September 16, 2004

The Honorable Phil Bredesen  
Governor of the State of Tennessee  
Tennessee State Capitol  
Nashville, Tennessee  37243-0001  

Re:  TennCare Reform Proposal  

Dear Governor Bredesen:  

Thank you for the opportunity to comment on the TennCare reform proposal. AARP shares your belief that the TennCare program provides important services to Tennesseans who need assistance. We also agree that to be sustainable over the long term, the program must be reformed. We therefore applaud your reform goals aimed at ensuring that this important program protects children, pregnant women, persons with disabilities and the frail elderly, is fiscally viable, and provides high quality health and long-term care to some of the state’s most vulnerable citizens. 

We are pleased with many of the provisions of the reform proposal, especially those targeted at reducing program fraud and abuse and those that would attempt to control prescription drug costs through the implementation a comprehensive drug utilization program. We are concerned however, that some of the proposals could hinder the effectiveness of the reform measures, and may result in unanticipated program costs as well as negative enrollee health consequences. We are particularly concerned about a new definition of medical necessity that places all of the discretion in the hands of program administrators who have no direct knowledge of the patient’s particular circumstances. We are also concerned about the potential impact of the proposal’s aggressive use of therapeutic substitution within the pharmacy program, as well as a lack of exceptions to benefit limits – especially with regard to prescription drug coverage. In addition, we find the proposed changes to beneficiary appeal rights to be especially problematic. Finally, the state’s refusal to provide notice to beneficiaries who are coming close to hitting the benefit limits should be reconsidered. There are other ways to contain program costs that would not be so harmful to vulnerable Tennesseans, and we would be pleased to continue to provide assistance to you and your staff in identifying those alternatives. 

These and other specific concerns are more fully discussed below in the order in which they appear in the proposal. As you know, many of the proposals are without precedent, and their combined effect is to fundamentally alter TennCare and its role as the state’s health care safety net. AARP is concerned that, in addition to the specific problems discussed below, the far-reaching and untested nature of certain elements of the proposal is bound to produce adverse outcomes that are unforeseen and unintended. We are unaware of any state ever having embarked on policies of such sweeping scope or potential economic impact.
DEFINITION OF MEDICAL NECESSITY

While we appreciate your effort to clearly define medical necessity, we have serious concerns about how the definition will be operationalized, and urge the state to consider adding language to the proposal that gives the highest priority to respect for medical evidence, the patient-provider relationship and the individualized judgment of treating physicians. In that regard we urge that the medical necessity determination and documentation process be easily navigable and understandable to providers so that access to appropriate services is ensured. Most troubling is the statutory language requiring the use of a “least costly alternative,” which is defined to include “observation, lifestyle or behavioral changes, or no treatment at all.” As it stands, the language potentially gives the TennCare bureau too much authority to override the physicians studied judgment, result in substandard care for enrollees, and potentially create increased costs for the TennCare program. We urge you to add language to the proposal which clearly states how this definition is to be applied and respects the detailed beneficiary appeal rights protected by federal law, including some sort of interim recourse for the beneficiary.

AARP is also concerned by the broad redefinition of experimental and investigational treatments that are excluded from coverage. We appreciate the modification of the statute to permit off-label use of a drug for a use that “can be shown to be widespread, to be generally accepted by the professional medical community as an effective and proven treatment in the setting and for the condition for which it is used”. That standard should be applied to all other forms of medical treatment. Otherwise, TennCare patients will not have access to much of modern medical care that is known to be safe and effective.

The definition of medical necessity is a fundamental part of the reform package and will affect access to care for all TennCare enrollees. The waiver request acknowledges concerns about the definition and promises to address them through regulation. We strongly urge you to release those regulations as soon as possible, so that AARP and the public can comment on them, and so that we can evaluate our stance regarding federal review of the waiver request in light of the adequacy of the regulatory corrections.

BENEFIT LIMITS

We are very concerned about the proposed limit on benefits for some of the TennCare Standard population. Our concerns are heightened in light of the state’s intention to eliminate the two safety net programs proposed earlier. Many TennCare beneficiaries are going to have health care needs that exceed the amounts of the caps. These people, many of whom have very limited financial resources will have no where to turn to get the medical help that they need. We believe that this provision can be significantly improved by adding provisions that allow individuals to exceed the cap under certain circumstances. We urge you to develop an exceptions process that is responsive to individual medical conditions.

