State Demonstrations to Integrate Care for Dual Eligibles

Demonstration Proposal

Tennessee

Summary: In 2011, Tennessee was competitively selected to receive funding through CMS' *State Demonstrations to Integrate Care for Dual Eligible Individuals.* As part of this Demonstration, CMS provided support to the State to design a demonstration proposal that describes how it would structure, implement, and monitor an integrated delivery system and payment model aimed at improving the quality, coordination, and cost-effectiveness of services for dual eligible individuals. Through the demonstration proposal, the State must demonstrate its ability to meet or exceed certain CMS established standards and conditions including beneficiary protections. These standards and conditions include factors such as beneficiary protections, stakeholder engagement, and network adequacy among others. In order for CMS to determine whether the standards and conditions have been met, States are asked to submit a demonstration proposal that outlines their proposed approach for integrating care for dual eligible individuals. The Bureau of TennCare has submitted this proposal for CMS review.

As part of the review process, CMS will seek public comment through a 30-day notice period. During this time interested individuals or groups may submit comments to help inform CMS' review of the proposal.

CMS will make all decisions related to the implementation of proposed demonstrations following a thorough review of the proposal and supporting documentation. Further discussion and/or development of certain aspects of the demonstration (e.g., quality measures, rate methodology, etc.) may be required before any formal agreement is finalized.

Publication of this proposal does not imply CMS approval of the demonstration.

Invitation for public comment: We welcome public input on this proposal. To be assured consideration, please submit comments by 5 p.m., E.T. June 21, 2012. You may submit comments on this proposal to TN-MedicareMedicaidCoordination@cms.hhs.gov.

TENNCARE PLUS

A Proposal for an Integrated Medicaid/Medicare Model

Response to RFP CMS-2011-0009

Bureau of TennCare
Nashville, Tennessee
May 17, 2012

FOREWORD

This proposal is being submitted to the Medicare-Medicaid Coordination Office (MMCO), which is located within the Centers for Medicare and Medicaid Services (CMS). It reflects input received from people who are dual eligible, family members and stakeholder groups, including those that represent dual eligible members, providers, and Medicaid as well as Medicare Advantage health plans. Certainly, we acknowledge that we have not achieved consensus on all of the key design elements, with many stakeholders preferring the enrollment flexibilities available to dual eligible members today. We have attempted to address the underlying concerns raised by these groups (i.e., choice, access, and continuity of care), while also proposing a model that we believe can be implemented, and that can achieve the desired quality and cost-effectiveness goals. Some of the concerns expressed, e.g., the integration of Part D benefits and the timelines for submission of the proposal and date for implementing the demonstration, are driven by CMS requirements, and outside the scope of the State's authority to change.

We want to begin by saying that the Bureau of TennCare is fully committed to the concept of fully integrated care for Full Benefit Dual Eligible (FBDE) members. We know that FBDE members are among the most fragile persons we serve in TennCare today, and we also recognize that they are one of the most costly populations for the Medicaid and Medicare programs combined. It is obvious that the States and the Federal government can find better, more cost-effective ways to deliver health care services to these persons. It also seems clear that escalating costs will ultimately force national policy reform with respect to programs and services for the dual eligible population; simply maintaining the status quo is not an option. States can either develop and implement innovative programs for integrating care for this population in a way that demonstrates improved quality and cost efficiency, or they can wait for a one-size-fits-all approach to be developed for them, with little opportunity to tailor based on the strengths of existing delivery systems.

Integration of care has been a key principle of the TennCare program for some time now. TennCare today is an almost fully integrated product, with all Medicaid eligible members, including those who are FBDE, enrolled in managed care for their Medicaid services.[1] We have seen the benefits of integration in terms of quality as well as cost effectiveness, and we are confident that our staff has the expertise, the experience, and the commitment to design and implement a successful model of integrated care for FBDE members.

Accordingly, we believe that all members are best served in integrated programs that are member centered, well managed, and accountable for assuring timely access to appropriate, cost-effective care in the most integrated setting appropriate. Like many States, we believe that the potential of integrated care programs will never be fully realized outside a mandatory model, meaning a model in which all beneficiaries receive care through managed and coordinated delivery systems. Years of experience with Medicare Advantage and persistently low penetration rates in nearly every state in the country[2] are evidence that wariness about managed care will continue to drive beneficiary decisions to remain in

[1] Members with intellectual disabilities receive all of their services other than ICF/MR and HCBS waiver services through the managed care program. PACE participants are enrolled in a capitated managed care arrangement with Alexian Brothers.

[2] Of the roughly 8.2 million dual eligible nationwide, only about 800,000 (less than 10 percent) participate in the coordinated or integrated options currently available, despite years of efforts to enroll them voluntarily.

largely “unmanaged” delivery systems, with continued challenges for members, providers, and payers alike.

We recognize that today, however, stakeholder groups as well as Medicare policy leaders are not yet ready to take what we believe will be a giant leap forward in improving delivery systems for the dual eligible population. We further recognize that Medicare policy leaders are not yet ready to consider the kind of true integration of funding and services (whether at the federal or state level), and the alignment of regulatory and other administrative requirements and processes that would allow these programs to realize their full potential. We hope that these demonstrations can help pave the way for further exploration of those options in the future. For now we have elected, based on input received, not to propose the mandatory model we think would be most beneficial for those who are FBDE, but rather, to propose a passive enrollment process, a transition period with full continuity of services and providers for members, and the ability to opt out *at any time* thereafter in order to enroll and retain as many people as possible in an integrated delivery model.

We greatly admire and respect the effort that has been put into this project by the newly established Medicare Medicaid Coordination Office (MMCO). The MMCO staff has put out hundreds of pages of guidance, held numerous meetings and conference calls, and spent many hours working with States to help them shape a final product that can be implemented within a very short time period, even when not all the answers to questions asked by States are available. Trying to bring together two large and very different systems to serve a common group of enrollees is nothing short of a herculean task.

While the model described in this proposal is not the “ideal” model that we believe has the greatest potential for improved quality and cost-effectiveness, it reflects what we believe is possible within the current public policy environment, and it most assuredly reflects Tennessee’s commitment to success—on behalf of our members, those who advocate for them, our providers, the TennCare program, the State of Tennessee, and the MMCO. It is our hope and our belief that we not only can, but indeed, must improve how care is delivered for dual eligible beneficiaries in Tennessee and across the country.

A. Executive Summary

The TennCare managed care demonstration has been in place for 18 years and has matured into a well-managed, member-focused system of care that is characterized by integration of almost every benefit except Medicare.

All 1.2 million TennCare members, including those who are dual eligible (eligible for Medicare benefits as well as TennCare), are enrolled in TennCare Managed Care Organizations (MCOs) that furnish them with an array of services including primary and acute care services, behavioral health services, and, for adults who are elderly or who have physical disabilities, long-term services and supports (LTSS). The MLTSS (Managed LTSS) component, called TennCare CHOICES, has enabled the State to achieve remarkable progress in its rebalancing efforts.

Enrollment in TennCare MCOs has been mandatory for all TennCare members since the program began. Coordination of care for dual eligible members is problematic, however, since the MCOs have little visibility into what Medicare services a member might need or be receiving.

The Bureau of TennCare is seeking to develop a new system of care for persons who are dually eligible for Medicare and Medicaid. Building on a solid foundation of managed care experience, this system of care will be called "TennCare PLUS" and will integrate Medicare and Medicaid benefits in a seamless continuum of care that is focused on the member and his needs.[1] Cost savings will be achieved primarily by appropriate management of care rather than by changes in provider reimbursement.

This proposal has been prepared in response to RFP-CMS-2011-0009, as well as State Medicaid Director Letter 11-008 (July 8, 2011) and draft guidance provided by the Medicare and Medicaid Coordination Office (October 19, 2011). The model is a capitated approach to integration for dual eligible members. Table 1 summarizes the proposed design. The State assures CMS that it will abide by the draft Special Terms and Conditions dated January 2012.

Table 1
Summary of the Proposed Demonstration Design

Target Population	All FBDE members except PACE[2] participants
Total Number of Full Benefit Medicare-Medicaid Beneficiaries Statewide	~136,000
Total Number of Beneficiaries Eligible for Demonstration	~136,000
Geographic Service Area	Statewide

[1] LTSS for persons with intellectual disabilities (including ICF/MR and Section 1915(c) waiver services) will remain carved out of the Demonstration, but dual eligible members receiving these services will be part of the demonstration for all other Medicare and Medicaid services.

[2] PACE is the Program of All-Inclusive Care for the Elderly. There is one PACE program in Tennessee at present. It is located in Chattanooga and serves 325 people.

Summary of Covered Benefits	· Medicaid State Plan/1115 waiver services including physical and behavioral health and LTSS for the elderly and adults with physical disabilities · Medicare Parts A, B, and D · Supplemental basic dental, vision and hearing · Care management/coordination and disease management
Financing Model	Capitated
Summary of Stakeholder Engagement/Input	Presentations and discussions with key stakeholder groups; written input/recommendations; 30-day public comment period; 2 public meetings held during public comment period
Proposed Implementation Date(s)	January 1, 2014

B. Background

i. Overall Vision for the Demonstration.

The overall vision for the proposed demonstration is an integrated system of care for all who are Full Benefit Dual Eligible (FBDE) Tennesseans. We define FBDE members as persons who are enrolled in Parts A (hospital insurance) and/or B (medical insurance) of Medicare, or Part C (Medicare Advantage or Medicare managed care) as an alternative to A and B, and who are also enrolled in the TennCare managed care program.

The disjointed, complicated, and inefficient nature of the current Medicare and Medicaid delivery system for FBDE members has been well-documented across the nation. FBDE members and their families are expected to successfully navigate on their own a complex system of overlapping and often confusing Medicare and Medicaid benefits, provider networks, and program requirements. Day-to-day challenges as simple as knowing what services are covered, which providers to use, which insurance card to use, and whom to call for assistance can lead to member frustration and dissatisfaction, as well as higher costs and lower quality of care.

Similarly, providers must negotiate two complex sets of enrollment processes, program requirements, and billing and payment systems, with little or no information regarding other care the member has received.

Medicaid MCOs are focused on improving coordination and quality of care, but have little visibility into the services that Medicare is paying for—whether preventive care is received timely, whether evidence-based guidelines are being used to manage chronic conditions, or even when a member is hospitalized and may need services beyond the scope of the Medicare benefit (e.g., LTSS) upon discharge.

Tennessee has been involved in aggressive rebalancing of LTSS for persons who are elderly and adults who are physically disabled through our CHOICES program, and the lack of coordination between Medicaid and Medicare has been a significant concern. NInety percent of the CHOICES population are FBDE members, with an even higher percentage of FBDE persons among CHOICES members receiving Medicaid-reimbursed institutional care in a Nursing Facility (NF). Admission of FBDE members to TennCare CHOICES frequently comes about after a Medicare acute inpatient stay, followed by Medicare

Skilled Nursing Facility (SNF) services, and then a transition to Medicaid NF services once the Medicare SNF benefit has been exhausted. The Medicare benefit and payment structure (e.g., up to 100 days of SNF care following a 3-day inpatient stay and minimal HCBS alternatives) misaligns financial incentives, inadvertently encourages the use of the highest cost services, and increases institutional expenditures across both programs. The cost is reflected not just in increased costs across both programs, but also, and more importantly, in terms of the erosion of self-determination and natural supports for the person.

Lack of timely access to Medicare data has made efforts by Medicaid MCOs to coordinate care challenging, if not impossible. Tennessee has tried to address this problem by requesting Medicare data from CMS and providing this data to the MCOs via a recently amended Coordination of Benefits Agreement (COBA) between TennCare and CMS. While the data the State has received has been helpful, it is not real-time data and it contains significant gaps. For example, Medicare Part C encounter data is missing, and there is no financial information accompanying available Medicare Part D data. Information about denied claims, which can yield insight into services requested and services used, is not included.

While there are a small number of Medicare Advantage (MA) Special Needs Plans for Dual Eligible members (D-SNPs) operating in Tennessee (including two D-SNPs offered by TennCare MCOs), the geographic service areas are in many cases limited, and overall MA penetration based on non-mandatory enrollment has been low. Moreover, even for the roughly 25,000 D-SNP members enrolled in a TennCare MCO for Medicaid services, the vastly different administrative processes, separate payment streams, and misaligned financial incentives have largely undermined efforts to coordinate care across both programs in a meaningful way.

TennCare PLUS will offer a fully integrated and seamless system of care for FBDE members centered around a medical home that is easier for members to navigate. MCOs will be required to ensure access to all services in a manner that is sensitive to the beneficiary's language and culture, and to ensure member privacy and access to health records. Members will have one unified set of benefits, a robust provider network available to deliver care, a single insurance card, and 24 hour access to care management as needed to assist with all of their care needs. The goal will be to help members access the care they need in a timely manner from an array of qualified providers in the most integrated setting appropriate.

Providers can enroll with an MCO using a single, unified enrollment (including credentialing) process, obtain prior authorization (as required) for covered benefits, bill that MCO for Medicare and Medicaid reimbursement of services provided to FBDE members, and receive a single payment, encompassing Medicaid's reimbursement of FBDE cost-sharing responsibilities. Medicare Part D benefits will be offered by the MCOs as part of the blended benefit package. Members will have one card to use in accessing all services covered by both Medicare and TennCare.

Using the SNP model of care (the MCO's process for the coordination and delivery of care to members that is required by CMS for D-SNPs), MCO interdisciplinary teams will assess the physical and behavioral health, functional, and social support needs of all FBDE members, develop (in conjunction with the member and his or her representative) an individualized person-centered care plan for each member, employ evidence-based practices, and empower members to better manage chronic health conditions for improved health and quality of life outcomes, manage care transitions between providers and settings, and ensure timely access to cost-effective home and community based alternatives, when appropriate.

Of particular import, the program will be characterized by extensive beneficiary protections. For example, the appeals process in use at TennCare that will be uniformly applied to all dual demonstration benefits, with the exception of Part D pharmacy benefits, is possibly the most thorough and most beneficiary-friendly of any system in the country. This process is described in Section D.iii. While the State intends to passively enroll FBDE members (excluding PACE program participants) into the dual demonstration, members will have the opportunity to exercise freedom of choice between MCOs contracted to administer the demonstration in the region of the State where the member lives and to opt out of the demonstration *at any time* following the six-month transition period as described in Section C.i.b. below.

It may be useful to include here a word about the interaction between the dual demonstration and the TennCare demonstration. TennCare is itself a demonstration program, offering managed care services to all 1.2 million members, the majority of whom are not dual eligible. The dual demonstration will be layered on top of the TennCare demonstration. Persons participating in the dual demonstration will be participating, in effect, in two demonstration programs—the TennCare demonstration PLUS the dual demonstration. Hence the name "TennCare PLUS."

ii. Description of the Medicare-Medicaid Enrollee Population that would be Eligible to Participate in the Demonstration.

There will be no FBDE members who will be specifically excluded from the proposed demonstration, except PACE program participants who are already enrolled in a fully integrated program design. Attachment A provides data about the FBDE population in Tennessee.

C. Care Model Overview

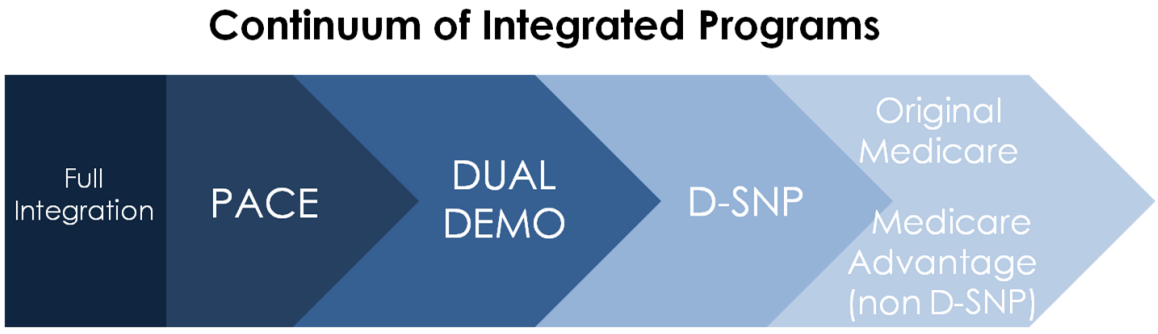
i. Description of Proposed Delivery System/Programmatic Elements.

a. Geographic service area.

TennCare PLUS will be available statewide.

b. Enrollment method(s).

Integrated Medicare/Medicaid programs exist on a continuum, ranging from models where funding, benefits, and administration are fully aligned (PACE) to those where funding, benefits, and program administration are distinctly separate and not coordinated across the two programs (Original Medicare or Medicare Advantage non-D-SNP plans).



The goal of the State's proposed enrollment method is to encourage as many FBDE members as possible to participate in the most integrated delivery models, while also being mindful of concerns regarding continuity of services and providers that have been expressed by numerous stakeholder groups.

