STATE OF TENNESSEE
DEPARTMENT OF FINANCE AND ADMINISTRATION
DIVISION OF HEALTH CARE FINANCE AND ADMINISTRATION
BUREAU OF TENNCARE
310 Great Circle Road
NASHVILLE, TENNESSEE 37243

January 4, 2013

Dear TennCare Stakeholder:

I hope each of you had a wonderful holiday season and that this finds your New Year off to a good start.

Please find attached a letter sent just before the holiday requesting to withdraw the State's proposal to participate in a Financial Alignment Demonstration for dual eligible members. The reasons for the decision are outlined in detail in the letter, and include:

- Concerns pertaining to the methodology by which Tennessee health plans would be reimbursed under the demonstration, including how shared savings could potentially impact the State's rebalancing efforts;
- Programmatic concerns regarding key policy decisions that could impede the effectiveness of the State's proposed demonstration; and
- Delays that would make it difficult, if not impossible, for the State to achieve a successful implementation within the prescribed timeframes.

To be sure, the most important point in the letter is our unwavering belief in the potential of truly integrated care models to improve care for the dual eligible population and a continued commitment to steps that will help us improve the quality and cost-effectiveness of care for dual eligible members in Tennessee. To that end, we will stay the course of implementing strengthened MIPPA agreements (Medicare Improvements for Patients and Providers Act—agreements required by the federal government) with existing Dual Eligible Special Needs Plans (D-SNPs) in Tennessee, and going forward, will leverage existing Medicare Part C authority and education efforts to help align members' enrollment in the same plan for their Medicare and Medicaid benefits. In addition, we will continue to work with the dedicated team from the Medicare-Medicaid Coordination Office to explore ways that we may be able to better align administrative requirements across the programs, as well as other potential strategies that may help us to achieve our shared vision for this population. It is our sincere hope that as these demonstrations progress, CMS and stakeholders across the country will be more open to the kinds of flexibilities needed to create a truly integrated program design.

We appreciate all of the input we have received, and look forward to continuing to work together to improve care for dual eligible beneficiaries.

Sincerely,

Patti Killingsworth

Patti Killingsworth, Assistant Commissioner
Chief of Long Term Services and Supports

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December 21, 2012

Ms. Melanie Bella
Director, Medicare-Medicaid Coordination Office
Centers for Medicare and Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Dear Ms. Bella:

The purpose of this letter is to respectfully request to withdraw the proposal submitted by the State of Tennessee for a Financial Alignment Demonstration (FAD) for full benefit dual eligible beneficiaries (FBDEs) enrolled in Medicaid as well as Medicare.

We remain convinced that Tennessee is well positioned to successfully integrate Medicare and Medicaid benefits—with nearly two decades of managed care experience across all Medicaid populations including FBDEs, an integrated program for Medicaid physical and behavioral health and LTSS, robust contract requirements and state infrastructure to monitor plan performance, and demonstrated improvements in quality and cost efficiency. Nonetheless, there are a number of reasons based upon which we have determined that pursuing the proposed FAD at this time is not in the best interest of FBDE beneficiaries in Tennessee, providers who serve this population, our managed care plans, and the State.

Our greatest concerns pertain to the methodology by which plans would be reimbursed under the FAD model. We appreciate the preliminary risk score data provided to the State. Our actuary has used the data to conduct some very preliminary analysis, but we are unable to resolve our concerns that demonstration plans will be paid less than existing Medicare Advantage plans serving the dual eligible population, but with higher expectations around quality and coordination of care. While we understand the savings targets to be negotiable and we absolutely believe that savings will be realized, not just anticipating, but indeed *making* those reductions on the front end may have the unintended consequence of forcing plans too quickly to shift their focus away from what we believe are the hallmarks of a seamless transition: continuity of services for members and continuity of payments to providers.

Moreover, there are factors which may undermine potential savings, including the recent settlement agreement by HHS of a class action suit that will clarify Medicare coverage criteria for Skilled Nursing Facility, home health and outpatient therapy services, allowing the benefits to be provided even when the beneficiary is no longer making improvement (the so-called "improvement standard"), but instead are needed to maintain the beneficiary's current condition or to prevent or slow deterioration. While

HHS has advised that they "expect no changes in access to services or costs," nearly all accounts of the agreement make clear the expected increase in utilization of these Medicare services, which will have significant implications for dual demos. First, the historical data used to establish plan rates will not accurately reflect future utilization and payments for these services. Further, if states are obligated to use Medicare medical necessity standards for benefits covered in both programs (see programmatic concerns below), it could also increase utilization of the overlapping Medicaid benefits—namely home health therapies and in our case, level 2 Nursing Facility reimbursement (for persons who require skilled and/or rehabilitative services for which a higher level of Medicaid reimbursement is provided).

