstration. In this circumstance, the state must adopt, subject to CMS approval, a modified budget neutrality agreement as necessary to comply with such change. The modified agreement will be effective upon the implementation of the change. The trend rates for the budget neutrality agreement are not subject to change under this STC. The state agrees that if mandated changes in the federal law require state legislation, the changes shall take effect on the day such state legislation becomes effective, or on the last day such legislation was required to be in effect under the federal law.

c. The state certifies that the data it provided to establish the budget neutrality expenditure limit are accurate based on the state's accounting of recorded historical expenditures or the next best available data, that the data are allowable in accordance with applicable federal, state, and local statutes, regulations, and policies, and that the data are correct to the best of the state's knowledge and belief. The data supplied by the state to set the budget neutrality expenditure limit are subject to review and audit, and if found to be inaccurate, will result in a modified budget neutrality expenditure limit.

~~d. To account for changes in enrollment beyond a 1 percentage point threshold above or below the baseline enrollment, an adjustment to the aggregate cap will be made using the following process each year.~~

~~i. The historical baseline year will be enrollment from State fiscal year 2019 (7/1/18 – 6/30/19). This base year enrollment will be used as the comparison point for risk corridor adjustments until the rebasing for Year 6 of the demonstration.~~

ii. The enrollment threshold will be applied to each of the five EG groups listed below.

A. Disabled
B. Child <=18
C. Adult >=65
D. Adult <=64
E. Duals

iii. Once annually, the state has the ability to adjust the current DY WOW amounts with a risk corridor. The aggregate cap will be automatically adjusted by October 1 of each DY based on enrollment data for the prior DY and will be a retroactive adjustment to the cap for the full prior DY. For example, DY1 enrollment will be reviewed in DY2 and the aggregate cap will be adjusted up or down for any variance in enrollment greater than 1 percentage point.

A. The actual annual enrollment value is taken, and then 101% of the base enrollment value from state fiscal year 2019 for that EG is subtracted from it.

B. The resulting difference is multiplied by the corresponding year's projected PMPM for that particular EG. The corresponding year's PMPM is determined by taking the base year PMPM (SFY19 total expenditures for that EG divided by SFY19 total enrollment for that EG) and trending it forward annually using the President's budget trend rate for that EG.

C. The resulting amount is added to the annual cap for that EG for the demonstration year in which enrollment as exceeded.

iv. The state is at risk for any increase up to 1 percentage point above projected enrollment from the base period.

v. If the EG group annual enrollment is less than 99% of the baseline:

A. The actual annual enrollment value is subtracted from 99% of the base enrollment value from state fiscal year 2019 for that EG.

B. The resulting difference is multiplied by the corresponding year's projected PMPM for that particular EG. The corresponding year's PMPM is determined by taking the base year PMPM (SFY19 total expenditures for that EG divided by SFY19 total enrollment for that EG) and trending it forward annually using the President's budget trend rate for that EG group.

~~C. The resulting product is subtracted from the current annual cap for that EG group for that demonstration year in which enrollment was less than 99% of the projections.~~

d. In the event that pharmacy costs begin to increase above historical trend levels, the state will be permitted to submit data that demonstrates this to CMS and request that an appropriate adjustment be made to the budget neutrality PMPMs to account for unusual levels of pharmacy inflation.

~~vi~~. e. Projected PMPM

	Base Year	Trend Rate	DY 1	DY 2	DY 3	DY 4	DY 5
EG1 Disabled	$1,515.31	5.4%	$1,728.83	$1,822.19	$1,920.59	$2,024.30	$2,133.61
EG2 Over 65	$1,182.01	4.5%	$1,319.83	$1,379.22	$1,441.28	$1,506.14	$1,573.92
EG3 Children	$253.67	5.5%	$290.11	$306.06	$322.89	$340.65	$359.39
EG4 Adults	$442.62	5.3%	$503.79	$530.49	$558.60	$588.21	$619.38
EG5 Duals	$890.18	5.5%	$1,018.04	$1,074.03	$1,133.10	$1,195.42	$1,261.17

~~76.~~75. Enforcement of Budget Neutrality.

XI. MONITORING BUDGET NEUTRALTIY FOR THE DEMONSTRATION

~~77.~~76. Limit on Title XIX Funding.

~~78.~~77. Risk. ~~Tennessee shall be at risk for the aggregate cap and the state accepts risk for both enrollment and per capita costs, subject to the enrollment risk corridors describe in these STCs. CMS assures that the demonstration expenditures do not exceed the levels that would have been realized had there been no demonstration.~~

Tennessee shall be at risk for the per capita cost (as determined by the method described in this Section) for Type 1 and Type 2 TennCare enrollees in the eligibility groups (EGs) described in STC 83 (Eligibility Groups (EGs) Subject to the Budget Neutrality Agreement) under this budget neutrality agreement, but not at risk for the number of demonstration eligibles in each of the groups. By providing FFP for all Type 1 and Type 2 TennCare enrollees in the specified EGs, Tennessee shall not be at risk for changing economic conditions that impact enrollment levels. However, by placing Tennessee at risk for the per capita costs for TennCare enrollees in each of the EGs under this agreement, CMS assures that the Federal demonstration expenditures do not exceed the level of expenditures that would have occurred had

there been no demonstration. Tennessee will be at risk for both per capita costs and enrollment for Type 3 TennCare eligibles.

~~79.~~78. **Special Circumstances Adjustment.**

~~80.~~79. **Calculation of the Budget Neutrality Limits and How They Are Applied.** To calculate the budget neutrality limits for the demonstration, separate annual budget limits are determined for each DY on a total computable basis. Each annual budget limit is the sum of the ~~aggregate~~ PMPM cap components specified in these STCs, which are calculated by trending forward the last full year of the state's historical cost~~s~~ PMPMs and multiplying those by the applicable member months to project ~~fixed~~ total computable dollar expenditure amounts. ~~This does not include any adjustments for enrollment variance greater than the risk corridor.~~ The annual limits for all DYs are then added together, along with a DSH adjustment of $622,384,474 annually, to obtain a budget neutrality limit for the entire demonstration period. The federal share of this limit will represent the maximum amount of FFP that the state may receive during the demonstration period for the types of demonstration expenditures described below. The federal share will be calculated by multiplying the total computable budget neutrality expenditure limit by the appropriate Composite Federal Share.

~~81.~~80. **Main Budget Neutrality Test.**

~~82.~~81. **Medicaid Expenditure Groups (MEG).**

~~83.~~82. **Eligibility Groups (EGs) Subject to the Budget Neutrality Agreement.** Individuals who are eligible under TennCare and whose expenditures are funded at title XIX matching rates will be one of three types:

a. Type 1 - are currently eligible under Tennessee's Medicaid state plan (Title XIX state plan mandatory or optional eligible population) - counted in the "with" and "without" waiver calculations;

b. Type 2 - could be eligible under Tennessee's Medicaid state plan if Tennessee amended its state plan or could be eligible for a Section 1915(c) waiver for aged and disabled adults pursuant to 42 C.F.R. 435.217 (Title XIX demonstration- eligible hypothetical population) – counted in the "with" and "without" waiver calculations; and

c. Type 3 – are only eligible with Section 1115 demonstration authority (Title XIX demonstration-eligible expansion population) - counted only in the "with" waiver calculations.

~~**Table 11: Main Budget Neutrality Test**~~

~~MEG~~	~~PC or Aggregate~~	~~DY 1~~	~~DY 2~~	~~DY 3~~	~~DY 4~~	~~DY 5~~
~~All~~	~~Agg Cap~~	~~$9,356,603,867~~	~~9,721,165,197~~	~~$10,133,757,745~~	~~$10,566,395,812~~	~~$11,020,053,654~~

~~84.~~83. **Hypothetical Budget Neutrality.** When expenditure authority is provided for coverage of populations or services that the state could have otherwise provided through its Medicaid state plan or other title XIX authority (such as a waiver under section 1915 of the Act), CMS considers these expenditures to be "hypothetical;" that is, the expenditures would have been eligible to receive FFP elsewhere in the Medicaid program. For these hypothetical expenditures, CMS makes adjustments to the budget neutrality test which effectively treats these expenditures as if they were for approved Medicaid state plan services. Hypothetical expenditures, therefore, do not necessitate savings to offset the otherwise allowable services. This approach reflects CMS's current view that states should not have to "pay for," with demonstration savings, costs that could have been otherwise eligible for FFP under a Medicaid state plan or other title XIX authority; however, when evaluating budget neutrality, CMS does not offset non-hypothetical expenditures with projected or accrued savings from hypothetical expenditures. That is, savings are not generated from a hypothetical population or service. To allow for hypothetical expenditures, while preventing them from resulting in savings, CMS currently applies a separate, independent Hypothetical Budget Neutrality Tests, which subject hypothetical expenditures to pre-determined limits to which the state and CMS agree, and that CMS approves, as a part of this demonstration approval. If the state's WW hypothetical spending exceeds the supplemental test's expenditure limit, the state agrees (as a condition of CMS approval) to offset that excess spending by savings elsewhere in the demonstration or to refund the FFP to CMS.

a. **Hypothetical Budget Neutrality Test 1.** The table below identifies the MEGs that are used for Hypothetical Budget Neutrality Test 1. MEGs that are designated "WOW Only" or "Both" are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the Hypothetical Budget Neutrality Test is calculated based on all MEGs indicated as "WW Only" or "Both." MEGs that are indicated as "WW Only" or "Both" are counted as expenditures against this budget neutrality expenditure limit. Any expenditures in excess of the limit from Hypothetical Budget Neutrality Test are counted as WW expenditures under the Main Budget Neutrality Test.

Table ~~12~~ 11: Hypothetical Budget Neutrality Test									
MEG	**~~PC or Agg*~~**	**WOW Only, WW Only, or Both**	**~~BASE YEAR~~**	**TREND**	**~~DY 1~~**	**~~DY 2~~**	**~~DY 3~~**	**~~DY 4~~**	**~~DY 5~~**
EG6E Expan Adult	~~Agg~~	Both	~~$132,966~~	0%	~~$132,966.00~~	~~$132,966.00~~	~~$132,966.00~~	~~$132,966.00~~	~~$132,966.00~~
EG7E Expan Child	~~Agg~~	Both	~~$3,704,282~~	5.5%	~~$3,908,017.51~~	~~$4,122,958.47~~	~~$4,349,721.19~~	~~$4,588,955.85~~	~~$4,841,348.43~~
EG8 Med Exp Child	~~Agg~~	Both	~~$-~~	5.5%	~~$-~~	~~$-~~	~~$-~~	~~$-~~	~~$-~~
EG9 H-Disabled	~~Agg~~	Both	~~$21,589,906~~	5.4%	~~$22,755,761~~	~~$23,984,572~~	~~$25,279,739~~	~~$26,644,845~~	~~$28,083,666~~
EG10 H-Over 65	~~Agg~~	Both	~~$4,797,121~~	4.5%	~~$5,012,991~~	~~$5,238,576~~	~~$5,474,312~~	~~$5,720,656~~	~~$5,978,085~~
EG11 H-Duals	~~Agg~~	Both	~~$355,865,535~~	5.5%	~~$375,438,140~~	~~$396,087,237~~	~~$417,872,035~~	~~$440,854,997~~	~~$465,102,022~~
EG13 Katie Backett Part A	~~Agg~~	Both	~~$36,000,000~~	5.4%	~~$37,944,000~~	~~$39,992,976~~	~~$42,152,597~~	~~$44,428,837~~	~~$46,827,994~~
EG15 Katie Beckett Part C	~~Agg~~	Both	~~$177,561~~	5.4%	~~$187,149~~	~~$197,255~~	~~$207,907~~	~~$219,134~~	~~$230,967~~
EG 16 MEC Additions	~~Agg~~	Both	~~$0~~	--	~~–~~	~~–~~	~~–~~	~~–~~	~~–~~

b. **Hypothetical Budget Neutrality Test 2:** The table above identifies the MEGs that are used for Hypothetical Budget Neutrality Test. MEGs that are designated "WOW Only" or "Both" are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the Hypothetical Budget Neutrality Test is calculated based on all MEGs indicated as "WW Only" or "Both." MEGs that are indicated as "WW Only" or "Both" are counted as expenditures against this budget neutrality expenditure limit. Any expenditures in excess of the limit from Hypothetical Budget Neutrality Test are counted as WW expenditures under the Main Budget Neutrality Test.

~~85.~~84. **DSH Adjustment.** The DSH adjustment is based upon Tennessee's DSH allotment for 1992 and was calculated in accordance with current law. Table 13 gives the DSH adjustments for DY 1 through DY 10, and shows the total computable. These totals reflect changes to the calculation of DSH allotments resulting from the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, and the temporary increase in DSH allotments provided under Section 5002 of the American Recovery and Reinvestment Act of 2009. Beginning in DY 10, the DSH adjustment was held constant while awaiting to determine the impact of Medicaid expansion under the Affordable Care Act on uncompensated care and DSH. Beginning with DY 15, the DSH adjustment is considered "Virtual DSH" for purposes of paying for uncompensated care due to Medicaid shortfall under the demonstration. The federal share of the DSH adjustment is based on the state's federal medical assistance percentages (FMAP) for the applicable demonstration year.

Table ~~13~~ 12

	DSH Adjustment (total computable)
TennCare III DY 1-2	$508,936,029 (this amount is contingent on close out reconciled expenditures in TennCare II DY19 not exceeding the 6 month amount of this figure being claimed for the period end on December 31, 2020.
TennCare III DYs ~~2~~ 3-10	No less than ~~$508,936,029~~ $622,384,474 or actual expenditures, whichever is less and up to actual documented and allowable costs within budget neutrality limit in each year thereafter

~~86.~~85. **Composite Federal Share.**

~~87.~~86. **Exceeding Budget Neutrality.**

a. CMS will enforce the budget neutrality agreement over the life of the demonstration approval period, which extends from January 8, 2021 – December 31, 2030. CMS will rebase the "without waiver" expenditure amounts to better reflect actual expenditures after 5 years, consistent with the CMS budget neutrality policy applying rebasing every 5 years. No later than July 1, 2025, the state will provide updated actual expenditure data to rebase the base year calculations and CMS will adjust the aggregate cap to reflect actual spending during the demonstration. The base year starting January 1, 2026 will be updated to reflect actual expenditures/PMPMs for the demonstration period of July 1, 2023 through June 30, 2024, consistent with the same time period used to for the base for DY 1 of the TennCare III demonstration. This expenditure data will be trended forward 30 months (mid-point to midpoint) by the President's budget trend to set the expenditure cap (prior to any enrollment risk corridor adjustment) for DY 6 of the TennCare III demonstration. ~~At this time, the enrollment base for the enrollment risk corridor calculation will also be rebased to July 1, 2023 through June 30, 2024 (state fiscal year 2024). This rebased enrollment period will serve as the base for enrollment risk corridor calculations in DY 6 through DY 10.~~ The Main Budget Neutrality Test may incorporate net savings from TennCare II prior demonstration period of DY15 through DY19 (but not from any earlier approval period). TennCare II carryover savings will be available for the 10-years of the demonstration and will not be affected by rebasing during the demonstration period.

b. ~~Up to 55 percent~~ The federal portion of newly accrued savings may be used as federal expenditures for DSIPs as described in STC 32 ~~concerning quality performance~~.

c. The state will be able to carry over the savings accrued during the TennCare II demonstration period from DY15 through DY19. However, those savings will be limited for use in this demonstration for the following expenditures:

   i. Maintenance of TennCare II Medicaid benefits and coverage in place as of December 31, 2020.

   ii. Uncompensated Care Fund for Charity Care up to the actual reconciled expenditures in TennCare II DY19, annualized.

d. If at the end of the demonstration approval period the budget neutrality limit has been exceeded, the excess federal funds will be returned to CMS. If the demonstration is terminated prior to the end of the demonstration period, the budget neutrality test will be based on the time period through the termination date.

e. **Mid-Course Correction.** If at any time during the demonstration approval period CMS determines that the demonstration is on course to exceed its budget neutrality expenditure limit, CMS will require the state to submit a corrective action plan for CMS review and approval. CMS will use the threshold levels in the tables below as a guide for determining when corrective action is required.

Main Budget Neutrality Test

Table ~~14~~ 13: Main Budget Neutrality Test Mid-Course Correction Calculations		
	Cumulative Target Definition	**Percentage**
DY1	Cumulative budget neutrality limit plus	2.0 percent
DY1 through DY2	Cumulative budget neutrality limit plus	1.5 percent
DY1 through DY3	Cumulative budget neutrality limit plus	1.0 percent
DY1 through DY4	Cumulative budget neutrality limit plus	0.5 percent
DY1 through DY5	Cumulative budget neutrality limit plus	0.0 percent

XII. EVALUATION OF THE DEMONSTRATION

~~88.~~87. **Cooperation with Federal Evaluators.** As required under 42 CFR 431.420(f), the state must cooperate fully and timely with CMS and its contractors in any federal evaluation of the demonstration or any component of the demonstration. This includes, but is not limited to, commenting on design and other federal evaluation documents and providing data and analytic files to CMS, including entering into a data use agreement that explains how the data and data files will be exchanged, and providing a technical point of contact to support specification of the data and files to be disclosed, as well as relevant data dictionaries and record layouts. The state must include in its contracts with entities who collect, produce or maintain data and files for the demonstration, that they must make such data available for the federal evaluation as is required under 42 CFR 431.420(f) to support federal evaluation. The state may claim administrative match for these activities. Failure to comply with this STC may result in a deferral being issued as outlined in STC ~~46~~ 45.

~~89.~~88. **Independent Evaluator.**

~~90.~~89. **Draft Evaluation Design.** The state must submit, for CMS comment and approval, a draft Evaluation Design pertinent to this demonstration approval period, no later than one hundred eighty (180) days after the approval of the demonstration. The draft Evaluation Design must be developed in accordance with Attachment J (Developing the Evaluation Design) of these STCs, and must include a timeline for key evaluation activities including evaluation deliverables, as outlined in STCs ~~94~~ 93 and ~~95~~ 94.

~~91.~~90. Evaluation Design Approval and Updates.

~~92.~~91. Evaluation Questions and Hypotheses. Consistent with Attachments A and B (Developing the Evaluation Design and Preparing the Evaluation Report) of these STCs, the evaluation documents must include a discussion of the evaluation questions and hypotheses that the state intends to test. Each demonstration component should have at least one evaluation question and hypothesis. The hypothesis testing should include, where possible, assessment of both process and outcome measures. Proposed measures should be selected from nationally-recognized sources and national measures sets, where possible. Measures sets could include CMS's Core Set of Health Care Quality Measures for Children in Medicaid and CHIP, Consumer Assessment of Health Care Providers and Systems (CAHPS), the Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults, and/or measures endorsed by National Quality Forum (NQF).

The evaluation must outline and address well-crafted hypotheses and research questions for all of the demonstration components. For example, the hypotheses for the demonstration evaluation must relate to (but are not limited to) efforts to improve population health through administrative and budget flexibilities, and whether these flexibilities with risk-sharing promote the goals of fiscal sustainability (providing a comprehensive understanding of how the state is using savings), the CHOICES program, ECF CHOICES program, and the state plan and demonstration populations enrolled in those programs. The DSIP program and other added benefits will also be assessed in their effectiveness, in particular focusing on the additional services covered and populations served. This assessment will study outcomes, such as coverage, beneficiary access to care and health outcomes, and any improvements in provider and service delivery networks.

Hypotheses for premiums under the Katie Beckett program must relate to (but are not limited to) outcomes, such as beneficiary familiarity with premiums as a feature of commercial coverage, and likelihood of enrollment and enrollment continuity. Hypotheses for suspension or disenrollment for non-compliance must relate to (but are not limited to) outcomes such as the following: beneficiary compliance with demonstration requirements, enrollment continuity, and health status (as a result of greater enrollment continuity). The evaluation will also assess insurance and health outcomes of former beneficiaries disenrolled or suspended or voluntarily separating from the program. Furthermore, hypotheses for the waiver of retroactive eligibility must relate to (but are not limited to) the following outcomes: likelihood of enrollment and enrollment continuity, enrollment when people are healthy, and health status (as a result of greater enrollment continuity). The state must include hypotheses and measures related to access to managed long term services and supports, as well as improved health outcomes and beneficiary satisfaction for CHOICES and ECF CHOICES programs~~, as well as access to and cost of medically necessary prescription drugs~~.

In addition, the state must investigate cost outcomes for the demonstration as a whole, including but not limited to: administrative costs of demonstration implementation and operation, Medicaid health service expenditures, provider uncompensated costs, and the impact of the DSIP program on generating net Medicaid costs or savings. Finally, the state

must use hypothesis tests aligned with other demonstration goals and cost analyses together to assess the demonstration's effects on Medicaid program sustainability.

The findings from each evaluation component must be integrated to help inform whether the state met the overall demonstration goals, with recommendations for future efforts regarding all components.

~~93.~~92. **Evaluation Budget.**

~~94.~~93. **Interim Evaluation Reports.**

~~95.~~94. **Summative Evaluation Report.**

~~96.~~95. **Corrective Action Plan Related to Evaluation.**

~~97.~~96. **State Presentations for CMS.**

~~98.~~97. **Public Access.**

~~99.~~98. **Additional Publications and Presentations.**

Attachment G
Certified Public Expenditures Protocol

Preamble

This protocol governs the use of certified public expenditures to furnish the non-Federal share of expenditures claimed for Federal participation under the ~~Unreimbursed Public Hospital Costs Pool for Certified Public Expenditures~~ Public Hospital Costs Sub-Pool of the Virtual DSH Fund. (~~paragraph 53.d~~ See STC 67.a and the distribution methodology described in STC 68.). The protocol is based on the following elements:

Appendix B

Documentation of Public Notice

Notice of Change to the TennCare III Demonstration
Amendment 4

Published July 19, 2022

The Commissioner of the Tennessee Department of Finance & Administration is providing official notification of intent to file an amendment to the TennCare III demonstration. This amendment, which will be known as "Amendment 4," will be filed with the Centers for Medicare & Medicaid Services (CMS). In Amendment 4, TennCare is proposing modifications to the TennCare demonstration in response to a letter from CMS on June 30, 2022, requesting that Tennessee address certain limited areas of "concern" in the current TennCare III demonstration. The proposed modifications are described in more detail below.

Description of Amendment and Affected Populations

Since 1994, Tennessee has operated its Medicaid program under the authority of an 1115 demonstration program known as TennCare. The current iteration of the TennCare demonstration, known as "TennCare III," began operating on January 8, 2021. Since that time, Tennessee has significantly expanded the scope of coverage and benefits available under Medicaid in Tennessee, including extending Medicaid postpartum coverage from 60 days to 12 months, providing dental benefits for pregnant and postpartum beneficiaries, implementing a chiropractic benefit for adult beneficiaries, expanding the scope of home- and community-based services (HCBS) available through the demonstration, and increasing enrollment in HCBS (with the goal of eliminating all waiting lists for HCBS programs). In addition, in the past year Tennessee has submitted a demonstration amendment to CMS to expand TennCare's coverage of adopted children in Tennessee, and Tennessee is currently working to implement a dental benefit for all adults enrolled in TennCare. Over time, these enhancements to coverage and benefits are expected to contribute to improved health outcomes for TennCare beneficiaries (a key goal of the TennCare demonstration). These investments are a confirmation and validation of the commitment the state of Tennessee made upon implementation of TennCare III and an indicator of the kinds of improvements made possible by the terms and conditions of TennCare III.