All FBDE members are currently enrolled in managed care plans for their Medicaid benefits, including LTSS for CHOICES program participants. At implementation, the State intends to passively enroll all FBDE members, except PACE program participants, into the demonstration, with default assignment to the TennCare health plan in which each member is currently enrolled for Medicaid benefits. Particularly for members enrolled in CHOICES, this will help to preserve established relationships with Care Coordinators, and with in-home LTSS providers.

Existing FBDE members will have an opportunity during the 2014 Medicare open enrollment period (October 15 - December 7, 2013) to exercise freedom of choice between TennCare MCOs contracted to administer the demonstration in their region of the State, and otherwise in accordance with TennCare hardship criteria (see paragraphs 39 and 41 in the Special Terms and Conditions of the TennCare demonstration), which will be amended under the dual demonstration to include lack of access to particular Part D pharmacy benefits based on the respective health plans' formularies.[3] Even though there is an exceptions process for obtaining drugs covered by Medicare but not on a particular Part D plan's formulary, because each MCO will establish its own Part D formulary, consideration of hardship in these circumstances will offer additional consumer protections and help to ensure more efficient access to necessary medications.

The date when a request to change MCOs is effective will be January 1, 2014, the date of implementation of TennCare PLUS. Participants in the dual demonstration must have the same health plan for all Medicare (including Part D) and Medicaid benefits; they cannot choose one TennCare MCO for Medicare and another TennCare MCO for Medicaid.

TennCare will work with stakeholders to develop easy-to-understand information that will be provided to all FBDE members in advance of the Medicare open enrollment period (see Beneficiary Protections described in D.iii.a.) and will manage changes in MCO assignment and enrollment/disenrollment from TennCare PLUS.

We do not believe it is possible that enrollment into or out of the dual demonstration can be managed by the 1-800 Medicare line, as effective counseling will require up-to-date access regarding a member's TennCare MCO assignment, including the limited special populations that can elect to enroll (or remain) in TennCare Select.[4]

Members who do not elect to change MCOs during the 2014 Medicare open enrollment period will remain with their current Medicaid MCO, which will become responsible for all dual demonstration benefits on January 1, 2014. Extensive continuity of care requirements (see Beneficiary Protections described in Section D.iii.b.) regarding current courses of treatment, including prescription drugs, as well as providers (whether in or out of network) will help to ensure as seamless a transition as possible for

[3] It should be noted that the State has requested the following addition to the list of five situations that are not considered hardship situations, as specified in paragraph 41 of the Special Terms and Conditions of the TennCare demonstration: The enrollee's Primary Care Provider (PCP) is no longer in the MCO's network, the enrollee wants to continue to see the current PCP, and has refused alternative PCP or provider choices offered by the MCO.

[4] TennCare Select is available in all three regions, but only to certain populations. See paragraph 40 of the Special Terms and Conditions of the TennCare demonstration.

members, while also providing the greatest opportunity for participation in high quality, integrated programs of care.

FBDE members currently enrolled in a D-SNP may avoid passive enrollment in the dual demonstration by opting to remain with their current D-SNP plan during the 2014 Medicare open enrollment period. While we cannot ensure the preferred degree of integration under that arrangement, TennCare will strengthen MIPPA agreements with D-SNPs to at least improve coordination across the two programs and benefit plans. (See Section C.v.d., TennCare PLUS and integrated programs via Medicare Advantage Special Needs Plans (SNPs) or PACE programs.)

Likewise, all *new* FBDE members who have not chosen to participate in PACE will be passively enrolled in a qualified demonstration plan, as follows:

- Those Medicare beneficiaries who become TennCare eligible (and thereby attain FBDE status) will be able to exercise freedom of choice of TennCare MCOs as part of the Medicaid application process and the MCO change process that follows.[5]
- Those TennCare beneficiaries who become Medicare eligible (and thereby attain FBDE status) will be able to exercise freedom of choice of TennCare MCOs during the next annual Medicare open enrollment period (since they will have already exercised freedom of choice with respect to their Medicaid MCO.) MCO changes outside these processes will occur only based on TennCare's hardship criteria, which will be modified for the demonstration.

All FBDE members passively enrolled in the dual demonstration (at implementation on January 1, 2014 or thereafter upon attaining FBDE status) may opt out of the dual demonstration altogether *at any time* after a 6-month transition period following the member's actual enrollment into the dual demonstration. (Note: They cannot opt out of the TennCare demonstration. In Tennessee, Medicaid benefits are offered only through managed care.) For example, for members enrolled into the dual demonstration on January 1, the transition period would be January 1 through June 30 of that year. For members enrolled after the initial implementation on January 1, 2014, the member may opt out *at any time* following a 6-month transition period or at the next Medicare open enrollment period, whichever comes first.

During the transition period, members will continue to receive Medicare services in place immediately prior to their enrollment in the dual demonstration, including prescription drugs, from their current providers (whether in or out of the MCO's network), with reimbursement as specified in Section E.2 below. The purpose of this transition period is to allow time for new members to do the following: (1) orient to the dual demonstration and its benefits; (2) complete a health risk assessment and participate in developing a personalized plan of care; (3) particularly for persons with chronic conditions, begin to build a relationship between the member and a care management team that will work with the member to implement the plan of care and coordinate the services and supports needed; and (4) try out the new integrated benefits and the MCO's customer service. It will also allow time for the MCO to identify specific patient/physician relationships (PCP and specialists), allowing the MCO to confirm network participation, and/or target enrollment of those providers into the demonstration during the 6-month transition period while continuity of care requirements are in place. In instances where the provider is unwilling to participate, the MCO will work with the member to transition seamlessly to an in-network provider. Pursuant to the terms of a Consent Decree under which the State operates, members will be

[5] The MCO selection and change processes are described in paragraph 41 of the Special Terms and Conditions of the TennCare waiver.

provided a notice of any change in PCP, and may select another PCP from the MCO's network of contract providers.

Options available to the member include all of the current arrangements, including PACE (when available in the member's area), D-SNP, another Medicare Advantage plan, and Fee-for-Service (FFS) Medicare. The member must remain in managed care for Medicaid, including LTSS benefits. In order for the State to meet its commitment to demonstrate measurable improvement in quality measures during the 3-year demonstration, members who opt out of the demonstration altogether will not be able to re-enroll in the demonstration until the next Medicare open enrollment period, with an effective date of enrollment on the following January 1st.

The proposed enrollment process is summarized and illustrated in Attachment B.

c. Care Management and Care Coordination.

The cornerstone of any integrated program is effective care management and care coordination, centered around a medical home for each member. There are two distinct processes that are already in use in the TennCare program. These processes are discussed below.

I. Care management and care coordination in the "regular" TennCare program.

TennCare MCOs are already required to maintain an MCO case management program that includes the following components:

- A systematic approach to identify members who need case management (CM);
- Assessment of member needs;
- Development of an individualized plan of care;
- Implementation of the plan of care, including coordination of care that actively links the member to providers and support services; and
- Program evaluation (satisfaction and effectiveness) which shall include the following:
  - The rate of in-patient admissions and re-admissions of CM members;
  - The rate of Emergency Department (ED) utilization by CM members; and
  - Percent of member satisfaction specific to CM.

At a minimum, MCOs must offer case management to members who are at high risk or have unique, chronic, or complex needs. This includes but is not limited to members with co-occurring mental illness and substance abuse and/or co-morbid physical health and behavioral health conditions.

II. Care coordination in the TennCare CHOICES program.

For members enrolled in the CHOICES MLTSS component of the program, a more intensive, comprehensive and person-centered care coordination model is employed, with active participation of members and their family members or representatives, as appropriate in the care planning process. Care coordination is defined as the continuous process of: (1) assessing a member's physical, behavioral, functional, and psychosocial needs; (2) identifying the physical health, behavioral health, and long-term care services and other social support services and assistance (e.g., housing or income assistance) that are necessary to meet identified needs; (3) ensuring timely access to and provision, coordination and monitoring of physical health, behavioral health, and long-term care services needed to help the member maintain or improve his or her physical or behavioral health status or functional abilities and maximize independence; and (4) facilitating access to other social support services and assistance

needed in order to ensure the member's health, safety and welfare, and as applicable, to delay or prevent the need for more expensive institutional placement.

Each CHOICES member has an assigned care coordinator who is responsible for coordinating care across the continuum, serving as the primary point of contact for the member regarding physical and behavioral health care, and LTSS, and assisting the member with social support needs. Care coordination for MLTSS members is high touch, on-the-ground, and face-to-face, with minimum monthly contact requirements for persons residing in community settings. Care coordinators are expected to develop relationships with members and their families, engage members and families in needs assessment/care planning processes, and work with the PCP to address the member's needs and to coordinate specialty and inpatient care. Detailed contract requirements (see Section 2.9.6., pp. 95-143 of the TennCare Contractor Risk Agreement available at http://www.tn.gov/tenncare/forms/middletnmco.pdf) and protocols prescribe stringent timeframes within which initial assessments must be completed, plans of care developed, and LTSS initiated upon a member's enrollment in the program, as well as the intervals at which members must be contacted to monitor implementation of the plan of care and to identify and address the member's changing needs.

Comprehensive needs assessment is conducted upon enrollment and thereafter on at least an annual basis or upon any significant change in a member's needs or circumstances, including (depending on where the member resides):

- A change of residence or primary caregiver or loss of essential social supports;
- A significant change in health and/or functional status;
- A pattern of recurring falls;
- Loss of mobility;
- Frequent hospitalizations;
- Frequent emergency department utilization;
- An incident, injury or complaint;
- Report of abuse, neglect or exploitation; or
- Any event that significantly increases the perceived risk to a member.

III. Care coordination in the dual demonstration.

In the dual demonstration, the State will build upon existing case management and disease management processes and requirements, as well as extensive care coordination requirements for persons enrolled in the State's MLTSS program that will be applied to demonstration participants receiving MLTSS. MCOs will comply with all SNP Model of Care (MOC) Requirements, including, but not limited to:

- Mandatory health risk assessment of physical and behavioral health, and functional (Activities of Daily Living--ADL) needs of all dual demonstration participants within 90 days of enrollment and at increments of no more than 365 days thereafter to determine how well the member's needs are being met and to maintain/improve the member's condition;
- Individualized Care Plan for each dual demonstration participant developed with input from the member and his/her family member(s), as appropriate
- Interdisciplinary care team;
- A provider network having specialized expertise and use of clinical practice guidelines and protocols;
- MOC training for personnel and provider network; and

- Evaluation methodology (performance and health outcome measurement) to ensure care effectiveness.

The health risk assessment (HRA) may be conducted by phone, but must include gathering of information from the member (or an authorized representative), and shall not be based solely on review of medical records. MCOs will be permitted to utilize proprietary instruments for purposes of conducting the HRA; however required elements include initial screening of physical and behavioral health and functional (ADL) needs; dental, vision, and hearing status; height and weight; current health conditions and risks for health conditions, including heart attack or stroke; prescribed medications; pain; verification of the member's PCP and specialists; recent hospital admissions and/or ED utilization; medical equipment and supplies used and/or needed; and substance use/abuse.

Because default assignment in the demonstration will be to the TennCare health plan in which each member is currently enrolled for Medicaid benefits, MCOs may, upon approval by TennCare, be permitted to begin HRAs after members have been notified of the demonstration but *before* January 1, 2014. This will help to ensure as seamless a transition as possible for demonstration participants, and offers the greatest opportunity to achieve targeted quality and cost-effectiveness measures. For members transitioning between MCOs, demonstration health plans will be required to share certain minimum information, including the HRA, which can then be used by the new health plan as they assume responsibility for the member's care management.

For persons enrolled in the CHOICES MLTSS program, comprehensive assessments have already been completed and needs assessment are ongoing (at a minimum annually), such that an additional HRA will not be required. The health risk assessment (or alternative CHOICES comprehensive assessment and other information, including but not limited to Medicare and/or Medicaid encounter data and other health records) will be used to identify, assess and stratify the needs of dual demonstration participants as shown in Table 2 based on the intensity of care management/coordination needed by the member:

Table 2
Care Management Strata in the Dual Demonstration

Type	To Whom Applicable in the Dual Demonstration	Focus	Specific Requirements
Inpatient/ discharge care management stratum	Participants in the following inpatient settings: Acute, psychiatric, inpatient rehab, Long Term Acute Care (LTAC) and short-term (Medicare legacy[6]) SNF	Aggressive management of care transitions between providers and settings, i.e., planning for timely and appropriate discharge to the most integrated care setting appropriate, including timely provision of home-based care, primary care follow-up, medication reconciliation and management, and post-discharge follow-up regarding ongoing care	

[6] By "Medicare legacy," we mean the Medicare benefit as it existed prior to the dual demonstration. By "Medicaid legacy," we mean the Medicaid benefit as it existed prior to the dual demonstration.

Type	To Whom Applicable in the Dual Demonstration	Focus	Specific Requirements
		needs in order to prevent re-admission.	
NF care coordination stratum	Participants receiving long-term (Medicaid legacy[7]) CHOICES NF services	Improved management of chronic conditions and the identification of targeted strategies related to improving health, functional, or quality of life outcomes or to increasing and/or maintaining functional abilities, including coordination of services beyond the scope of the NF benefit.	For persons enrolled in CHOICES, all CHOICES care coordination requirements will remain applicable, including assessment at least annually of the member's potential for and interest in transition to the community, as well as transition planning and implementation for members identified as candidates for transition .
	Participants receiving inpatient hospice in a NF		To be defined in the TennCare Contractor Risk Agreement.
HCBS care coordination stratum	Participants receiving CHOICES HCBS in CHOICES Groups 2 (NF eligible) or 3 (not NF eligible, but "at risk" of NF placement without HCBS)	Comprehensive coordination of physical and behavioral health services and LTSS needed to help the member maintain or improve his or her physical or behavioral health status or functional abilities and maximize independence and quality of life in the community for as long as possible.	All CHOICES care coordination requirements will remain applicable.
	Participants receiving home health or private duty nursing services on an ongoing basis and hospice (excluding inpatient hospice in a NF).		To be defined in the TennCare-MCO contract.
Care management for non-LTC members with	Non-LTC participants with complex conditions	Evidence-based health and medication management, stabilization of chronic	

[7] Ibid.

Type	To Whom Applicable in the Dual Demonstration	Focus	Specific Requirements
complex conditions		conditions, and monitoring access to care.	
Care management for "healthy" duals	Participants with no or relatively few and very stable physical or behavioral health conditions	Timely access to and utilization of appropriate preventive care, and continued management of stable conditions.	

With respect to the NF care coordination stratum, MCOs will be encouraged to implement, in partnership with physicians and SNFs, a Nurse Practitioner model of care coordination model as the preferred care coordination model for long-term NF residents, and the establishment of a medical home in the facility. At the heart of the NP model is effective and continuous communication among the member, the member's family, the NP, the member's PCP, and the facility, centered around the needs and preferences of the member. By identifying even subtle changes in condition and treating these changes early and in place whenever possible, the member is able to avoid difficult transfers in and out of the hospital, and cost of care is reduced. Financial incentives are aligned by the MCO's ability to authorize SNF services without a 3-day inpatient stay, as requested under the dual demonstration's benefit design. The NP model will require extensive time and effort to develop partnerships with each SNF as well as physicians, and thus is expected to develop throughout the course of the dual demonstration. Further, there must be sufficient penetration of dual demonstration participants within a facility (or closely located facilities), and the cost of NP services must be offset by improved management of inpatient hospital, SNF, and ER services, for the model to be cost effective.

As part of initial and ongoing care management/care coordination efforts, MCOs will conduct more in-depth assessments as needed in order to identify and address member needs and to ensure that the right care is provided in the right place at the right time. Members may move back and forth between the strata defined above, as their needs or conditions change or in response to an acute event, with adjustment of the intensity of care management/coordination, including frequency of contacts and interventions, as appropriate. All care management/care coordination levels will include member assessment, development and implementation of a person-centered plan of care in conjunction with the member and his/her family members (as desired), monitoring and ensuring timely access to care, and intensive management of transitions between providers and care settings to maximize continuity of care.

d. Available networks of medical and supportive service providers that are appropriate for and proficient in addressing the needs of the target population.

Current TennCare MCOs have a vast provider network that can be leveraged for provider participation in the demonstration. Roughly 83 percent of licensed physicians practicing in Tennessee currently participate with one or more TennCare MCOs. We anticipate that many (if not most) of those who do not currently participate in TennCare likely participate in Medicare and will want to continue to provide care to established patients. TennCare will use Medicare data to identify providers most utilized by existing Medicare FFS participants, so MCOs can target enrollment of those providers into the demonstration to ensure continuity of care. In addition, identifying specific patient/physician relationships (PCP and specialists) will be part of the Health Risk Assessment, allowing the MCO to confirm network participation, and/or target enrollment of those providers into the demonstration

during the 6-month transition period while continuity of care requirements are in place. MCOs will be required to establish separate agreements and/or amendments to existing agreements for participation in the demonstration, and provider network files must identify the MCO's demonstration network for purposes of confirming network adequacy under the special exceptions process.

