1101 Kermit Drive Suite 605
Nashville, TN 37217

October 26, 2018

Wendy Long, MD
Director
Division of TennCare
310 Great Circle Road
Nashville, TN 37243

Dear Dr. Long:

NAMI Tennessee, the state chapter of the National Alliance on Mental Illness, appreciates the opportunity to submit comments on Tennessee's 1115 Waiver Amendment, "Amendment 38 to the TennCare II Demonstration." NAMI is the nation's largest grassroots mental health organization dedicated to building better lives for the millions of Americans affected by mental illness.

Access to coverage and care is essential for people with mental illness to successfully manage their condition and get on a path of recovery. Medicaid is the lifeline for much of that care, as the nation's largest payer of behavioral health services,[i] which provides health coverage to 27 percent of adults with a serious mental illness[ii]. TennCare is the largest payer for mental health and substance use treatment services in the state. While Amendment 38 would apply new work requirements for TennCare beneficiaries who mainly consist of children and their caregivers, pregnant women, and women with breast or cervical cancer, NAMI remains concerned that the demonstration proposal would jeopardize access to care and would have broader, harmful implications for individuals living with mental health conditions in Tennessee. Therefore, NAMI Tennessee urges the Division of TennCare to withdraw this proposal.

Unnecessary Risks for People with Mental Health Conditions, Diagnosed and Undiagnosed

NAMI appreciates Tennessee's goal to "support member efforts to achieve their education- and employment-related goals." However, Tennesseans who receive coverage through TennCare often have significant obstacles to employment that are not erased by taking away their health care. NAMI also recognizes that people with mental illness are disproportionately unemployed. Only 1 in 5 adults with mental health conditions who receive community mental health services are competitively employed—and the numbers drop to only 6.7% for adults with a diagnosis of schizophrenia.[iii] Employment offers many benefits to people with mental illness, and most people who live with mental health conditions want to work. However, work requirements present unnecessary risks for people with mental health conditions.

NAMI recognizes that Tennessee's proposal includes exemptions for "individuals…mentally incapable of work," "medically frail," and "individuals with…an acute medical condition validated by a medical professional that would prevent them from complying." While these exemption may capture some people with mental health conditions, NAMI remains concerned that the exemptions will not capture all

people with mental health conditions who would otherwise be adversely impacted by work requirements. Serious mental illnesses are, by their very nature, chronic and recurring conditions that fluctuate in severity over time. This means that an individual could be in a state of recovery at the time they are assessed and face few obstacles to working. However, the person's condition could change rapidly, impacting their ability to alert TennCare of their decline. Consequently, the beneficiary experiencing a crisis or decline in their condition could lose both their employment and health care coverage at the very time they need access to mental health care the most. Sadly, we know what happens when people with a mental illness don't get treatment; they end up in hospital emergency rooms, in jail, or on the streets with worse long-term outcomes and at greater cost to the state and the federal government.

Arkansas is currently implementing a similar policy requiring Medicaid enrollees to report their hours worked or their exemption. As of October 1, four months into implementation, the state has terminated coverage for 8,462 individuals and locked them out of coverage until January 2019.[iv] An additional 12,589 individuals had one or two months of noncompliance and are at risk for losing coverage in the coming months.[v] In another case, after Washington state changed its renewal process from every twelve months to every six months and instituted new documentation requirements in 2003, approximately 35,000 fewer children were enrolled in the program by the end of 2004.[vi] We have additional concerns about implementing work requirements before the Tennessee Eligibility Determination System (TEDS) is fully operational. Battling technical issues and administrative red tape in order to keep coverage should not take away from patients' or caregivers' focus on maintaining their or their family's health.

Unnecessary Administrative Costs

NAMI is also concerned about the cost of implementing this demonstration proposal. Studies show that work requirements do not lead to long-term, stable employment. Instead, they increase state administrative costs and complexity.[vii] States such as Michigan, Pennsylvania, Kentucky, and Virginia have estimated that setting up the administrative systems to track and verify exemptions and work activities will cost tens of millions of dollars.[viii] Tennessee's fiscal impact statement estimated the program would cost approximately the state and federal government $39.8 million over the course of the waiver.[ix] These costs would divert resources from TennCare's core goal – providing health coverage to those without access to care. Rather than spending scarce public resources on the administration of new requirements, NAMI urges the state to instead implement evidence-based supported employment programs, which have proven effective in helping vulnerable populations, such as people with mental illness recover and return to work.[x] This meets the intent of the demonstration proposal without the adverse consequences presented by a mandatory work requirement.