After consideration of the issues raised by CMS in its June 30, 2022, letter, Tennessee is confident these issues can be addressed while still maintaining the core goals and key principles of the TennCare III demonstration. Accordingly, Amendment 4 proposes the following modifications to the TennCare III demonstration.

1. *Financing of the Demonstration*

As with all Medicaid 1115 demonstration projects, CMS requires that the TennCare demonstration be budget neutral for the federal government (i.e., the demonstration cannot result in Medicaid costs to the federal government that are greater than what the federal government's Medicaid costs would have been absent the demonstration). Like a number of other state demonstrations, the budget neutrality framework for the TennCare III demonstration was initially calculated on an "aggregate cap" basis. In its June 30, 2022, letter, CMS requested that the demonstration's budget neutrality framework be calculated instead on a "per member per month cap" basis.

Tennessee is confident that the TennCare III demonstration is in fact budget neutral for the federal government and can be demonstrated to be so via any number of methodologies. As such, consistent with CMS' request, Amendment 4 includes a proposal to assess budget neutrality for the TennCare demonstration using a per member per month (PMPM) cap. Amendment 4 proposes no other changes to the demonstration's budget neutrality framework.

2. *Demonstration Expenditure Authorities*

Consistent with CMS' request of June 30, 2022, and the proposed change to TennCare's budget neutrality framework described above, Amendment 4 proposes corresponding changes to the framework governing the state's expenditure authorities under the demonstration. This component of the demonstration recognizes savings produced to the federal government by the state under the demonstration and provides a mechanism for the state to reinvest a portion of those savings in initiatives to improve the health of Medicaid beneficiaries. This ability to be recognized for responsible and effective Medicaid program operation through additional federal funding, which can then be reinvested into the Medicaid program, is a fundamental principle of TennCare III.

In Amendment 4, Tennessee requests federal financial participation (FFP) for designated state investment programs (DSIPs). A list of identified and approved programs is included as Attachment O of the TennCare demonstration. These programs support access to healthcare across a variety of domains, spanning mental health, public health, community services, and child health services.

In order to ensure the budget neutrality of these additional federal expenditures, the state requests that the amount of DSIP expenditure authority each year be based on the extent (if any) to which the state's expenditures for that year are below its budget neutrality cap (now calculated on a per member per month basis), up to a maximum amount equivalent to the federal share of the designated state investment programs specified in the demonstration. This arrangement recognizes the role that these programs play in improving the health of Medicaid enrollees and the communities in which they live and will support the state's efforts to make investments in improving the health of Medicaid beneficiaries over the life of the demonstration (e.g., adult dental services, expanded 12-month postpartum coverage, enhancements to home- and community-based services, etc.).

3. *Closed* Formulary

The TennCare III demonstration includes expenditure authority for pharmacy and related flexibilities that allow Tennessee to exclude certain drugs from the state's Medicaid prescription drug formulary (subject to a number of conditions and protections). This flexibility was requested by the state and approved by CMS in recognition of the growing costs of prescription drugs—an increasing number of which are accelerated approval drugs with limited or inadequate evidence of clinical efficacy—and the lack of tools available to states to meaningfully manage these costs within the existing Medicaid policy framework.

While we regard this flexibility as a permissible and reasonable use of the Secretary's authority under Section 1115 to test novel approaches to the financing and delivery of Medicaid benefits, at CMS' request, the state is proposing to remove this expenditure authority and its associated flexibilities from the TennCare demonstration. In lieu of this flexibility, the state requests that the demonstration's STCs be modified to provide for an adjustment to the demonstration's PMPM caps in instances when prescription drug costs materially affect the average per-member cost of care.

The inclusion of this proposed change in Amendment 4 is not an indication that Tennessee's concerns with the rising cost of prescription drugs or the lack of mechanisms to meaningfully control drug costs within the existing Medicaid policy framework have been alleviated. Tennessee encourages CMS to use the tools at its disposal—including both its regulatory powers under Title XIX and its authority to

waive rules and statute under Section 1115—to implement strategies to address this critical issue.

These proposed changes address the issues identified by CMS while maintaining the primary goals and objectives of the TennCare demonstration.

Expected Impact on Enrollment and Expenditures

Amendment 4 does not propose any changes to TennCare eligibility or benefits and will not result in any changes to enrollment or expenditures under the TennCare demonstration. As noted above, this amendment will result in changes to the way that the demonstration's budget neutrality is calculated.

Evaluation Impact

The state's evaluation design for the demonstration (currently under CMS review) will be modified to reflect that the expenditure authority related to pharmacy and its associated flexibilities are no longer part of the demonstration. Research questions and hypotheses related to the implementation of a closed formulary will be removed from the evaluation design.

In addition, the tools used by CMS and the state to monitor budget neutrality for the demonstration will be modified to reflect the changes to the budget neutrality framework described above (i.e., to reflect the change from an aggregate cap budget neutrality framework to a per member per month cap budget neutrality framework).

Waiver and Expenditure Authorities Requested

The state is requesting no changes to the waiver and expenditure authorities currently approved for the TennCare demonstration other than those described above. All other waiver and expenditure authorities approved for the TennCare demonstration will continue to be in effect under this amendment.

Public Notice Process

TennCare has taken a variety of steps to ensure that members of the public are notified of Amendment 4. These measures include the development and maintenance of this webpage, as well as notices published in newspapers of general circulation in Tennessee communities with 50,000 or more residents. TennCare has disseminated information about the proposed amendment via its social media accounts (e.g., Facebook, Twitter). TennCare has also notified members of the Tennessee General Assembly of its intent to submit Amendment 4.

Public Input Process

TennCare is seeking feedback on Amendment 4 prior to its submission to CMS. Members of the public are invited to offer comments regarding Amendment 4 from July 19, 2022, through August 19, 2022.

Members of the public who wish to comment on the proposed amendment may do so through either of the following options:

- Comments may be sent by email to public.notice.tenncare@tn.gov.
- Comments may be mailed to

  Aaron Butler, Director of Policy
  Division of TennCare
  310 Great Circle Road
  Nashville, TN 37243.

TennCare always appreciates input. In order to be considered for the final draft of Amendment 4, feedback must be received no later than August 19, 2022. Individuals wishing to view comments submitted by members of the public may submit their requests to the same physical address and/or email address at which comments are being accepted.

Draft of Amendment 4

A draft of TennCare's proposed demonstration amendment is located at https://www.tn.gov/content/dam/tn/tenncare/documents2/Amendment4Draft.pdf. Copies of the draft amendment are also available in each county office of the Tennessee Department of Health. Once comments received during the public input period have been reviewed and considered, a final draft of the amendment will be prepared. The final draft will be submitted to CMS and will then be made available through the webpage located at https://www.tn.gov/tenncare/policy-guidelines/waiver-and-state-plan-public-notices.html.

TennCare Page on CMS Web Site

As the federal agency with oversight authority over all Medicaid programs, CMS offers its own online resources regarding the TennCare Demonstration. Interested parties may view these materials at https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/waivers_faceted.html.

TN Division of TennCare

July 19, 2022

The Honorable Randy McNally
Lt. Governor and Speaker of the Senate
Suite 700 Cordell Hull Building
Nashville, Tennessee 37243

The Honorable Cameron Sexton
Speaker of the House of Representatives
Suite 600 Cordell Hull Building
Nashville, Tennessee 37243

Dear Lt. Governor McNally and Speaker Sexton:

This letter is written to inform you that the Division of TennCare intends to submit an amendment to the TennCare Demonstration (TennCare III) to the Centers for Medicare and Medicaid Services (CMS). This Demonstration Amendment will be known as Amendment 4 and is in response to CMS' June 30, 2022, letter requesting that TennCare address certain limited "concerns" with the current TennCare III demonstration.

Amendment 4 will make modifications to the waiver with the intent to alleviate CMS concerns while maintaining the primary goals and objectives of TennCare III. These modifications include:

1. Determining budget neutrality for the TennCare demonstration using a per member per month (PMPM) cap arrangement;
2. Revising the demonstration expenditure authorities while continuing to recognize savings produced by the state as a mechanism for reinvestments in the TennCare program; and
3. Removing the expenditure authority for pharmacy and associated pharmacy flexibilities from the demonstration.

Beginning today, the draft amendment will be available for public comment for 30 days.

As we have shared previously, we are encouraged by CMS' continued support for the major concepts and priorities of TennCare III, which rewards Tennessee for the sound, efficient and effective operation of the TennCare program via additional federal dollars that can then be reinvested to enhance TennCare benefits and services and serve additional Tennesseans in need. This financing structure and policy represent the core, fundamental principle of TennCare III.

With your support and leadership, TennCare III has been in effect and in operation since January of 2021. And in that time, tremendous investments have been made in the TennCare program, including reducing program waiting lists for home and community-based services; enhancing maternal health benefits; improving payments for behavioral health, dental, home and community-based services, and public hospital providers; and adding comprehensive adult dental services for the first time in Tennessee's history. These investments are a confirmation and validation of the state's commitment upon

implementation of TennCare III and an indicator of the very kinds of program improvements made possible by the waiver now and in the future.

In accordance with T.C.A. § 71-5-104(b), copies of this letter are being sent electronically to all members of the General Assembly. In addition, a summary of Amendment 4 (including a draft version of the amendment itself) is available on the TennCare website located at http://www.tn.gov/tenncare/.

As always, I am available to address any questions or concerns you may have related to this or any other TennCare matter.

Thank you for your continued partnership and support of TennCare III.

Sincerely,

[redacted]

Stephen Smith
Director

cc: The Honorable Members of the General Assembly

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TennCare is proposing a new amendment to the TennCare waiver. Amendment 4 proposes changes to the waiver's budget neutrality model and expenditure authorities. The public comment period for Amendment 4 is open through August 19, 2022.
Learn more at https://www.tn.gov/.../tenncare-begins-amendment-process....

For information on the public notice, visit https://www.tn.gov/.../Amendment4ComprehensiveNotice.pdf **See less**

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TennCare
@TennCare

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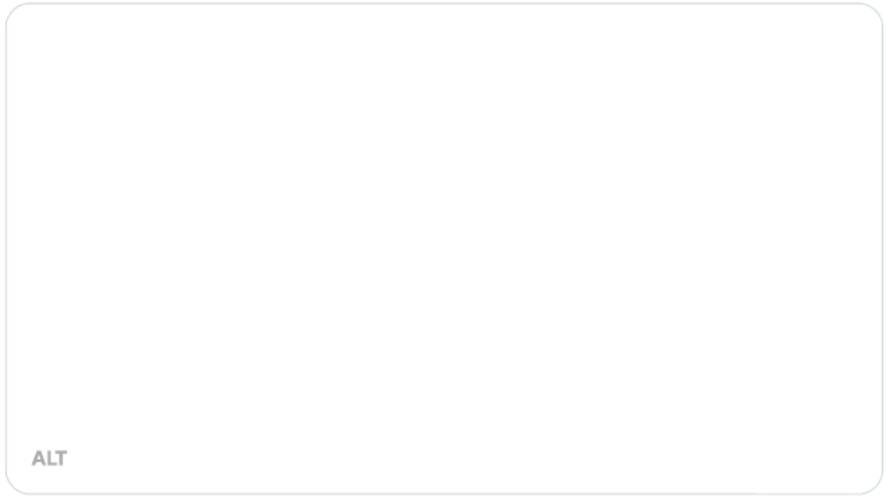

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Before me personally appeared Jim Stevens, who being duly sworn that he is the Legal Sales Representative of the CHATTANOOGA TIMES FREE PRESS, and that the Legal Ad of which the attached is a true copy, has been published in the above named newspaper and on the corresponding newspaper website on the following dates, to-wit:

TFP Times Free Press 07/24/22; TFP TimesFreePress.com 07/24/22

And that there is due or has been paid the CHATTANOOGA TIMES FREE PRESS for publication the sum of $279.10. (Includes $10.00 Affidavit Charge).

[redacted]

Sworn to and subscribed before me this date:27th day of July, 2022

[redacted]

My Commission Expires 02/28/2023

Seemala K. Thompson-Kippers
STATE OF TENNESSEE NOTARY PUBLIC
HAMILTON COUNTY

Chattanooga Times Free Press

400 EAST 11TH ST
CHATTANOOGA, TN 37403

Notice of Change in TennCare III Demonstration
Amendment 4

The Commissioner of the Tennessee Department of Finance & Administration is providing official notification, pursuant to 59 Fed. Reg. 49249, of intent to file an amendment to the TennCare III Demonstration. The amendment, which will be known as "Amendment 4," will be filed with the Centers for Medicare and Medicaid Services (CMS), a federal agency located in Baltimore, Maryland.

In Amendment 4, TennCare is proposing three changes to the TennCare demonstration. These changes are in response to a letter from CMS on June 30, 2022, requesting that Tennessee make certain modifications to the TennCare demonstration. These changes are as follows: (1) Tennessee is proposing to assess budget neutrality for the TennCare demonstration using a "per member per month (PMPM) cap" framework rather than an "aggregate cap" framework; (2) Tennessee is proposing to receive federal financial participation (FFP) for designated state investment programs specified in Attachment O of the TennCare demonstration, based on the extent (if any) to which the state's expenditures for a given year are below the budget neutrality cap, up to a maximum amount equivalent to the federal share of the designated state investment programs; and (3) Tennessee is proposing to remove the existing expenditure authority for pharmacy and related flexibilities from the demonstration. These changes will address the issues identified by CMS while maintaining the key principles and core goals of the TennCare demonstration.

Amendment 4 does not propose any changes to TennCare eligibility or benefits and will not result in any changes to enrollment or expenditures under the TennCare demonstration. As noted above, Amendment 4 will result in changes to the way that the demonstration's budget neutrality is calculated.

The full public notice associated with this amendment, including a comprehensive description of the amendment, is available on the TennCare website at https://www.tn.gov/content/dam/tn/tncare/documents2/Amendment4ComprehensiveNotice.pdf.

Members of the public who wish to comment on TennCare's proposal may send written comments by mail to Mr. Aaron Butler, Director of Policy, Division of TennCare, 310 Great Circle Road, Nashville, Tennessee 37243, or by email to public.notice.tenncare@tn.gov. Persons wishing to review copies of written comments received may submit their requests to the same email and/or physical address. The last day on which comments will be accepted is August 19, 2022.

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commercial appeal
PART OF THE USA TODAY NETWORK

# of Affidavits: 2

TENNCARE BUREAU STAT
310 GREAT CIRCLE RD

NASHVILLE, TN 37243-1700

Affidavit of Publication

State of Wisconsin

County of Brown

Personally appeared before me, said legal clerk, of MEMPHIS PUBLISHING COMPANY, a corporation, publishers of The Commercial Appeal, morning and Sunday paper, published in Memphis, Tennesse, who makes oath in due form of law, that she is Legal Clerk of the said Memphis Publishing Company, and that the accompanying and hereto attached notice was published in the following edition of The Commercial Appeal to-wit :

07/24/22

Amend 4-PH
TENNCARE BUREAU STAT 307573

[redacted]

Subscribe and sworn to before me this 24th day of August, 2022

[redacted]

Notary Public

My commission expires 8-21-26

Ad Number: 0005345300

NICOLE JACOBS
Notary Public
State of Wisconsin

Ad Number: 0005345300 Run Dates: 07/24/22

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AFFIDAVIT OF PUBLICATION

0005345391
Newspaper Jackson Sun

State of Tennessee

Account Number NAS-00381001
Advertiser BUREAU OF TENNCARE

BUREAU OF TENNCARE
310 GREAT CIRCLE RD
NASHVILLE, TN
37243

TEAR SHEET ATTACHED

[redacted] Sales Assistant for the above mentioned newspaper,

hereby certify that the attached advertisement appeared in said newspaper on the following dates:

07/22/22

[redacted]

Subscribed and sworn to before me this 22 day of July 2022

Charly Neel
Notary Public

CHARLY NEEL
STATE OF TENNESSEE
NOTARY PUBLIC
DAVIDSON COUNTY
MY COMMISSION EXPIRES 5-7-2024

Affidavits Requested:
1

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The City of Jackson will receive sealed requests for proposals for the remodel of the JTA Transfer Center until 2:00 p.m., Wednesday August 17th, 2022. Invitation must be obtained from zpolk@JACKSONTN.GOV . Proposals must be mailed or delivered to City Hall, 115 E. Main St., Suite 202, Jackson, TN 38301 Attn: Purchasing. The award is subject to the funding requirements of the Federal Transit Administration, State of Tennessee, and local municipality. This procurement shall be in accordance with Federal Transit Administration rules and regulations. DBE's will be afford full opportunity to submit proposals in response to this Request for Proposal. The contractor is required to comply with all applicable Equal Employment Laws and Regulations. The City re-

Continued to next column

Continued from last column

serves the right to waive informalities and to reject any and all bids/proposals. The City of Jackson is an Equal Opportunity Title VI employer.
Zach Polk
Director of Purchasing
dept. 41610

0005345766

USA Southside Storage
58 Witt McKnight Dr.
Jackson, Tn 38301
731-427-1443

Notice of Public Auction:
Hayes Herron Unit 412
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Carlotto Murrell Unit 906
The auction will be held online at www.storageauctions.com on Saturday July 23 at 12pm CST.

Public Notices

0005346391

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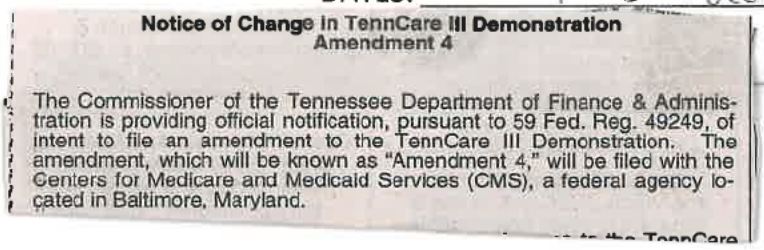
AD# 1603139

DATES: 7-21-2022



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State of Tennessee)
Carter County)
Washington County)

Teresa Hicks makes the oath that she is a Representative of The Johnson City Press , a daily newspaper published in Johnson City, in said County and State, and that the advertisement was published in said paper for 1 insertion (s) commencing on 7-21-2022 and ending on 7-21-2022.

[redacted]

Sworn to and Subscribed before me this 7 21 2022

Month Day Year

[redacted]

Marsha McNalley
Notary Public

My commission expires on 11/30/2024

This legal notice was published online at www.johnsoncitypress.com and www.publicnoticeads.com during the duration of the run dates listed. This publication fully complies with Tennessee Code Annotated 1-3-20

THE JOHNSON CITY PRESS
204 W. Main Street
Johnson City, TN 37604

AFFIDAVIT OF PUBLICATION

AD# 1603139

DATES: 7-21-2022

State of Tennessee)
Carter County)
Washington County)

Teresa Hicks makes the oath tha

daily newspaper published in Joh

advertisement was published in

7-21-2022 and e

Sworn to and Subscribed before

Notary Public

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MARSHA MCNALLEY
STATE OF TENNESSEE NOTARY PUBLIC
WASHINGTON COUNTY
MY COMMISSION EXPIRES NOVEMBER 30, 2024

This legal notice was published online at www.johnsoncitypress.com and www.publicnoticeads.com during the duration of the run dates listed. This publication fully complies with Tennessee Code Annotated 1-3-20

Knoxville
NEWS SENTINEL
PART OF THE USA TODAY NETWORK

Attn: Jona
STATE OF TN BUREAU O F TENNCARE
310 GREAT CIRCLE ROAD

NASHVILLE, TN 37243

State of Wisconsin }

County of Brown }

Before me, the undersigned, a Notary Public in and for said county,this d: personally came said legal clerk first duly sworn, according to law, says that he/she is a duly authorized representative of *The Knoxville News-Sentinel*, a daily newspaper published at Knoxville, in said county and state, and that the advertisement of

(The Above-Referenced)

of which the annexed is a copy, was published in said paper in the issues dated:

07/22/2022

and that the statement of account herewith is correct to the best of his/he

[redacted]

Subscribed and sworn to before me this July 22 2022

[redacted]

Notary Public

5.15.25
My commission expires

Publication Cost: $211.68
Ad No: 0005345765
Customer No: 1318536

# of Affidavits 1
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NANCY HEYRMAN
Notary Public
State of Wisconsin

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AFFIDAVIT OF PUBLICATION

0005345379
Newspaper Leaf Chronicle

State of Tennessee

Account Number NAS-00381001
Advertiser BUREAU OF TENNCARE

BUREAU OF TENNCARE
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NASHVILLE, TN
37243

TEAR SHEET ATTACHED

[redacted] Sales Assistant for the above mentioned newspaper, hereby certify that the attached advertisement appeared in said newspaper on the following dates:

07/22/22

[redacted]

Subscribed and sworn to before me this 22 day of July 2022

Notary Public

CHARLY NEEL
STATE OF TENNESSEE
NOTARY PUBLIC
DAVIDSON COUNTY
MY COMMISSION EXPIRES 5-1-2024

Affidavits Requested:

1

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all kinds of things...

General Merchandise

LEAF-CHRON. N.PAPERS FROM THE 9-1-1 ATTACK., 5 days. Sept. 12-16,2001. V.g. cond., $10. (931)220-1767

WANT TO MAKE SOME QUICK CASH?
Place a Classified ad today and sell your unwanted treasures!
615-242-SALE

Public Notices

Wanted to Buy

LOOK!

INSTANT CASH PAID for baseball cards, sports memorabilia, autographs, game used sports items, coins, gold, silver, watches, diamonds, old toys, trains, comic books, old photos, military, presidential, huge collections, lots of others. Scott, 513-295-5634 Instant Cash Paid - goodasgold@roadrunner.com

Real Estate Rentals
great places to live...

Apt Furnished

Available Now!

Clarksville behind Lowes Madison St $500.00, 1 bdrm, 1 ba, off-st pkg, refs req'd, no smkg,no pets, (931)472-9283

Find a new JOB in the Classifieds!

Public Notices

Real Estate Homes
starting fresh...

Commercial

EQUAL HOUSING OPPORTUNITY

Equal Housing Opportunity

All real estate advertising in this newspaper is subject to the Federal Fair Housing Act of 1968 as amended which makes it illegal to advertise "any preferences, limitation, or discrimination based on race, color, religion, sex, handicap, familial status or nation origin, or an intention to make any such preference, limitation or discrimination.

"This newspaper will not knowingly accept any advertisement for real estate which is in violation of the law. Our readers are hereby informed that all dwellings advertised in this newspaper area available on an equal opportunity basis. To complain of discrimination, call HUD Toll-free at 1-800-669-9777. For hearing impaired call 1-800-927-9275.

Public Notices

Automotive Cars
best deal for you...

Recreational Vehicle

ATTENTION

I BUY CAMPERS, TRAILERS, & MOTOR HOMES- ALL TYPES. ready to go or need work. For FAST CASH Call Lawrence at 931-242-3135

Professional Service
all your needs...

Business Service

A REPAIRS UNLIMITED
- Carpentry
- Drywall
- Roofing
- Siding
- Doors
- Windows
- Plumbing & Electric.