Consistent with the preferred requirement standard established by MMCO, TennCare PLUS MCOs will be required to meet Medicare network adequacy standards for "legacy" Medicare benefits and prescription drugs, subject to an exceptions process jointly administered by CMS and TennCare that will be defined in the MOU between CMS and the State. The exceptions process may be applied in areas where Medicare network standards (which are based on total Medicare Advantage enrollment) may not reflect the number of dual eligible beneficiaries.

- Network adequacy standards met by the MCO without application of a special exceptions process shall not require further review.

- Special exceptions shall include appropriate pre-determined provider/facility exceptions set forth in the CMS Health Services Delivery Tables for Medicare Advantage applicants, and may include the use of single case agreements for the provision of care from non-contract providers. The special exceptions process shall include standards as outlined in Table 3 below.

Table 3
Standards Used in the Special Exceptions Process

Topic	Standard
Minimum Number of Providers	The number of FBDE members assigned to the MCO, divided by 1,000, and then multiplied by the CMS Minimum Provider Ratio
Maximum Travel Time and Distance Criteria	Shall be based on the FBDE members assigned to the MCO and shall not be limited by the county (or region) in which the provider is located, so long as the provider serves members residing in the county
Insufficient Number of Providers/Beds in the Service Area	Shall take into consideration specific providers/facilities that have refused to contract with the health plan at a reasonable rate
Reasonable Rate	A rate consistent with what the provider would receive in FFS Medicare, taking into account the level of Medicaid reimbursement for Medicare cost-sharing obligations

Documentation of local community standards and patterns of care will be taken into consideration when reviewing rural areas.

CMS will be responsible for initial review of network adequacy, based on health plan submissions via HPMS. TennCare will be responsible for targeted review of special exceptions based on the definitions above, using provider network submission files, with final certification of network adequacy jointly determined by CMS and the State.

In preparation for the readiness review process, TennCare will establish milestone deliverable dates by which MCOs are expected to have achieved a certain percentage of compliance with Medicare network adequacy standards.

TennCare will also continue to monitor network adequacy of all Medicaid (including MLTSS) benefits offered under the demonstration in accordance with TennCare network adequacy standards and processes.

II. **Description of Proposed Benefit Design.**

FBDE members enrolled in the demonstration will have access to a full array of physical and behavioral health and LTSS benefits, including pharmacy services.

FBDE members will continue to have access to all TennCare covered services, as medically necessary. In addition, those FBDE members who meet financial and level of care eligibility and are enrolled in the CHOICES program will have access to NF and an array of HCBS. A complete list of these services is included in Section V of the Special Terms and Conditions of the TennCare demonstration.

All Medicare Part A, Part B, and Part D services will be covered under the new dual demonstration proposal.

The TennCare MCOs will be accountable for managing the full range of Medicare and TennCare benefits provided under the dual demonstration.

III. **Description of New Supplemental Benefits to be Added.**

In addition to comprehensive care coordination and disease management, we propose to offer supplemental benefits to TennCare PLUS members that elect to remain in the program. Our ability to offer these benefits is contingent upon the establishment of MCO rates by CMS that are sufficient to cover the cost of these benefits (as well as the costs of providing care coordination, disease management, and other administrative functions that are critical to the program's success and to ensuring quality care for our members). Proposed new supplemental benefits to be added for the demonstration population are listed in Table 4. These benefits would be available upon the conclusion of the 6-month transition period to members that elect to remain enrolled in the demonstration.

Table 4
Supplemental Benefits to be Offered Under TennCare PLUS

Supplemental Benefit	Limitations
Preventive dental services	1 oral exam, 1 cleaning, and 1 set of dental X-rays per year as prescribed by a network dentist
Comprehensive dental services up to $250 per calendar quarter	Defined procedure list to include diagnostic examinations, extractions, and routine restorations
Dentures	Up to 50 percent of the cost of one full set or partial dentures, not to exceed $500 every two years
Routine vision exams	1 per year with refraction
Vision hardware	Lenses, frames, and contact lenses up to $150 per year
Routine hearing exams	1 per year
Hearing aids	Up to $500 every two years; batteries excluded

iv. Discussion of Evidence-Based Practices to be Employed as Part of the Overall Care Model.

Tennessee has been a leader in setting quality standards for Medicaid recipients for several years. Beginning in 2006, the Bureau of TennCare began requiring all of its Managed Care Organizations (MCOs) to be accredited by the National Committee for Quality Assurance (NCQA) and to report a full set of Medicaid HEDIS (Healthcare Effectiveness Data and Information Set) and CAHPS (Consumer Assessment of Healthcare Providers and Systems) data annually. Because of these requirements, the TennCare MCOs have developed strong Quality Improvement Programs, based on national standards, that will be utilized to ensure the quality of care provided to the demonstration population.

Disease Management

Each MCO is also required to implement nine (9) disease management (DM) programs that address such topics as high-risk obstetrics, diabetes, congestive heart failure, asthma, coronary artery disease, chronic-obstructive pulmonary disease (COPD), bipolar disorder, depression, and schizophrenia. In addition, they must also offer a program for obesity that is provided as a cost effective alternative service. Each DM program must utilize evidence-based clinical practice guidelines that have been formally adopted and updated as described in current NCQA standards.

The MCO's guidelines must be reviewed and revised whenever the practice guidelines change and at least every two (2) years. All educational materials (brochures, scripts etc.) for members must also be reviewed and updated concurrently with the update of the Clinical Practice Guidelines to assure the materials reflect current evidence-based information. Evidence-based practices are further integrated into the State's medical necessity definition and requirements, which will be applied across all benefits provided under the demonstration.

HEDIS

In addition to the above efforts, each MCO is currently required to submit a full set of HEDIS measures each year. Not only is the information from the HEDIS measures used for accreditation purposes but it is analyzed in depth by the EQRO and reported to the Bureau of TennCare. The information is then used to determine areas needing improvement by each health plan.

The success of these efforts is evidenced by HEDIS results over the last 5 years (2007-2011) which reflect:

- Improvement in 7 of 8 adult diabetic measures including: HbA1c testing, retinal eye exams, and LDL-C screening and control; and
- Improvement in management of cardiovascular conditions including: cholesterol screening, cholesterol management, and control of high blood pressure.

Evidence-Based Behavioral Health Practices

With respect to behavioral health services, integration offers a coordinated approach to the delivery of needed services and supports, including Mental Health Case Management that is not reimbursed by Medicare, even in special circumstances, but which has been demonstrated to play a critical role in improved outcomes for people with the most serious psychiatric disorders. Team approaches to Level I case management covered under TennCare PLUS will include models such as Assertive Community Treatment (ACT) and the Program of Assertive Community Treatment (PACT), both of which have been demonstrated through extensive research and evaluation to improve outcomes and cost effectiveness.

Evidence-Based Medical Necessity

Evidence-based practices are further integrated into the State's medical necessity definition and requirements employing a hierarchy of evidence, i.e., a ranking of the weight given to medical evidence depending on objective indicators of its validity and reliability, including the nature and source of the medical evidence, the empirical characteristics of the studies or trials upon which the medical evidence is based, and the consistency of the outcome with comparable studies. The hierarchy in descending order, with Type I given the greatest weight, is:

(a) Type I: Meta-analysis done with multiple, well-designed controlled clinical trials;
(b) Type II: One or more well-designed experimental studies;
(c) Type III: Well-designed, quasi-experimental studies;
(d) Type IV: Well-designed, non-experimental studies; and
(e) Type V: Other medical evidence defined as evidence-based

This medical necessity definition and requirements will be consistently applied across all benefits provided under the dual demonstration. MCO Utilization Management programs must employ criteria that are objective and based on medical, behavioral health and/or long term care evidence, to the extent possible; developed, adopted, and reviewed with the involvement of appropriate practitioners; and annually reviewed and updated as appropriate.

Electronic Health Records

Pursuant to the HITECH Act, 79 hospitals and nearly 2,000 eligible professionals have registered their use of Electronic Health Records (EHR) with TennCare to improve workflow and increase safety through evidence-based decision support, quality management, and outcomes reporting, with over $20 million in EHR incentive payments during 2011.

Consumer Direction

Under the Special Terms and Conditions established in the State's approved 1115 waiver for the CHOICES Managed LTSS program, the consumer direction option is organized and administered in accordance with best practices principles recognized by CMS as reflected in Attachment E to the waiver[8] and consistent with guidance set forth in *Developing and Implementing Self-Direction Programs and Policies: A Handbook.* These include, but are not limited to:

- Employer authority, including the ability to hire, manage and dismiss workers
- Flexibility with respect to the services received through consumer direction and the ability to participate in consumer direction for some services while also receiving services from traditional provider agencies
- The ability to designate a representative to serve as the employer of record
- The ability to employ family members (with certain exceptions)
- The ability to self-direct workers in the performance of certain health care tasks
- Uniform education and training for members/representatives and workers
- Uniform member materials, including a Consumer Direction Handbook
- The use of a statewide contracted Fiscal Employer Agent to fulfill the financial administrative functions for members participating in consumer direction

[8] See http://www.tn.gov/tenncare/forms/tenncarewaiver.pdf.

- The availability of a Supports Broker to assist members in fulfilling consumer direction responsibilities
- An individual risk agreement signed by the member and a backup plan detailing alternative available supports in the event a member's scheduled worker is unexpectedly unavailable.
- An incident management program for State-defined "critical incidents", including uniform reporting and investigation requirements

Building on these well-established requirements and processes, TennCare MCOs (two, out of three, of which already operate SNPs) are well positioned to infuse evidence-based practices throughout their care management models, as required in the SNP model of care requirements that will be applied under the demonstration.

v. Description of how the Proposed Model Fits with Ongoing Activities.

a. TennCare PLUS and current Medicaid waivers and/or State plan services available to this population.

Participants in TennCare PLUS will be eligible for all services available under the TennCare demonstration and the Medicaid State plan that are available to this population, including CHOICES services for persons who are elderly and disabled, if they qualify. TennCare PLUS participants will also be eligible for services available under any of the State's three 1915(c) Home and Community Based Services waivers for persons with intellectual disabilities waivers, if they qualify. Upon the strong recommendations of advocates, these HCBS will be offered outside the demonstration. While we believe there is tremendous value in integrating benefits across the continuum for all dual eligible members and will continue to explore opportunities for improved integration, coordination and cost efficiency on behalf of persons with intellectual disabilities, integration of LTSS for this population into the managed care program cannot be achieved within the expedited timeframes for implementation of these demonstrations in a manner that would ensure a seamless transition for these members.

Recently, TennCare implemented within its TennCare Select plan an integrated health services delivery model (called SelectCommunity) for persons enrolled in these waiver programs. Each waiver participant who elects to opt into SelectCommunity is assigned a Nurse Care Manager who is charged with continuous assessment of the member's physical and behavioral health needs, ensuring timely access to medically necessary physical and behavioral health services, implementation of a person-centered medical home model for primary care, and ongoing coordination with services provided through the State's 1915(c) waivers to better facilitate coordination of physical and behavioral health needs across services and service delivery settings. While not an integrated model with respect to LTSS, it nonetheless offers improved coordination of services for persons receiving these services. SelectCommunity will be a TennCare PLUS MCO option available to Section 1915(c) waiver participants with intellectual disabilities.

Persons electing to remain in a different TennCare PLUS MCO will receive care coordination as described in Section C.III., and MCOs will be obligated to coordinate with waiver Support Coordinators and providers to provide seamless access to care across the continuum.

Because neither ICF/MR services nor the comprehensive array of services offered under these waivers are Medicare benefits, there is little opportunity for cost shifting. On the other hand, there is significant opportunity for improved coordination of care—in particular, coordination of behavioral health services

that are often needed by persons with intellectual disabilities across the Medicare and Medicaid continuum.

b. TennCare PLUS and existing managed long-term care programs.

There is one Medicaid managed long-term care program in Tennessee, and that is the CHOICES program for persons who are elderly and adults with physical disabilities. TennCare PLUS participants will be eligible for the CHOICES program if they qualify.

c. TennCare PLUS and existing specialty behavioral health plans.

Behavioral health has already been integrated into the services offered by TennCare MCOs. TennCare PLUS participants will be eligible for these services as medically necessary.

d. TennCare PLUS and integrated programs via Medicare Advantage Special Needs Plans (SNPs) or PACE programs.

MIPPA Agreements with remaining Tennessee D-SNPs will be strengthened with detailed requirements regarding ongoing exchange of eligibility and encounter data, notifications to the TennCare MCO of all FBDE member hospital and SNF admissions, and collaboration with the TennCare MCO on all discharge planning processes. While this will not avoid cost-shifting, eliminate duplicative administrative processes, or offer members an integrated benefit plan with a single entity responsible for coordinating care across the continuum, it will at least improve the timeliness of information available for care coordination purposes. Persons who choose PACE will receive their services outside the demonstration under this alternative fully integrated program design.

e. TennCare PLUS and other State payment/delivery efforts underway.

TennCare Managed Care Organizations are currently exploring alternative payment options, including bundled payments for specific procedures. The demonstration will offer greater opportunities to explore these models to further incent quality improvement, care management, and integrated care delivery.

f. TennCare PLUS and other CMS payment/delivery efforts or demonstrations.

Since TennCare is a managed care program, while many of these types of initiatives are underway, they are not necessarily affiliated with specific CMS payment/delivery efforts or demonstrations. MCOs are currently exploring ACO or ACO-like models, as well as other payment/delivery options and demonstrations that could incent quality improvement, care management and integrated care delivery. Further, the State operates a Money Follows the Person Rebalancing Demonstration, which is coordinated with the CHOICES MLTSS, as well as the State's Section 1915(c) waivers for persons with intellectual disabilities. Demonstration participants that meet MFP eligibility criteria will be permitted to enroll in the MFP demonstration.

g. TennCare PLUS and quality oversight.

TennCare has systems in place for oversight and monitoring in order ensure continuous quality improvement, including an ability to collect and track data on key metrics related to the model's quality

and cost outcomes. These include measures regarding beneficiary experience, access to and quality of covered benefits, and utilization data. Listed below are activities that currently, or will in the future, incorporate the dual eligible population.

- Quality Strategy (QS)– Each year the Division of Quality Oversight submits an updated Quality Strategy to CMS. A section will be added for the dual demonstration project where current activities and plans, and data, will be outlined and submitted.

- Disease Management Programs – continued with duals reported separately.

- HEDIS/CAHPS pending approval from NCQA to exclude duals from our regular Medicaid HEDIS data as we currently do. Medicaid HEDIS and CAHPS data are currently collected annually on all TennCare members with the exception of the dual eligible population. This data is currently not collected because Medicare data has not been available. TennCare is proposing to collect all Medicare and SNP HEDIS measures on the individuals enrolled in the dual demonstration project with the exception of two (2) SNP measures (Care for Older Adults and Medication Reconciliation Post-Discharge). Additionally, we are proposing to collect the Adult CAHPS data for the dual eligible population as well. TennCare's External Quality Review Organization (EQRO) annually reviews all HEDIS/CAHPS data and prepares a report showing results for each health plan. The EQRO will be reviewing and reporting on the dual eligible data as well.

- Quality Management – Annually each MCO must provide a program description, work plan, and evaluation to the Bureau of TennCare for review and approval. This document must address physical health, behavioral health, and long-term care services. The dual demonstration project will be incorporated into these documents.

- QM/QI Committee - Each health plan must maintain a committee that oversees all quality functions.

- Utilization Management – Annually each MCO must submit to TennCare a program description, work plan, and evaluation that addresses ED utilization and ED diversion efforts. The MCO must also assure that appropriately licensed personnel are making medical necessity decisions and appropriate practitioners are involved in developing UM criteria.

- NCQA Accreditation for Medicaid health plans. NCQA accreditation standards are considered the toughest in the nation and the gold standard in health plan accreditation. Health plans accredited by NCQA report clinical quality and patient experience measures, and allow the results of those measures to be publicly reported for purposes of comparing the plan's performance over time and against other health plans. NCQA standards for Medicaid health plans (Quality Management and Improvement, Utilization Management, Credentialing and Recredentialing, Members' Rights and Responsibilities, Member Connections) measure the systems and processes the health plan has in place to deliver quality services to all members, including those who are dual eligible, and to protect the members' rights.

- Complex Case Management (NCQA standards) – QI 7 of the NCQA accreditation standards is very similar to SNP 1 of the NCQA evaluation standards. The major difference between the two is the look-back period (3 months for SNP vs 12 months for NCQA). The Model of Care requirements for the MCOs require a Health Risk Assessment and an individual care plan for each participant. Typically for the Medicaid product, each health plan goes through a predictive modeling process to determine those

individuals with a need for more intensive management. However, for the dual demonstration population, stratification levels have been prescribed.