CO-PAYMENT STRUCTURE

AARP strongly opposes any co-payment structure that has great potential to create barriers to receipt of services. We are especially concerned about the imposition of cost-sharing obligations on the very poor in order for them to access primary preventive services. These people are the poorest of the poor and often the sickest of the sick. Yet the state is proposing to
impose onerous cost-sharing requirements on this population. The end result is likely to be higher costs to the state as these persons avoid needed care for financial reasons and ultimately show up at hospitals with conditions that would have been less costly to treat had the person sought care earlier. We urge you to reconsider this aspect of your proposal, and at the very least to eliminate the co-payment requirement for primary care services for persons with income at or below 100% of the federal poverty level.

MONTHLY PREMIUMS

The proposal adds a new requirement for sliding scale monthly premiums for persons at or above 100% of the federal poverty level, and intends to increase those amounts annually by as much as the rate of medical inflation. We urge you to reconsider imposing a blanket inflation factor at this time. We believe that a better alternative would be to make modest premium increases only when program financing requires it rather than to make annual increases even though program financing is strong.

We are also concerned about the proposed shift of 123,000 Optional Medicaid enrollees, half of whom are adults, to the TennCare Standard program, as this will result in the imposition of a number of serious disadvantages for those affected. These include subjecting those Optional Medicaid adults above poverty to premium obligations that are now barred by federal Medicaid law. This group will include grandparents who are acting as caretaker relatives, or who are in the two year waiting period for Medicare to kick in. These are Medically Needy enrollees who have qualified because they have incurred catastrophic medical expenses that cause them to “spend down” into eligibility. They are in very dire financial straits, even though they have incomes above poverty. The effect will be to drive many of these people from the program, a result that is inconsistent with the goal of maintaining enrollment levels. An early survey of people who disenrolled from Oregon’s Medicaid program following a premium increase found significant access problems, with 60 percent reporting an unmet health need and nearly 80 percent reporting an unmet mental health need. Those with chronic conditions were particularly adversely affected

APPEAL RIGHTS

We oppose the provisions which would curtail the legitimate appeal rights of beneficiaries. There are a great number of issues that could be the legitimate subject of appeal. Yet the state seeks to identify just a few items that it feels should be subject to appeal and asks the federal government to give it permission to ignore any appeal requests that are not related to the few items that the state has identified. We urge you to reconsider these provisions, and suggest that you find other ways to discourage frivolous appeals.

In addition, we believe that is indefensible for the state to take the position that is does not have an affirmative duty to notify beneficiaries of when they are appropriating their benefit limit or that they have reached it. Failure to give such notice will surely result in beneficiaries incurring unintended costs. This will be especially burdensome to persons with very low income who may have limited literacy and financial skills. Because the state will be in the best position to know when a benefit limit is either approached or reached, we urge you to make these notices available to all beneficiaries.
REMOVAL OF OUT-OF-POCKET MAXIMUMS

We have concerns about the proposal to remove out-of-pocket maximums “in the interest of simplicity.” The effect is to increase the cumulative financial burdens on the sickest patients, who are disproportionately a senior population. The request is vague and suggests that the state is seeking permission to increase prescription drug co-payments whenever it feels like doing so. We respectfully request that you clarify the provision, and develop criteria – including legislative review and public comment – for circumstances under which co-payment increases will be sought.

POINT-OF-SERVICE DENIAL OF PHARMACEUTICALS AND OTHER SERVICES

We are pleased to see that the proposal does not impose pharmacy cost sharing obligations on children. However, we cannot support the provision that allows Tennessee pharmacists and other providers to deny a subset of the TennCare Standard population – those with very limited income – access to needed pharmaceuticals or other services because they are unable to make the required co-payment.

Not providing this important low-income protection to the TennCare Standard population will inevitably result in denial of necessary services to those with great need and very limited ability to pay. It could also lead to higher overall TennCare costs in the long run, as conditions that readily respond to timely therapies would go untreated, potentially resulting in the need for more expensive non-pharmaceutical treatments. In addition, the proposal does not provide for interim beneficiary protections pending appeal, nor does it spell out any type of meaningful appeal process. AARP cannot support a provision that leaves beneficiaries with very limited income without potentially lifesaving drugs or other needed therapies, or that does not make temporary provisions to protect the health of low-income beneficiaries.

NON-COVERAGE OF OVER-THE-COUNTER DRUGS

Your proposal sets forth a blanket prohibition on coverage of over-the-counter drug, yet you encourage their use as a less costly alternative to a prescribed drug. As a minimum, we ask that you change your policy to state that an over-the-counter drug will be reimbursed when it is used to substitute for a legitimately prescribed one.