Call 931-801-7859

Home Improvement

ALL WE DO IS HOME REPAIR & HANDYMAN SERVICES:
- Decks
- Fencing
- Complete Remodeling

★ 931-220-5263 ★

KUCINSKI DRY WALL
We're the Business that Does Small Jobs & Repairs!!

NOTICE OF TRUSTEE'S FORECLOSURE SALE

Sale at public auction will be on **September 7, 2022** at **11:00 am**, local time at the 2nd Floor Lobby Door of **Montgomery County Courthouse, 1 Millennium Plaza, Clarksville, TN 37040** pursuant to the Deed of Trust executed by Anthony Collier for the benefit of Mortgage Electronic Registration Systems, Inc., as nominee for DAS Acquisition Company, LLC, as Beneficiary, dated April 20, 2021, of record in **Instrument Number 1312145, Volume 2084, Page 1529** in the Register Of Deeds Office for Montgomery County, Tennessee, ("Deed of Trust"), conducted by James E. Albertelli, P.A. d/b/a ALAW, a Florida corporation duly authorized to conduct business in Tennessee, having been appointed Trustee, all of record in the Register of Deeds Office for Montgomery County, Tennessee. Default in the performance of the covenants, terms, and conditions of said Deed of Trust has been made; and the entire indebtedness has been declared due and payable.

Party entitled to enforce the debt: Lakeview Loan Servicing, LLC

Other Interested Parties:

The hereinafter described real property located in Montgomery County will be sold to the highest call bidder subject to all unpaid taxes, prior liens and encumbrances of record:

BEING LOT NO. 56 ON THE PLAN OF RIVER CHASE (CLUSTER), AS SHOWN BY PLAT OF RECORD IN PLAT K, PAGES 216 & 217, REGISTER'S OFFICE FOR MONTGOMERY COUNTY, TENNESSEE, TO WHICH PLAT REFERENCE IS HEREBY MADE FOR A MORE COMPLETE DESCRIPTION.

BEING THE SAME PROPERTY CONVEYED TO ANTHONY COLLIER, AN UNMARRIED MAN BY WARRANTY DEED OF BILL MACE RECORDED IN MONTGOMERY COUNTY OFFICIAL RECORDS BOOK 2084, PAGE 1526.

CLASSIFIED ads

Your Source Public Notices for the latest...

Your Source Public Notices for the latest...

Assorted Merch all kinds of things...

General Merchandise

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LOOK!

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Available Now!
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A REPAIRS UNLIMITED
•Carpentry •Drywall
•Roofing •Siding
•Doors •Windows
•Plumbing & Electric.
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Home Improvement

ALL WE DO IS HOME REPAIR & HANDYMAN SERVICES:
✓ Decks ✓ Fencing
✓ Complete Remodeling
★ 931-220-5263 ★

KUCINSKI DRY WALL
We're the Business that Does Small Jobs & Repairs!!
• Textured Ceilings
• Painting • Installation
• Taping • Finishing
• Radiant Heat Removal
Call Steve - 931-645-8027

Public Notices

0005345379

Notice of Change in TennCare III Demonstration Amendment 4

The Commissioner of the Tennessee Department of Finance & Administration is providing official notification, pursuant to 59 Fed. Reg. 49249, of intent to file an amendment to the TennCare III Demonstration. The amendment, which will be known as "Amendment 4," will be filed with the Centers for Medicare and Medicaid Services (CMS), a federal agency located in Baltimore, Maryland.

In Amendment 4, TennCare is proposing three changes to the TennCare demonstration. These changes are in response to a letter from CMS on June 30, 2022, requesting that Tennessee make certain modifications to the TennCare demonstration. These changes are as follows: (1) Tennessee is proposing to assess budget neutrality for the TennCare demonstration using a "per member per month (PMPM) cap" framework rather than an "aggregate cap" framework; (2) Tennessee is proposing to receive federal financial participation (FFP) for designated state investment programs specified in Attachment O of the TennCare demonstration, based on the extent (if any) to which the state's expenditures for a given year are below the budget neutrality cap, up to a maximum amount equivalent to the federal share of the designated state investment programs; and (3) Tennessee is proposing to remove the existing expenditure authority for pharmacy and related flexibilities from the demonstration. These changes will address the issues identified by CMS while maintaining the key principles and core goals of the TennCare demonstration.

Amendment 4 does not propose any changes to TennCare eligibility or benefits and will not result in any changes to enrollment or expenditures under the TennCare demonstration. As noted above, Amendment 4 will result in changes to the way that the demonstration's budget neutrality is calculated.

The full public notice associated with this amendment, including a comprehensive description of the amendment, is available on the TennCare website at https://www.tn.gov/content/dam/tn/tenncare/documents2/Amendment4ComprehensiveNotice.pdf.

Members of the public who wish to comment on TennCare's proposal may send written comments by mail to Mr. Aaron Butler, Director of Policy, Division of TennCare, 310 Great Circle Road, Nashville, Tennessee 37243, or by email to public.notice.tenncare@tn.gov. Persons wishing to review copies of written comments received may submit their requests to the same email and/or physical address. The last day on which comments will be accepted is August 19, 2022.

Copies of this notice will be available in each county office of the Tennessee Department of Health.

We do not treat people in a different way because of their race, color, birth place, language, age, disability, religion, or sex. https://www.tn.gov/tenncare/members-applicants/civil-rights-compliance.html

WANT TO MAKE SOME QUICK CASH?
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615-242-SALE

Public Notices

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BEING THE SAME PROPERTY CONVEYED TO ANTHONY COLLIER, AN UNMARRIED MAN BY WARRANTY DEED OF BILL MACE RECORDED IN MONTGOMERY COUNTY OFFICIAL RECORDS BOOK 2084, PAGE 1526.

Street Address: The street address of the property is believed to be 1294 Highgrove Ln, Clarksville, TN 37043, but such address is not part of the legal description of the property. In the event of any discrepancy, the legal description herein shall control.

Map/Parcel Number: 089C A 05600 00011080

Current owner(s) of the property: Anthony Collier

This sale is subject to all matters shown on any applicable recorded Plat or Plan; and unpaid taxes and assessments; any restrictive covenants, easements or setback lines that may be applicable; rights of redemption, equity, statutory or otherwise, not otherwise waived in the Deed of trust, including right of redemption of any governmental agency, state or federal; and any and all prior deeds of trust, liens, dues, assessments, encumbrances, defects, adverse claims and other matters that may take priority over the deed of Trust upon which this foreclosure sale is conducted or are not extinguished by this foreclosure sale. THE PROPERTY IS SOLD WITHOUT ANY REPRESENTATIONS OR WARRANTIES, EXPRESSED OR IMPLIED, RELATING TO TITLE, MARKETABILITY OF TITLE, POSSESSION, QUIET ENJOYMENT OR THE LIKE AND FITNESS FOR A GENERAL OR PARTICULAR USE OR PURPOSE. The title is believed to be good, but the undersigned will sell and convey only as Trustee.

The right is reserved to adjourn the sale to another time certain or to another day, time, and place certain, without further publication upon announcement on the day, time, and place of sale set forth above or any subsequent adjourned day, time, and place of sale.

If you purchase the property at the foreclosure sale, the entire purchase price is due and payable at the conclusion of the auction in the form of a certified check made payable to or endorsed to Albertelli Law Trust Account. No personal checks will be accepted. To this end, you must bring sufficient funds to outbid the Lender and any other bidders. Insufficient funds will not be accepted. Amounts received, in excess of the winning bid, will be refunded to the successful purchaser at the time the foreclosure deed is delivered. This property is being sold with the express reservation that the sale is subject to confirmation by the Lender or Trustee. This sale may be rescinded by the Trustee at any time.

THIS IS AN ATTEMPT TO COLLECT A DEBT, AND ANY INFORMATION OBTAINED WILL BE USED FOR THAT PURPOSE.

James E. Albertelli, P.A. d/b/a ALAW, Trustee
401 Commerce Street, Suite 150
Nashville, TN 37219
PH: (615) 265-0835
FX: (615) 265-0836
File No.: 22-006072

AFFIDAVIT OF PUBLICATION

0005345408
Newspaper The Tennessean

State of Tennessee

Account Number NAS-00381001
Advertiser BUREAU OF TENNCARE

BUREAU OF TENNCARE
310 GREAT CIRCLE RD
NASHVILLE, TN
37243

TEAR SHEET ATTACHED

Jackie Cooper Sales Assistant for the above mentioned newspaper, hereby certify that the attached advertisement appeared in said newspaper on the following dates:

07/22/22

[redacted]

Subscribed and sworn to before me this 22 day of July 2022.

[redacted]
Notary Public

CHARLY NEEL
STATE OF TENNESSEE
NOTARY PUBLIC
DAVIDSON COUNTY
MY COMMISSION EXPIRES 5-7-2024

Affidavits Requested:

1

0005345408NOTICEOFCHANGEINTENNCAREIIIDEMONS

Adopt Me Pets
all your favorites...

Domestic Pets

ADORABLE
AIREDALE TERRIERS PUPPIES
Full blooded, 7wks old, de-wormed, shots, tails docked, dew claws removed. $650. Pulaski, TN. 731-514-0037

Bernedoodle, 3 Females/2 Males, , 6 weeks, Black/Black and White, cuddly Bernedoodle puppies, ready for their new homes the week of July 18. Health check, first shots, CKC registration. See full details at our website: thesugardoodlebarn.com $1,000 (270)932-1365 Godsnewhelper@yahoo.com

Boston Terrier Pups, 9 weeks, rare chocolate/white, hazel eyes, Reg. Shots & Wormed. $850/ea. C/T: 615-415-2769

Cava-Poo, Male, 8 weeks, blk, brn, & wht, sweet, lively UTD shots, microchip, collar,leash, carrier incl. Text Mia (210)601-7000 $1500

Cavapoo Puppies CKC registered $1200 Call (931)625-4640 TENTOBCOOL@yahoo.com

Place your ad today!
Call 242-SALE

Domestic Pets

Frenchton Puppies - CKC, Females, Ready to go. $800. 270-308-5144

GREAT DANE PUPPIES CKC, Gorgeous colors, Blue eyes. Harlequin & Blue Merles, Ready Now! Parents on site. Males & Females. Well Socialized! $350 & Up Please call: 865-221-3842

Labrador Retriever Pups, AKC Reg., Championship Hunting/Performance lines $700. Health guarantee, chipped, wormed & vaccinated. 205-243-9269

Malti-Poo Puppies - 10 wks, 2 males, CKC Registered. $850 ea. Maltese Puppies, 2 males, $1000 ea, 2 females, $1200 ea. CKC Registered. 615-585-1067

Morkie Pups, REG.. First Shots, Dewormed, Happy & Healthy, $950. Call Deb: 727-484-4765. Camden,Tn.

Old English Sheepdog pups. b. 4/9. AKC. $750. Sire, dam and granddam on premises. Very playful pups. Males and Females. 270-524-5621

One call delivers your classified ad all over Middle Tennessee.
Call 242-SALE, today!

Domestic Pets

AKC registered
Poodle Puppy, Miniature, Male, 8 Wks., Beautiful Black/Blue, AKC Reg., Champion Parents, Vet checked, 1st shots. Pet price $2,000 (931)743-8126 www.bluespringspoodles.com

Saint Bernard puppies , 8 weeks Union City, Tn $$1500 (731)592-2225

Sheepdoodle pups. Beautiful R1. Old English Sheepdog dam, Standard Poodle sire, b. 5/28. $750. M & F, (270)524-5621

Siberian Husky Pups- 2, white w/ blues eyes, male & female, AKC champion bloodline, 5 months. $600/ea . 931-212-4437

Snorkie Pups- non shed, hypoallergenic, utd on shots, health guarantee. $450. Call/text for info & pics: 931-252-0600

AKC registered
Standard Poodles, AKC, Male & Females, , Ready to go Aug 15th, Brown & Parti's AKC Standard Poodles. Males & Females. Parents health tested $1500 (615)430-0588 megangilbert92609@gmail.com

Domestic Pets

YORKIE PUPPIES - CKC, 11 wks, 2 males $900 ea., Also **Teddy Bears**, 11wks, 2 fem's; $900 ea. All have shots/wormed. info call 615-672-3930

Whats Hot Announce
messages & notices...

Announcements

Auction Sale 1741 West Main St, Suite B Franklin, TN July 19th at 10am, 1999 Dodge Durango 1B4HS28Y8XF570528, 2010 Honda Civic 2HGFA1F50AH500643, 2013 Ford Fusion 3FA6P0HR3DR302663, 2015 Ford Fusion 3FA6P0HD1FR234370, 2018 Honda Accord 1HGCV1F37JA089276, 2017 Ford Fiesta 3FADP4BJ7HM138286, 2003 Saturn Vue 5GZCZ63B03S894317, 2014 Toyota Corolla 2T1BURHE0EC081273, 1997 Ford Club Van 1FBJS31LXVHB81257, 2010 Chevrolet 1500 3GCRCREA2AG105902, 2008 Subaru Impreza JF1GH61668G813218, 2013 Acura RDX 5J8TB3H5XDL014910,

FINDING WORK SHOULDN'T BE WORK.

jobs. ZipRecruiter

Get started by visiting
jobs.tennessean.com

Public Notices

0005345367

NOTICE
Cause No: 2022-AD-629
IN THE CHANCERY COURT FOR ROANE COUNTY, TENNESSEE

IN RE: THE ADOPTION OF FEMALE CHILD
Alexis Jade Crabtree DOB: 1/13/2014

By: Docket No: 2022-AD-629
TRENTON LEE CATRON and
ELIZABETH NICOLE CATRON,

Petitioners,

verses

ROBBIE SCOTT MCCONKEY,
Respondent.

IN THIS CAUSE, it appearing from the ORDER OF PUBLICATION, that the Respondent, Robbie Scott McConkey's residence is unknown and cannot be ascertained upon diligent inquiry, it is ORDERED that publication be made for four (4) consecutive weeks, in the Tennessean, to notify Respondent, to file an ANSWER with this Court and send a copy to Petitioners attorney, Lauren R. Biloski, whose address is 1710 Oak Ridge Hwy, Clinton, TN 37716, within 30 days from the last date of publication, or a judgment by default may be entered against Respondent. Failure to appear may result in the termination of Respondent's parental rights to the above-named child. The cause is set for hearing before this Court on the xxxx day of To be determined at 9:00 a.m. to provide Respondent with an opportunity to appear and defend.
THIS the 12th day of July, 2022.
CLERK AND MASTER

Public Notices

0005345408

Notice of Change in TennCare III Demonstration Amendment 4

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Members of the public who wish to comment on TennCare's proposal may send written comments by mail to Mr. Aaron Butler, Director of Policy, Division of TennCare, 310 Great Circle Road, Nashville, Tennessee 37243, or by email to public.notice.tenncare@tn.gov. Persons wishing to review copies of written comments received may submit their requests to the same email and/or physical address. The last day on which comments will be accepted is August 19, 2022.

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Great Buys Yard Sale
neighborly deals...

Davidson Southwest

Berenice Denton Estate Sales
615-292-5765

HUGE SHELBYVILLE SALE
July 21-July 23. 9am-4pm
407 E. Franklin St., TN 37160
House Full of Beautiful Furniture & Decor

For pics go to www.berenicedenton.com

Davidson West

Nashville, SYLVAN PARK NEIGHBORHOOD YARD SALE, 46th Ave / Murphy Rd, July 23rd, 8-2, Dir: Look for sellers with balloons or see www.sylvanpark.org/yardsale for map

Williamson County

Nashville: 71 Timberline Dr. Sat.7/23; 7a-2p
★ MULTI FAMILY GARAGE SALE! ★
Lawn mower, golf equip., gas grill, treadmill, furniture, gaming system, HH items & toys

Other Areas

ESTATE SALE

Pulaski - 235 North 1st St, Fri 7/22 & Sat 7/23, 9-4pm. A lot of antiques & more!!

Your merchandise is as good as gone. Call 242-SALE today.

Public Notices

Public Notices

Assorted Merch
all kinds of things...

General Merchandise

★ I BUY ★ OLD STEREO EQUIPMENT ★ Speakers, amps, tuners. Please Call: 615-260-9569

Wanted to Buy

Buying Gold, Silver & Platinum coins, PCGS coins, silver dollars & old currency, Pre 1972 sports cards 615-497-9852

WANTED
Comic Books. 1980s and earlier. Few or Many! Collector, not Dealer. I pay Good Prices. Also buy Vintage Posters. ★ 615-596-7604 ★

LOOK!
INSTANT CASH PAID for baseball cards, sports memorabilia, autographs, game used sports items, coins, gold, silver, watches, diamonds, old toys, trains, comic books, old photos, military, presidential, huge collections, lots of others. Scott, 513-295-5634 Instant Cash Paid - goodasgold@roadrunner.com

RECORDS & CDs WANTED-LPs/45s/78s Personal & DJ Collections/Promo Items Old Stock etc. CASH PAID. 615-256-6763

We Thin &/or Remove Your Overgrown/ or Unwanted Monkey Grass/Liriope
We Pay For Most Varieties
There is no charge for this service!!
Call Dave @: 334-703-7122

Real Estate Rentals
great places to live...

Rooms For Rent

KNIGHTS INN - weekly/monthly rates & efficiencies- Free local calls, free HBO & WIFI $250 & up. 615-678-6526

Real Estate Homes
starting fresh...

Commercial

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Automotive Cars
best deal for you...

Autos Wanted

1960's or 1970's Car with GOOD eye appeal and in GOOD working Cond. Also looking for Class B-RV, in GOOD working cond. ★ 615-596-7604 ★

CLASSIC CARS WANTED all conditions considered for classic cars & trucks foreign or American call/text (443)641-6770

Cars

Buick 2001 Park Ave Ultra, black, 4 door, <56K miles, looks & runs great. $4,000obo. Call 615-662-1511

Recreational Vehicle

ATTENTION
I BUY CAMPERS, TRAILERS, & MOTOR HOMES- ALL TYPES. ready to go or need work. For FAST CASH Call Lawrence at 931-242-3135

Wanted:
A job where my ideas count.
Find what you want in
The Tennessean Classifieds.

Business & Service Directory

to advertise, email: **ServiceDirectory@tennessean.com** or call: **800.828.4237**

Professional Service
all your needs...

Home Improvement

Christian's Handyman Service
Paint, Pressure Wash,

Home Improvement

LOOK
ENGLISH HOME

Home Improvement

MIKE'S PAVING

Lawn - Garden Care

AL LANDSCAPING SERVICES
Lawn Maintenance, Mulching,

Lawn - Garden Care

COOK'S LAWNCARE SERVICE & LANDSCAPING
Sod Installantion,
Hedge Trimming, Beds Mulched, Aerating & Seeding,

STATE OF TENNESSEE
COUNTY OF OBION

Personally appeared before me, the undersigned Notary Public for Obion County Tennessee, David CRITCHLOW, who on oath says he is the publisher of the Union City Daily Messenger a daily newspaper of general circulation, published at Union City in said county and state, and that the hereto attached

Notice of Change

Notice was published in said paper for 1 ~~consecutive~~ days as follows:

7/26, _____, _____, _____, 2022

Publisher [redacted]

Publisher's Fee $ 242.78

Subscribed and sworn to before me this 2nd day of

August, 2022

Notary Public [redacted]

DONNA L. GIBSON
STATE OF TENNESSEE NOTARY PUBLIC
OBION COUNTY

CLASSIFIEDS

Misc. For Sale • Services • Real Estate • Help Wanted

Appliances

FOR SALE: Air Conditioners small large clean and cold 731 796 0996 885 8258

Satellites

ATTENTION VIAGRA users Generic 100 mg blue pills or generic 20 mg yellow pills Get 45 plus 5 free $99 + S/H Guaranteed no prescription necessary Call Today 1 877 707 5707 (TnScan)

DISH NETWORK. $59 99 for 190 Channels! Blazing Fast nternet $19 99/mo (where available) Switch & Get a FREE $100 Visa Gift Card FREE Voice Remote FREE HD DVR FREE Streaming on ALL Devices Call today! 1 844 274 6074 (TnScan)

Health

VIAGRA AND C AL S USERS! A cheaper alternative to high drugstore prices! 50 Pill Special Only $99! 100% guaranteed CALL NOW 866 974 1464 (TnScan)

Want to Buy

TOP CA$H PA D FOR OLD GU TARS! 1920 1980 Gibson Martin Fender Gretsch Epiphone Guild Mosrite Rickenbacker Prairie State D Angelico Stromberg And Gibson Mandolins / Banjos 866 846 4260 (TnScan)

Check It Out In The CLASSIFIEDS

Notice

NOTICE
The Messenger screens all classified ads prior to publishing in order to protect our readers from scams

Our customers are important to us f you see an ad that you are unsure of or if you respond to an ad that is a scam please contact us

The Messenger Classifieds Department 731-885-0744

Invitation to Bid

BID NOTICE
1 2011 Dodge Dakota V N#
107RE2BK4B5709398
2 1972 Chevrolet Fire Truck
V N# CCE632V132387
3 1951 Chevrolet Fire Truck
V N# 3UW C2746
4 1967 Chevrolet Tanker Truck
V N# CE5375158489
The Town of Troy is taking sealed bids on the vehicles listed above The bids are to be placed in a sealed envelope along with name telephone number and vehicle number which are located on the windshields The bids are to be dropped off at Troy City Hall The address is 116 West Harper Street Troy TN 38260 The vehicles can now be viewed at the old the Storey Sawmill located at
306 East Bright Street
Troy TN 38260
The Town of Troy reserves the right to reject any and all bids
The bids will be opened on Friday July 29 2022 at 10 00AM at City Hall in Troy
7/21/2022, 7/26/2022, 7/28/2022

Messenger Classifieds 731-885-0744

BID NOTICE
The Obion County Board of Education is accepting bids for the purchase of new tires for school buses
The tires must have a tread depth of 23/32nd minimum The tires must be 16 ply H rated tires The tires must be brand new no caps or used tires and the tire size must be 11R 22 5 Tires with a tread depth less than 23/32nd will not be accepted Bids will be accepted until 10 00 a m on Monday August 1st 2022 The sealed bids will be opened at 10 00 a m at the Obion County Board office on Monday August 1st 2022 All bids must be sent to and opened at the Board Office The address for the Board office is 1700 N Fifth Street Union City TN 38261 These prices must include any disposal fees and the bid must be good for one year The Obion County Board of Education reserves the right to accept or refuse any bid

Legal

NOTICE TO CREDITORS 35,134 ESTATE OF MELVIN LEON WILLIAMS (Deceased)
Notice is hereby given that on the 7th day of July 2022 Letters Testamentary in respect of the estate of Melivn Leon Williams who died June 23 2022 were issued to the undersigned by the Chancery Court of Obion County Tennessee All persons resident and non resident having claims matured or unmatured against the estate are required to file the same with the Clerk of the above named Court on or before the earlier of the dates prescribed in (1) or (2) otherwise their claims will be forever barred
(1)
(A) Four (4) months from the date of the first publication (or posting as the case may be) of this notice if the creditor received an actual copy of this notice to creditors at least sixty (60) days before the date that is four (4) months from the date of the first publication (or posting); or
(B) Sixty (60) days from the date the creditor received an actual copy of the notice to creditors if the creditor received the copy of the notice less than sixty (60) days prior to the date that is four (4) months from the date of first publication (or posting) as described in (1) (A); or
(2) Twelve (12) months from the decedent s date of death
This 12th day of July 2022
Rita Lynne McDaniel
Exec
Attorney for the Estate
H A Nohsey
Paula Rice
Clerk and Master
7/14/2022 7/21/2022