- Performance Improvement Projects (PIPs) – Each health plan is currently required to conduct two (2) clinical and (3) non-clinical PIPs utilizing the CMS "Protocols for Conducting Performance Improvement Projects". One must be related to behavioral health and two must be in the area of long-term care. The guidelines for PIPs incorporate all of the requirements for SNP Chronic Care Improvement Programs and SNP Quality Improvement Programs. Because 90% of CHOICES participants are dual eligible, PIPs for the dual population will almost certainly help to improve processes and outcomes of care for CHOICES members. Accordingly, in order to accommodate the dual eligible demonstration project, TennCare will change its requirements for the MCOs to the following:

    - One (1)-behavioral health
    - One (1) – long-term care
    - One (1) clinical chronic condition for duals (must identify enrollees with multiple or sufficiently severe chronic conditions to allow them to benefit from the PIP)
    - One (1) discretionary for the Medicaid population
    - Two (2) discretionary for the dual population

- CHOICES Care Coordination – Each MCO is required to provide care coordination services to individuals enrolled in Tennessee's Long Term Support Services Program (LTSS). As a part of this program the plans are required to assess a member's physical, behavioral, functional, and psychosocial needs; identify physical, behavioral, long-term care, and social needs; and develop and implement an individualized plan of care for each eligible enrollee. Routine ongoing follow-up is then completed by the enrollee's assigned care coordinator. Any of the dual demonstration members, who meet the CHOICES criteria, will also receive services through this program. See Section C.1.c for a detailed discussion of care coordination.

D. Stakeholder Engagement and Beneficiary Protections

i. Engagement of Stakeholders During the Design Phase of the Proposal.

In many ways, planning for this project actually began in 2008, when the State engaged an incredibly broad array of stakeholders in the integration of Nursing Facility (NF) services and HCBS for the elderly and adults with physical disabilities in the existing managed care program. Groups involved in the design and implementation of the CHOICES program included:

- AARP
- Tennessee Disabilities Coalition
- Independent Living Center of Middle Tennessee
- Memphis Center for Independent Living/ADAPT
- Tennessee Council on Developmental Disabilities
- Alzheimer's Association
- Tennessee Conference on Social Welfare
- Tennessee Aging and Disability Resource Connection, including the Arc of Tennessee, Homemaker Services Association, Statewide Independent Living Council of Tennessee, Tennessee Association of Adult Day Care Providers, Tennessee Association of Housing and Redevelopment Agencies, Tennessee Respite Coalition, and the Vanderbilt Kennedy Center

Provider and delivery system-related groups also involved in the design and implementation of CHOICES included:

- Nursing Home industry/providers
- Tennessee Association of Home Care
- Tennessee Association of Homes and Services for the Aging
- Tennessee Commission on Aging and Disability
- Area Agencies on Aging and Disability and the Development Districts
- the Tennessee Ombudsman Program.

Following the unanimous passage by the Tennessee General Assembly of sweeping long-term care reform legislation mandating the establishment of the CHOICES program, the State continued to work hand-in-hand with many of these groups in the implementation of the new program via teleconference and face-to-face meetings, with nearly day-long meetings dedicated to key topics such as Care Coordination, Quality, and Consumer Direction.

These meetings continue on a periodic basis, with stakeholder calls at least monthly, or more frequently as needed to address questions or issues that may arise. Because Tennessee's dual demonstration will build on its existing integrated programs, the decision was made to use this group as the starting point of discussions pertaining to the dual demonstration, engaging additional stakeholders as needed to ensure a broad array of perspectives and to provide opportunities for feedback.

To promote a collaborative effort to enhance the long-term care service delivery system while maintaining a member-centered focus, under the CHOICES program, each MCO is required to establish in each Grand Region of operation its own CHOICES Advisory Group, comprised of CHOICES members, members' representatives, advocates, and providers, including representatives from nursing facility as well as HCBS providers. At least fifty-one percent (51 percent) of the group must be CHOICES members and/or their representatives (e.g., family members or caregivers). The groups meet on at least a quarterly basis to provide input and advice regarding the CHOICES program and policies, the planning and delivery of long-term care services, CHOICES QM/QI activities, program monitoring and evaluation, and member, family and provider education. Rather than establishing separate Advisory Groups for the dual eligible demonstration, the State plans to expand the scope of these groups (and their membership, as applicable) to encompass the full array of benefits managed by the MCO, including Medicare as well as Medicaid services.

In addition to ongoing discussions with established stakeholder groups, preliminary education and information regarding the State's plans to integrate the Medicare benefit for dual eligible members was presented to the following groups:

- Tennessee Health Services and Development Agency (8/24/11)
- Tennessee Association for Home Care (3/28/11)
- Tennessee Chapter of the Assisted Living Federation of America (4/18/11)
- Tennessee Association of Homes and Services for the Aging (8/3/11)

More in-depth discussion of the State's dual demonstration planning grant and the State's initial design strategy as well as invitation to provide input have been presented to the following groups:

- CHOICES Stakeholder Calls (see explanation above – 2/14/11, 4/11/11, 5/9/11, 6/13/11, 10/10/11)
- AARP (State and National organization) (3/8/11, ongoing informal meetings and discussions)
- Tennessee's Medical Care Advisory Committee (11/30/11 and 4/11/12)
- Amerigroup National Advisory Board (5/3/11)
- Tennessee Alliance for Legal Services (10/13/11)

- Dual Demonstration Stakeholder Meeting (12/9/11)
- Tennessee Health Management, Inc. (1/24/12 and 5/11/12)
- TennCare Advocates Meeting (2/13/12)
- AARP, Tennessee Disability Coalition, Alzheimer's TN, Mental Health America of Middle Tennessee (3/5/12 and 3/29/12; MHAMT 3/29/12 only)
- Tennessee Health Care Association (3/6/12)
- National Healthcare Corporation (3/6/12)
- LeadingAge Tennessee (3/6/12 and 4/20/12)
- Arc of Tennessee (4/11/12)
- Tennessee Hospital Association Home Care Group (4/19/12)
- TennCare Director Stakeholder Call (including MCOs, Tennessee Hospital Association, Tennessee Medical Association, and Hospital Alliance of Tennessee – 4/24/12)
- Signature Health Care (4/24/12)
- Tennessee Association for Home Care (4/30/12)
- Tennessee Hospital Association webinar (5/1/12)
- LTSS Stakeholder Meeting (5/2/12)
- Public Hearings (5/3/12 and 5/8/12)

Presentations included an overview of CMS opportunities for integration and discussion of key design elements, including enrollment, benefits, and member protections. Meetings included discussion of key design elements as well as opportunities to discuss stakeholder concerns and recommendations.

The State has been holding weekly implementation meetings with its Managed Care Organizations. Representatives of these organizations have a wealth of experience to bring to the table in thinking about how to improve quality and coordination of care for members while managing costs and creating a model program for broader implementation in other states.

Finally, the State has also met in person and by phone with several of the Medicare Advantage plans that also operate D-SNPS in Tennessee to share information regarding the demonstration proposal and to hear feedback and concerns.

- Windsor Health Group (4/11/12)
- Cigna (HealthSpring Inc.) (4/12/12 and 5/4/12)

ii. Plans for Ongoing Stakeholder Engagement.

TennCare will continue to review feedback received during the public comment period and engage in further discussion as necessary to understand and address concerns and to integrate recommendations into the program design, as appropriate, as negotiation of the MOU with CMS proceeds. We will continue a longstanding practice of meeting regularly with stakeholder groups, providing information and gathering input as the program design is finalized with CMS, and as it is implemented to quickly identify and resolve any issues or concerns that may arise. Once the MOU is signed, TennCare and our contracted MCOs will host meetings in each region of the State to present program information and respond to questions that stakeholders may have, including more in-depth training for demonstration providers. In addition, MCOs will leverage existing CHOICES Advisory Groups, and expand membership as necessary, to provide a forum for ongoing sharing of information and input regarding program policy and operations at the health plan level, and to inform statewide program and policy decisions. Finally, TennCare will continue to work with stakeholders through a variety of established processes, which will

be expanded as needed to afford additional opportunities for meaningful input and to improve the program.

iii. Beneficiary Protections

a. Education and outreach

The State will work with stakeholders and with CMS to develop and disseminate clear, concise, and consistent materials about the program, including enrollment, benefits, and member appeal rights and processes, and to develop an outreach/education plan for educating and assisting FBDE members and their families. All materials will include a toll-free number that members can call with questions in the beneficiary's language, with well-trained customer service representatives that are able to answer questions and respond appropriately to concerns. The State will coordinate with Tennessee's State Health Insurance Program (SHIP) counselors, Area Agencies on Aging and Disability, the Department of Intellectual and Developmental Disabilities and their contracted Support Coordination agencies, community-based organizations, and demonstration providers to help educate and inform members about the program, and to support them in the enrollment process. Special attention will be dedicated to persons residing in institutional or community based residential alternative settings, including strategies to engage providers, LTC Ombudsmen, and community-based advocacy groups in providing face-to-face education and assistance.

b. Continuity of care

During the six-month transition period following initial enrollment, demonstration participants will be permitted to continue to utilize any of the primary care providers and other physicians with whom they have established relationships, and to continue all currently authorized courses of treatment that are covered by Medicare, including Part D prescription drugs, regardless of the MCO's formulary, and regardless of that provider's participation with the MCO. This would include access to hospitals where members' physicians have privilege to practice. The provider will be reimbursed in accordance with 2012 "Effective" Medicare rates, i.e., 80 percent of the 2012 FFS Medicare reimbursement rate, plus the applicable portion of cost sharing that would typically be paid by the Medicaid program. This will ensure continuity of care for the member without any disruption in access to care or established relationships, and also afford time for MCOs to pursue contract negotiations with any providers delivering care to FBDE members that may not have elected participation prior to the January 1, 2014 go-live date. In instances where the provider is unwilling to participate, the MCO will work with the member to transition seamlessly to an in-network provider.

In addition, MCOs will be obligated to review the member's currently prescribed medications based on the health plan's formulary, and to work with members and their prescribing providers to transition to formulary options, where appropriate, or to pursue a special exception. These processes can then help inform the member's decision whether to remain in the demonstration, or to opt out once the transition period has expired, but without any disruptions in care.

c. Quality of care complaints

While most enrollee issues are handled through our already established appeals process (see below), quality of care complaints are handled slightly differently. Each MCO is required to have a process for handling quality of care complaints that includes the following requirements:

- The health plan's Quality Improvement Committee must review member complaints.

- Within five (5) business days of receipt of the complaint, the MCO must provide written notice to the member that the complaint has been received and must give the expected date of resolution.
- Complaints must be resolved within 30 days.

When a member complains directly to the Bureau of TennCare, calls are forwarded to the Division of Quality Oversight where the complaint is logged into a tracking database. Depending on the nature of the complaint, the health plan is notified of the complaint either by secure e-mail, telephone, or both. The health plan is then given a deadline by which a response must be submitted to the Bureau outlining contacts with the enrollee, providers, etc, along with any corrective action taken. Depending on the situation Quality Oversight staff may contact the member directly to clarify any outstanding issues. If necessary, further follow-up with the health plan will be initiated until a resolution is reached.

d. Appeals

Operating under a federal court order (the *Grier Revised Consent Decree*), TennCare has one of the most comprehensive, thorough and member-focused systems of due process in the country.

Explicit requirements define the instances in which notice is required, the specific elements that must be included in each notice, the timelines within which notices must be issued, and the timelines within which all appeals must be resolved. A set of prescribed templates are used by all MCOs for these notices.

All appeals are filed directly with the Medicaid agency (not the health plan), and may be filed 24 hours a day, 7 days a week, using a toll-free phone line that is staffed with live operators. On-call staff at TennCare and the MCOs are available after hours to immediately address urgent issues.

Systematic workflow processes (including lots of redundancies) ensure that each appeal is processed in a consistent manner and resolved within the prescribed timeframes. Any medical necessity determination that is the subject of appeal (which has already been reviewed by the MCO's medical director) must be reviewed again by a separate physician who did not make the original determination, by clinical staff at TennCare, and if upheld, by contracted physicians with Keystone Peer Review Organization, Inc., in accordance with evidence-based medical necessity guidelines (see Section iv. Discussion of Evidence-Based Practices to be Employed as Part of the Overall care Model).

Because all appeals pertaining to Medicaid services must be processed in accordance with this Order, an aligned member appeals system can only be accomplished under the demonstration by processing all demonstration member appeals for Medicare (as well as Medicaid) services (excluding Part D) in accordance with these requirements. Appeals for Part D pharmacy services will continue to be handled in accordance with established Medicare processes.

e. Changes in MCO assignment

All members passively enrolled in the demonstration at implementation will have the opportunity to select an MCO from the MCOs approved to provide services in that region, and annually thereafter as part of the Medicare Open Enrollment Period.

All members passively enrolled in the demonstration after January 1, 2014, will have the opportunity to exercise their selection of an MCO at the time an application for TennCare is completed (which will have occurred prior to enrollment in the demonstration). Applicants who do not select an MCO are assigned

to one that is available in the area in which they live. Once enrolled, members have 45 calendar days from the date of the MCO assignment notification letter to change MCOs for any reason. After the 45-day change period, members may only change MCOs based on proof of TennCare hardship criteria. These timelines and once a year opportunity to change MCOs are, in accordance with federal regulations and the authority currently granted by CMS under the State's 1115 waiver, afforded to all TennCare members, including those who are dual eligible.

Individuals who are returning to TennCare after a lapse in eligibility will be reassigned to their former MCO if the lapse lasted for less than 63 days. This assignment is an initial assignment only; members are given 45 calendar days from the date of the letter informing them of their re-enrollment in TennCare to change MCOs if they wish. After the initial 45-day period, members electing to change MCOs must follow the State's hardship criteria and procedures.

Any denial of a request to change MCOs is processed as an appeal in accordance with extensive protections afforded under the *Grier Revised Consent Decree*.

f. Privacy of Health Records

TennCare requires that its staff, MCOs and their contracted providers ensure the privacy of members' health information and provide members with access to their health records.

E. Financing and Payment

i. Description of Proposed State-level Payment Reforms.

The State is pursuing a modified version of the capitated financial alignment model outlined in the July 8, 2011, State Medicaid Director letter.

ii. Payments to Health Plans and Providers.

Managed Care Organizations (MCOs) contracted to administer benefits to demonstration participants will be reimbursed on a risk-adjusted capitated basis in accordance with the guidance set forth by CMS for capitated financial alignment models, except that the State requests that CMS use risk corridors for the Medicare portion of the blended capitation payment that it will pay directly to MCOs for Parts A, B and D services for at least the first year of the demonstration. Unlike traditional SNP application processes where MCOs submit bids that take into account the rates negotiated with providers in order to develop an adequate network as well as the MCO's anticipated administrative costs of administering its model of care, and which the MCO has had opportunity to review for purposes of ensuring the program's viability, MCOs in the demonstration are being asked to contract with providers and invest significant resources in the development of care models without benefit of any payment information, including projected savings targets or quality withhold measures and processes. It therefore seems reasonable and in the best interest of members who will be enrolled in these programs and the best interest of the demonstration itself to offer risk corridors. Insufficient rates pose a tremendous risk to health plans, to the State and CMS, and most importantly to members enrolled in these plans. Risk corridors will serve to ensure the stability of the demonstration and decrease the exposure of plans where allowed costs exceed plan payments for the Parts A, B and D benefits. It will also help to ensure that (in the event the demonstration rates established by CMS are significantly higher than actual experience) an appropriate level of funding can be recovered and apportioned between CMS and the State as shared savings not accounted for in the original savings target. Plans would always be at full

financial risk for all spending on supplemental benefit coverage. The corridors could be widened or perhaps eliminated in subsequent years, once enough experience is gained to ensure the adequacy of the rates, and with assurance that rates will be reviewed at least annually and upon any significant event that would effect a plan's enrollment, or required benefits or provider payments, with adjustment based upon a positive or negative change greater than a specified percentage.

For the Medicaid portion of the capitation payment (including Medicaid legacy benefits and MLTSS) that TennCare will pay to MCOs, the non LTSS component of the blended rate will be risk adjusted using the John Hopkins ACG® Case-Mix System (ACG System) or alternative methodology (we are interested in exploring the Hierarchical Condition Categories—the Medicare risk adjustment system—for FBDE members), and the MLTSS component of the blended rate for demo participants also enrolled in Groups 1 (NF) or 2 (Comprehensive HCBS) or of the CHOICES managed LTSS component of the program will be risk adjusted based on the mix of members in institutional versus home and community based settings. These rate components will also be reviewed following the initial open enrollment period prior to implementation of the demonstration, and at least annually following the open enrollment period, with adjustment of the non-LTSS component of the rates and budget-neutral adjustment of the LTSS component of the rates in accordance with the methodology set forth in the TennCare Contractor Risk Agreement.

With respect to provider payments, the expectation is that demonstration savings will result primarily from better coordination and management of care, and not from reduced rates of reimbursement to providers. At the same time, because CMS requires that the demonstrations achieve savings, reimbursement is not expected to exceed current Medicare FFS payments for traditional Medicare Parts A and B services.