The requirement of a quality withhold which will be tied to measures yet to be determined during the MOU negotiations adds uncertainty regarding whether such measures can be achieved and the withhold returned—particularly when taking into account key policy decisions around enrollment (no mandatory enrollment, no lock-in period and continuous open enrollment of plans and Medicare program options, including fee-for-service) that will result in constant churn of plan membership and undermine hopes of avoiding costly member acquisition and retention efforts. In short, demonstration plans are expected to compete with D-SNPs and other Medicare Advantage plans, but will have additional constraints and lower payments that make the playing field far from level since savings reductions and quality withholds will reduce the funds available to provide supplemental benefits. In addition, as payments to Medicare Advantage plans are reduced pursuant to the Affordable Care Act, they are expected to charge higher premiums, increase cost-sharing, reduce their network of providers, or reduce supplemental benefits. Yet, FAD plans (whose rates will be tied in part to payments to MA plans, but with *additional* reductions) will not have many of these options, and with even lower rates (even after taking into account the SGR fix) will be hamstrung to offer supplemental benefits sufficient to support member acquisition and retention.

Further, while the ability to actively intervene and manage hospital discharges for dual eligible members has tremendous opportunity to support the State's rebalancing efforts, it remains unclear how the rate setting process will impact the State's rebalancing efforts as it relates to using savings from reduced utilization of Medicaid Nursing Facility services to help cover expanded access to HCBS, or whether instead, a significant portion of those savings will be redirected to the federal government based on the application of aggregate savings target to the Medicare A/B and Medicaid components of the integrated rate, in accordance with both payers' proportional share of such savings. (Per CMS guidance in the *Joint Rate-Setting Process Under the Capitated Financial Alignment Initiative, "...regardless of whether savings accrue from reducing hospitalizations (for which Medicare is primary) or reducing nursing facility placements (for which Medicaid is primary), both payers will benefit under the integrated approach.")* Though the intent is to allow both programs to share savings and reinvest them in the health care system as appropriate, the diversion of savings from reduced Medicaid NF utilization to the Medicare program would significantly impede the State's rebalancing efforts, as such funding would no longer be available to support the expansion of HCBS (to duals as well as non-duals) in order to divert and delay placement in nursing facilities.

Finally, we have critical concerns regarding the timing of rate development as it relates to expected implementation of the demonstrations. We believe it is unreasonable to expect our demonstration plans to negotiate provider agreements in order to develop their networks without knowing the rates they will be paid to deliver care for their members and whether such rates will be adequate to cover the commitments they are making. By the same token, developing an adequate network will require that health plans can advise providers regarding the compensation they will receive under the FAD. This is exacerbated by the elimination of bad debt payments to hospitals and skilled nursing facilities under the demonstrations. While CMS has expressed that such payments will be accounted for in the rate

development process as it is for MA plans, the lack of written guidance on this issue leaves tremendous uncertainty among key provider groups regarding the viability of this approach.

In addition to these financial concerns, we have key programmatic concerns based on the pre-established parameters set forth in CMS letter of January 25, 2012 and reflected in certain sections of the Massachusetts MOU, which, based on our understanding, the MMCO has indicated will be consistently applied across all demonstration states.

In addition to enrollment (highlighted above), we have significant concerns around medical necessity. Based on MMCO explanations of the Massachusetts MOU, the distinction between "legacy" Medicare and "legacy" Medicaid benefits is maintained, with Medicare coverage standards being applied to legacy Medicare benefits, Medicaid medical necessity standards applicable to legacy Medicaid benefits, and where benefits overlap (e.g., home health, DME), the more generous (in most cases, Medicare) standard being applied. A unified approach would be possible if a State is willing and able to conform to the more generous Medicare coverage standard for all (including Medicaid) benefits. As you are aware, Tennessee's medical necessity definition is established in State law. The definition is implemented consistent with a federal court order (the *Grier* Revised Consent Decree), applying clear evidentiary standards with respect to the weight given the treating provider's medical opinion. Accordingly, we do not believe that it would be permissible or desirable to apply Medicare coverage criteria to Medicaid benefits in Tennessee.