Incomplete Application

NAMI Tennessee also notes that the federal rules at 431.408 pertaining to state public comment process require at (a)(1)(i)(C) that a state include an estimate of the expected increase or decrease in annual enrollment and expenditures if applicable. The intent of this section of the regulations is to allow the public to comment on a Section 1115 proposal with adequate information to assess its impact. However, on pages 5 of this proposal, the Department states that "*Some number of individuals may transition off of TennCare and into other coverage options as their earnings increase; however, it is not possible to reliably project the magnitude of this decrease in enrollment at this time*." We urge TennCare to update the waiver amendment with the estimated expenditure and estimate enrollment change and reopen the

state comment period for an additional 30-days.

Ultimately, we believe that imposing work requirements will take Tennessee backwards without furthering the goals of the Medicaid program. NAMI urges Tennessee to withdraw this proposal as it will not promote patient care and will likely harm patients with mental health conditions. We encourage the department to focus on solutions to implement evidence-based supported employment for TennCare recipients. Thank you for the opportunity to provide comments.

Sincerely,

Jake Coffey, MA, MPH
Director of Advocacy

On behalf of NAMI Tennessee

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[i] Medicaid and CHIP Payment and Access Commission, "Behavioral Health in the Medicaid Program—People, Use, and Expenditures," June 2015, https://www.macpac.gov/publication/behavioral-health-in-the-medicaid-program%E2%80%95people-use-and-expenditures/

[ii] Rebecca Ahrnsbrak, Jonaki Bose, Sarra Hedden, Rachel N. Lipari, and Eunice Park-Lee, "Key Substance Use and Mental Health Indicators in the United States: Results from the 2016 National Survey on Drug Use and Health," Substance Abuse and Mental Health Services Administration, September 2017, https://www.samhsa.gov/data/sites/default/files/NSDUH-FFR1-2016/NSDUH-FFR1-2016.pdf

[iii] Tim Knettler, Ted Lutterman et al, NRI, *Latest Trends in State Mental Health Agencies.* https://www.nasmhpd.org/sites/default/files/latest-trends-in-state-mental-health-agencies.pdf (August 8, 2016).

[iv] Arkansas Department of Health and Human Services, Arkansas Works Program, August 2018. Accessed at: https://ccf.georgetown.edu/wp-content/uploads/2018/09/091218_AWReport_Final.pdf.; Arkansas Department of Health and Human Services, Arkansas Works Program, September 2018. Accessed at: https://m.arktimes.com/media/pdf/9.18_-_aw_work_requirements_report.pdf.

[v] Arkansas Department of Health and Human Services, Arkansas Works Program, August 2018. Accessed at: https://ccf.georgetown.edu/wp-content/uploads/2018/09/091218_AWReport_Final.pdf.; Arkansas Department of Health and Human Services, Arkansas Works Program, September 2018. Accessed at: https://m.arktimes.com/media/pdf/9.18_-_aw_work_requirements_report.pdf.

[vi] Tricia Brooks, "Data Reporting to Assess Enrollment and Retention in Medicaid and SCHIP," Georgetown University Health Policy Institute Center for Children and Families, January 2009.

[vii] Jane Perkins, Mara Youdelman & Ian McDonald, National Health Law Program, *Work Requirements: Not a Healthy Choice*, http://www.healthlaw.org/publications/browse-all-publications/medicaid-work-requirementsnot-

[viii] Senate Fiscal Agency, Bill Analysis for SB 897, March 21, 2018, http://www.legislature.mi.gov/documents/2017-2018/billanalysis/Senate/pdf/2017-SFA-0897-S.pdf; House Committee on Appropriations, Fiscal Note for HB 2138, April 16, 2018, http://www.legis.state.pa.us/WU01/LI/BI/FN/2017/0/HB2138P3328.pdf; Misty Williams, "Medicaid Changes Require Tens of Millions in Upfront Costs," Roll Call, February 26, 2018, https://www.rollcall.com/news/politics/medicaid-kentucky.

[ix] Tennessee General Assembly Fiscal Review Committee. Fiscal Note HB 1551- SB 1728. February 12, 2018. Accessed at: http://www.capitol.tn.gov/Bills/110/Fiscal/HB1551.pdf

[x] Examples of successful evidence-based programs include IPS Supported Employment (which places people with mental illness in competitive jobs in the community) and the comprehensive service array in First Episode Psychosis programs (FEP) that

includes supported employment. Both these interventions have been shown to improve the employment outcomes of people with mental illness at rates far higher than the national average.