For the duration of the 3-year demonstration, TennCare will establish a rate methodology for participating hospitals, skilled nursing facilities and physicians that approximates reimbursement for traditional Medicare Parts A and B services at the lesser of billed charges or the 2012 "Effective Medicare FFS Payment." The Effective Medicare FFS Payment is the net payment the provider would receive for a specific service provided to a dual eligible individual *if that individual was not enrolled in the demonstration,* taking together the primary FFS payment by Medicare and the secondary payment of cost sharing by Medicaid. For example, as it is currently applied in the FFS system, for a typical Part B service, the provider would receive 80 percent of the allowable amount plus the applicable Medicaid crossover payment for the member's cost sharing, which is typically less than 20 percent. Providers must accept this reimbursement as payment in full, and cannot balance bill the member. This approach is intended to maintain payment levels for these three major provider groups comparable to current reimbursement, while ensuring protections for members against balance billing.

This shall not preclude any provider from electing to enter into an agreement with one or more TennCare PLUS MCOs for alternative value-based reimbursement methodologies that align incentives between payers and providers in order to promote evidence-based best practices and to engage providers in care management and key quality improvements, including (but not limited to) shared risk or savings arrangements, quality incentive payments, etc., with focus on such improvements as reduced avoidable hospital admissions, reduced hospital readmissions, and discharge to more integrated care settings when appropriate. Such value-based arrangements will be explored across provider types, including those dedicated to management of certain chronic conditions, e.g., chronic renal disease, and those dedicated to particular aspects of the care continuum, e.g., hospice or home health.

To facilitate continuity of critical supplemental payments for hospitals during the three-year period, including DSH and UPL (as noted in the January 2012 *"Medicare-Medicaid Financial Alignment Demonstrations-Standards & Conditions"*), for participating hospitals and SNFs, MCO provider agreements/amendments will specify maximum allowable billed charges of 100 percent of FFS Medicare rates and reimbursement in accordance with the "Effective Medicare FFS Payment" methodology set forth above, in order to permit facilities to continue to claim the difference as bad debt.

For other provider types, or for services without a specifically defined level of Medicare reimbursement, MCOs may leverage existing contracted Medicare or Medicaid agreements and rates, negotiate new rates, or apply the "Effective Medicare FFS Payment" as described above; however, the MCO's rates shall not exceed the "Effective Medicare FFS Payment" methodology established by TennCare, and balance billing of members by providers will be strictly prohibited. For members utilizing Medicaid legacy Nursing Facility services or CHOICES HCBS, payment will be based on the TennCare standard fee schedules.

With respect to providers that elect not to participate in the demonstration, MCOs will pay 100 percent of the "Effective Medicare FFS Payment" (see above) only for emergent and urgent care, and for out-of-network care provided during the 6-month transition period. Non-emergent/urgent care delivered to demonstration participants by non-participating providers will be reimbursed only with prior authorization and in accordance with existing out-of-network reimbursement policy for the TennCare program, i.e., the lesser of billed charges or 80 percent of the lowest in-network demonstration rate. As with participating providers, non-participating providers must accept this as payment in full, and cannot balance bill the member. Providers will be able to bill members for non-emergent/urgent out-of-network care that is not prior authorized only with (1) notification to the member prior to the delivery of the service that the provider does not participate with the MCO and the care will not be covered by the member's health plan; and (2) signature from the member acknowledging financial responsibility for payment of the service.

F. Expected Outcomes

i. State's Ability to Monitor, Collect, and Track Data.

Tennessee is in a very fortunate position in regard to being able to monitor, collect, and track data on key metrics related to quality and cost outcomes. The State currently requires its TennCare MCOs to be NCQA-accredited, and part of NCQA accreditation involves the yearly collection of audited HEDIS measures (quality of care, access to care, utilization of services) and CAHPS (beneficiary experience and perception of access to care) measures. MCOs are required to contract with NCQA-certified HEDIS and CAHPS contractors for data collection. The results are reported to TennCare's EQRO, QSource, for data aggregation and reporting. Tennessee will be extending the HEDIS/CAHPS data collection requirement to the TennCare PLUS population, including new measures which are specifically applicable to this population. As with Medicaid HEDIS and CAHPS measures, the EQRO will collect and report data for SNP measures. MCOs will submit certified results of SNP measures to TennCare, but not to NCQA, as these measures are beyond the scope of the accreditation survey for Medicaid health plans. TennCare has had discussions with NCQA and has expressed willingness to "pilot" new HEDIS measures specifically for dual eligible populations that are currently in development.

In addition, Tennessee has a wealth of utilization and cost information contained in encounter data submitted by MCOs, fee-for-service claims for services carved out of the capitated program, and a portion of claims from the Medicare fee-for-service program.

The TennCare Health Care Analytics Unit, staffed primarily with healthcare statisticians and economists, examines health care utilization and cost trends on a monthly basis and will be tasked with the tracking and reporting of utilization and cost data for the TennCare PLUS population. Measures that the unit now tracks for the TennCare population include Emergency Department utilization (for physical and behavioral health conditions), inpatient admit rates and lengths of stay (for physical and behavioral health conditions), aggregate costs, costs as a percent of total expenditures, and per member per month costs (by claim type and population for inpatient hospital, outpatient hospital, various practitioner types, miscellaneous—which includes DME and home health—and long-term care. In addition, for the CHOICES population specifically, the following costs are tracked and broken out by HCBS/level 1 nursing facility/level 2 nursing facility: members with claims, amount paid by TennCare, cost per person, bed days, and cost per day. The same types of information will be tracked and reported for the TennCare PLUS population, with the ability to provide a complete analysis of Medicare as well as Medicaid utilization and costs for the dual eligible population.

Beneficiary experience and perception of access to care will be assessed using both the Adult CAHPS (Consumer Assessment of Healthcare Providers and Systems) and the Health Outcomes Survey (HOS). The TennCare MCOs are currently required to complete the CAHPS survey annually and will be required to conduct the HOS for the dual demonstration period**.** CAHPS indicators are specified in Attachment C.

If there are not sufficient numbers within a health plan to provide an adequate sample, reporting will be done at either a statewide or regional level. The EQRO will analyze the data once it is collected and will make the determination of a reporting level that assures reliable data.

Quality of Care will be measured by using the Medicare HEDIS set plus all but two (2) of the SNP HEDIS measures. The HEDIS data collected are listed in Attachment D.

Access to care and service utilization will be measured using the following indicators:

- Number of services (overall and by specific type) per 1,000 dual eligible beneficiaries
- Average number of services per beneficiary (overall and by specific type)

These will be available for demonstration participants using encounter data from demonstration plans, and for other D-SNP participants via encounter reporting requirements specified in the strengthened MIPPA Agreements. In order to establish baselines and for purposes of comparison with dual eligible persons that opt out of these integrated or coordinated models, we will need complete Medicare (including Part C) encounter data from CMS.

Tennessee agrees to collect and/or provide data to CMS as needed to inform program management, rate development and evaluation.

ii. Potential Improvement Targets.

For each of the potential improvement targets specified below that rely on encounter data, TennCare will have encounter data from demonstration plans, and for other D-SNP participants via encounter reporting requirements specified in the strengthened MIPPA Agreements. In order to establish baselines and for purposes of comparison with dual eligible persons that opt out of these integrated or coordinated models, we will need complete Medicare (including Part C) encounter data from CMS.

Potential improvement targets are listed below.

Improvement Target: Decrease in Potentially Avoidable Hospitalizations.

According to research conducted for the CMS Office of Policy, 26 percent of all hospitalizations for dual eligible beneficiaries could be categorized as "potentially avoidable."[9] Congestive heart failure, chronic obstructive pulmonary disease/asthma, pneumonia, dehydration, and urinary tract infections were responsible for more than 80 percent of duals' potentially avoidable hospitalizations. As a target we are envisioning a statistically significant decrease in the percentage of dual eligible hospitalizations that are potentially avoidable. We intend to use a 3M software product (also used by CMS and other states) designed to identify potentially avoidable hospitalizations.

Improvement Target: Decrease in 30-Day Readmission Rate.

According to a 2009 analysis by Jencks et al.[10], nearly 20% of Medicare FFS beneficiaries are rehospitalized within 30 days after discharge. It is likely that dual eligible beneficiaries, being a sicker population than typical Medicare beneficiaries, are rehospitalized at a rate even higher than that. Using encounter data, we envision performing analysis to show 30-day rehospitalization rates for this population and achieving statistically significant improvement in this indicator over time, as the TennCare PLUS program matures.

Improvement Targets: Decrease in Emergency Room Visits for Problems Associated with Chronic Conditions, Decrease in Percentage of Duals Residing in Nursing Facilities.

Good, accessible, and well-coordinated/integrated care for a wide variety of chronic health conditions experienced by dual eligible members (e.g. COPD, congestive heart failure) should result in fewer trips to the emergency room for problems associated with these conditions.

In addition, well-coordinated care in conjunction with adequate home and community-based supportive services should result in a decreased need for nursing home placements among duals. The TennCare CHOICES program, which was implemented statewide in August 2010, provides individuals who meet nursing facility-level placement criteria the choice of receiving home and community-based services, so long as such services can be safely and cost-effectively provided in the community.

Using encounter data, we envision performing analyses to show lower rates of emergency room visits for duals for chronic conditions that could be treated and managed more efficiently through office visits and patient self-management. In addition, changes in the percentage residing in nursing facilities can be assessed.

Improvement Target: Greater Satisfaction with Care.

Good, accessible, and well-coordinated/integrated care should also lead to higher levels of satisfaction with care. TennCare members (including those who are dual eligible) now participate in the CAHPS survey, and demonstration participants will be identified and sampled in sufficient quantity to provide reliable estimates. We anticipate achieving statistically significant increases in rates of satisfaction over time, as the TennCare PLUS program matures.

Improvement Target: Greater Use of Preventive Care and Monitoring/Management of Chronic Conditions.

[9] Walsh, E. et al. "Cost Drivers for Dually Eligible Beneficiaries: Potentially Avoidable Hospitalizations from Nursing Facility, Skilled Nursing Facility, and Community-Based Services Waiver Programs," August 2010, report prepared by RTI International for Centers for Medicare and Medicaid Services, Office of Policy.

[10] Jencks, S. et al. Rehospitalizations Among Patients in the Medicare Fee-for-Service Program, *New England Journal of Medicine*, 2009, 360:1418-1428.

Use of preventive services and monitoring of chronic conditions should likewise increase when care is better coordinated and able to be accessed easily by dual eligible members. A number of the HEDIS measures can be used to establish baseline rates of the use of preventive care and monitoring/management of chronic conditions in the dual population. We anticipate achieving statistically significant increases in rates of monitoring/management of chronic conditions and use of preventive care over time, as the TennCare PLUS program matures.

iii. Expected Impact on Costs.

TennCare recognizes that the first priority of any new demonstration—particularly one of this magnitude—will be seamless transition. Particularly during the 6-month transition period, MCOs will focus on continuity of care for members and continuity of payment for providers. Once the program is stabilized, MCOs will be able to begin to turn attention to the kinds of improvements that can be made on an individual as well as service delivery system level that can achieve improvements in quality while also reducing cost.

It is important to note that TennCare members have received their Medicaid benefits through managed care for nearly two decades. Extensive investments have already been made in care management and coordination that have yielded average per person expenditures significantly less than the national average and trends well below National Medicaid and commercial insurers (see Attachment E.)

While there may be some minimal savings in Medicaid payments for Medicare cost-sharing, we anticipate increased spending in home and community based services, as these more cost-effective options are made available to demonstration participants in lieu of more expensive institutional care, when appropriate.

It is important to note that TennCare has, since 2010, used managed care to expand access to home and community based services to the elderly and adults with physical disabilities and to rebalance its long-term care system. The availability of more cost-effective service delivery options has been particularly critical as the population ages, and the demand for LTSS has increased. The State cannot afford to have any of the savings that may be achieved through its ongoing rebalancing efforts diverted to shared savings under the demonstration that would accrue primarily to the federal government (in proportion to its historical Medicare expenditures and Medicaid Federal Financial Participation), with a relatively small percentage given back to the State. Rather, it is critical that these funds can continue to be used by TennCare to expand access to quality home and community-based alternatives and support our rebalancing efforts.

With respect to Medicare benefits, we anticipate the potential for savings in the following areas, with minimal savings opportunity in year 2, and moderate savings opportunity in year 3 of the demonstration:

- Reduced administrative costs where requirements can be fully aligned
- Reduced hospital admissions and re-admissions and emergency department use
- More appropriate use of institutional post-acute settings, and transition to more cost-effective integrated settings when possible.

Ongoing opportunity for members to opt out of the integrated and coordinated benefit design back into a fragmented and unmanaged fee-for-service system or other Medicare Advantage plan not coordinated

with TennCare will significantly undermine the potential savings, and will increase administrative expenses, including those related to member acquisition and retention activities.

G. Infrastructure and Implementation

i. State Infrastructure/Capacity.

With nearly two decades of managed care experience across the entire 1.2 million Medicaid eligible population, the Bureau of TennCare clearly has the infrastructure and capacity to implement and oversee the proposed demonstration although some additions will be necessary in order to meet project goals. The Bureau has an established leadership team that is specifically organized to administer and oversee a managed care delivery system. Further, currently MCO contractors, selected via a competitive procurement process, are well-capitalized and experienced managed care entities, two of which have managed long-term care experience in numerous other states, and the third which has been with the program since its inception.

Major administrative contracts include HP, the Bureau of TennCare's MMIS Manager; Q Source, the External Quality Review Organization (EQRO) that also serves as the Quality Improvement Organization (QIO) for Medicare; and HMS, the Recovery Audit Contractor (RAC) and the Third Party Liability (TPL) contractor.

Tennessee has the infrastructure and capacity to receive and analyze all Medicare encounter data for dual eligible members from demonstration plans. Currently, the State receives only data for crossover claims for dual eligible beneficiaries (claims where TennCare has some payment obligation). Receipt of all encounter data (Medicare FFS as well as Medicare Advantage) would allow the TennCare Health Care Analytics staff to develop the following key metrics for the dual eligible population: aggregate costs, costs as a percent of total expenditures, and per member per month costs (by claim type and population for inpatient hospital, outpatient hospital, various practitioner types, miscellaneous—which includes DME and home health—and long-term care—level 1 and level 2 nursing facility, HCBS).

The Bureau has a staff of 21 individuals in the Quality Oversight Division. These individuals monitor HEDIS/CAHPS data, review and approve Performance Improvement Projects, review and approve the MCO Quality Management Programs, conduct site visits with the MCOs, and review all quality reports submitted by the MCOs. The Director and Assistant Director of the Division are registered nurses who have been with the Bureau in the Quality Oversight Division for the last six years.

ii. Waivers Needed.

We have reviewed the draft guidance issued by the Medicare-Medicaid Coordination Office (MMCO) and also conducted our analysis of the Medicare Part C regulations and have concluded that Tennessee's proposal will require a waiver of certain regulations. In addition, Tennessee through its existing contracts and State law has many processes in place that are substantially equivalent to Medicare rules and regulations, though they may differ in certain details. Rather than requesting a waiver of these rules, Tennessee asks that CMS deem the existing state processes to be compliant with these regulations. Finally, we have also identified certain Medicare Part C regulations that are not applicable to Tennessee's proposed approach, such as Subpart F regarding submission of bids, premiums, and related information and plan approval. We seek confirmation that no waiver is

necessary for these regulations. We understand that these details will be finalized in the MOU between CMS and the State.

iii. Initial description of the overall implementation strategy and anticipated timeline, including the activities associated with building the infrastructure necessary to implement the proposed demonstration. States should identify key tasks, milestones, and responsible parties, etc.

Implementation of the demonstration has already commenced, with IT and business design discussions (based on the proposed design as well as operational assumptions not yet clarified by CMS). In addition, MCOs have developed provider agreements and/or amendments for network development, in order to meet the readiness review timelines for network adequacy.

Next steps include (many will be ongoing simultaneously):

- Continue IT design and development
- Negotiate MOU with CMS
- Rate setting
- Execute 3-way agreements between CMS, TennCare and each demonstration plan
- Develop contractor risk agreement modifications between TennCare and each MCO
- Develop comprehensive readiness review approach and timeline
- Develop and promulgate state administrative rules
- Modify/enhance internal business processes
- Systems testing, including all interfaces

H. Feasibility and Sustainability

i. Potential barriers/challenges and/or future State actions that could impact the State's ability to successfully implement proposal and strategies for addressing them

Perhaps the greatest challenge to the program's implementation is the expedited timeframe for the program's implementation. While we understand and appreciate the need to coordinate with the Medicare Open Enrollment period, there is risk in implementing such comprehensive initiatives quickly if CMS is unable to provide all of the information that States need in a timely manner.

We recognize the tremendous work that must be done to align two incredibly complex programs and to overcome the respective biases of each program, and commend the incredible efforts of the Medicare Medicaid Coordination Office and the leadership it provides. That said, because so much detail remains unknown, IT and business design and development is hampered. Our preference with any new initiative would always be complete end-to-end testing of all processes before any materials are mailed to members. In this case, we believe that while critical elements, e.g., meeting Medicare network adequacy standards, can be validated prior to initial member mailings, activities to fully ready the program for implementation and to complete end-to-end testing would need to continue all the way up until the preferred implementation date of January 1, 2013. Accordingly, we have proposed an implementation date of January 1, 2014.