NOTICE
N THE JUVEN LE COURT OF MAD SON COUNTY TENNESSEE
STATE OF TENNES SEE
DEPARTMENT OF CH L DREN S SERV CES
PET T ONER
N THE MATTER OF nfant Male Doe DOB 06/21/2022
A CH LD UNDER E GHT EEN (18) YEARS OF AGE
ORDER FOR PUBL CA T ON

Legal

n this cause it appears to the Court from the allega tions of the Petition that the Department of Children s Services is seeking to de clare nfant Male Doe a voluntarily delivered child pursuant to T C A § 36 1 142 a copy of said Petition may be obtained at the Office of the Juvenile Court Clerk of Madison County Jackson Tennessee The child was born on June 21 2022 in Jackson Tennessee at approximately 34 weeks gestation has brown hair blue eyes weighed 4 17 pounds at birth and was 43 cm in length The mother voluntarily delivered the child at Jackson Madison County General Hospital for adoption on June 24 2022 The mother is believed to be of Caucasian descent and is believed to be from Obion County Tennessee The father s demographics are unknown Failure by the biological mother to seek contact with the child through the Department of Children s Services or to revoke the voluntary delivery within thirty (30) days of the date of the last publication of notice shall constitute abandonment of the child and of the mother s interests The putative father of said child who fails to claim paternity by contacting the Department or by registering with the putative father registry within thirty (30) days of the date of the last publication of notice shall be barred from thereafter bringing any action to establish paternity of the infant Such failure will constitute abandonment of any right to notice of or to a hearing in any judicial proceeding for the adoption of such infant and that consent of such putative father shall not be required for adoption of the infant n the event that the biological mother or the putative father require additional information they should contact Brittany Buckley counsel for the Department of Children s Services 225 Martin Luther King Drive Jackson Tennessee 38301; telephone 731 421 2000
T S THERE FORE ORDERED that said biological mother and putative father enter their appearance herein on 9/29/22 at 11 00 a m a rule day of said Court and that a copy of this order be published for four consecutive weeks in The West Tennessee News a newspaper circulated in Madison County Tennessee and The Union City Daily Messenger a newspaper circulated in Obion County Tennessee
The Final Hearing to terminate the parental rights of the biological mother and of the putative father is scheduled for 10/11/22 at 11 00 a m Failure of said persons claiming an interest in the child to appear at the final hearing will result in the loss of their parental rights to the child
ENTERED this 7th day of July 2022
/s/ Christy R Little
Juvenile Court Judge
APPROVED FOR ENTRY
/s/ Brittany Buckley BPR # 038417
Attorney for State of Tennessee
Department of Children s Services
225 Martin Luther King Drive
Jackson Tennessee 38301
731 421 2000
7/14/2022, 7/21/2022, 7/28/2022, 8/4/2022

NOTICE TO CREDITORS 35,135 ESTATE OF Pamela Cox (Deceased)
Notice is hereby given that on the 8th day of July, 2022, Letters Testamentary in respect of the estate of Pamela Cox who died July 5, 2022 were issued to the undersigned by the Chancery Court of Obion, County, Tennessee. All persons, resident and non-resident, having claims, matured or unmatured, against the estate are required to file the same with the Clerk of the above named Court on or before the earlier of the dates prescribed in (1) or (2) otherwise their claims will be forever barred:
(1)
(A) Four (4) months from the date of the first publication (or posting as the case may be) of this notice if the creditor received an actual copy of this notice to creditors at least sixty (60) days before the date that is four (4) months from the date of the first publication (or posting); or
(B) Sixty (60) days from the date the creditor received an actual copy of the notice to creditors if the creditor received the copy of the notice less than sixty (60) days prior to the date that is four (4) months from the date of first publication (or posting) as described in (1) (A); or
(2) Twelve (12) months from the decedent's date of death,
This 12th day of July, 2022
James Andrew Cox
Exec
Attorney for the Estate
H A. Nohsey
Paula Rice
Clerk and Master
7/14/2022, 7/21/2022

Notice of Change In TennCare III Demonstration Amendment 4
The Commissioner of the Tennessee Department of Finance & Administration is providing official notification pursuant to 59 Fed Reg 49249 of intent to file an amendment to the TennCare Demonstration The amendment which will be known as "Amendment 4 " will be filed with the Centers for Medicare and Medicaid Services (CMS) a federal agency located in Baltimore Maryland
n Amendment 4 Tenn Care is proposing three changes to the TennCare demonstration These changes are in response to a letter from CMS on June 30 2022 requesting that Tennessee make certain modifications to the Tenn Care demonstration These changes are as follows (1) Tennessee is proposing to assess budget neutrality for the TennCare demonstration using a "per member per month (PMPM) cap" framework rather than an "aggregate cap" framework; (2) Tennessee is proposing to receive federal financial participation (FFP) for designated state investment programs specified in Attachment O of the Tenn Care demonstration based on the extent (if any) to which the state s expenditures for a given year are below the budget neutrality cap up to a maximum amount equivalent to the federal share of the designated state investment programs; and (3) Tennessee is proposing to remove the existing expenditure authority for pharmacy and related flexibilities from the demonstration These changes will address the issues identified by CMS while maintaining the key principles and core goals of the TennCare demonstration
Amendment 4 does not propose any changes to TennCare eligibility or benefits and will not result in any changes to enrollment or expenditures under the TennCare demonstration As noted above Amendment 4 will result in changes to the way that the demonstration s budget neutrality is calculated
The full public notice associated with this amendment including a comprehensive description of the amendment is available on the TennCare website at https //www tn gov/content/dam/tn/tenncare/documents2/Amendment4ComprehensiveNotice pdf
Members of the public who wish to comment on Tenn Care s proposal may send written comments by mail to Mr Aaron Butler Director of Policy Division of TennCare 310 Great Circle Road Nashville Tennessee 37243 or by email to
public notice tenncare@tn gov Persons wishing to review copies of written comments received may submit their requests to the same email and/or physical address The last day on which comments will be accepted is August 19 2022
Copies of this notice will be available in each county office of the Tennessee Department of Health
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NOTICE TO CREDITORS 35,136 ESTATE OF Frederick Lee Mahan (Deceased)
Notice is hereby given that on the 11th day of July 2022 Letters Administration in respect of the estate of Frederick Lee Mahan who died July 5 2022 were issued to the undersigned by the Chancery Court of Obion County Tennes see All persons resident and non resident having claims matured or unmatured against the estate are required to file the same with the Clerk of the above named Court on or before the earlier of the dates prescribed in (1) or (2) otherwise their claims will be forever barred
(1)
(A) Four (4) months from the date of the first publication (or posting as the case may be) of this notice if the creditor received an actual copy of this notice to creditors at least sixty (60) days before the date that is four (4) months from the date of the first publication (or posting); or
(B) Sixty (60) days from the date the creditor received an actual copy of the notice to creditors if the creditor received the copy of the notice less than sixty (60) days prior to the date that is four (4) months from the date of first publication (or posting) as described in (1) (A); or
(2) Twelve (12) months from the decedent s date of death
This 12th day of July 2022
Jurline Mahan Harris
Admx
Attorney for the Estate
Taylor Hatcher Smith
Paula Rice
Clerk and Master
7/14/2022, 7/21/2022

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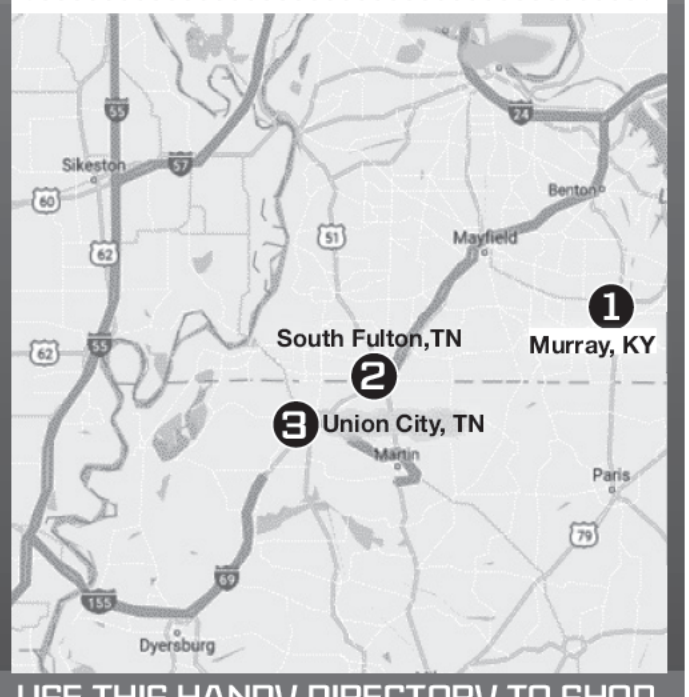

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Appendix C

Public Comments

August 19, 2022

Aaron Butler
Director of Policy
Division of TennCare
310 Great Circle Road
Nashville, TN 37243

Re: Amendment 4 to TennCare III Medicaid Section 1115 Demonstration

Dear Director Butler:

The American Cancer Society Cancer Action Network (ACS CAN) appreciates the opportunity to comment on the proposed amendment to Tennessee's TennCare III demonstration, and we thank the Division of TennCare for making changes in response to public comments. ACS CAN is making cancer a top priority for public officials and candidates at the federal, state, and local levels. ACS CAN empowers advocates across the country to make their voices heard and influence evidence-based public policy change, as well as legislative and regulatory solutions that will reduce the cancer burden. As the American Cancer Society's nonprofit, nonpartisan advocacy affiliate, ACS CAN is critical to the fight for a world without cancer.

ACS CAN appreciates Tennessee's goal of promoting the health of low-income Tennesseans. We applaud the state's decision to eliminate plans for an aggregate funding cap and the adoption of a closed formulary. We oppose the state's plan to continue to waive retroactive coverage (especially for a 10-year period). More than 42,200 Tennesseans are expected to be diagnosed with cancer in 2022[1] and there are nearly 350,250 cancer survivors in the state[2] – many of whom are receiving health care coverage through the TennCare program. ACS CAN wants to ensure that cancer patients and survivors in Tennessee will have adequate access and coverage under the Medicaid program, and that program requirements do not create barriers to care for low-income cancer patients, survivors, and those who will be diagnosed with cancer.

Financing Model

ACS CAN commends the state for eliminating the planned aggregate cap funding model. This plan would have fundamentally altered the Medicaid program in Tennessee, shifting the funding from a percentage match, whereby the program's funding adjusts automatically to account for the number of enrollees and rising health care costs, to one where annual funding for the program would be capped. Moving forward with the aggregate cap model could have significantly reduced low-income

[1] American Cancer Society. *Cancer Facts & Figures 2022*. Atlanta, GA: American Cancer Society; 2022.
[2] American Cancer Society. *Cancer Treatment & Survivorship Facts & Figures 2022-2024*. Atlanta, GA: American Cancer Society; 2022.

American Cancer Society Cancer Action Network, Inc.
655 15th Street, NW, Suite 503, Washington, D.C. 20005
202.661.5700
fightcancer.org

cancer patients', survivors', and their families' access to affordable, comprehensive health care in the state.

Access to Prescription Drugs

ACS CAN commends the state's decision to eliminate plans to adopt a closed formulary. There is no single oncology drug that is medically appropriate to treat all cancers. Cancer is not just one disease, but hundreds of diseases. Cancer tumors respond differently depending on the type of cancer, stage of diagnosis, and other factors. As such, oncology drugs often have different indications, different mechanisms of action, and different side effects – all of which need to be managed to fit the medical needs of an individual. Oncologists take into consideration multiple factors related to expected clinical benefit and risks of oncology therapies and the patient's clinical profile when making treatment decisions. For example, one fourth of cancer patients have a diagnosis of clinical depression,[3] which may be managed with pharmaceutical interventions that may limit cancer treatment options because of drug interactions or side effects. As such, when enrollees are in active cancer treatment, it can be particularly challenging to manage co-morbid conditions.

Allowing for the use of a closed formulary would have severely restricted a physician's ability to prescribe the medically appropriate treatment for an individual without going through a lengthy appeals process. Denying enrollees access to medically appropriate therapies can result in negative health outcomes, which can increase Medicaid costs in the form of higher physician and/or hospital services to address the negative health outcomes.

Program Lockout for Member Fraud

The state plans to suspend or terminate the eligibility of individuals who have been determined to be guilty of fraud and to prevent them from re-enrolling for up to 12 months. ACS CAN supports state efforts to reduce or eliminate fraud from health care programs. However, we are concerned that suspending or terminating the eligibility of individuals without a robust appeals process in place could place a substantial financial burden on enrollees and cause significant disruptions in care, particularly for individuals in active cancer treatment. During the proposed suspension or termination period, low-income cancer patients will likely have no access to health care coverage, making it difficult or impossible to continue treatment. For those cancer patients who are mid-treatment, a loss of health care coverage could seriously jeopardize their chance of survival. Being denied access to one's cancer care team could have a significant impact on an individual's cancer prognosis and the financial toll that the lock-out would have on individuals and their families could be devastating. Therefore, we urge the state to provide details of a robust appeals process before implementing plans to suspend or terminate the eligibility of individuals who have been determined to be guilty of fraud.

[3] American Cancer Society, *Coping with Cancer: Anxiety, Fear, and Depression*. Available at https://www.cancer.org/treatment/treatments-and-side-effects/emotional-side-effects/anxiety-feardepression.html.

Waiver of Retroactive Eligibility

Medicaid currently allows retroactive coverage if: 1) an individual was unaware of his or her eligibility for coverage at the time a service was delivered; or 2) during the period prospective enrollees were preparing the required documentation and Medicaid enrollment application. Retroactive eligibility in Medicaid is a policy that prevents some of the most economically vulnerable individuals from incurring large and long-lasting amounts of medical debt. Policies that reduce or eliminate retroactive eligibility could place a substantial financial burden on enrollees and cause significant disruptions in care, particularly for individuals battling cancer. Therefore, we are concerned about the state's request to continue to waive retroactive eligibility. We urge the state to remove this provision.

Many uninsured or underinsured individuals who are newly diagnosed with a chronic condition already do not receive recommended services and follow-up care because of cost.[4,5] In 2019, three in ten uninsured adults went without care because of cost.[6] Waiving retroactive eligibility could mean even more people are unable to afford care and forgo necessary care due to cost.

Safety net hospitals and providers also rely on retroactive eligibility for reimbursement of provided services, allowing these facilities to keep the doors open. For example, the Emergency Medical Treatment and Labor Act (EMTALA) requires hospitals to stabilize and treat individuals in their emergency room, regardless of their insurance status or ability to pay.[7] Retroactive eligibility allows hospitals to be reimbursed if the individual treated is eligible for Medicaid coverage. Likewise, Federally Qualified Health Centers (FQHCs) offer services to all persons, regardless of that person's ability to pay or insurance status.[8] Community health centers also play a large role in ensuring low-income individuals receive cancer screenings, helping to save the state of Tennessee from the high costs of later stage cancer diagnosis and treatment. For these reasons, we urge the state program to remove this provision.

Conclusion

We appreciate the opportunity to provide comments on the latest amendment to the TennCare III Demonstration. The preservation of eligibility and coverage through the TennCare program remains critically important for many low-income Tennesseans who depend on the program for cancer and chronic disease prevention, early detection, diagnostic, and treatment services. We urge the state to

---

[4] Hadley J. Insurance coverage, medical care use, and short-term health changes following an unintentional injury or the onset of a chronic condition. *JAMA*. 2007; 297(10): 1073-84.

[5] Foutz J, Damico A, Squires E, Garfield R. The uninsured: A primer – Key facts about health insurance and the uninsured under the Affordable Care Act. *The Henry J Kaiser Family Foundation*. Published January 25, 2019. Accessed November 2019. https://www.kff.org/report-section/the-uninsured-a-primer-key-facts-about-health-insurance-and-the-uninsured-under-the-affordable-care-act-how-does-lack-of-insurance-affect-access-to-health-care/.

[3.] Tolbert J, Nov 06 ADP, 2020. Key Facts about the Uninsured Population. KFF. Published November 6, 2020. Accessed August 17, 2021. https://www.kff.org/uninsured/issue-brief/key-facts-about-the-uninsured-population/.

[7] Centers for Medicare & Medicaid Services. Emergency medical treatment & labor act (EMTALA). Updated March 2012. Accessed October 2019. https://www.cms.gov/regulations-and-guidance/legislation/emtala/.

[8] National Association of Community Health Centers. America's Health Centers' Snapshot. Published August 2021. Accessed August 2021. https://www.nachc.org/wp-content/uploads/2020/10/2021-Snapshot.pdf.

reinstate retroactive eligibility and eliminate plans to lock out members charged with fraud in light of the potential impact these policies could have on low-income Tennesseans' access to lifesaving health care coverage, particularly those individuals with cancer, cancer survivors, and those who will be diagnosed with cancer during their lifetime.

Maintaining access to quality, affordable, accessible, and comprehensive health care coverage and services is a matter of life and survivorship for thousands of low-income cancer patients and survivors, and we look forward to working with the state to ensure that all people are positioned to win the fight against cancer. If you have any questions, please feel free to contact Maddie.Bushnell@cancer.org.

Sincerely

Maddie Bushnell
Tennessee Government Relations Director
American Cancer Society Cancer Action Network

STATE OF TENNESSEE
COUNCIL on DEVELOPMENTAL DISABILITIES
DAVY CROCKETT TOWER, FIRST FLOOR
500 JAMES ROBERTSON PARKWAY
NASHVILLE, TENNESSEE 37243-0228
PHONE 615-532-6615 FAX 615-532-6964

August 19, 2022

Director Stephen Smith
Division of TennCare
310 Great Circle Rd.
Nashville, TN 37243

Director Smith,

On behalf of the TN Council on Developmental Disabilities, we submit the following public comment on Amendment 4:

We support rescinding the closed formulary model from TennCare III, which was a major concern and part of our original public comments on TennCare III. Our members are people who experience lifelong and complex disabilities that encompass rare and often multiple co-occurring conditions. For example, one member's daughter has a rare genetic disorder that only 2,500 people in the world experience, plus co-occurring autism and epilepsy. Only a name brand drug for seizures is effective for this young woman. Finding prescription drugs that are effective in such complex cases requires flexibility and options without barriers to adjusting as needed. We are relieved to see this change.

We recommend that before finalizing Amendment 4, TennCare add commitments to direct future shared savings to benefit the disability community. Specifically, we would like to see shared savings used toward:

- Ongoing investments in raising wages for Direct Support Professionals (DSP), who carry out the critical HCBS component of TennCare. Because of the ongoing workforce crisis, services approved for HCBS are not available to people enrolled – equating to a loss of service access.
- Ongoing adjustments to the expenditure caps in HCBS to keep up with inflation and DSP wages. As with raising DSP wages, raising expenditure caps is necessary for access to services.
- Continuing enrollment and avoiding waiting lists in HCBS.

In July 2022, we signed on to a letter sent to TennCare by a group of disability organizations that identified those priorities above.

Finally, **we continue to see a need for TennCare to communicate about TennCare III implementation with the disability community, specifically.** While professionals in the field can monitor TennCare's website for public notices, the people impacted by them – Tennesseans with disabilities and their families – often cannot. Recent public hearings have not explained TennCare III's impact on recipients, which has been a major source of fear and some misinformation. We urge TennCare to schedule regular informational briefings focusing on practical information for the people who are impacted by Medicaid, including people with disabilities. Briefings should be promoted widely in advance, offered in plain language, and recorded so people who work during the day can view at their convenience. The Council is eager to assist.

Sincerely,

[redacted]

Lauren Pearcy
Executive Director

CYSTIC FIBROSIS FOUNDATION®

August 16, 2022

Aaron Butler
Director of Policy
Division of TennCare
310 Great Circle Road
Nashville, Tennessee 37243

RE: TennCare III Demonstration, Amendment 4

Dear Mr. Butler,

Thank you for the opportunity to comment on the progress of Tennessee's TennCare demonstration. On behalf of people with cystic fibrosis (CF) living in Tennessee, we write to applaud the state for the positive changes made to its 1115 waiver and express our concerns with some remaining proposals. Specifically, we want to recognize the positive developments of removing the closed formulary, the "shared savings" mechanism, and the aggregate cap payment structure. Eliminating these policies will preserve access for people with CF who rely on Medicaid. Despite these positive changes, we continue to oppose the retroactive coverage waiver provision. We fear waiving this benefit jeopardizes patient access to quality and affordable healthcare and therefore urge that Tennessee revise its waiver application and remove this harmful provision.

Cystic fibrosis is a life-threatening genetic disease that affects close to 40,000 children and adults in the United States, including over 750 in Tennessee. Roughly a third of adults living with CF in the state rely on Medicaid for some or all of their health care coverage. CF causes the body to produce thick, sticky mucus that clogs the lungs and digestive system, which can lead to life-threatening infections. As a complex, multi-system condition, CF requires targeted, specialized treatment and medications. If left untreated, infections and exacerbations caused by CF can result in irreversible lung damage, and the associated symptoms of CF lead to early death, usually by respiratory failure.

Funding Model and Formulary Changes

We applaud Tennessee for removing its aggregate cap framework and its proposal to operate a commercial-style closed formulary. CFF recognizes that drug cost growth contributes to the increasing strain on state budgets, and we appreciate the state's investment in its patients by removing the proposed closed formulary. Furthermore, the previous provisions to establish an aggregate cap and "shared savings" mechanism created incentives for the state to cut costs, which could adversely impact access to care. For people with CF, lack of proper care can severely compromise their health by leading to increased hospitalizations, reduced lung function, or decreased nutritional status. Removing these proposals will eliminate incentives for Tennessee to reduce costs that could curtail access to care for patients with serious chronic conditions like cystic fibrosis.

Removal of Retroactive Eligibility

The CF Foundation opposes Tennessee's decision to continue to waive retroactive coverage in TennCare. Retroactive eligibility helps ensure continuous coverage for people with CF who experience changes in insurance status and become Medicaid eligible. There are many reasons why Tennesseans, including people with CF, may not be able to submit a timely Medicaid application when they become eligible. Someone with CF may be consumed by a complicated medical situation—such as an extended hospitalization—making it difficult to

complete an application. Applications can be burdensome and confusing, and people may not realize their coverage has lapsed until they seek care.

Retroactive eligibility helps adults living with CF in Tennessee who rely on Medicaid avoid gaps in coverage and costly medical bills and is an especially important safeguard for those who have lost their job or are experiencing changes in their insurance status as a result of the COVID-19 pandemic. Without it, people with CF may face significant out-of-pocket costs. Cystic fibrosis care and treatments are costly, even with coverage. According to a survey conducted by George Washington University of 1,800 people living with CF and their families, over 70 percent indicated that paying for health care has caused financial problems such as being contacted by a collection agency, having to file for bankruptcy, experiencing difficulty paying for basics like rent and utilities, or having to take a second job to make ends meet. And while 84 percent received some form of financial assistance in 2019 to pay for their care, almost half reported still having problems paying for at least one medication or service in that same year.[1]

Conclusion

Thank you for the opportunity to provide comments on the TennCare III demonstration. As the health care landscape continues to evolve, we look forward to working with the state of Tennessee to improve the lives of all people with cystic fibrosis. Please consider us a resource moving forward. If you have any questions about cystic fibrosis or would like to discuss the importance of access to care for the CF community, please contact Sage Rosenthal at srosenthal@cff.org or (301) 841-2632.