Another key issue is around medical appeals. Again, based on published pre-established parameters and MMCO explanations of the Massachusetts MOU, the expectation for both Medicare and Medicaid benefits is the more generous Medicare standard with 60 days to file an appeal, 30 days to resolve standard appeals and 72 hours for expedited appeals, excluding Part D services, which follow Part D rules. This conflicts with the federal court under which all Medicaid medical appeals are processed and would not be operationally feasible given the volume of medical appeals (some 30,000 each year including all categories of "issues") processed under the TennCare program by the State Medicaid Agency (as is required pursuant to court order). Moreover, there is an expectation that appeals regarding "legacy" Medicare benefits go to the Medicare Independent Review Entity (IRE), appeals regarding "legacy" Medicaid benefits go to the State's Medicaid appeal process, and that overlapping benefits automatically go to the Medicare IRE but can be appealed simultaneously to Medicaid, with the decision most favorable to the enrollee binding. Beyond the confusion that such a process will cause for members (who we had hoped would have a seamless benefit package and a single, streamlined appeals process), it would not be permissible under the terms of our court order for appeals of overlapping Medicaid benefits to be processed in this manner. While we appreciate the willingness of the MMCO to acknowledge and consider states' legal constraints, because the Medicare appeals standards are more generous than Medicaid, compliance with existing consent decrees will preclude a unified and streamlined approach to medical appeals in Tennessee. As a related matter, applying the Medicaid continuation of benefits requirements to Medicare benefits pending the first level of appeal—a standard which does not apply today—is not accounted for in the historical Medicare spend and would increase program costs.

Finally, while we recognize and appreciate the tremendous burden undertaken by the small, but incredibly capable and dedicated team at CMMO in working with 26 states still pursuing one or more of the FAD models or an alternative demonstration, as deadlines have continued to push out, we are concerned that the lack of clarity regarding a final program design for Tennessee will not permit a successful implementation by January 1, 2014, and bumps up against other competing priorities and decision points that make pursuing a demonstration impractical at this time.

Although MMCO staff have been accessible and tremendously supportive, at this juncture, we have not received any formal feedback on our proposal and MOU negotiations have not commenced. In addition, it appears that many of the decision items thought to previously be part of the MOU process are instead being pushed to 3-way contract discussions, and that many states anticipate the 3-way contract discussions being even more in-depth than MOU negotiations.

As you are aware, as these demonstrations have evolved and we have become increasingly concerned about key programmatic decisions that have been made, we had already begun contingency planning in an effort to ensure that we have some mechanism for at least improving the coordination of care for FBDE members, in the event agreement on an MOU was not reached. In addition to strengthening MIPPA agreements with D-SNPs in Tennessee, we are contemplating a requirement that all Medicaid MCOs also become D-SNPs in all counties of their Medicaid plan's operation. However, as those applications are also due in February, and in light of the conflicting and cumulative burden placed upon health plans by pursuing both paths simultaneously, we must determine the course we will take by the end of 2012.

Further, we are at a critical juncture with respect to our competitive procurement process for our Medicaid managed care organizations. In the Middle Tennessee Region, our contracts will expire in 2014. In the East and West Tennessee Regions, our contracts will expire in 2013, but with the ability to extend through 2015. As you know, our contracting approach for the FAD would have leveraged the prior competitive procurement process, integrating Medicare benefits into the array of services already coordinated by Medicaid health plans on behalf of FBDE beneficiaries enrolled in those plans. A new competitive procurement in the middle of these demonstrations would result in disruption to FBDE members and undermine the demonstrations' quality and cost efficiency goals. Thus, we are at a critical decision point in terms of moving forward with a competitive procurement as planned, or potentially requesting to extend the current contracts further—until the end of the 3-year demonstration period. Given the myriad of concerns and uncertainties, we have decided at this juncture to withdraw the proposal submitted by the State of Tennessee for a financial alignment demonstration for FBDE members. We remain committed to integrated care delivery models and will continue on a course that will move us in that direction, leveraging Part C authority and education efforts to help align members' enrollment in the same plan for their Medicare and Medicaid benefits. We believe there are tremendous opportunities to deliver higher quality and better coordinated care for these members, and we hope that as these demonstrations progress, CMS and stakeholders across the country will be more open to the kinds of flexibilities needed to create a truly integrated program model.

We sincerely appreciate the support of you and your team throughout this process and wish you and other states success in these demonstrations. We hope that we can continue to work with the MMCO team to identify other potential strategies that may help to advance our shared vision of an integrated delivery system for the dual eligible population in Tennessee.

Respectfully,

Darin J. Gordon
Director

cc: Leeann Comfort