This will allow time for CMS to complete key design elements such as specifications of the enrollment file exchange, and to allow adequate time thereafter for IT system design and testing before any notices are mailed to members. It will also allow time for savings targets to be finalized and rates developed

and shared with demonstration plans, and for execution of the State's MOU with CMS and the 3-way contracts between CMS, the State and demonstration plans. Moreover, it will allow adequate time for a comprehensive readiness review that will allow us to move forward with confidence that we and our MCOs are fully prepared to manage a seamless transition for members and providers, and to ensure continuity of care as well as payment.

As a result, however, there are two other challenges that could potentially impact the State's ability to successfully implement the proposal. One is the potential implementation of ACA on January 1, 2014, which would require a significant amount of State resources. The other is the renewal of the TennCare demonstration, which expires on June 30, 2013. In both cases, assistance from CMS would be helpful in managing projects. This assistance could include such things as clarifying requirements, consolidating requests to the State, and streamlining reviews of materials submitted by the State.

ii. State statutory and/or regulatory changes.

We do not believe that any statutory changes are needed to implement the demonstration. Administrative Rules will be promulgated once the MOU is complete and prior to the program's implementation on January 1, 2014.

iii. State funding commitments or contracting processes necessary before full implementation can begin.

Once the MOU between CMS and the State is finalized and 3-way contracts between CMS, TennCare and each demonstration plan are executed, TennCare will make any additional modifications in the Contractor Risk Agreement between TennCare and each MCO. Modifications will also be needed to the State's contract with Q Source.

iv. Scalability of the proposed model and its replicability in other settings/States.

With the recent integration of LTSS for the elderly and adults with physical disabilities, the TennCare demonstration program is one of the few fully integrated Medicaid programs in the country today. The recent proliferation of materials regarding the value of integration (benefits as well as funding) and increasing dissatisfaction with out-of-control growth in health care expenditures without commensurate high quality outcomes has led policy leaders at state and national levels to increasingly look to integrated and coordinated care programs as the preferred delivery model. Over the past months, Tennessee has been contacted by nearly 20 states for information and technical assistance regarding various aspects of managed care, and has hosted multiple states onsite. Integration of Medicare benefits for one of the most expensive and complex populations served in our program today is a logical next step in the evolution of our integrated program, and positions us not only to continue to improve the quality and cost-effectiveness of care in Tennessee, but to continue to assist other States, many of whom have less experience in administering managed care programs and who have further to go in terms of integrating benefit components, than Tennessee.

v. Letters of support.

Letters written in support of the TennCare PLUS proposal are included as Attachment F.

I. Additional Documentation (as applicable)

Public Notice

The State provided public notice in accordance with the draft Special Terms and Conditions sent to us by CMMI.

On April 13, 2012, we posted a draft version of the proposal, along with a "TennCare PLUS Introduction and Overview" summarizing key points. We included the following information:

- A mailing address, an email address, and a telephone number which could be used to submit comments, along with instructions for requesting copies of written comments; and
- The locations, dates, and times of two public hearings to seek public comment on the proposal.

In addition, the State published a public notice in newspapers of the widest circulation in the eight Tennessee cities with 50,000 or more citizens. The proposal was discussed with the State's Medical Care Advisory Committee in a meeting that took place on April 11, 2012.

We conducted two public meetings for the purpose of soliciting comments. One meeting was held on May 3, 2012, at the Bordeaux Library in Nashville, and the other meeting was held on May 8, 2012, at Legislative Plaza in Nashville. At each meeting, Patti Killingsworth, the Bureau's Chief of Long-term Services and Supports, gave a 30-minute PowerPoint presentation summarizing the proposal. A copy of her presentation was posted on the website along with the other TennCare PLUS materials.

We did not attempt to answer questions during the hearings. Instead, we asked persons with questions to submit those in writing, so that we could post them on the website along with our answers. We thought this was a more fair approach, and would afford persons who were unable to attend the hearing the same access to this information as persons who were present.

Tennessee has no Federally recognized Indian tribes, Indian health programs, or urban Indian health organizations with which to consult or from which to seek advice.

By the close of the comment period, we had received comments and/or questions from a number of provider groups, advocate groups, health plans, and individuals.

Commenters expressed general support for the "practical sense" of the proposal, as one commenter put it, and they especially liked the addition of supplemental benefits and 24-hour access to care management. Their concerns dealt with the most basic elements of a traditional managed care program, such as restriction of enrollee choice decisions to certain times of the year and use of medical necessity principles in making coverage decisions. Some persons raised questions about potential network adequacy issues, as well as the comprehensiveness of Part D pharmacy benefits. Persons representing individuals with developmental and intellectual disabilities wanted to be certain that the special needs of their constituencies were given careful consideration. Provider representatives posed a number of questions about payment policies and how potential savings that the program is able to achieve might be distributed.

J. Interaction with Other HHS/CMS Initiatives

- Partnership for Patients:

The goal of reducing hospital readmissions is consistent with the values and principles of the demonstration and a key priority in the care management process. The most intensive model of care management will be dedicated to persons in an inpatient setting (acute, psychiatric, I/P rehab, LTAC and short-term (Medicare legacy) SNF). The focus of inpatient/discharge care management will be aggressive management of care transitions (i.e., planning for timely and appropriate discharge to the most integrated care setting appropriate, including timely provision of home-based care, primary care follow-up, medication reconciliation and management, and post-discharge follow-up regarding ongoing care needs in order to prevent re-admission).

- HHS Action Plan to Reduce Racial and Ethnic Health Disparities:

Starting October 1, 2011, TennCare MCOs are required to submit a *Data Collection Strategy Report* that describes how they intend to collect data in accordance with the HHS initiative to implement a multifaceted health disparities data collection strategy. The report must include the MCO's plans for collection and reporting of data in five specific demographic categories in accordance with the new provisions of the Affordable Care Act: race, ethnicity, gender, primary language, and disability status, including persons enrolled in the demonstration. MCOs plans must also include how the collected data will be used to integrate information across systems in order to enhance TennCare data, any system changes that will be needed, and timelines for implementation.

- Million Hearts Campaign:

The rate of deaths from heart disease in Tennessee is significantly higher than the national average. It is the leading cause of death among women and men, and overall, accounts for 1 in every 4 deaths in the State.

Congestive heart failure and coronary artery disease are therefore two of the ten conditions for which TennCare MCOs are already obligated to conduct evidence-based disease management activities, along with obesity and diabetes, which are among the most significant risk factors for heart disease. With the integration of Medicare benefits, dual eligible participants will be included in these activities. Health risk assessments will screen for these and other risk factors (e.g., high overall blood cholesterol, high blood pressure, lack of physical activity, and use of tobacco products) in order to target member education and health promotion, as well as other disease management activities.

ATTACHMENT A

Description of the TennCare PLUS Demonstration Population

Description of the TennCare PLUS Demonstration Population

	Overall	Individuals receiving LTSS in institutional settings		Individuals receiving LTSS in HCBS settings		Individuals not receiving LTSS
		CHOICES (NFs)	ICFs/MR	CHOICES (HCBS)	ICF/MR HCBS Waivers	
Overall total	136,084	20,418	720	7,515	5,209	102,222
Individuals age 65+	66,047	18,189	140	5,292	608	41,818
Individuals under age 65	70,037	2,229	580	2,223	4,601	60,404
Individuals with serious mental illness	48,049	12,671	185	2,447	2,415	30,311
Individuals by sex						
• Females	84,896	14,753	334	5,394	2,297	62,118
• Males	51,188	5,665	386	2,121	2,912	40,104
Enrollment by MCO						
• Amerigroup[1]	20,880	3,194	105	1,328	991	15,263
• BlueCare[2]	48,989	6,033	344	2,421	1,977	38,216
• United[3]	64,827	11,153	130	3,766	1,861	47,919
• TennCare Select[4]	1,388	38	141	0	380	824

[1] Amerigroup is available only in the Middle Tennessee Region.

[2] BlueCare is available in the East and West Tennessee Regions.

[3] United is available in all three regions.

[4] TennCare Select is available in all three regions, but only to certain populations. See paragraph 40 of the Special Terms and Conditions of the TennCare demonstration.

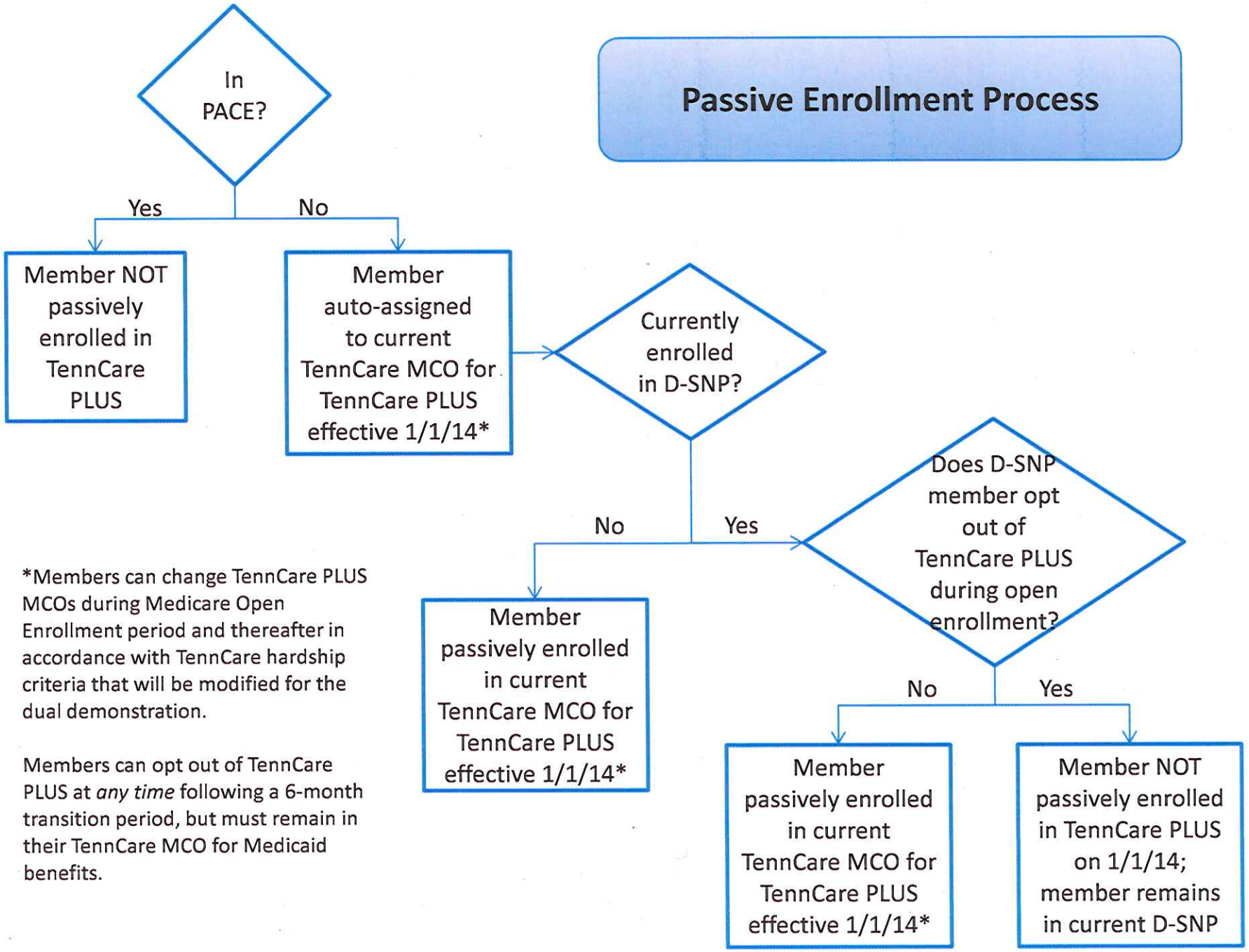
ATTACHMENT B

Enrollment into TennCare PLUS

Enrollment into TennCare PLUS

Dates	Actions
Prior to Medicare Open Enrollment Period (October 15 – December 7, 2013)	All FBDEs will be contacted with information about TennCare PLUS and informed of their options. • PACE participants may "opt in" to TennCare PLUS, but will not be auto assigned or passively enrolled in the demonstration. • FBDE members not enrolled in PACE will be notified of auto assignment to their current TennCare MCO for TennCare PLUS benefits, and their option to change MCOs during the Medicare Open Enrollment period. • FBDE members in D-SNPs will be advised how they may "opt out" of their passive enrollment into TennCare PLUS during the Medicare Open Enrollment period, and remain with their existing D-SNP for Medicare services.
Medicare Open Enrollment Period (October 15 – December 7, 2013)	All FBDE members may change TennCare PLUS MCOs, if they wish. Those who are already enrolled in D-SNPs will be given the opportunity to "opt out" of TennCare PLUS and remain with their existing D-SNP for Medicare services. They will remain enrolled in TennCare for their Medicaid services.
December 7, 2013 – December 31, 2013	FBDE members who are new to TennCare and who are not enrolling in PACE will have a chance to choose their MCO for TennCare PLUS. They will have a chance to change MCOs during the 45-day period after they are enrolled. Existing TennCare members who have already selected an MCO and become FBDE will remain in their current MCO for TennCare PLUS benefits.
January 1, 2014	All FBDE members who are not enrolled in PACE and D-SNP members who did not elect to "opt out" so that they could remain with their D-SNP will be passively enrolled into TennCare PLUS for a transition period of 180 days. The only reason they will be allowed to "opt out" during this period will be if they choose PACE where it is available. At the end of the 180-day period, they will be allowed to "opt out" of the dual demonstration *at any time*, but they will not be allowed to re-enroll until the next Medicare open enrollment period. They must remain in their TennCare MCO for all Medicaid services.
Post-January 1, 2014	As Medicare eligible persons gain Medicaid eligibility and become new FBDEs, they will be allowed to choose an MCO. They will have a chance to change MCOs during the 45-day period after they are enrolled. Existing TennCare members that attain Medicare eligibility will have already selected an MCO and will be passively enrolled in that MCO for TennCare PLUS. New FBDE members will be enrolled into TennCare PLUS for 180 days, unless they elect to "opt out" for PACE, or where it is available, or are already in a Medicare D-SNP and opt out of passive enrollment. At the end of the 180-day period, they will be allowed to "opt out" of the dual demo *at any time*, but they will not be allowed to re-enroll until the next Medicare open enrollment period. Unless they move to PACE, they will stay with their MCOs for all Medicaid services.

Passive Enrollment Process



*Members can change TennCare PLUS MCOs during Medicare Open Enrollment period and thereafter in accordance with TennCare hardship criteria that will be modified for the dual demonstration.

Members can opt out of TennCare PLUS at *any time* following a 6-month transition period, but must remain in their TennCare MCO for Medicaid benefits.

ATTACHMENT C

Adult CAHPS

(Consumer Assessment of Healthcare Providers and Systems)

Indicators

Adult CAHPS (Consumer Assessment of Healthcare Providers and Systems) Indicators

- Getting Needed Care (Always and Usually)
- Customer Service (Always and Usually)
- Getting Care Quickly (Always and Usually)
- How Well Doctor's Communicated (Always and Usually)
- Shared Decision Making (Definitely Yes)
- Rating of Personal Doctor
- Rating of Specialist Seen Most Often
- Rating of All Health Care
- Rating of Health Plan
- Percentage reporting having a personal doctor
- Percentage reporting that it was never easy to schedule an appointment with a specialist
- Percentage reporting never being able to promptly schedule an appointment for routine care
- Average rating of personal doctor
- Average rating of overall healthcare
- Average rating of health plan.