Sincerely,

Mary B. Dwight
Chief Policy & Advocacy Officer
Senior Vice President, Policy & Advocacy
Cystic Fibrosis Foundation

[1] https://hsrc.himmelfarb.gwu.edu/cgi/viewcontent.cgi?article=1056&context=sphhs_policy_briefs

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2 International Plaza, Suite 825
Nashville, TN 37217
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August 19, 2022

Mr. Stephen Smith
Director
Division of TennCare
310 Great Circle Road
Nashville, TN 37243

Via Email: public.notice.tenncare@tn.gov

Re: Public Comment by Disability Rights Tennessee on TennCare III Amendment 4

Dear Mr. Smith:

Disability Rights Tennessee (DRT) appreciates the opportunity to offer public comment on the Proposed TennCare III Amendment 4. We understand that Amendment 4 is in response to the changes proposed by the Centers for Medicare & Medicaid Services (CMS) to the TennCare III Section 1115 Demonstration (11-W-00369/4) on June 30, 2022. The letter from CMS suggested that CMS had significant concerns related to three items in 11-W-00369/4 and asked for a response mitigating those concerns. DRT believes that the Division of TennCare has responded positively to each of those three concerns. Our opinions are set out below in more detail.

DRT does have other ongoing concerns about the Special Terms and Conditions (STCs) which are also set out below.

We support CMS's request that the closed formulary model be removed from the demonstration, and DRT applauds the amendment to 11-W-00369/4 that removes that closed formulary expenditure authority and its associated flexibilities from the TennCare Demonstration. For many persons with complex and/or numerous disabilities, only a name brand drug, or a particular combination of drugs, is effective. Finding prescription drugs that are effective in these cases requires flexibility and options without barriers to adjustment as needed. Removal of the closed formulary model is essential for this type of flexibility.

While TennCare states in its proposed Amendment 4 that it believes this authority is a permissible and reasonable use of the Secretary's authority under Section 1115, DRT disagrees. As we have previously stated, the STCs allowed Tennessee to implement a closed prescription drug formulary for adult beneficiaries. Despite not covering prescription drugs as required by the Medicaid Act, Tennessee was allowed by that approval to continue to receive generous rebates from pharmaceutical manufacturers. That allowance was and is inconsistent with Section 1115 since Section 1115 only allows waivers of the Medicaid provisions in Section 1396a, and thus the allowance of a waiver of

Medicaid provisions in Section 1396r-8, which governs the development and use of a prescription drug formulary, was not an allowable exercise of the Secretary's authority. The exceptions process in the approval was not sufficient to ensure that beneficiaries would have access to medically necessary drugs and thereby would have a negative effect on health outcomes.

As previously stated, DRT has clients that would have been negatively affected by that approval, so DRT is both pleased and thankful for this proposed action by TennCare asking that the Closed Formulary authority for pharmacy and associate pharmacy flexibilities expenditure authority be removed from the demonstration. It is a step consistent with CMS's request and the Medicaid Act.

Next, CMS requested that TennCare submit a new financing and budget neutrality model, based on a traditional per member per month cap instead of an aggregate cap. Additionally, CMS requested that TennCare modify the STCs to more explicitly state that Tennessee cannot cut benefits or coverage in effect on December 31, 2021 without an amendment to the demonstration, subject to additional public comment period and CMS approval.

In response to this request, TennCare has proposed as follows:

> "Budget neutrality is most commonly demonstrated through either an "aggregate cap" framework or a "per capita cap" framework. See for example State Medicaid Director Letter #18-009 (August 22, 2018) regarding budget neutrality policies for Section 1115(a) Medicaid demonstration projects. The TennCare demonstration's budget neutrality framework is currently calculated on an aggregate cap basis. In its June 30, 2022, letter, CMS requested that the state submit an amendment in which the demonstration's budget neutrality would instead be calculated on a per capita cap basis. The state believes that the TennCare demonstration is budget neutral for the federal government and that it can be demonstrated to be so via any number of methodologies. Therefore, consistent with CMS' request, the state proposes in this amendment to assess budget neutrality for the TennCare demonstration via a "per member per month cap" framework and requests that the demonstration's special terms and conditions be modified accordingly. "

While it appears that TennCare continues to believe its old model was consistent with the Medicaid Act, it has nonetheless made a proposal in Amendment 4 which is consistent with CMS's request and the Medicaid Act. DRT applauds this proposed change in Amendment 4.

As we have previously noted after setting out examples of the effect on mental health care of our clients that comes from using an aggregate cap on spending as a measure, the use of an aggregate cap is inconsistent with Section 1396b.

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, that previous approval permits deviation from the financing scheme set forth in that provision. For example, under the previous approval, if Tennessee spends more than the aggregate cap, it will not receive federal reimbursement for its excess costs. That meant that the State would have received an FMAP for its total expenditures on medical assistance that would be lower than the FMAP Congress has required

in section 1396b. Section 1115 does not give the secretary the authority to make that change. For this reason, DRT appreciates the recognition of this concern in its proposed Amendment 4.

Finally CMS has suggested that:

> "We support the state's policy goals to expand coverage and benefits and propose that instead of the current framework for savings and investment, CMS will work with the state on necessary expenditure authorities to meet common goals. In place of the structure in the current demonstration, the state should include in the demonstration amendment a request for expenditure authority for state reinvestments for initiatives that the state would like to support with budget neutrality savings (e.g., adult dental services, expanded 12-month postpartum coverage and enhanced home and community-based services; etc.)."

TennCare has proposed:

> "This component of the demonstration recognizes savings produced to the federal government by the state under the demonstration and provides a mechanism for the state to reinvest a portion of those savings in initiatives to improve the health of Medicaid beneficiaries. In this amendment, Tennessee requests federal financial participation (FFP) for designated state investment programs (DSIPs). These federal expenditures would be authorized by Section 1115(a) as costs not otherwise matchable (CNOMs). A list of identified and approved programs is included as Attachment O of the TennCare demonstration. These programs support access to healthcare across a variety of domains, spanning mental health, public health, community services, and child health services. Currently, state funds support these services and programs to meet health needs that Medicaid, as it is currently structured, does not. Many of the individuals served by these programs receive services alongside of people who are Medicaid-eligible, and many of them are individuals who churn in and out of Medicaid eligibility, creating a confusing and inefficient system for consumers and communities to navigate. In order to ensure the budget neutrality of these additional federal expenditures, the state requests that the amount of DSIP expenditure authority each year be based on the extent (if any) to which the state's expenditures for that year are below its budget neutrality cap (now calculated on a per member per month basis), up to a maximum amount equivalent to the federal share of the designated state investment programs specified in the demonstration. This arrangement recognizes the role that these programs play in improving the health of Medicaid enrollees and the communities in which they live and will support the state's efforts to make investments in improving the health of Medicaid beneficiaries over the life of the demonstration (e.g., adult dental services, expanded 12-month postpartum coverage, enhancements to home- and community-based services, etc.)."

DRT appreciates and supports this revised approach to the demonstration Expenditure Authorities. It is consistent with and remedies our previously expressed concerns.

While DRT appreciates the steps TennCare has taken to remedy certain problematic aspects of TennCare III in Amendment 4, DRT continues to have concerns about the:

1. Ongoing waiver of retroactive eligibility;
2. Ten-year term of the waiver; and
3. Racial inequity of the waiver as presently configured.

The ongoing waiver of retroactive coverage, even with the exceptions of EPSDT services and pregnancy services, is an increase in financial pressure on small hospitals in Tennessee. Tennessee has experienced more rural hospital closures than any other state.[i] Tennessee's hospitals, like those across the nation, experienced a dramatic drop in revenue throughout the COVID-19 pandemic, and they continue to lose money.[ii] The closure of Scott County hospital in Jamestown means that travel times for ambulances taking persons to emergency rooms has increased dramatically, resulting in potentially life and death consequences for the persons transported.[iii] With the closure of Scott County hospital, getting to the next available emergency facility is a time consuming and difficult task. For someone who is having a stroke or is otherwise in need of immediate emergency medical care, this is a dire situation.

Given the stated purpose of the approval of the TennCare III Demonstration to be able to realize economies, it is difficult if not impossible to see how there will be any improvement in the plight of rural hospitals in Tennessee. As a result, health outcomes of rural Tennesseans will not improve.

DRT respectfully suggests that Tennessee should further amend its TennCare III Demonstration by withdrawing the request to eliminate retroactive coverage for Medicaid beneficiaries. There is nothing experimental about waiving retroactive coverage. Numerous 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. To the extent that the waiver had any experimental value at that time, that is not the case now. 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.[iv] In fact, the lie is put to the proposition that there is anything experimental about the approval of TennCare III by the simple fact that, as of August 2019, no state that had a waiver of retroactive coverage (of which there were 30 demonstrations in 27 states) had done a formal evaluation of these policies, and there is little information on whether or how they will evaluate retroactive eligibility policies.[v]

In addition, eliminating retroactive coverage subverts the objectives of the Medicaid Act because it "by definition, reduce[s] coverage" for people not currently enrolled in Medicaid.[vi] Without retroactive coverage, Medicaid beneficiaries forgo vital health care and/or incur significant medical expenses, which they often cannot pay, thereby further pressuring hospitals financially with predictable bad results.

Additionally, DRT respectfully suggests that TennCare further amend the TennCare III Demonstration by not requesting the project last for 10 years. Section 1115 allows the Secretary to waive Medicaid Act requirements only for an experimental, pilot, or demonstration project, and only "to the extent and for the period necessary" to enable the state to carry out its experiment.[vii] Congress did not enact section 1115 to allow CMS to make long-term policy changes. As DRT has previously described in detail, TennCare III is not a valid experiment. Even if it were, there is simply no reason that Tennessee would need 10 years to conduct its experiment.

DRT acknowledges that, in 2017, CMS issued an Informational Bulletin announcing its intent "[w]here possible, . . . [to] approve the extension of routine, successful, non-complex" section 1115(a) waivers for a period of up to 10 years. Because the policy is contrary to section 1115, it should be reversed. In any event, the policy does not permit approving TennCare III for 10 years. As proposed now, TennCare III contains old features that Tennessee has not proven to be successful (*e.g.*, retroactive coverage).

Finally, DRT notes the ongoing racial inequity of the TennCare III demonstration as it presently exists and as amended. 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.[viii] As a result, nonwhite individuals are much more likely than white individuals to rely on Medicaid for their health care.[ix] By restricting access to Medicaid coverage and services, TennCare III disproportionately harms people of color.

In so doing, the project perpetuates and exacerbates existing racial health disparities in the State.[x] For example, the infant mortality rate in Tennessee is almost twice as high for Black infants as for white infants. And critically, Black Tennesseans have been disproportionately affected by COVID-19, accounting for 20% of cases and 36% of deaths and only 17% of the population.[xi] Instead of granting Tennessee waivers that 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. Empirical research establishes conclusively that Medicaid expansion has reduced mortality and morbidity.[xii] It also enhances families' financial security, thereby contributing to their ability to address social determinants of health.

DRT provides individual case services to hundreds of persons with disabilities each year. In the last year, 26.1% are persons who are Black. Also in the last year, DRT provided individual investigation services to over a hundred persons with disabilities, of whom 42.9% were Black. We also have several systemic investigations in which persons with disabilities are affected, and those investigations involve persons who are Black vastly more than their prevalence in the general population.

DRT is actively monitoring and conducting investigations at a DCS facility in rural Tennessee. Of the youth interviewed by DRT at the facility, ninety-six percent (96%) were Black, approximately eighty percent (80%) were prescribed psychoactive medications, and all were described by the nursing staff as having PTSD. Nearly all were victims of Adverse Childhood Experiences (ACES) and/or had experienced childhood trauma. These youth could be described as victims of the structural racism and inequality in Tennessee. Furthermore, they have been directly affected by the existing racial health disparities in Tennessee. As victims of childhood trauma, they have experienced the now well documented negative effects of trauma on health.

Specifically, a recent meta-analysis considers how ACES affects the epigenome.[xiii] In short, ACES is associated with methylation of specific gene sites, and long-term this is associated with development of psychiatric illness in adulthood. Childhood maltreatment may mediate epigenetic mechanisms through DNA methylation, thereby affecting physiological responses and conferring a predisposition to an increased risk for psychopathology and forensic repercussions. In other words, the trauma and ACES these youth have experienced before and during their placement at this facility

have affected their ability to respond physiologically, often as a result of the ongoing effects of structural racism and inequality.

This stress is a social determinant of health. Social and economic factors can shape individuals' health behaviors, and social and economic factors are the primary drivers of health outcomes.[xiv]

DRT appreciates, applauds, and congratulates TennCare for the forward thinking and progressive step it has taken through Amendment 4 and the positive response to the suggestions from CMS in its recent letter concerning the TennCare III Demonstration. DRT respectfully suggests to TennCare that it should further propose amendments to the TennCare III Demonstration waiver that address the ongoing issues of the waiver of retroactive eligibility, the ten-year term of the waiver, and the racial inequity of the waiver as presently configured.

DRT appreciates the opportunity to comment

If there are any further questions, or if further discussion is appropriate, please contact Lisa Primm or Jack Derryberry at DRT.

Respectfully Submitted:

[redacted]

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[i] *Available at* https://dailyyonder.com/rural-tennessee-is-losing-more-hospitals-than-anywhere-in-the-country-but-covid-19-isnt-fully-to-blame/2021/07/27/

[ii] *Available at* https://dailyyonder.com/rural-tennessee-is-losing-more-hospitals-than-anywhere-in-the-country-but-covid-19-isnt-fully-to-blame/2021/07/27/ *citing* https://jamanetwork.com/journals/jama/fullarticle/2765698

[iii] *Available at* https://dailyyonder.com/rural-tennessee-is-losing-more-hospitals-than-anywhere-in-the-country-but-covid-19-isnt-fully-to-blame/2021/07/27/

[iv] *See, e.g.*, *Beno v. Shalala*, 30 F.3d 1057, 1069 (9th Cir. 1994).

[v] See, https://www.macpac.gov/wp-content/uploads/2019/08/Medicaid-Retroactive-Eligibility-Changes-under-Section-1115-Waivers.pdf at page 2. MACPAC is the

[vi] *Stewart v. Azar*, 313 F. Supp. 3d 237, 265 (D.D.C. 2019).

[vii] 42 U.S.C. § 1115(a); *see also id*. § 1115 (d)(2), (f)(6) (limiting the extension of "state-wide, comprehensive demonstration projects" to one initial extension of up to 3 years (5 years, for a waiver involving dual eligible individuals) and one subsequent extension not to exceed 3 years (5 years, for Medicare-Medicaid waivers)).

[viii] *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).

[ix] *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).

[x] *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/.

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

[xii] 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.

[xiii] *Available at* https://www.tandfonline.com/doi/full/10.1080/20961790.2019.1641954

[xiv] *Available at* https://www.kff.org/racial-equity-and-health-policy/issue-brief/beyond-health-care-the-role-of-social-determinants-in-promoting-health-and-health-equity/

HCA Healthcare | TriStar Division

August 18, 2022

Aaron Butler
Director of Policy
Division of TennCare
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public.notice.tenncare@tn.gov

Re: Public Input Process – Comments on Amendment 4, TennCare III Demonstration

Thank you for the opportunity to submit comments on Amendment 4 of the TennCare III Demonstration. HCA is pleased to participate as a provider in the TennCare program and to provide the following comments.

As one of the longest operating Medicaid managed care programs in the nation, with nearly 30 years of experience, TennCare continues to be a leader in delivery system transformation. In 2021, the Centers for Medicare and Medicaid Services (CMS) approved a 10-year extension of TennCare III, which builds on the success of the prior programs. HCA applauds the State's continued efforts at integrating physical health, behavioral health, and long-term-care services under a managed care model, providing high quality of care to enrollees, ensuring enrollees' satisfaction with services, and improving health outcomes for enrollees. HCA agrees that managed care organizations (MCOs) are critical to achieving TennCare III goals, and HCA believes that the State should consider adopting strategies that complement and strengthen MCOs' efforts to integrate and improve care for enrollees.

To that end, HCA believes that Tennessee can build on TennCare achievements and advance federal and state goals to provide high-quality care for TennCare enrollees by establishing a managed incentive payment arrangement consistent with 42 C.F.R. § 438.6(b)(2). HCA recommends that Tennessee expand the amendment to request a modification to the demonstration's special terms and conditions (STCs) to allow for an adjustment to the demonstration's Per Member Per Month (PMPM) caps to accommodate the cost of a managed incentive payment arrangement.

Establishing a managed incentive payment arrangement is a natural next step for a mature managed care program such as TennCare, which has served Medicaid enrollees for almost three decades. The payment arrangement would foster collaboration between MCOs and providers and advance healthcare quality initiatives that align with the State's Medicaid quality strategy.

Tennessee would design incentive arrangements to specify the activities, targets, performance measures, or quality-based outcomes to be achieved by the MCO, consistent with Tennessee's Medicaid quality strategy. Tennessee could also structure the incentive payment arrangement to complement quality initiatives proposed in the State's Shared Savings Quality Measure Protocol.

This amendment is an optimal vehicle to request CMS approval for a PMPM cap adjustment for a managed incentive payment arrangement. Tennessee would submit the adjustment concurrently with the State's proposal to change the demonstration's budget neutrality framework from an aggregate cap to a per capita cap. Inasmuch as the incentive payment program may be implemented without a waiver, the program should not impact funding for other State priorities because the cost of the incentive payment program would be built into the PMPM caps. This adjustment request is not unprecedented: in June, CMS approved a Waiver amendment from Kansas to incorporate the costs of a state-directed payment program into its 1115 Waiver budget cap. In the approval letter, CMS stated that the "amendment will adjust the without-waiver budget neutrality baseline for the current and future demonstration years to account for the revised payments under the state directed payment component ...."

If CMS and Tennessee require additional time to work out the specific PMPM adjustment amounts, the STCs could include language that approves a future adjustment without the need for a new waiver amendment. This approach could work like Tennessee's request to adjust the PMPM caps for prescription drug costs that materially affect the per-member cost of care, after eliminating the closed formulary. Also, such a request is not unprecedented. In Vermont's 1115 Waiver demonstration approved in June, the STCs permit a future adjustment to budget neutrality for provider rate increases, pending an appropriation. In 2021, and reaffirmed in 2022, Texas received approval from CMS to adjust its 1115 Waiver's budget neutrality PMPMs to incorporate planned state-directed payments pending approval by the state legislature.

Very truly yours,

Mitch Edgeworth
TriStar Division President

August 19, 2022

Aaron Butler
Director of Policy
Division of TennCare
310 Great Circle Road
Nashville, TN 37243

Dear Director Butler:

Re: Amendment 4 to the TennCare III Demonstration

Thank you for the opportunity to provide feedback on Tennessee's TennCare program.

The undersigned organizations represent millions of individuals facing serious, acute and chronic health conditions in Tennessee. We have a unique perspective on what individuals and families need to prevent disease, cure illness and manage chronic health conditions. The diversity of our organizations and the populations we serve enable us to draw upon a wealth of knowledge and expertise that is an invaluable resource regarding any decisions affecting the Medicaid program and the people that it serves. We urge TennCare to make the best use of the recommendations, knowledge and experience our organizations offer here.

The purpose of the Medicaid program is to provide healthcare coverage for low-income individuals and families, and our organizations are committed to ensuring that TennCare provides quality and affordable healthcare coverage. Many of our organizations submitted detailed comments to the Centers for Medicare and Medicaid Services (CMS) during the September 2021 comment period on the current TennCare demonstration.[1] We thank TennCare for making multiple changes responsive to these comments in Amendment 4, including the removal of the closed formulary and the removal of the aggregate cap.

Our organizations offer the following comments on these areas of Amendment 4 to the TennCare III Demonstration, as well as additional changes we urge you to make before submitting the amendment to CMS:

Closed Formulary
Our organizations support the removal of the closed formulary from the demonstration. Diseases present differently in different patients, and prescription drugs have different indications, different mechanisms of action and different side effects, depending on the person's diagnosis and comorbidities. A closed formulary limits the ability of providers to make the best medical decisions for their patients and jeopardizes patients' access to evidence-based care.

TennCare patients include very low-income pregnant women, the elderly, children and the blind and disabled. The Medicaid population does not have the luxury of shopping around for health plans, unlike participants in the commercial insurance market, and so these individuals likely would have lost access to needed medications under the closed formulary proposal. Our organizations appreciate that the closed formulary policy has been removed and believe that Medicaid enrollees in Tennessee will benefit from this change.

Funding Structure
Our organizations support the proposed changes to the funding structure, including the removal of the aggregate cap. Aggregate caps that limit the amount of federal funding provided to a state could force the state to either make up the difference with state funds or make cuts to the Medicaid program that would reduce access to care for the patients we represent. Program cuts would likely have resulted in enrollment limits, benefit reductions, reductions in provider payments or increased out-of-pocket cost-sharing for Medicaid enrollees.

Our organizations also appreciate the strengthened language in the standard terms and conditions which make it explicit that TennCare will not have the ability to reduce patient benefits and coverage without prior approval. It is important that these protections be in place to ensure access to care for Tennesseans.

Demonstration Expenditure Authority
Our organizations support the goals of many of the designated state investment programs (DSIPs) that Tennessee discusses in Amendment 4, such as community-based clinics, behavioral safety net services, and prescription medication support. However, as negotiations with CMS over expenditure authority move forward, we urge the state and CMS to put guardrails in place to ensure that spending meets the needs of beneficiaries. For example, Tennessee should have a fixed demonstration budget for the DSIPs rather than an opened ended limit to ensure that there are not incentives in place that would reduce spending on important services for patients with Medicaid coverage. Additionally, the state should report how the DSIP funds are spent to ensure that they are actually spent and used for approved, Medicaid-related programs.

Retroactive Coverage
Our organizations remain concerned by the continued waiver of retroactive coverage for non-pregnant adults in Amendment 4. Retroactive coverage in Medicaid prevents gaps in coverage by covering individuals for up to 90 days prior to the month of application, assuming the individual is eligible for Medicaid coverage during that time frame. It is common that individuals are unaware they are eligible for Medicaid until a medical event or diagnosis occurs. Retroactive coverage allows patients who have

been diagnosed with a serious illness to begin treatment without being burdened by medical debt prior to their official eligibility determination, providing crucial financial protections to newly enrolled beneficiaries.

Medicaid paperwork can be burdensome and often confusing. A Medicaid enrollee may not have understood or received a notice of Medicaid renewal and only discovered the coverage lapse when picking up a prescription or going to see their doctor. In Indiana, Medicaid recipients were responsible for an average of $1,561 in medical costs with the elimination of retroactive eligibility.[2] Without retroactive eligibility, Medicaid enrollees could then face substantial costs at their doctor's office or pharmacy. This can lead to patients that are newly diagnosed with health conditions delaying their treatment.

Our organizations strongly urge TennCare to reinstate retroactive coverage for all Medicaid eligibility groups in the state. This is in line with the objectives of Medicaid and would improve the affordability of care for patients in Tennessee.