In addition, we are very concerned that the proposal does not provide adequate access to over the counter prescription drugs for persons living in long-term care institutions. This oversight is especially disturbing given that these persons have only $30.00 per month available to them for discretionary expenses, yet they are commonly prescribed many drugs that are purchased over the counter. The impact on this population is just one example of why the removal of OTC coverage will have undesirable effects for both consumers and the state.

PHARMACY BENEFIT

In general, we are encouraged by the proposed changes to the pharmacy benefit. Although we need to see more specifics, we support the use of evidence-based research to formulate
Preferred Drug Lists. We also support the work of a P&T committee that is expert in evidence-based research and whose membership can address any special considerations based on ethnicity, gender, age, or particular conditions.

We do need to see the specific lists of drugs for each designation and understand how drugs and classes of drugs were designated. In addition, we would like to see specific language concerning prior approval processes, as well as consumer protections with respect to physician override, emergency supply while appeals of a prior authorization denial are reviewed, and the appeals process.

We are strongly opposed to the proposal to exclude antihistamines and gastric acid reduction drugs from the prescription drug formulary. We believe that to do so would place “substantial programmatic savings” ahead of patient health and safety. Instead of a blanket prohibition, we urge you to adopt a fail first policy that would allow for coverage of a prescribe antihistamine or a gastric acid reducing drug, after TennCare has first covered the OTC version of the drug and, in the opinion of the treating physician, it has not achieved the desired outcome.

INABILITY TO OBTAIN MODIFICATIONS OF EXISTING CONSENT DECREES

The state has recognized that full implementation of the reform proposal will require modification of one or more court-issued consent decrees, and that if the state is unable to obtain the necessary decrees, that it intends to further reduce the number of covered prescriptions, and/or to eliminate the optional outpatient pharmacy benefit for some or all TennCare enrollees. AARP strongly opposes any further limits on prescription drugs benefits. Not only will this approach harm beneficiaries, it will also increase program costs as persons who could have successfully treated with drug therapies have to go without until their conditions worsen, requiring costly hospitalizations. We urge you to hold the line on coverage and remove this onerous provision.

AUTHORITY TO MODIFY WAIVER

We are strongly opposed to the proposal’s request for blanket authority to amend the waiver. The request for pre-approved authority to implement sweeping waiver modifications is far too broad, and is especially onerous because it does not specifically provide the opportunity for legislative review or public comment. These concerns are even greater under the authority requested to allow the Governor to bypass the proposed Advisory Commission process during the first year following waiver amendment approval. We urge you to develop a reasonable approach to amending the waiver: one that is circumscribed and that provides meaningful opportunities for the state legislature and the citizens of Tennessee to be heard.

PREFERRED COST CONTAINMENT ALTERNATIVES

We have shared with Commissioner Goetz specific suggestions with regard to additional program cost-containment measures which we believe are sound and would have a relatively minor impact on enrollees’ health. While these must all be considered carefully and each has potential drawbacks, we believe they merit consideration as you go forward in developing your proposed reforms. They include the following alternatives:
• Consider suggestions provided by CMS on September 9th on ways to safety and effectively control pharmacy costs, including more aggressive generic substitution policies, and enhanced supplemental rebate agreements through multi-state pooling;

• Employ more aggressive and systematic use of retrospective prescription drug utilization review;

• Enact reform of the state’s antiquated nursing home payment system, which provides significant annual increases without significant regard to the quality, quantity or nature of the services being provided;

• Immediately begin offering long-term care services in alternative settings as appropriate, including assisted care living facilities, for current nursing home residents;

• Implement more aggressive and systematic pharmacy cost containment initiatives in nursing homes, including pharmacy case management, physician profiling, and reform of the current system for purchasing prescription drugs for nursing home residents;

• Place higher priority on disease management that offers significant savings in the future and can improve health care to those opting for the program;

• Bring payments to the TennCare managed care contractors into line with the substantially lower rates that other states and commercial plans pay for similar administrative services.

Because the proposed reforms are prompted by fiscal concerns, it is vitally important to accurately project the growth of the program, as well as the likely savings to be obtained from the proposed policy changes. AARP is particularly concerned that projections of savings from some of the proposals may fail to fully offset downstream increases in other medical expenses that will result from reducing timely access to necessary medical care. Though difficult to quantify in a precise manner, these offsetting costs are clearly real and substantial, and have been well documented over many years. This important consideration must be considered as you weigh various proposed alternatives.

Thank you for considering our comments. If you have any questions please contact our state legislative director, Brian McGuire, at (615) 726-5104.

Sincerely,

Helen M. Wingard, MPA
State Director