ATTACHMENT D

HEDIS

(Healthcare Effectiveness Data and Information Set)

Measures

HEDIS (Healthcare Effectiveness Data and Information Set) Measures

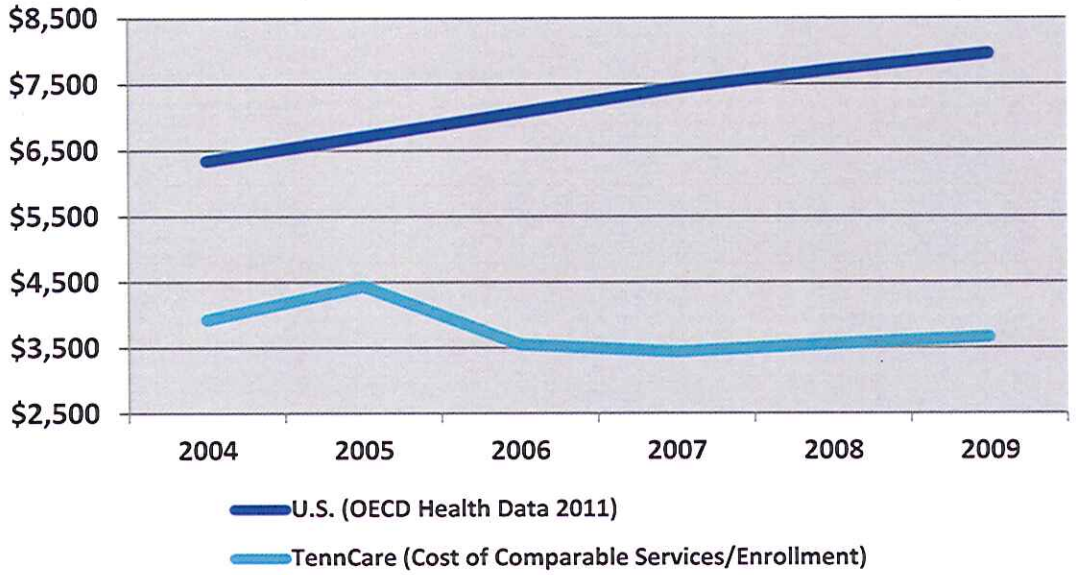
- Adults' Access to Preventative/Ambulatory Health Services
- Adult BMI assessment
- Antibiotic Utilization
- Ambulatory Care
- Antidepressant Medication Management
- Disease Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis
- Board Certification
- Breast Cancer Screening
- Call Abandonment Time
- Call Answer Time
- Controlling High Blood Pressure
- Comprehensive Diabetes Care
- Cholesterol Management for Patients with Cardiovascular Conditions
- Colorectal Cancer Screening
- Use of High Risk Medications in the Elderly
- Potentially Harmful Drug Disease Interactions In the Elderly
- Fall Risk Management (from Health Outcomes Survey)
- Frequency of Selected Procedures
- Follow-Up After Hospitalization for Mental Illness
- Glaucoma Screening in Older Adults
- Identification of Alcohol and Other Drug Services
- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
- Inpatient Utilization – General Hospital/Acute Care
- Language Diversity of Membership
- Annual Monitoring for Patients on Persistent Medications
- Mental Health Utilization
- Management of Urinary Incontinence in Older Adults (from Health Outcomes Survey)
- Osteoporosis Management in Women who had a Fracture
- Osteoporosis Testing in Older Women (from Health Outcomes Survey)
- Physical Activity in Older Adults (from Health Outcomes Survey)
- Persistence of Beta-Blocker Treatment After a Heart Attack
- Pharmacotherapy Management of COPD Exacerbation
- Plan All-Cause Readmission
- RRU-Cardiovascular Conditions
- RRU-COPD
- RRU-Diabetes
- Race/Ethnicity Diversity of Membership
- RRU-Hypertension
- Use of Spirometry testing in the Assessment and Diagnosis of COPD

ATTACHMENT E

Medical Inflation Trend

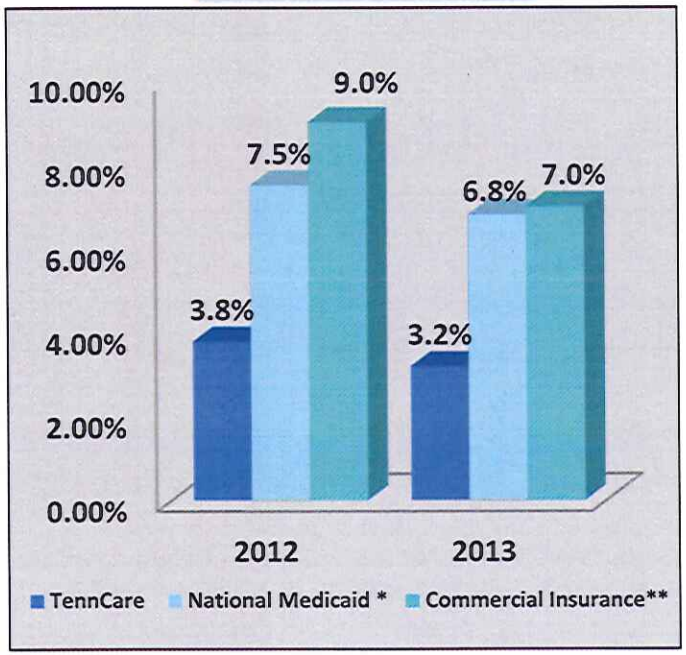
Medical Inflation Trend

U.S. Expenditure on Health Care Per Capita Vs. Comparable TennCare Per Member Cost



Although TennCare continues to beat national Medicaid and commercial insurance inflation trends, some medical inflation will always exist. For FY 2013, we project the trend for the TennCare and Cover Tennessee programs will cost an estimated $87 million state ($79M TennCare, $8M CoverKids). This increase in cost is due to medical inflation, enrollment, and shifts in enrollment within program categories. Additionally, the federally-mandated requirement to fund wraparound payments for Federally Qualified Health Centers and Rural Health Clinics will cost an estimated $10.6 million (state dollars).

Projected Medical Inflation Trends



*Source: OMB 2012; CMS National Health Expenditure Data 2013
**Source: PricewaterhouseCoopers

TennCare trend remains below national Medicaid trends even as many other states have made significant program reductions.

ATTACHMENT F

Letters of Support

BILL HASLAM
GOVERNOR
STATE OF TENNESSEE

Ms. Melanie Bella, Director
Medicare-Medicaid Coordination Office
Centers for Medicare and Medicaid Services
200 Independence Avenue, SW
Mail Stop: Room 315-H
Washington, DC 20201

RE: Letter of Support for TennCare PLUS

Dear Ms. Bella:

When I became Governor of the great State of Tennessee, I understood fully the fiscally conservative leadership role I would need to fulfill with respect to health care—because it is important to Tennesseans, but also because a high quality, well-managed, and financially sustainable health care system is essential in order to avoid the consumption of limited State resources that are also needed to address other important priorities, such as education.

Early on, as I began working with Medicaid Director Darin Gordon and the team at TennCare, I found a shared value and vision for delivering high quality, cost-effective health care in our State, and a common concern for one population in particular who have incredibly complex needs and who drive a disproportionate share of Medicaid as well as Medicare spending: dual eligibles. Even before CMS announced opportunities to plan and propose demonstrations to integrate care for dual eligibles, TennCare had begun to research – at my direction – various options for delivering care to this population in a more coordinated and cost efficient manner.

The goals of improved quality, cost efficiency, and customer experience are hallmarks of the TennCare program. With nearly two decades of managed care experience across all Medicaid populations, including dual eligibles, and a program that has already successfully integrated physical and behavioral health care and long term services and supports (with tremendous success in rebalancing), Tennessee is uniquely positioned to help lead the nation in implementing innovative solutions to serve the dual eligible population.

It is therefore with pleasure that I write this letter of support for TennCare's proposal to implement an integrated program of care for full benefit dual eligibles, "Response to RFP CMS-2011-0009." Our State

has seen the benefits of integration in terms of quality as well as cost effectiveness, and I am confident that TennCare has the expertise, the experience, and the commitment to design and implement a successful model of integrated care for dual eligible Tennesseans.

Thank you for your consideration of TennCare's proposal.

Sincerely,

Bill Haslam

STATE OF TENNESSEE
DEPARTMENT OF COMMERCE AND INSURANCE
500 JAMES ROBERTSON PARKWAY
NASHVILLE, TENNESSEE 37243-5065
615-741-6007

BILL HASLAM
GOVERNOR

JULIE MIX MCPEAK
COMMISSIONER

May 16, 2012

Ms. Melanie Bella, Director
Medicare-Medicaid Coordination Office
Centers for Medicare and Medicaid Services
200 Independence Avenue, SW
Mail Stop: Room 315-H
Washington, DC 20201

RE: Letter of Support for TennCare PLUS

Dear Ms. Bella:

The Tennessee Department of Commerce and Insurance ("TDCI) supports the efforts of the Bureau of TennCare in its proposal to implement an integrated program of care for full benefit dual eligible recipients in Tennessee, "Response to RFP CMS-2011-0009."

Since the beginning of the TennCare Program in 1994, TDCI has licensed and regulated the health entities that have provided healthcare services to over one (1) million Tennesseans. Over the last 18 years, TDCI has worked closely with the Bureau of TennCare to ensure that TennCare covered physical health, behavioral health, and, most recently, long-term care services were delivered to our most vulnerable citizens by financially and operationally sound managed care companies. The concept of fully integrating the provision of Medicare covered services into this proven delivery system is the logical next step to ensure that the full benefit dual eligible recipient receives appropriate and quality healthcare services provided in the most cost effective manner.

Furthermore, TDCI routinely process complaints from healthcare providers who are confused and frustrated from having to follow different medical management and claims billing policies and procedures for services rendered to dual eligible recipients in order to get reimbursed by the different payors. Being required to file two or more claims in order to receive full reimbursement for one healthcare service is a costly administrative burden for providers. We believe that the implementation of this integrated demonstration for dual eligible recipients will

result in cost efficiencies not only for the State and Federal governments but also for healthcare providers.

Therefore, TCDI offer this letter of support for your consideration of TennCare's proposal.

Sincerely,

Julie Mix McPeak
Commissioner

C: Darin J. Gordon, TennCare Director

STATE OF TENNESSEE
DEPARTMENT OF HEALTH

JOHN J. DREYZEHNER, MD, MPH
COMMISSIONER

BILL HASLAM
GOVERNOR

May 15, 2012

Ms. Melanie Bella, Director
Medicare-Medicaid Coordination Office
Centers for Medicare and Medicaid Services
200 Independence Avenue, SW
Mail Stop: Room 315-H
Washington, DC 20201

RE: Letter of Support for TennCare PLUS

Dear Ms. Bella:

The Tennessee Department of Health (TDH) wishes to express its support for the proposal from the Bureau of TennCare to implement an integrated program of care for full benefit dual eligibles in Tennessee, "Response to RFP CMS-2011-0009."

The TDH and our ninety-five county system of health departments are committed to the protection, promotion and improvement of the health and prosperity of Tennesseans. Our population health focus enables the support of prevention and care services across our state, available to persons who are dual eligibles. Our institutional protection mission engages the Department in licensing, inspection and complains investigation with the state's health professionals and health facilities that serve the dual eligible population.

We support the TennCare proposal to expand the use of its managed care expertise to enable the seamless delivery of health care and preventive services by Managed Care Organizations to the 130,000+ dual eligible patients in Tennessee. Improved care coordination across the now separated Medicare and Medicaid systems will benefit our citizens. Use of the evidence based practices and the encouragement of reporting improvements in quality of care initiatives are also important. We are very concerned about dual eligible beneficiaries as a medically vulnerable population, and we believe the TennCare proposal is a sensitive and efficient way to improve and expand care for these beneficiaries.

We therefore offer this letter of support and appreciate your consideration of TennCare's proposal.

Sincerely,

John J. Dreyzehner, MD, MPH, FACOEM
Commissioner

cc: Darin J. Gordon, TennCare Director
Bruce Behringer, Deputy Commissioner

3rd Floor, Cordell Hull Building
425 5th Avenue North * Nashville, TN 37243
(615) 741-3111 * www.tn.gov/health

STATE OF TENNESSEE
DEPARTMENT OF INTELLECTUAL AND DEVELOPMENTAL DISABILITIES
ANDREW JACKSON BUILDING, 15th FLOOR
500 DEADERICK STREET
NASHVILLE, TENNESSEE 37243

May 14, 2012

Ms. Melanie Bella, Director
Medicare-Medicaid Coordination Office
Centers for Medicare and Medicaid Services
200 Independence Avenue, SW
Mail Stop: Room 315-H
Washington, DC 20201

RE: Letter of Support for TennCare PLUS

Dear Ms. Bella:

The Department of Intellectual and Developmental Disabilities (DIDD) is pleased to support the efforts of the Bureau of TennCare in its proposal to implement an integrated program of care for full benefit dual eligibles in Tennessee, "Response to RFP CMS-2011-0009."

- This is a historic opportunity to align the Medicare and Medicaid programs for one of the most complex and expensive populations served across both programs. Tennessee's proposal, like the broader federal demonstration by the Centers for Medicare and Medicaid Services (CMS), is aimed at improving the quality of care while also delivering care in a more efficient manner.
- Tennessee is uniquely positioned to successfully implement an integrated care demonstration for dual eligibles.
- Tennessee has 18 years of managed care experience.
- All full benefit dual eligibles in Tennessee are already enrolled inTennCare managed care for their Medicaid services.
- Physical health and behavioral health services, as well as long term care services are already integrated into the managed care program
- Ongoing dialogue between the State and key stakeholders will help to ensure that the program is implemented in a way that will achieve the desired goals of quality and cost efficiency, ensure continuity of care and the stability of provider networks, and most importantly, the member's experience of care.

We therefore offer this letter of support and appreciate your consideration of TennCare's proposal.

Sincerely,

James M. Henry
Commissioner

JMH/ft

C: Darin J. Gordon, TennCare Director

STATE OF TENNESSEE
DEPARTMENT OF MENTAL HEALTH
11th FLOOR, ANDREW JOHNSON TOWER
710 JAMES ROBERTSON PARKWAY
NASHVILLE, TENNESSEE 37243

BILL HASLAM
GOVERNOR

E. DOUGLAS VARNEY
COMMISSIONER

May 15, 2012

Ms. Melanie Bella, Director
Medicare-Medicaid Coordination Office
Centers for Medicare and Medicaid Services
200 Independence Avenue, SW
Mail Stop: Room 315-H
Washington, DC 20201

RE: Letter of Support for TennCare PLUS

Dear Ms. Bella:

The Tennessee Department of Mental Health is pleased to support the efforts of the Bureau of TennCare in its proposal to implement an integrated program of care for full benefit dual eligibles in Tennessee, "Response to RFP CMS-2011-0009."

By being awarded this proposal, Tennessee has a historic opportunity to align the Medicare and Medicaid programs for one of the most complex and expensive populations served across both programs. Tennessee's proposal, like the broader federal demonstration by the Centers for Medicare and Medicaid Services (CMS), is aimed at improving the quality of care while also delivering care in a more efficient manner. As such, Tennessee is uniquely positioned to successfully implement an integrated care demonstration for dual eligible due to 18 years of managed care experience.

Tennessee is already integrating many of its services and all full benefit dual eligibles in Tennessee are already enrolled in TennCare managed care for their Medicaid services. Physical health and behavioral health services, as well as long term care services are already integrated into the managed care program.

Tennessee will ensure the program is implemented in a way that will achieve the desired goals of quality and cost efficiency, ensure continuity of care and the stability of provider networks,
and most importantly, the member's experience of care by hosting ongoing dialogue between the State and key stakeholders.

We therefore offer this letter of support and appreciate your consideration of TennCare's proposal.

Sincerely,

E. Douglas Varney
Commissioner

C: Darin J. Gordon, TennCare Director

STATE OF TENNESSEE
COMMISSION ON AGING AND DISABILITY
Andrew Jackson Building
500 Deaderick Street, Suite 825
Nashville, Tennessee 37243-0860

Jim Shulman
Executive Director

Phone (615) 741-2056
Fax (615) 741-3309

May 16, 2012

Ms. Melanie Bella, Director
Medicare-Medicaid Coordination Office
Centers for Medicare and Medicaid Services
200 Independence Avenue, SW
Mail Stop: Room 315-H
Washington, DC 20201

RE: Letter of Support for TennCare PLUS

Dear Ms. Bella:

The Tennessee Commission on Aging and Disability is pleased to support the efforts of the Bureau of TennCare in its proposal to implement an integrated program of care for full benefit dual eligibles in Tennessee, "Response to RFP CMS-2011-0009."

With efforts underway across the board to deal with the cost of healthcare, we applaud the efforts of both CMS and TennCare in attempting to come up with new practices aimed at managing care and controlling costs. As an advocacy group for older Tennesseans and adults with disabilities, we always worry about changes to programs. We also know, however, that the sound implementation of new programs can lead to better uses of resources to help people. With that understanding, we support TennCare's efforts with this new dual demonstration program and look forward to working with TennCare to provide a seamless system of services for all older Tennesseans and adults with disabilities.

We offer this letter of support and appreciate your consideration of TennCare's proposal.

Sincerely,

Jim Shulman
Executive Director

JS/ckw

C: Darin J. Gordon, TennCare Director

Amerigroup RealSolutions in healthcare

May 11, 2012

Ms. Melanie Bella, Director
Medicare-Medicaid Coordination Office
Centers for Medicare and Medicaid Services
200 Independence Avenue, SW
Mail Stop: Room 315-H
Washington, DC 20201

RE: Letter of Support for TennCare PLUS

Dear Ms. Bella:

Amerigroup is pleased to support the efforts of the Bureau of TennCare in its proposal to implement an integrated program of care for full benefit dual eligibles in Tennessee, "Response to RFP CMS-2011-0009."

We believe that Tennessee is uniquely positioned to successfully implement an integrated care demonstration for dual eligible members due to the facts that (1) all full benefit dual eligibles in Tennessee are currently receiving their Medicaid benefits through the TennCare managed care program and have been since 1994, and (2) Physical health, behavioral health and long term care services are already integrated into the managed care program.

We view this as a historic opportunity to align the Medicare and Medicaid program for one of the most complex and expensive populations served across both programs. But more importantly we believe that this Tennessee's proposal in line with the broader federal demonstration by the Centers for Medicare and Medicaid Services (CMS) is aimed at improving the quality of care while delivering the care in a more efficient manner.