Conclusion
Our organizations are pleased by the changes that have been proposed for TennCare in Amendment 4. We urge you to move forward with these policies, and make the additional changes we recommend above, when you submit Amendment 4 to CMS. Thank you for the opportunity to provide comments.

Sincerely,

American Cancer Society Cancer Action Network
American Heart Association
American Lung Association
Arthritis Foundation
Cancer*Care*
Cancer Support Community
Epilepsy Foundation
Hemophilia Federation of America
Lupus Foundation of America
March of Dimes
Mended Little Hearts
National Organization for Rare Disorders
National Patient Advocate Foundation
Susan G. Komen
The AIDS Institute
The Leukemia & Lymphoma Society

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[1] Health Partners Letter to Secretary Becerra re: TennCare 1115 Waiver. September 9, 2011. Available at: https://www.lung.org/getmedia/4a6256df-73e6-43ef-9fb6-4aefc979375a/health-partner-letter-re-tenncare-1115-waiver-(final).pdf

[2] Healthy Indiana Plan 2.0 CMS Redetermination Letter. July 29, 2016. Available at: 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

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August 19, 2022

Aaron Butler, Director of Policy
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Submitted via email to public.notice.tenncare@tn.gov

RE: Notice of Change to the TennCare III Demonstration Amendment 4

Dear Mr. Butler:

The Pharmaceutical Research and Manufacturers of America (PhRMA) appreciates the opportunity to comment on Tennessee's Amendment 4 to TennCare III, the current iteration of the TennCare demonstration, specifically the requested changes to the closed formulary flexibilities.

The Pharmaceutical Research and Manufacturers of America (PhRMA) represents the country's leading innovative biopharmaceutical research companies, which are devoted to discovering and developing medicines that enable patients to live longer, healthier and more productive lives. Since 2000, PhRMA member companies have invested more than $1.1 trillion in the search for new treatments and cures, including $102.3 billion in 2021 alone.

PhRMA thanks Tennessee for its request to remove the closed formulary expenditure authority and associated flexibilities from the TennCare demonstration. Tennessee has long been a leader for innovative Medicaid solutions that deliver better, higher quality care to TennCare members. We appreciate the conversations we have had with TennCare regarding prescription medicines and look forward to working with the state as a partner in continuing to develop a high-quality and value-driven Medicaid program.

Access to Medicines Addresses Health Inequities

PhRMA believes that diversity, equity, and inclusion are essential to the discovery of new medicines and that people of all economic, ethnic and racial backgrounds should have equitable access to treatment.[1] We support policies that will help achieve these goals, and we believe achieving equity in health care screening, diagnosis, and treatment is crucial to improving our health systems. In Tennessee, although nearly 70% of non-elderly adults receive their health coverage through a commercial plan, Medicaid is the dominant source of coverage for adults living under the federal poverty level: more than 40% of these adults are covered by Medicaid, while another 30% lack health coverage altogether.[2] Medicaid beneficiaries typically have no other options for health coverage that they can afford. Higher-income individuals, by

PhRMA "Building a Better Health Care System PhRMA's Patient-Centered Agenda" (available at https //phrma org/report/Building-a-Better-Health-Care-System-PhRMAs-Patient-Centered-Agenda)

[2] ennessee Health Coverage & Uninsured in State Health Facts Kaiser Family Foundation https //www k org/state-category/health-coverage-uninsured/?state= N

contrast, may have a choice among employer-sponsored plans and plans available on the Marketplace, and so can avoid plans that restrict access to the drugs they need. In addition to having lower incomes than the general population, TennCare beneficiaries are also significantly more likely to be people of color. Black Tennesseans are 8 times more likely to be enrolled in Medicaid compared to White Tennesseans; for Hispanic and Latino Tennesseans, Medicaid enrollment rates are *17 times* higher.[3]

These disparities in Medicaid enrollment are concerning in their own right and are all the more concerning when juxtaposed with the evidence of disparities in health outcomes for Medicaid beneficiaries: as compared to the general population, individuals covered by Medicaid have higher rates of serious and complex diseases, such as cancer,[4] and also higher rates of behavioral health and other chronic health conditions.[5] Therefore, maintaining access to medicines is a key component of decreasing health disparities in Tennessee.

Access to Coverage Has Health and Financial Implications

Delaying or not receiving medical care or treatments can have disastrous impacts on patient health and puts a tremendous strain on our health systems, as evidenced by recent studies of delayed care during the COVID-19 public health emergency. An analysis of projected cancer deaths during the public health emergency conservatively estimates those delays will result in 10,000 excess deaths over the next decade from breast and colorectal cancers alone.[6] On the other hand, a growing complementary body of evidence shows adherence to prescribed medicines is essential to improving outcomes for patients.[7 8 9] Specifically for Medicaid, research has found:

- Adherence to chronic disease medicines is associated with 40% fewer annual hospitalizations in Medicaid.[10]
- Among Medicaid beneficiaries with schizophrenia, improved adherence to antipsychotic medicines was shown to yield annual net savings of up to $3.3 billion, or $1,580 per patient per year, driven by lower hospitalizations, outpatient care, and criminal system involvement.[11]

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[3] See QuickFacts ennessee U S Census Bureau (last updated July 1 2019) https //www census gov/quick acts/ N Medicaid Coverage Rates or the Nonelderly by Race/Ethnicity ennessee Kaiser Family Foundation (2019) https //www k org/medicaid/state-indicator/nonelderly-medicaid-rate-by-raceethnicity/

[4] Hsu CD Wang X Habi DV Jr Ma CX Johnson KJ Breast cancer stage variation and survival in association with insurance status and sociodemographic actors in US women 18 to 64 years old Cancer 2017 Aug 15 123(16) 3125-3131 doi 10 1002/cncr 30722 Epub 2017 Apr 25 PM D 28440864 Mahal AR Mahal BA Nguyen PL Yu JB Prostate cancer outcomes or men aged younger than 65 years with Medicaid versus private insurance Cancer 2018 Feb 15 124(4) 752-759 doi 10 1002/cncr 31106 Epub 2017 Oct 30 PM D 29084350 Rosenberg AR Kroon L Chen L Li C Jones B nsurance status and risk o cancer mortality among adolescents and young adults Cancer 2015 Apr 15 121(8) 1279-86 doi 10 1002/cncr 29187 Epub 2014 Dec 9 PM D 25492559 PMC D PMC5231922 Wang N Bu Q Yang J Liu Q He H Liu J Ren X Lyu J nsurance status is related to overall survival in patients with small intestine adenocarcinoma A population-based study Curr Probl Cancer 2020 Feb 44(1) 100505 doi 10 1016/j currproblcancer 2019 100505 Epub 2019 Sep 17 PM D 31548047

[5] Wen H Saloner B Cummings JR Behavioral And Other Chronic Conditions Among Adult Medicaid Enrollees mplications For Work Requirements Health A (Millwood) 2019 Apr 38(4) 660-667 doi 10 1377/hltha 2018 05059 PM D 30933585 ("People with behavioral health and other chronic health conditions were more likely to be enrolled in Medicaid than those without any identi ied health conditions ") Chapel JM Ritchey MD Zhang D Wang G Prevalence and Medical Costs o Chronic Diseases Among Adult Medicaid Bene iciaries Am J Prev Med 2017 Dec 53(6S2) S143-S154 doi 10 1016/j amepre 2017 07 019 PM D 29153115 PMC D PMC5798200

[6] Norman E Sharpless COV D-19 and Cancer Science 19 Jun 2020 DO 10 1126/science abd3377

[7] MS nstitute or Healthcare n ormatics Avoidable costs in US healthcare the $200 billion opportunity rom using medicines more responsibly June 2013

[8] MC Roebuck et al "Medication Adherence Leads o Lower Health Care Use And Costs Despite ncreased Drug Spending " Health A airs 30 no 1 (2011) 91-9

[9] Lloyd Jenni er et al "How much does medication nonadherence cost the Medicare ee- or-service program? " Medical care 57 3 (2019) 218-224

[0] MC Roebuck et al mpact o Medication Adherence on Hospitalization in Medicaid Proceedings o the 21st Annual nternational Meeting nternational Society o Pharmacoeconomics and Outcomes Research 2016 May Washington DC

ZS Predmore et al mproving Antipsychotic Adherence among Patients With Schizophrenia Savings or States Psychiatric Services in Advance 2015 66 343–345

- The offsetting effects of medicines can also be also realized in Medicaid, in which a 1% increase in drug utilization has been shown to correlate with a 0.2% decrease in Medicaid spending for adults.[12]

Again, PhRMA thanks Tennessee for requesting the removal of the closed formulary expenditure authority and associated flexibilities from the TennCare demonstration. We look forward to continuing to work with TennCare, patients, and other stakeholders to move toward a high-quality, value-driven Medicaid program. Thank you, again, for the opportunity to comment.

Sincerely,

Kristina Moorhead

Deputy Vice President, State Policy

[2] MC Roebuck et al mpact o Medication Adherence on Hospitalization in Medicaid Proceedings o the 21st Annual nternational Meeting nternational Society o Pharmacoeconomics and Outcomes Research 2016 May Washington DC

Planned Parenthood
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Tennessee and North Mississippi

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August 19, 2022

Aaron Butler, Director of Policy
Division of TennCare
310 Great Circle Road
Nashville, TN 37243

Submitted electronically via public.notice.tenncare@tn.gov

RE: Planned Parenthood Association of Tennessee and North Mississippi Comments on Tennessee's Draft TennCare III Section 1115 Waiver Demonstration, Amendment 4

Dear Director Butler,

Planned Parenthood Association of Tennessee and North Mississippi (Planned Parenthood) is pleased to submit these comments regarding Tennessee's draft Amendment 4 application to its TennCare III Section 1115 Demonstration program (Draft Amendment Application). As a trusted sexual and reproductive health (SRH) care provider, educator and advocate, we appreciate the opportunity to provide input on this draft amendment application.

Planned Parenthood is a safety net provider for the populations in Tennessee most in need of health services. Planned Parenthood operates four health centers across the state of Tennessee and serves as a leading women's health care provider, educator and advocate of high-quality, affordable health care for women, men, and young people. Our health centers range in size and locations from small rural clinic practices to larger metropolitan clinics. Every year, our health centers provide affordable birth control, lifesaving cancer screenings, testing and treatment for sexual transmitted infections (STIs), and other essential care to over 17,000 patients. The vast majority of PPTNM patients have low incomes and 60 percent lack health insurance.

Medicaid is a vital part of the health care system and plays a major role in ensuring access to essential primary and preventive care services for women, men, and young people. Approximately 1 in 5 women of reproductive age use Medicaid,[1] and roughly two-thirds of adult women enrolled in Medicaid are in their reproductive years.[2] Nationally, for more than 40% of women giving birth, Medicaid is the source of coverage for essential care, including prenatal and delivery care; in Tennessee this figure is even

[1] Adam Sonfield, "Why Protecting Medicaid Means Protecting Sexual and Reproductive Health," Guttmacher Institute (Mar. 9, 2017), available at https://www.guttmacher.org/gpr/2017/03/why-protecting-medicaid-means-protecting-sexual-and-reproductive-health#.

[2] "Medicaid's Role for Women," Kaiser Family Foundation (Mar. 28, 2019), available at https://www.kff.org/medicaid/fact-sheet/medicaids-role-for-women/.

higher, with Medicaid covering 49 percent of births.[3] Finally, the program is the largest payer of reproductive health care coverage in the country, paying for 75 percent of family planning services.[4]

Planned Parenthood underscores that Medicaid is essential in narrowing health disparities and improving access to care for communities of color. Indeed, research shows that Medicaid expansion has contributed to such reductions in racial disparities in health coverage, in particular for Black and Hispanic individuals.[5] In addition, Medicaid expansion is associated with decreased disparities in some health outcomes for communities of color, including in infant and maternal health.[6]

Because women make up the majority of Medicaid enrollees, they are disproportionately impacted by changes to the TennCare III program.[7] In particular, Medicaid coverage of family planning services and supplies helps women's health, lives, educational success, and economic empowerment. Medicaid coverage is even more vital for women of color: due to racism and other systemic barriers that have contributed to income inequality, women of color disproportionately comprise the Medicaid population. Indeed, 31 percent of African-American women and 27 percent of Hispanic women are enrolled in Medicaid, compared to only 16 percent of white women,[8] and, therefore, Tennessean women of color are further impacted by this draft amendment application.

Planned Parenthood has previously commented on program features in TennCare III (formerly known as TennCare II, Amendment 42) during all the available comment periods, including in October 2019, December 2019, and September 2021.[9] First, we reiterate the concerns raised in those comments about the retroactive coverage provision, and Tennessee should reinstate retroactive coverage for all Medicaid enrollees before submitting this application to the Centers for Medicare and Medicaid Services (CMS). Second, we support the removal of the harmful program features in TennCare III, including the aggregate cap and shared savings financing structure and closed prescription drug formulary. Third, Planned Parenthood also supports the proposal to state more explicitly that Tennessee is not allowed to reduce coverage or benefits below the levels that were in place on December 31, 2020 in the program without a waiver amendment application. Finally, Planned Parenthood strongly urges Tennessee to fully expand Medicaid, further increasing access to health care services and narrowing disparities in the state.

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[3] "Births Financed by Medicaid," Kaiser Family Foundation (2020), available at https://www.kff.org/medicaid/state-indicator/births-financed-by-medicaid/.

[4] Usha Ranji, et al., "Financing Family Planning Services for Low-income Women: The Role of Public Programs," Kaiser Family Foundation (Oct. 25, 2019), available at https://www.kff.org/womens-health-policy/issue-brief/financing-family-planning-services-for-low-income-women-the-role-of-public-programs/.

[5] Madeline Guth, et al., "Effects of the ACA Medicaid Expansion on Racial Disparities in Health and Health Care," Kaiser Family Foundation (Sep. 30, 2020), available at https://www.kff.org/report-section/effects-of-the-aca-medicaid-expansion-on-racial-disparities-in-health-and-health-care-issue-brief/.

[6] *Id.*

[7] *Supra*, note 4.

[8] *Supra*, note 1.

[9] TennCare III (formerly known as TennCare II, Amendment 42) had three comment periods: state comment period closing in October 19, federal comment period closing in December 2019, and federal comment period on the approved Special Terms and Conditions closing in September 2021. See Letter to Director Stephen Smith, CMS (Jan. 8, 2021), available at https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/tn-tenncare-ii-cms-demo-appvl-01082021.pdf.

I. *The continued elimination of retroactive coverage decreases access to care and further harms Medicaid enrollees, and Tennessee should reinstate retroactive coverage for all Medicaid enrollees.*

Tennessee's draft amendment application leaves in place its waiver of retroactive coverage for all Medicaid enrollees except pregnant women and children. Planned Parenthood does not support this continued waiver of retroactive coverage and urges Tennesesee to reinstate this benefit for all Medicaid enrollees.

As Tennessee is aware, federal law and policy requires states to pay for covered services provided to individuals during the three month period prior to the date of applying for Medicaid coverage, provided that the individual would have been eligible during that period.[10] This provision helps safeguard enrollees' continuous access to care when there are delays in determining eligibility. Planned Parenthood underscores that retroactive coverage has been a requirement of the Medicaid program since 1972; waivers of retroactive coverage are a departure from this long-standing requirement.

Retroactive coverage is critical to reducing individuals' medical debt, as well as financial strain on the health care system that stems from uncompensated care. When individuals have coverage, they are more likely to be able to receive the care they need in a timely manner, which enables the health care system to treat conditions before they become more serious and more costly. Planned Parenthood also underscores the importance of retroactive coverage during the COVID-19 pandemic, which has seen enormous increases in Medicaid enrollment[11] due to the ongoing employment and income fluctuations many individuals are experiencing.[12] Ensuring access to timely care for all Medicaid enrollees is more important than it has ever been.

Timely access to care is particularly relevant in the context of family planning care, as only a few days without contraception can result in an unintended pregnancy. Moreover, STIs that go untested and untreated can spread throughout communities and cause lifelong problems, including infertility and pelvic inflammatory disease.[13] Urinary tract infections are one of the most common infections women experience and are easily treatable, but without treatment, can result in emergency room care, which can cost a state nearly $1,500 per patient.[14]

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[10] 42 U.S.C. § 1396a(a)(34); 42 C.F.R. § 435.914.

[11] Bradley Corallo and Robin Rudowitz, "Analysis of Recent National Trends in Medicaid and CHIP Enrollment," Kaiser Family Foundation (Aug. 3, 2022), available at https://www.kff.org/coronavirus-covid-19/issue-brief/analysis-of-recent-national-trends-in-medicaid-and-chip-enrollment/ (Data show that Medicaid/CHIP enrollment is increasing amid the coronavirus pandemic: from February 2020 to March 2021, enrollment increased by 10.5 million or 14.7 percent).

[12] Paul Shafer, et al., "Medicaid Retroactive Eligibility Waivers Will Leave Thousands Responsible for Coronavirus Treatment Costs," Health Affairs (May 8, 2020), available at https://www.healthaffairs.org/do/10.1377/hblog20200506.111318/full/.

[13] Chlamydia: Fact Sheet, Centers for Disease Control and Prevention (Jan. 23, 2014), available at https://www.cdc.gov/std/chlamydia/stdfact-chlamydia.htm.

[14] Nolan Caldwell, et al., "'How Much Will I Get Charged for This?' Patient Charges Top Ten Diagnoses in the Emergency Department,"Plos One Journal (Feb. 27, 2013), available at https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0055491.

In addition, data shows that retroactive coverage has positively impacted individuals in states that have kept this feature in their Medicaid programs. In New Hampshire, in one 16-month period, 4,567 Medicaid expansion individuals benefited from the policy, which paid more than $5 million for their medical expenses.[15] Conversely, data show that the absence of retroactive coverage has increased financial burdens for people with low incomes, as well as safety net providers that serve those individuals. In Indiana, nearly 14 percent of the parent and caretaker relatives eligibility group needed retroactive coverage, and individuals in this group incurred medical costs averaging $1,561 per person.[16] These costs would have been paid for by Medicaid if retroactive coverage was in place.[17] Finally, sixteen percent of providers in Indiana experienced increases in the provision of uncompensated care after retroactive coverage was waived.[18]

Retroactive coverage also bolsters critical provider participation in the Medicaid program as providers know in advance that they will be adequately compensated, which means that patients are better able to meaningfully access care. Medicaid programs are already faced with provider shortages, with more than two-thirds of states reporting difficulty in ensuring provider participation in Medicaid.[19] Provider shortages are particularly acute for women, as states are especially challenged in recruiting OB/GYNs. A report from the Department of Health and Human Services (HHS) Office of Inspector General (OIG) found that Medicaid managed care plans had extreme provider shortages, with only 42 percent of in-network OB/GYN providers able to offer appointments.[20]

Yet, despite the shortages of OB/GYN providers, women often rely on their OB/GYN providers as their main source of care.[21] Any policy, including the current lack of retroactive coverage, that reduces the availability of women's health providers in the Medicaid program can cause longer wait times for appointments and delays in accessing critical women's health care. Due to the unique way women experience the health care system, delays in access to OB/GYNs and other women's health care providers can also impact women's access to the broader health care system and result in women lacking access to other essential primary and preventive care. Sufficient provider participation is

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[15] Conditionally Approved Waiver of Retroactive Coverage, NHDHHS (Dec. 21, 2015), available at https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/nh/health-protection-program/nh-health-protection-program-premium-assistance-retro-cov-waiver-submission-12212015.pdf.

[16] Letter to Director McGuffee, CMS (Jul. 29, 2016), available at 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.

[17] *Id.*

[18] Harris Meyer, "New Medicaid Barrier: Waivers ending retrospective eligibility shift costs to providers, patients," Modern Healthcare (Feb. 9, 2019), available at https://www.modernhealthcare.com/article/20190209/NEWS/190209936/new-medicaid-barrier-waivers-ending-retrospective-eligibility-shift-costs-to-providers-patients.

[19] "States Made Multiple Program Changes, and Beneficiaries Generally Access Comparable to Private Insurance," Government Accountability Office (Nov. 2012), available at http://www.gao.gov/assets/650/649788.pdf; "Access to Care: Provider Availability in Medicaid Managed Care," Department of Health and Human Services, Office of the Inspector General (Dec. 2014), available at http://oig.hhs.gov/oei/reports/oei-02-13-00670.pdf.

[20] *Id.*

[21] *Id.*

essential to ensure Tennessee's success in improving its TennCare program. Indeed, health care coverage is meaningless if patients are unable to receive care from quality providers in a timely manner.

For all the reasons set forth above and retroactive coverage's importance to accessing timely SRH care, Planned Parenthood urges Tennessee to reinstate retroactive coverage for all Medicaid enrollees before proceeding forward with this application to CMS.

II. The removal of the aggregate gap and shared savings financing structure and closed prescription drug formulary will help to improve health care access for Medicaid enrollees, and Tennessee should proceed forward with these program changes.

Planned Parenthood commented in robust opposition to several of Tennessee's TennCare III program features, including the aggregate gap and shared savings financing structure and closed prescription drug formulary. These program features limit health care access for Medicaid enrollees, and Planned Parenthood is pleased to see that the state is proposing to remove these features from the TennCare III program. Tennessee should proceed forward with these changes in its amendment application to CMS.

A. The aggregate cap and shared savings financing structure do not promote the objectives of the Medicaid Act and will harm enrollees' access to health care.

The aggregate cap and shared savings financing structure in TennCare III directly conflicts with Section 1903 of the Medicaid Act[22] and does not promote the objectives of Medicaid. Section 1903 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.[23] Moreover, the aggregate cap and shared savings feature rewards Tennessee for reducing its Medicaid spending, threatening enrollees' access to health care services. Specifically, if Tennessee spends less than the aggregate cap in any given year, it can currently earn up to 55% of the federal savings achieved. This is a perverse incentive for Tennessee to reduce its Medicaid spending and decrease Medicaid enrollees' health care access.

The aggregate cap and shared savings in TennCare III does not promote Medicaid's objectives. It is a radical restructuring of federal Medicaid funding that can lead to both benefit and enrollment cuts. This runs counter to the foundational principles of Medicaid as a program that provides comprehensive

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[22] Social Security Act § 1903.

[23] See North Carolina Medicaid Reform Demonstration Approval Letter to Deputy Secretary Richard, CMS (Oct. 19, 2018), available at https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/nc/Medicaid-Reform/nc-medicaid-reform-demo-demo-appvl-20181019.pdf (CMS explicitly states in North Carolina's 1115 demonstration approval letter, "Section 1115(a)(1) waiver authority extends only to provisions of section 1902 of the Act, and does not extend to provisions of section 1905 of the Act, such as section 1905(b). Nor is CMS able to grant the state's request by providing expenditure authority under section 1115(a)(2)(A) of the Act. Section 1115(a)(2)(A) only permits state expenditures to be regarded as federally matcheable. It does not allow applicable federal match rates to be altered.").

health care coverage for all eligible people who need it. For these reasons, Tennessee should move forward with the proposed changes to remove these program features from TennCare III.

B. The closed prescription drug formulary for adult enrollees limits patient choice, including for contraceptives.

TennCare III currently has a closed prescription drug formulary for adult enrollees age 21 and over and the state covers only one drug per class, unless the state's benchmark plan used for its marketplace covers more. The only exceptions are for drugs in six "protected" classes—antidepressant, anticonvulsant, antipsychotic, immunosuppressive, cancer, and HIV/AIDS drugs—for which the state is required to cover nearly all drugs. Despite not covering prescription drugs as required by the Medicaid Act, Tennessee continues to receive generous rebates from manufacturers.

The closed prescription drug formulary limits patient choice and access, including for contraceptives. A majority of women who access care through publicly funded family planning providers said birth control has allowed them to take better care of themselves or their families (63 percent), complete their education (51 percent), support themselves financially (56 percent), or keep or get a job (50 percent).[24] Furthermore, greater access to all approved Food and Drug Administration (FDA) contraceptive methods[25] would help improve health outcomes for pregnancy-related illness, injury, and death, especially for women who have medical conditions that may be exacerbated by pregnancy.[26] In Tennessee, a state with alarming racial disparities in maternal health outcomes,[27] Black women would especially benefit from greater access to all FDA-approved contraceptive methods. Finally, in light of the Supreme Court decision in *Dobbs,* ensuring Medicaid enrollees can access their preferred method of contraception has become more important than ever.

For the reasons set forth in this section, we strongly urge Tennessee to proceed forward with the changes in its draft amendment application and remove the closed prescription drug formulary in its application to CMS.

III. Even more explicit Special Terms and Conditions (STCs) preventing a reduction of coverage or care is a positive development, and Tennessee should continue to agree to these terms.

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[24] Jennifer J. Frost and Laura Duberstein Lindberg, "Reasons for using contraception: Perspectives of US women seeking care at specialized family planning clinics," *Contraception,* Vol. 87, Issue 4 (Apr. 2013), available at https://www.guttmacher.org/sites/default/files/pdfs/pubs/journals/j.contraception.2012.08.012.pdf.

[25] Birth Control Guide, Food and Drug Administration, available at https://www.fda.gov/media/150299/download.

[26] Megan L. Kavanaugh and Ragnar Anderson, "Contraception and Beyond: The Health Benefits of Services Provided at Family Planning Centers," New York: Guttmacher Institute (Jul. 2013), available at http://www.guttmacher.org/pubs/health-benefits.pdf.

[27] "2022 Tennessee Maternal Mortality Annual Report," Tennessee Department of Health (Apr. 13, 2022), available at https://www.tn.gov/content/dam/tn/health/program-areas/maternal-mortality/MMR-2022-annual-report.pdf (In Tennessee, non-Hispanic Black women are 2.5 times more likely to die from a pregnancy-related cause than non-Hispanic White women).

Planned Parenthood supports Tennessee and CMS's desire to make clear in the Special Terms and Conditions (STCs) of the program that the state is not allowed to reduce coverage or care below the levels that were in place on December 31, 2020 without following the standard waiver amendment process. This is a positive development that ensures TennCare III enrollees have the same access to health care services throughout the duration of the program and are provided an opportunity to voice concerns if the state proposes to reduce those services and benefits. Tennessee should proceed forward with this commitment and ensure these STCs are included in the final approval for the program.

IV. Expanding Medicaid would increase access to necessary SRH care for women, including women of color, and help address existing disparities in the state; as such, Tennessee should expand Medicaid.

Planned Parenthood again urges Tennessee to use one tool at its disposal to effectively increase access to care and tackle health care disparities for people of color: fully expand Medicaid as envisioned under the Affordable Care Act (ACA). Notably, Medicaid expansion has been shown time and again to increase access to care and improve health outcomes, in particular for people of color.[28] It is associated with increased use of the most effective contraception (long-acting reversible contraception, LARC), especially among young people,[29] as well as contributing to the detection of undiagnosed HIV infections and increased use of HIV prevention services, such as preexposure prophylaxis medication (PrEP).[30] Tennessee is only one of twelve states that still refuses to provide coverage to eligible individuals up to 138 percent of the federal poverty level (FPL) through Medicaid expansion. If Tennessee were to expand Medicaid, more than 31,000 women of reproductive age, including 8,000 Black women, would gain access to a full range of SRH services.[31] As such, it is imperative that Tennessee expands Medicaid, and Planned Parenthood strongly urges Tennessee to do so.

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We appreciate the opportunity to comment on Tennessee's TennCare III draft Amendment 4 application. We strongly urge Tennessee to proceed forward with its proposed changes to remove the aggregate cap and shared financing structure, as well as closed prescription drug formulary. In addition, we urge Tennessee to reinstate retroactive coverage for all Medicaid enrollees and fully expand Medicaid. If you require additional information about the issues raised in this letter, please contact Ashley Coffield at 901-725-3003, acoffield@pptnm.org.

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[28] *Supra,* note 5.

[29] Blair G. Darney, et al., "Evaluation of Medicaid Expansion Under the Affordable Care Act and Contraceptive Care in US Community Health Centers," JAMA Network Open (Jun. 4, 2020), available at https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2766783.

[30] Bita Fayaz Farkhad, et al., "Effect of Medicaid Expansions on HIV Diagnoses and Pre-Exposure Prophylaxis Use," American Journal of Preventive Medicine (Jan. 24, 2021), available at https://www.ajpmonline.org/article/S0749-3797(20)30517-1/fulltext.

[31] Gideon Lukens and Breana Sharer, "Closing Medicaid Coverage Gap Would Help Diverse Group and Narrow Racial Disparities," Center on Budget and Policy Priorities (Jun. 14, 2021), available at https://www.cbpp.org/research/health/closing-medicaid-coverage-gap-would-help-diverse-group-and-narrow-racial.

Respectfully submitted,

Ashley Coffield

[redacted]

Ashley Coffield
President and CEO
Planned Parenthood of Tennessee and North Mississippi
2430 Poplar Avenue
Memphis, TN 38112

Tennessee Association for Home Care

August 19, 2022

Aaron Butler
Director of Policy
Division of TennCare
310 Great Circle Road
Nashville, TN 37243

Dear Mr. Butler,

The Tennessee Association for Home Care (TAHC) offers these comments on behalf of the home care providers currently serving so many of Tennessee's most vulnerable citizens through TennCare programs like CHOICES and ECF CHOICES. TAHC commends TennCare for leveraging the historic investment of federal funds to innovate in ways that directly and indirectly increase access for and expand services to TennCare recipients. We are particularly grateful for the recent wage increases for CHOICES and ECF CHOICES providers. We appreciate that TennCare III represents a shared commitment by TennCare and CMS to continually review, and when proper, revise and refine, certain components of the state Medicaid system.

Expenditure Caps

We share TennCare's ongoing concerns regarding system capacity and are committed to doing what we can to solve workforce-related challenges. We appreciate not only the recent wage increases for the CHOICES program—which we consider the critical first step to stabilizing the program—but also the recent increase in expenditure caps for CHOICES Group 3 and ECF CHOICES Groups 4-6. Still yet, we believe further increases may be required in order to ensure that the generous investment TennCare has made does not inadvertently work to limit access to services. As the rate of reimbursement improves, we must plan for expenditure caps to be met more quickly than in previous years, even when no additional services are being provided. Worker wages must not impact the nature or length of services authorized for CHOICES enrollees.

The expenditure caps for some TennCare programs have risen predictably and correspondingly to current financial factors and/or occurrences, like inflation and the pandemic. The cost neutrality cap for nursing home care (and by default, CHOICES Group 2), for example, has risen nearly 45% since 2010. However, it is our understanding that since the CHOICES program's inception, the expenditure cap for CHOICES Group 3 has risen only once—as part of Amendment 3—and by only about 20%. This conservative increase does not reflect changes in the cost to provide care for these vulnerable enrollees. It is not even congruent to the recent rate increase of just over 25%[1].

[1] This determination is based on the blended rate of $18.60 effective in 2020 and the rate of $23.44 effective July 1, 2022.

Providers serving CHOICES Group 3 are facing historic fuel costs, unprecedented labor shortages, inflation, and a myriad of other challenges. Expenditure caps must be updated routinely to reflect current industry challenges and market conditions.

Improving Rates for CHOICES and ECF CHOICES Providers

We recognize the generous investments TennCare has made in the CHOICES and ECF CHOICES program through recent wage increases for frontline workers and believe these investments will bring about meaningful progress toward the goal of optimizing provider capacity; however, the fact remains that providers continue to experience unsustainable cost increases on nearly every front. Unfortunately, because nearly all of the recent rate increase must be passed on to the frontline worker, the employing provider is in nearly the same position as before these investments. We recommend that additional rate increases be considered for the purpose of adequately compensating employing providers for the steeply increasing cost to provide services.

TAHC recognizes TennCare as one of its most important partners and appreciates this—and every opportunity—to provide input on TennCare policy.

Sincerely,

[redacted]

Maegan Carr Martin, JD
Executive Director
Tennessee Association for Home Care

TENNESSEE HEALTH CARE CAMPAIGN

Working for affordable access to high-quality health care for all Tennesseans

Date: August 18, 2022

To: Aaron Butler, Director of Policy, Division of TennCare

From: Judy Roitman, LMSW, Executive Director, Tennessee Health Care Campaign

Re: Comments on Amendment 4 to TennCare III

Thank you for the opportunity to comment on Amendment 4 to TennCare III. As you know, the Tennessee Health Care Campaign has requested in past comments on TennCare III that some of the changes being proposed in Amendment 4 would be made.

We sincerely believe that moving from an aggregate cap to a per capita cap financial framework will make it easier for TennCare to adjust to fluctuations in TennCare enrollment due to unexpected economic downturns such as the one that occurred in the early stages of the COVID-19 pandemic in spring of 2020.

THCC is also reassured by TennCare's clear statement to CMS that no reductions in coverage or benefits below those in place on December 31, 2020 would be made without following the standard amendment process established by CMS.

As we understand Amendment 4, any "savings" TennCare realizes below its per capita budget neutrality cap could only be invested in designated investment programs approved on Attachment O of the TennCare demonstration. These designated investment programs may support not only current TennCare enrollees but also other Tennesseans whose income hovers near the eligibility guidelines. We agree and support this clarification of eligible programs. We hope however that these investments will not replace existing support but serve to supplement direct state investments. We urge funding of programs that seek to rectify the deep and long-standing racial and geographic disparities in health, mental health, behavioral health, public health, community and family support services across our state.

We are also reassured by TennCare's willingness to abandon its pursuit of a closed formulary. We fully acknowledge that drug prices are highly inflated in the United States and that these high prices are challenging for states to manage. However, THCC believes that national efforts, such as those recently authorized by the Inflation Reduction Act, will be more effective in reining in costs than restricting access to vulnerable enrollees.

THCC recognizes that some recipients, due to the nature of their illnesses, may require very expensive medications to better manage their conditions and to achieve better outcomes. We have no problem with TennCare's request to provide for an adjustment to the demonstration's PMPM caps when prescription drug costs materially affect the average per-member cost of care. In those cases, however, we feel it is appropriate to request that TennCare monitor the cost-effectiveness of these medications

as part of the state's evaluation design rather than to remove formulary-related research questions and hypotheses from the evaluation design. We would also request that TennCare allow public comment about any changes to the TennCare III evaluation design.

Our one remaining concern is the 10 year approval period for this demonstration. We believe that any program of this magnitude warrants overall evaluation and reauthorization at least every five years. This is also a risky precedent for CMS to set for other states.

In conclusion, we appreciate the efforts of the State of Tennessee to respond to the concerns of both CMS and Tennessee health advocates in the changes proposed in Amendment 4.

August 19, 2022

Stephen Smith, Director
Division of TennCare
310 Great Circle Road
Nashville, TN 37243

RE: TennCare III Demonstration – Amendment 4 (Program Modifications)

Dear Director Smith:

The Tennessee Hospital Association (THA), on behalf of its more than 150 member hospitals and health systems, appreciates the opportunity to comment on the proposed Amendment 4 to the TennCare III Demonstration, which proposed program modifications in reponse to the Centers for Medicare & Medicaid Services' (CMS) July 30, 2022, letter.

TennCare has a history of innovation and is known for promoting a culture of continuous improvement. THA appreciates the agency's thoughtful consideration of potential modifications to its current waiver.

Financing of the Demonstration
CMS specifically requested that TennCare submit a new financing and budget neutrality model based on a traditional per member per month (PMPM) cap instead of the previously approved "aggregate cap." CMS additionally directed TennCare to update the special terms and conditions (STCs) to "more explicitly state that Tennessee cannot cut benefits or coverage in effect Dec. 31, 2021, without an amendment to the demonstration, subject to additional public comment period and CMS approval."

In Amendment 4, TennCare has complied with the aforementioned requests. THA supports the return to the assessment of budget neutrality using a per member per month cap framework and restatement of the protections for benefits and coverage.

However, THA reiterates previously stated concerns that similar protections should be in place to ensure adequate provider reimbursement is maintained. THA has concerns that without such protections, provider networks may become inadequate and access to care may decline. Medicaid reimbursement for hospitals has remained around 60 cents on the dollar for the last several years, and this reimbursement is proving even less adequate as hospitals face unprecedented cost increases.

Moreover, the inclusion of hospital supplemental payments within the budget neutrality cap creates barriers to addressing uncompensated care or establishing innovative payment models that prioritize shared goals of TennCare, CMS and providers within the state. Rather than scrutinizing new approaches to reimbursement solely through the lens of what is best for maintaining an adequate provider network, promoting the objectives of the Medicaid program and achieving high quality patient care, the cap instead forces TennCare to first consider the financial impact on budget neutrality and potential shared savings.

THA requests that TennCare and CMS also state their intentions to support the provider network as clearly as they intend to protect benefits and coverage and remove the perverse incentive that exists today for considering new value-based and uncompensated care payment programs by excluding supplemental payments from the budget neutrality cap.

Demonstration Expenditure Authorities
CMS suggested that TennCare include in the waiver amendment a request for expenditure authority for state reinvestments related to intiatives the state would like to support through "shared savings," or the savings produced when the program's expenditures are less than the budget neutrality cap. In response, TennCare has requested federal financial partipication (FFP) for the designated state investment programs (DSIPs) that are included in Attachment O of the current demonstration. As TennCare states, these are programs that facilitate access to healthcare across a variety of domains and currently are supported through state funds. The list includes community and faith-based clinics, behavioral health safety net, ID/DD safety net services, nurses and other providers and professionals in primary school, and CoverRx presciption mediciation support.

THA agrees that providing federal funding for these programs and services may contribute to improved access and benefits for beneficiaries. However, as TennCare negotiates with CMS on how the shared savings can be spent, THA requests that the state explore opportunities for other programs like charity care payments for Critical Access Hospitals (CAHs) that would stabilize provider networks and increase access to care for both Medicaid recipients and the at-risk population.

THA additionally seeks clarity on the state's ability to update Attachment O should additional programs be identified. What is the proposed process? Would a waiver amendment be needed everytime? Does the state plan to modify that list as needed over the lifetime of the demonstration? Why were the shared savings limited to only current TennCare programs being funded with state funds?

Closed Formulary
Citing issues with prescription drug costs and lack of management tools due to federal restrictions, TennCare requested a closed formulary with at least one drug available per therapeutic class. TennCare believed this would allow the state to better negotiate agreements with manufacturers because of guaranteed volume, which ultimately would generate cost savings for the state and federal governments.

In prior comments and conversations with TennCare, THA expressed concern over the commercial-style closed drug formulary, even with the modified exceptions process, and we appreciate CMS requesting this expenditure authority and flexibility be removed. Even when CMS approved this pharmcautical flexibility, the agency acknolwedged the concerns expressed in the public comment period and alerted TennCare that the state would have "increased oversight and monitoring to ensure that all beneficiaries have accces to needed pharmaceuticals."

While the most recent request from CMS does not provide great detail or reasoning for removing this flexibility specifically, CMS stated there were significant concerns on how this and the other flexibilities would "promote the objectives of Medicaid." As THA shared in previous comments, we believe the clinician is the most qualified to make decisions for their patients, and

not moving forward with a closed formulary allows the clinical benefits to be the top priority for Medicaid enrollees.

While TennCare is removing the expenditure authority and related flexibilities, the state is requesting the demontration's STCs allow for the PMPM caps to be adjusted in circumstances in which prescription drug costs materially affect the average per-member cost of care. THA understands and shares the concern the state has regarding rising prescription drug costs and is supportive of such adjustment. THA would appreciate the state also consider the impacts that its provider networks are facing.

In a recent report released by the American Hospital Association, GoodRX studied drug price increases and found that in January 2022, companies increased prices on more than 800 brand and generic drugs by an average of 5.1 percent. In another example, the price for the drug Humira, which is used to treat rheumatoid arthritis, Crohn's disease and others, increased 21 percent between 2019 and 2021. With these and other unsupported drug price increases, hospital drug expenses have skyrocketed. Total drug expenses were 28.2 percent higher at the end of 2021 than pre-pandemic levels. Over the last three years, drug expenses have increased as a share of all non-labor costs, rising from 8.2 percent in Jan. 2019 to 10.6 percent in Jan. 2022.

Should the PMPM caps be adjusted, THA requests that TennCare take steps to assure provider reimbursement is also appropriately adjusted to account for their increased costs for administering the care to TennCare members.

Conclusion

THA appreciates the attention given by the TennCare staff to many of the concerns raised through the various comment periods. THA believes with these additional changes, the state has provided several protections that benefit TennCare enrollees and the state. We appreciate your consideration of our comments and thank you for the opportunity to share our thoughts.

If you have any questions or wish to discuss anything in this letter, please contact me at wlong@tha.com or Amanda Newell at anewell@tha.com.

Sincerely,

[redacted]

Wendy Long, MD
President and CEO
Tennessee Hospital Association

August 19, 2022

Director Stephen Smith Division of TennCare
310 Great Circle Rd.
Nashville, TN 37243

Director Smith,

The Arc of Tennessee is eager to provide comments on behalf of our organization on Amendment 4.

We were pleased to see that the department will be rescinding the closed formulary model from TennCare III. We have been concerned with the potential negative implications that the closed formulary would for people with complex medical needs such as those with intellectual and developmental disabilities.

We recommend that before finalizing Amendment 4, TennCare add commitments to direct future shared savings to benefit the disability community. Specifically, we would like to see shared savings used toward:

• Ongoing investments in raising wages for Direct Support Professionals (DSP), who carry out the critical HCBS component of TennCare. Because of the ongoing workforce crisis, services approved for HCBS are not available to people enrolled – equating to a loss of service access.

• Ongoing adjustments to the expenditure caps in HCBS to keep up with inflation and DSP wages. As with raising DSP wages, raising expenditure caps is necessary for access to services.

• Continuing enrollment and avoiding waiting lists in HCBS.

In July 2022, we signed on to a letter sent to TennCare by a group of disability organizations that identified those priorities above.

In addition, we would like to see a mechanism that would allow transparency and public reporting on the use of the shared savings to ensure that the savings are used as intended to enhance the lives of people with intellectual and developmental disabilities .

Thank you for the opportunity to provide feedback. Please let me know if you have any questions. I can be reached at hhaines@thearctn.org .

Thank you,

Heidi Haines
720-238-7321

Tennessee Chapter

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN®

PO Box 159201
Nashville, TN, 37215-9201
Phone: 615.383.6004
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August 16, 2022

Aaron Butler
Director of Policy
Division of TennCare
310 Great Circle Road
Nashville, TN 3724

Dear Mr. Butler,

The Tennessee Chapter of the American Academy of Pediatrics (TNAAP) is a nonprofit organization representing over 1,000 primary care, medical subspecialty, and surgical specialty pediatricians from across the state who are dedicated to the health, safety, and well-being of all Tennessee infants, children, adolescents, and young adults. We thank you for the opportunity to provide comments on the proposed **Amendment 4** to the state's TennCare Section 1115 waiver, published July 19, 2022.

TNAAP applauds significant changes to the state's waiver proposal via this amendment. Most notably, we commend the state for removing the previously proposed block granted financing of TennCare. As noted in our October 2019 state comments and December 2019 federal comments, block granting would have significantly changed the existing financing structure of TennCare and left the state—and children and families who rely on the program—at risk, should state spending exceed an agreed-to cap. We laud the state's action to remove this provision. Similarly, we applaud the state's removal of the closed drug formulary for TennCare enrollees, which would have only allowed for one drug per therapeutic class. As reflected in our previous comments, we were highly concerned that such a closed formulary would have negatively affected the care children receive, as children are commonly prescribed drugs off-label. We appreciate and applaud the state's removal of this harmful provision as well.

Noting these significant improvements, two concerns remain. First, we are opposed to the state's waiver of retroactive coverage. While this waiver would not apply to all populations, its existence has the potential to impact entire families. This longstanding Medicaid protection—one not offered in the private market but explicitly included in Medicaid—ensures that health care expenses for three months prior to the Medicaid application date are also covered, provided the enrollee would have been eligible for Medicaid. This is particularly important for families who may lose coverage from an employer or face a sudden illness or injury.

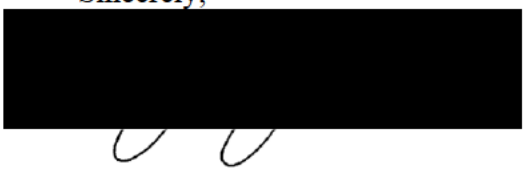
Eliminating retroactive eligibility could deter beneficiaries from seeking needed care for fear they would be responsible for medical bills they cannot afford; this can result in higher medical costs in the long-term as Medicaid eligible individuals delay seeking needed care. It could also result in increased rates of uncompensated care as physicians, hospitals, and pharmacies—many of whom may have agreed to provide acutely-needed services even before ensuring Medicaid coverage was secure—are not paid for some of the services they have already provided. For these reasons, we call for retroactive coverage to not be waived.

Also too, we note and oppose the ten-year time period proposed for this waiver extension. Section 1115 waivers are traditionally approved for five years, noting that such waivers are *demonstrations* and meant to provide the state and federal governments with insights into those provisions that work, and those that may need improvements. Locking this waiver in for ten years counters the experimental nature of the proposal; should provisions of the waiver be found harmful for children and families, the state would have to wait an entire decade to make changes. This is unnecessary—a five-year waiver would allow the state to continue successful provisions upon the next renewal, while at the same time affording the state the opportunity to address provisions that could need improvement. For these reasons, we recommend the state instead seek a five-year waiver extension.

As always, Tennessee's pediatricians look forward to working with the state to improve the care provided to all children in TennCare. We appreciate any thoughts you may have on our recommendations; should you have questions, please contact me at jyaun@uthsc.edu or our Executive Director, Ruth Allen, at ruth.allen@tnaap.org

Thank you for considering the recommendations of Tennessee's pediatricians as this waiver amendment moves forward.

Sincerely,



Jason Yaun, MD
President

August 18, 2022

Submitted via: public.notice.tenncare@tn.gov

Aaron Butler,
Director of Policy
Division of TennCare
310 Great Circle Road
Nashville, TN 37243.

Re: TennCare III Demonstration (Project No. 11-W-00369/4) Amendment 4 Program Modification

Dear Director Butler;

ViiV Healthcare (ViiV) appreciates the opportunity to submit comments to the Division of TennCare regarding the State of Tennessee's proposed amendment to the TennCare III demonstration.[1, 2]

ViiV is the only independent, global specialist company devoted exclusively to delivering advancements in human immunodeficiency virus (HIV) treatment and prevention. From its inception in 2009, ViiV has had a singular focus to improve the health and quality of life of people affected by this disease and has worked to address significant gaps and unmet needs in HIV care. In collaboration with the HIV community, ViiV remains committed to developing meaningful treatment advances, improving access to its HIV medicines, and supporting the HIV community to facilitate enhanced care, treatment and prevention.

As a manufacturer exclusively of HIV medicines, ViiV is proud of the scientific advances in the treatment of this disease. These advances have transformed HIV from a terminal illness to a manageable chronic condition. Effective HIV treatment can help people with HIV to live longer, healthier lives, and has been shown to reduce HIV-related morbidity and mortality at all stages of HIV infection.[3,4] Furthermore, effective HIV treatment can also prevent the transmission of the disease.[5]

ViiV provided multiple sets of written public comments between 2019 – 2021 to both CMS and the state of Tennessee on the various proposals that culminated in TennCare III. While we are pleased to see the state's withdrawal of the closed formulary proposal, and other policies that might have limited access to TennCare or benefits within the program, we wish to highlight the protections around HIV treatment and

[1] Tennessee. Notice of Change to the TennCare III Demonstration, Amendment 4. July 19, 2022 https://www.tn.gov/content/dam/tn/tenncare/documents2/Amendment4ComprehensiveNotice.pdf. Accessed August 11, 2022.
[2] Tennessee. Division of TennCare TennCare III Demonstration Project No. 11-W-00369/4 Amendment 4 Program Modifications DRAFT. https://www.tn.gov/content/dam/tn/tenncare/documents2/Amendment4Draft.pdf. Accessed August 11, 2022.
[3] Severe P, Juste MA, Ambroise A, et al. Early versus standard antiretroviral therapy for HIV-infected adults in Haiti. *N Engl J Med*. Jul 15 2010;363(3):257-265. Access ble at: https://pubmed.ncbi.nlm.nih.gov/20647201/.
[4] Kitahata MM, Gange SJ, Abraham AG, et al. Effect of early versus deferred antiretroviral therapy for HIV on survival. *N Engl J Med.* Apr 30 2009;360(18):1815-1826. Accessible at: https://pubmed.ncbi.nlm.nih.gov/19339714/.
[5] Rodger AJ, Cambiano V, Bruun T, et al. Risk of HIV transmission through condomless sex in serodifferent gay couples with the HIV-positive partner taking suppressive antiretroviral therapy (PARTNER): final results of a multicentre, prospective, observational study. Lancet. 2019 Jun 15;393(10189):2428-2438. Accessible at: https://pubmed.ncbi.nlm.nih.gov/31056293/.

prevention that were included in that propsal[6]. We urge the state to take additional steps to ensure that support is continued an incorporated in this amendment to the TennCare program. Doing so would build on efforts to end the HIV epidemic in the state.

The Medicaid Program Should Join Federal Efforts to End the HIV Epidemic

An estimated 1.2 million people in the United States are living with HIV and at least thirteen percent are unaware that they have the virus.[7] Despite groundbreaking treatments that have slowed the progression and burden of the disease, treatment of the disease is low – only half of diagnosed and undiagnosed people with HIV are retained in medical care according to the Center for Disease Control and Prevention (CDC.)

Since the earliest days of the epidemic, Medicaid has played a critical role in HIV care. Nationally, Medicaid is the largest source of coverage for people with HIV.[8] In fact, more than 42 percent of people with HIV who are engaged in medical care have incomes at or below the federal poverty level.[9] The program is an essential source of access to medical care and antiretroviral therapy (ART) drug coverage for people with HIV. Medical care and drug treatment not only preserve the health and wellness of people with HIV and improve health outcomes, but they also prevent new HIV transmissions.

Medicaid is also a significant provider of HIV prevention, specifically pre-exposure prophylaxis (PrEP).[10] When taken properly, PrEP can reduce the risk of acquiring HIV from sex by 99 percent and reduces risk by 74 percent among those who inject drugs.[11] However, of the approximately 1.2 million people in the U.S. indicated for PrEP, only 23.4 percent were receiving it as of 2019.[12] In Tennessee, the state's PrEP coverage ratio was only 17.9 percent in 2019 according to CDC.[13] Making PrEP available and accessible is an important step in reducing the number of new HIV diagnoses and ultimately ending the HIV epidemic.

In 2019, the U.S. Department of Health and Human Services (DHHS) released the "Ending the HIV Epidemic: A Plan for America (EHE)."[14] This plan proposes to use scientific advances in ART to treat people with HIV and expand proven models of effective HIV care and prevention. The plan coordinates efforts across government agencies to stop the HIV epidemic and focuses those efforts on local areas. The EHE Initiative is not only a landmark policy by all federal health agencies, it is also supported by the

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[6] TennCare II Demonstration, Project No. 11-W-00151/4, Amendment 42, Modified Block Grant and Accountability. November 20, 2019. https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/tn/tn-tenncare-ii-pa10.pdf

[7] Centers for Disease Control and Prevention (CDC). Monitoring selected national HIV prevention and care objectives by using HIV surveillance data—United States and 6 dependent areas, 2019. HIV Surveillance Supplemental Report 2021;26(No. 2). https://www.cdc.gov/hiv/pdf/library/reports/surveillance/cdc-hiv-surveillance-report-vol-26-no-2.pdf. Published May 2021. Accessed August 11, 2022.

[8] Kaiser Family Foundation. Medicaid and HIV. http://www.kff.org/hivaids/fact-sheet/medicaid-and-hiv/. Accessed August 11, 2022.

[9] Centers for Disease Control and Prevention (CDC). Behavioral and Clinical Characteristics of Persons with Diagnosed HIV Infection—Medical Monitoring Project, United States, 2016 Cycle (June 2016–May 2017). HIV Surveillance Special Report 21. Revised edition. June 2019, https://www.cdc.gov/hiv/pdf/library/reports/surveillance/cdc-hiv-surveillance-special-report-number-21.pdf. Accessed August 11, 2022.

[10] Kaiser Family Foundation. Medicaid and HIV. http://www.kff.org/hivaids/fact-sheet/medicaid-and-hiv/. Accessed August 11, 2022.

[11] Centers for Disease Control and Prevention (CDC). HIV Risk and Prevention: Pre-Exposure Prophylaxis (PrEP). https://www.cdc.gov/hiv/risk/prep/index.html. Accessed April 5, 2022.

[12] Centers for Disease Control and Prevention (CDC). Monitoring selected national HIV prevention and care objectives by using HIV surveillance data—United States and 6 dependent areas, 2019. HIV Surveillance Supplemental Report 2021;26(No. 2). https://www.cdc.gov/hiv/pdf/library/reports/surveillance/cdc-hiv-surveillance-report-vol-26-no-2.pdf. Published May 2021. Accessed August 11, 2022.

[13] Centers for Disease Control and Prevention (CDC). Monitoring selected national HIV prevention and care objectives by using HIV surveillance data—United States and 6 dependent areas, 2019. HIV Surveillance Supplemental Report 2021;26(No. 2). https://www.cdc.gov/hiv/pdf/library/reports/surveillance/cdc-hiv-surveillance-report-vol-26-no-2.pdf. Published May 2021. Accessed August 11, 2022.

[14] HIV.gov. Ending the HIV Epidemic. https://www.hiv.gov/federal-response/ending-the-hiv-epidemic/overview. Accessed May 31, 2022.

HIV community and the President's Advisory Council on HIV/AIDS (PACHA).[15] The EHE initiative targets seven states and 48 counties with high rates of transmission, including Shelby County in Tennessee.[16]

HIV disproportionately impacts the South with nearly half of new HIV infections in Southern states, like Tennessee.[17] As of 2019, there were 17,667 people living with HIV in Tennessee.[18] As of 2019, Tennessee exceeded the national average for viral load suppression (67.1 percent in Tennessee,[19] and 65.5 percent nationally[20]). Tennessee has made significant progress in addressing the HIV epidemic in recent years, with the Nashville "Ending the HIV Epidemic Plan"[21] and the Tennessee Human Immunodeficiency Virus (HIV) & Hepatitis C Virus (HCV) Outbreak Response Plan."[22] However, more needs to be done to ensure people with HIV receive the care they need. For example, the state could still improve engagement in medical care for those who have HIV. As of 2019, 5,459 people living with HIV in Tennessee were not getting the care they need.[23]

TennCare plays an important role in the efforts to end the HIV epidemic because almost half of people with HIV who are engaged in medical care have incomes at or below the federal poverty level.[24] TennCare is an essential source of access to medical care and ART drug coverage for people living with HIV—which preserve the health and wellness of people with HIV and prevent new HIV transmissions.

Therefore, the TennCare III Demonstration has an important role to play in achieving the goals of the EHE to continue to advance the care, treatment, and prevention needs of their enrollees with HIV and those vulnerable for acquiring HIV.

1. ViiV Opposes Closed Drug Formularies

The TennCare III demonstration waiver amendment would remove the closed formulary previously proposed by the state. We appreciate the state considering concerns by stakeholders (including ViiV) that expressed apprehension with implementation of a closed formulary and the state's decision to eliminate the closed formulary provision.

In general, proposals related to closed formularies or to therapeutic drug class limitations are specifically problematic for people with HIV. Medical challenges for people with HIV include an increased risk for, and prevalence of, comorbidities that require additional drug treatment such as depression and substance use disorders, as well as cardiovascular disease, hepatic and renal disease, osteoporosis, metabolic

[15] Presidential Advisory Council on AIDS (PACHA). Resolution in Support of "Ending the HIV Epidemic: A Plan for America" https://files.hiv.gov/s3fs-public/PACHA-End-HIV-Elimination-Resolution-passed.pdf. Accessed August 11, 2022.
[16] HIV.gov. Ending the HIV Epidemic – Priority Jurisdictions: Phase 1. https://www.hiv.gov/federal-response/ending-the-hiv-epidemic/jurisdictions. Accessed May 31, 2022.
[17] HIV.gov. Ending the HIV Epidemic – Priority Jurisdictions: Phase 1. https://www.hiv.gov/federal-response/ending-the-hiv-epidemic/jurisdictions. Accessed May 31, 2022.
[18] AIDS Vu: Tennessee. https://aidsvu.org/local-data/united-states/south/tennessee/. Accessed August 11, 2022.
[19] AIDS Vu: Tennessee. https://aidsvu.org/local-data/united-states/south/tennessee/. Accessed August 11, 2022.
[20] AIDS Vu: United States. https://aidsvu.org/local-data/united-states/. Accessed August 11, 2022.
[21] Nashville.gov. Nashville Ending the Epidemic Plan. https://www.nashville.gov/sites/default/files/2021-04/190530-EndingTheEpidemicPlan.pdf?ct=1617904563. Accessed
[22] Tennessee Department of Health. Tennessee Human Immunodeficiency Virus (HIV) & Hepatitis C Virus (HCV) Outbreak Response Plan. January 2018. https://www.cdc.gov/hiv/pdf/programresources/guidance/cluster-outbreak/cdc-hiv-hcv-pwid-response-plan.pdf. Accessed August 11, 2022.
[23] AIDS Vu: Tennessee. https://aidsvu.org/local-data/united-states/south/tennessee/. Accessed August 11, 2022.
[24] Centers for Disease Control and Prevention (CDC). Behavioral and Clinical Characteristics of Persons with Diagnosed HIV Infection—Medical Monitoring Project, United States, 2016 Cycle (June 2016–May 2017). HIV Surveillance Special Report 21. Revised edition. June 2019, https://www.cdc.gov/hiv/pdf/library/reports/surveillance/cdc-hiv-surveillance-special-report-number-21.pdf. Accessed August 11, 2022.

disorders, and several non–AIDS-defining cancers.[25,26] The most common non-infectious co-morbidities of HIV are hypertension, hyperlipidemia, and endocrine disease.[27] Thus, people with HIV must have access to a robust formulary that provides physicians with the ability to prescribe the right treatments at the right time for their patients.

Aging people with HIV often experience non-HIV related comorbidities[28] that require polypharmacy which can increase risk for drug-drug interactions. In 2018, over half (51 percent) of people in the U.S. living with diagnosed HIV were aged 50 and older.[29] Polypharmacy is common in older patients with HIV; therefore, there is a greater risk of drug-drug interactions between antiretroviral drugs and concomitant medications. Potential drug interactions have been reported in 29 percent of HIV patients taking antiretroviral therapy.[30] Potential for drug-drug interactions should be assessed regularly, especially when starting or switching antiretroviral therapy and concomitant medications.[31]

We encourage state Medicaid programs to cover all antiretrovirals in alignment with the DHHS Guidelines for the Use of Antiretroviral Agents in Adults and Adolescents with HIV. Broad access to the full array of available treatment options is vital in HIV treatment, and thus prevention of transmission of HIV. People with HIV must have access to a robust formulary that provides physicians with the ability to prescribe the right treatments at the right time for their patients. Open access to antiretroviral therapies is important for people with HIV in order to achieve viral suppression and maintain wellness.

Effective treatment of HIV not only improves the health outcomes of people with HIV, but also can prevent transmission of HIV to others. When a person with HIV receives and maintains effective HIV treatment and receives quality medical care, they can reach viral suppression. Viral suppression means that the virus has been reduced to a level in the body that is undetectable by standard tests.[32] Viral suppression results in reduced mortality and morbidity and leads to fewer costly medical interventions.[33]
Viral suppression also helps to prevent new transmissions of the virus. When successful treatment with an antiretroviral regimen results in virologic suppression, secondary HIV transmission to others is effectively eliminated. The National Institute of Allergy and Infectious Diseases (NIAID) supported research that demonstrated when people with HIV achieve and maintain viral suppression, there is no risk scientifically of transmitting HIV to their HIV-negative sexual partner.[34] Multiple subsequent studies also showed that people with HIV on ART who had undetectable HIV levels in their blood, had essentially

[25] Gallant J, Hsue PY, Shreay S, Meyer N. Comorbidities Among US Patients With Prevalent HIV Infection—A Trend Analysis. J Infect Dis. 2017 Dec 19;216(12):1525-1533. Accessible at: https://pubmed.ncbi.nlm.nih.gov/29253205/.
[26] Rodriguez-Penney AT, Iudicello JE, Riggs PK, et al. Co-Morbidities in Persons Infected with HIV: Increased Burden with Older Age and Negative Effects on Health-Related Quality of Life. AIDS Patient Care STDS. 2013 Jan;27(1):5-16. Accessible at: https://pubmed.ncbi.nlm.nih.gov/23305257/.
[27] Gallant J, Hsue PY, Shreay S, Meyer N. Comorbidities Among US Patients With Prevalent HIV Infection—A Trend Analysis. J Infect Dis. 2017 Dec 19;216(12):1525-1533. Accessible at: https://pubmed.ncbi.nlm.nih.gov/29253205/.
[28] Schouten J, Wit FW, Stolte IG, Kootstra NA, van der Valk M, et al. Cross-sectional comparison of the prevalence of age-associated comorbidities and their risk factors between HIV-infected and uninfected individuals: the AGEhIV cohort study. Clin Infect Dis. 2014 Dec 15;59(12):1787-97. Access ble at: https://pubmed.ncbi.nlm.nih.gov/25182245/.
[29] Centers for Disease Control and Prevention. HIV and Older Americans," CDC. https://www.cdc.gov/hiv/group/age/index.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fhiv%2Fgroup%2Fage%2Folderamericans%2Findex.html. Accessed August 11, 2022.
[30] Deutschmann E, Bucher HC, Jaeckel S, et al. Prevalence of potential drug-drug Interactions in patients of the Swiss HIV cohort study in the era of HIV integrase inhibitors. Clin Infect Dis. 2021 Oct 5;73(7):e2145-e2152. Access ble at: https://pubmed.ncbi.nlm.nih.gov/32634832/.
[31] Panel on Antiretroviral Guidelines for Adults and Adolescents. Guidelines for the Use of Antiretroviral Agents in Adults and Adolescents with HIV. Department of Health and Human Services. https://clinicalinfo.hiv.gov/en/guidelines/hiv-clinical-guidelines-adult-and-adolescent-arv/whats-new-guidelines. Accessed August 5, 2022.
[32] National Institutes of Health (NIH). Ten things to Know about HIV Suppression. https://www.niaid.nih.gov/diseases-conditions/10-things-know-about-hiv-suppression. Accessed May 25, 2022.
[33] Stricker SM, Fox KA, Baggaley R, et al. Retention in care and adherence to ART are critical elements of HIV care interventions. AIDS Behav. 2014 Oct;18 Suppl 5:S465-7. Accessible at: https://pubmed.ncbi.nlm.nih.gov/24292251/.
[34] National Institute of Allergy and Infectious Diseases. HIV Undetectable=Untransmittable (U=U), or Treatment as Prevention. https://www.niaid.nih.gov/diseases-conditions/treatment-prevention. Accessed April 7, 2022.

no risk of passing the virus on to their HIV-negative partners sexually.[35,36] As a result, the CDC estimates viral suppression effectiveness in preventing HIV transmission at 100 percent.[37]

Reduced transmissions not only improve public health, but also save money. Preventing new transmissions offers a substantial fiscal benefit to the state. It is estimated people with HIV who are not retained in medical care may transmit the virus to an average of 5.3 additional people per 100-person years.[38] A recent study of commercially insured people with HIV compared to individuals without HIV found that mean all-cause costs were almost seven times higher in those with HIV, culminating in an average discounted incremental cost of $850,557 in cumulative costs from ages 25-69.[39] Successful treatment with an antiretroviral regimen results in virologic suppression and virtually eliminates secondary HIV transmission to others. As a result, it is possible to extrapolate that successful HIV treatment and medical care of each infected patient may save the system up to $4.5 million by preventing further transmission to others. These savings can only occur if people with HIV have access to medical care, receive treatment, and remain adherent to their prescribed therapy. For these reasons, we support the elimination of the closed formulary in TennCare III.

2. ViiV Encourages Protections for Access to Antiretrovirals Within Medicaid

ViiV applauds the state of Tennessee for the policy included in its TennCare III proposal that would protect access to antiretrovirals for both HIV treatment and prevention.[40] While we do not support closed formularies, we recognize this important policy and urge the state to carry forward efforts to protect access to antiretrovirals within TennCare.

We urge state Medicaid programs and other coverage entities to institute policies to protect open access to antiretroviral drugs in Medicaid, similar to the protections found in Medicare Part D, and also to support extension of this protection to antiretroviral drugs utilized for HIV prevention, specifically HIV pre-exposure prophalaxis (PrEP).

ViiV supports access to PrEP for all at-risk populations. As noted previously, according to DHHS, of the approximately 1.2 million people in the U.S. indicated for PrEP, only 23.4 percent were receiving it as of 2019.[41] In Tennessee, the state's PrEP coverage ratio was only 17.9 percent in 2019 according to CDC.[42] Making PrEP available and accessible is an important step in reducing the number of new HIV diagnoses and ultimately ending the HIV epidemic. The HIV epidemic continues to have a disproportionate impact on some communities. PrEP has the potential to address HIV specific disparities and possibly other disparities in health care. For instance, studies have shown a correlation between increased PrEP uptake and

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decreases in new HIV diagnoses in the U.S. PrEP use is also associated with increased engagement in ongoing health care.[43]

For these reasons, we urge the state, to maintain protections around antiretrovirals for HIV treatment and HIV PrEP in the TennCare program.

Thank you for your consideration of our comments. We hope that the state of Tennessee will work to further the goal of ending the HIV epidemic and use this waiver amendment to support these objectives.

Sincerely,

[redacted]

Ramon Gardenhire
South Region Government Relations Director,
ViiV Healthcare

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From: Melissa Davidson <[redacted]>
Sent: Wednesday, August 10, 2022 7:24 AM
To: PUBLICE NOTICE TENNCARE
Subject: [EXTERNAL] Comment

I am an adult with TNcare and my son has it as well. I take him to the dentist as much as I can because I don't want his oral health being as bad as mine. While searching for low cost dental clinics this week because I am in need, I am realizing there is none. They are all completely full and not accepting new patients or since you have medical coverage with TnCare (not dental) they consider that I guess not underinsured enough or is a facility that only provides cleanings and I'm in need of much more than that right now. So as I'm struggling to find anyone that can help me I ran across this proposed bill in which I had no knowledge of and just want to say it would be a life savior, literally, if dental was added on so people like me could go to the dentist and not have to worry about being in pain because you cannot afford the hundreds and even thousands of dollars it is going to cost for your oral needs. I wouldn't even mind a copay or monthly payment of some sort to help try and balance the extra cost. So I am all in favor of the tncare expansion/change.

Thank you for allowing comments on it.

From: Charles Clark Lawrence <[redacted]>
Sent: Friday, August 19, 2022 9:32 PM
To: PUBLICE NOTICE TENNCARE
Subject: [EXTERNAL] My Wife Is Uninsured, We Are Impoverished

My name is Charles Clark Lawrence.

I am 39 and legally disabled with severely complicated mental health issues and am in ongoing treatment. I do not want to be on disability, and I am doing all that I can to get to where I can function and work. It is complicated.

My wife is 40. She has been unemployed and uninsured since we have been married. Upon marriage, I saw her physical condition, day in and day out, with 2-3 bleeding periods a month, variable rupturing ovarian cysts with ovaries that were at 8cm each with bursts that were so painful that she would pass out from the severity and be bedridden for days to weeks, every single time.

That is not normal, but that is Her normal.

We applied for disability because she needs extensive medical care that we cannot pay for, and that she fulfilled in her part of the social contract of Social Security. She was denied. I wrote Lamar Alexander a long handwritten letter, and his office agreed to be updated on her appeal case. It was denied due to a lack of medical evidence, which, on only my income, we did not have the ability to cover.

She was a professional chef, top of her class from Dorsey.

For the coming-up-on 8 years of marriage on September 15th, I have been made very keenly aware of the absolute neglect and callousness of the State of Tennessee towards people who need extensive medical care, are well under the poverty line, and these people suffer immensely, in this case even getting told From A Tenncare Worker that "you'd have a better chance at getting insurance if you were black or had kids already".

My wife has a complex umbrella of conditions involving Severe PCOS/Endometriosis/Uterine-Fibroids along with osteoarthritis, chronic migraines, and she is anemic. She has been told by doctors here in Tennessee that she is sterile from calcified ovaries, and that is also why she sometimes bleeds for so long and has so much pain, from calcified eggs (much like kidney stones) erraticly being released down her fallopian tubes, and why it happens 2-3 times per month.

I am ashamed to be a Tennesseean to see that our state did not take the opportunity for ALL PEOPLE that need help in our state, to be able to get help, all on account of hyper-polarized political lines. That is a sad, and historically typical, southern ignorance that I had hoped we were past by now.

The fact that our politicians' pissing contest means more than taking care of 1/10 of Tennessee consituents that are in dire need of help is something that I am going to bring to light Right Here and Now in this moment.

For a state that so heavily prides itself on being the Volunteer State, the only thing I have seen in our so-called leadership in regards to this matter is Volunteering feigned action in the form of callous and flaccid pig-headedness that proliferates Hate, Mysogyny, Inequality, and Corruption behind the mask of buckling tradition.

Where is there any sort of justice in our state, where you have a better chance of having needed healthcare by going to prison or being committed? ? ? ? ? ? ? ? ? ?