We are pleased to have participated with State staff and other stakeholders in working sessions convened by TennCare to identify and address program design and operational issues. The proposal reflects much of the discussion and input contributed by stakeholders in the working sessions. We look forward to participating in ongoing dialogue between the State and key stakeholders to ensure that the program is implemented in a way that will achieve the desired quality improvement, cost efficiency, and provider network stability that ensures continuity of care but most importantly, positively impact the member experience of care.

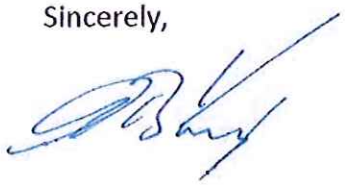
22 Century Blvd., Suite 310
Nashville, Tennessee 37214
615.231.6065

www.amerigroupcorp.com

The TENNCARE PLUS proposal presents a thoughtful, pragmatic, and well-rounded approach to integration of care for dual eligibles. Consequently, Amerigroup believes that TENNCARE PLUS will be a great success and will serve as a model for integrating care for this population.

We therefore offer this letter of support and appreciate your consideration of TennCare's proposal.

Sincerely,



Al King
Chief Executive Officer
Amerigroup Tennessee

c: Darin J. Gordon, TennCare Director

UnitedHealthcare®
Community Plan

May 15, 2012

Ms. Melanie Bella, Director
Medicare-Medicaid Coordination Office
Centers for Medicare and Medicaid Services
200 Independence Avenue, SW
Mail Stop: Room 315-H
Washington, DC 20201

RE: Letter of Support for TennCare PLUS

Dear Ms. Bella:

United Healthcare Community Plan of Tennessee is pleased to support the efforts of the Bureau of TennCare in its proposal to implement an integrated program of care for full benefit dual eligibles in Tennessee, "Response to RFP CMS-2011-0009."

UnitedHealthcare believes that Tennessee's proven extensive experience with an integrated Medicaid managed care system demonstrates its commitment to developing and implementing innovative solutions for coordination of care for this complex population. Currently in Tennessee all full benefit dual eligibles are already enrolled in TennCare managed care for their Medicaid services, and Tennessee's proposal is geared toward delivering care in a more efficient manner and improving the quality of care.

Since 2007, UnitedHealthcare has partnered with the TennCare Bureau as a managed care organization initially serving the middle Tennessee region and expanding to the east and west regions in 2008. We currently serve TennCare enrollees statewide. In 2010, TennCare created the CHOICES program which provided a statewide restructuring of the long-term care service delivery for Medicaid enrollees. Through this restructuring, long-term care, physical and behavioral health services are provided through an integrated managed care model, coordinated by the managed care organizations. UnitedHealthcare has established strong networks statewide to ensure access to covered services and quality of care for enrollees, including Long Term Services and Supports for both home-and-community-based individuals and nursing facility members.

Additionally, UnitedHealthcare maintains a state-wide Dual-Special Needs Plan (D-SNP). This D-SNP currently offers a robust network of physicians, hospitals and ancillary services across the state of Tennessee that meets Medicare network adequacy standards. UnitedHealthcare is well positioned to address ongoing growth of the network as additional Medicare-Medicaid Individuals enroll. Because of our strong presence in Tennessee, UnitedHealthcare is confident that the rapid additional network growth needed for the integrated Medicare-Medicaid model can be attained.

As an example of rapid network implementation, UnitedHealthcare was able to contract and credential a fully compliant LTSS network in less than a five-month time period. The current approach that the Bureau of TennCare is taking on an integrated program for full benefit dual eligibles will allow for UnitedHealthcare to be well prepared with a network to meet the needs of the Medicare-Medicaid eligibles.

8 Cadillac Drive Suite 100, Brentwood, TN 37027
1-800-690-1606 www.uhccommunityplan.com
UnitedHealthcare Plan of the River Valley, Inc.

We are committed to meeting the unique needs of the Medicare-Medicaid population and agree that dual integration is essential to improving quality of care. The Bureau of TennCare and UnitedHealthcare have proven a dedication to quality in Tennessee as evidenced by the mandated NCQA accreditation of the managed care organizations and the steady rise in Medicaid HEDIS measures over the last five years. UnitedHealthcare maintains a commendable NCQA accreditation.

The TennCare Bureau has worked collaboratively on the integrated program of care for full benefit dual eligibles and assures ongoing dialogue with UnitedHealthcare and other participating health plans. We share a common goal in preparing to align the Medicare and Medicaid programs while focusing on quality of care, efficiency and ease for the member and cost-savings for one the most complex populations served.

We therefore offer this letter of support and appreciate your consideration of TennCare's proposal.

Sincerely,

Scott Bowers
President and CEO
UnitedHealthcare Community Plan of Tennessee

C: Darin J. Gordon, TennCare Director

8 Cadillac Drive Suite 100, Brentwood, TN 37027
1-800-690-1606 www.uhccommunityplan.com
UnitedHealthcare Plan of the River Valley, Inc.

UnitedHealthcare
COMMUNITY & STATE

Catherine K. Anderson, MPA
National Vice President
Complex Care Products
UnitedHealthcare Community & State
37 West 2000 South
Driggs, ID 83422

May 14, 2012

Darin J. Gordon
Deputy Commissioner of the Division
of Health Care Finance & Administration
310 Great Circle Road
Nashville, Tennessee 37243

Dear Mr. Gordon:

We are pleased to support the State of Tennessee's goals of improving the quality of care provided to individuals who are eligible for Medicare and Medicaid. UnitedHealthcare's national team has been working closely with our Community Plan of Tennessee in developing programs focused on an integrated approach for the Medicaid-Medicare Enrollees.

We offer our national experience in shaping an effective, integrated program for Tennessee's Medicare-Medicaid Enrollees, and we will continue to support our Community Plan of Tennessee to improve care to this complex population. We are pleased to support your efforts to implement an integrated approach based upon the financial models proposed by CMS.

Thank you for your commitment to engage UnitedHealthcare and other health plans in a meaningful dialogue. We look forward to the ability to shape a program that improves quality and reduces the costs associated with these complex individuals.

Sincerely,

Catherine K. Anderson, MPA
National Vice President, Complex Care Products
UnitedHealthcare Community & State

VSHP Volunteer State Health Plan

1 Cameron Hill Circle
Chattanooga, Tennessee 37402-2555

bcbst.com

May 14, 2012

Ms. Melanie Bella, Director
Medicare-Medicaid Coordination Office
Centers for Medicare and Medicaid Services
200 Independence Avenue, SW
Mail Stop: Room 315-H
Washington, DC 20201

RE: Letter of Support for TennCare PLUS

Dear Ms. Bella:

Blue Cross Blue Shield of Tennessee (dba Volunteer State Health Plan) is pleased to support the efforts of the Bureau of TennCare in its proposal to implement an integrated program of care for full benefit dual eligibles in Tennessee, "Response to RFP CMS-2011-0009."

Dual eligible Tennesseans have been enrolled in Medicaid managed care for almost two decades. However, the lack of a truly integrated product for Medicare and Medicaid services has significantly reduced the ability of the state to truly coordinate the broad array of services used by Dual members. It is difficult to ask a member to learn and navigate one government health care system such as Medicaid. However, our current system asks the most frail and elderly population to actually learn two complex government systems – Medicaid and Medicare. This current approach is clearly not the way to treat our dual eligible members.

We feel Dual integration is a positive and natural evolution of the managed care system in Tennessee. Tennessee has already taken many positive steps towards improving the care of seniors in the Medicaid program. For example, the TennCare Choices program empowered seniors to be involved in the delivery of their long term care services. We also compliment the Bureau on being the first state in the nation to require health plans to become NCQA certified and require the most extensive list of HEDIS quality measures. It is important to note that Duals are not included in the current HEDIS measurements because their services are so fragmented and disjointed. We believe the inclusion of services will allow true comprehensive quality measurement for dual enrollees for the first time in history.

We believe that the TennCare Plus proposal will not only improve the quality of care delivered but also provide services in a much more efficient manner. Blue Cross Blue Shield of Tennessee (BCBST) has several assets that we believe will contribute to the overall effort of improving the lives of Dual eligible members.

First, we have a specific institutional mission centered on the health and well being of Tennesseans. We're an independent, locally governed health plan company - meaning we live and work alongside our Tennessee business customers and plan members. BCBST has been involved with the TennCare program

since its inception in 1994. As a result, we are very aware of the Tennessee market place and the needs of 50,000 Dual eligible members that we already serve as a secondary insurer.

Secondly, we praise the TennCare Plus proposal for emphasizing the provision of quality healthcare services. We fully believe this emphasis will ultimately improve the members experience and the overall health outcomes of the population. We have placed a high priority on improving our HEDIS scores and our employee base has embraced the mission of quality.

BCBST also has strong provider networks. BCBST is the largest commercial insurer in Tennessee covering over 3 million Tennesseans in all regions of the state. Our Medicaid network (BlueCare), which covers Medicaid members in two of the state's three geographic regions, exceeds federal network adequacy standards. We are proposing to use our BlueCare network in the TennCare Plus program and we are confident that no other organization in the state would compare in terms of network size.

Lastly, we are excited about the opportunity to utilize our care coordination experience gained in the TennCare Choices program. We believe this valuable experience will greatly impact the lives of duals with complex conditions. It is truly a blessing to witness the dedication and expertise of our nurses as they work towards finding solutions that truly improve quality of life. We support the request for a 180 day lock-in period for this very reason. It is imperative that care coordinators are given an appropriate amount of time to forge a relationship with dual members and their families. Managed Care relies on a long term relationship as we work through complex situations. It would be a great loss of opportunity if we simply copy the standards of current Dual SNP plans and allow the duals to remain a transient population moving in and out of various health plan or fee for service relationships.

We also support the mandatory 180 day period in order to drive compliance with mandatory disease management programs. It is critical to develop a consistent approach to managing many health conditions. We believe that many critical aspects of managed care are best achieved through the development of a long term relationship between members, providers, and health plans.

This is a unique opportunity because changing the dual delivery systems appears to be a universally shared goal. We urge you to allow states to leverage their expertise in Medicaid as you consider this proposal. Dual demonstration proposals will work if the States are allowed to pursue projects that work at a local level. The Bureau of TennCare is in a better position to understand what provisions will work in Tennessee. Conversely, State governments will struggle if they are asked to behave like traditional Medicare Advantage plans.

We, therefore, offer this letter of support and appreciate your consideration of TennCare's proposal.

Sincerely,

Scott C. Pierce
President and CEO, Volunteer State Health Plan
1 Cameron Hill
Chattanooga, TN 37402

C: Darin J. Gordon, TennCare Director

May 16, 2012

Ms. Melanie Bella, Director
Medicare-Medicaid Coordination Office
Centers for Medicare and Medicaid Services
200 Independence Avenue, SW
Mail Stop: Room 315-H
Washington, DC 20201

RE: Letter of Support for TennCare PLUS

Dear Ms. Bella:

AARP is pleased to support the efforts of the Bureau of TennCare in its proposal to implement an integrated program of care for full benefit dual eligibles in Tennessee, "Response to RFP CMS-2011-0009."

With approximately 136,000 dual eligibles in Tennessee, the Bureau of TennCare seeks to integrate across the two programs through this demonstration project. As an organization that focuses on consumer protections, AARP supports the efforts to improve quality while coordinating care to the most vulnerable population. Additionally, the Bureau of TennCare has both the capacity and infrastructure in place for quality management and performance improvement processes.

AARP values the ongoing dialogue with the Bureau and looks forward to continued stakeholder involvement in both process development and implementation.

We therefore offer this letter of support and appreciate your consideration of TennCare's proposal.

Sincerely,

Rebecca B. Kelly

Rebecca B. Kelly, MPA
State Director
AARP Tennessee

C: Darin J. Gordon, TennCare Director

STATE OF TENNESSEE
COUNCIL on DEVELOPMENTAL DISABILITIES
PARKWAY TOWERS, SUITE 130
404 JAMES ROBERTSON PARKWAY
NASHVILLE, TENNESSEE 37243-0228
PHONE 615-532-6615 TTY 615-741-4562 FAX 615-532-6964

May 15, 2012

Ms. Melanie Bella, Director
Medicare-Medicaid Coordination Office
Centers for Medicare and Medicaid Services
200 Independence Avenue, SW
Mail Stop: Room 315-H
Washington, DC 20201

RE: Letter of Support for TennCare PLUS

Dear Ms. Bella:

The Tennessee Council on Developmental Disabilities would like to offer our support of the efforts of the Bureau of TennCare in its proposal to implement an integrated program of care for full benefit dual eligible members in Tennessee, "Response to RFP CMS-2011-0009."

Assuring access to affordable and appropriate health care for Tennesseans with intellectual and developmental disabilities is one of the Council's major priorities. The coordination of health benefits for Tennesseans across Medicare and Medicaid funding streams is an important way Tennessee can improve its health care delivery system, and the Council appreciates TennCare's efforts towards this goal with the creation of the TennCare PLUS dual demonstration project. This program has the potential to improve the quality of health care opportunities for Tennesseans with intellectual and developmental disabilities, while also delivering care in a more efficient manner.

The Council appreciates the opportunity to offer suggestions to the Bureau of TennCare related to the proposal. TennCare has shown a commitment to leading an ongoing dialogue between the State and key stakeholders that will help to ensure that the program is implemented in a way that will achieve the desired goals of quality and cost efficiency,

ensure continuity of care and the stability of provider networks, and most importantly, the member's experience of care.

The Council supports the current proposed start date of TennCare Plus for January 1, 2014 to allow for time to further refine the structure of the program and fully inform enrollees about all upcoming changes and available options.

We look forward to collaborating with TennCare, individuals with intellectual and developmental disabilities and other stakeholders to create an appropriate, efficient and effective system of coordinating health care for individuals eligible for both Medicare and Medicaid. We therefore offer this letter of support and appreciate your consideration of TennCare's proposal.

Sincerely,

Wanda Willis

Wanda Willis
Executive Director

C: Darin J. Gordon, TennCare Director

TENNESSEE

TN4AAD

Association of Area Agencies on Aging and Disability

May 14, 2012

Ms. Melanie Bella, Director
Medicare-Medicaid Coordination Office
Centers for Medicare and Medicaid Services
200 Independence Avenue, SW
Mail Stop: Room 315-H
Washington, DC 20201

RE: Letter of Support for TennCare PLUS

Dear Ms. Bella:

The Tennessee Association of Area Agencies on Aging and Disability is pleased to support the efforts of the Bureau of TennCare in its proposal to implement an integrated program of care for full benefit dual eligibles in Tennessee in response to RFP CMS-2011-0009.

The Bureau of TennCare has 18 years of managed care experience for the Medicaid population in Tennessee. This managed care model integrates and coordinates all physical health, behavioral health, and long term support services.

This experience provides a unique opportunity to align Medicare and Medicaid programs to improve the quality of care and at the same time maximize efficiencies by eliminating duplication and bringing all benefits into a single managed care system.

TennCare has developed a strong stakeholders group that we believe will assure the program meets or exceeds the desired goals and outcomes.

We therefore offer this letter of support of TennCare's proposal.

Sincerely,

Aaron Bradley

Aaron Bradley, President
Tennessee Association of Area Agencies on Aging and Disability

AAAD

9111 Cross Park Drive, Suite D-100 / Knoxville, Tennessee 37923 / 865 691-2551, 4216

May 14, 2012

Ms. Melanie Bella, Director
Medicare-Medicaid Coordination Office
Centers for Medicare and Medicaid Services
200 Independence Avenue, SW
Mail Stop: Room 315-H
Washington, DC 20201

RE: Letter of Support for TennCare PLUS

Dear Ms. Bella:

The East Tennessee Area on Aging and Disability, a division of the East Tennessee Human Resource Agency, is pleased to support the efforts of the Bureau of TennCare in its proposal to implement an integrated program of care for full benefit dual eligibles in Tennessee in response to RFP CMS-2011-0009.

This proposal provides a unique opportunity to align the Medicare and Medicaid programs to improve efficiencies and provide a higher quality of care to consumers.

Tennessee has 18 years of managed care experience. The managed care organizations, that contract with the Bureau of TennCare, provide physical health and behavioral health services along with long term support services through an integrated and coordinated care model.

TennCare has developed an excellent group of stakeholders that will be utilized to assure the program meets the desired goals related to consumer quality and program efficiencies.

We therefore offer this letter of support of TennCare's proposal.

Sincerely,

Aaron Bradley

Aaron Bradley, Director
East Tennessee Area Agency on Aging and Disability

9111 Cross Park Drive; Suite D-100
Knoxville, Tennessee 37923
865 691-2551
865 691-2555 (f)

FIRST TENNESSEE
AREA AGENCY ON AGING
AND DISABILITY

FIRST TENNESSEE DEVELOPMENT DISTRICT • 3211 NORTH ROAN STREET • JOHNSON CITY, TN 37601
TEL: 423-928-3258 • FAX: 423-926-8291 • WWW.FTAAAD.ORG

May 15, 2012

Ms. Melanie Bella, Director
Medicare-Medicaid Coordination Office
Centers for Medicare and Medicaid Services
200 Independence Avenue, SW
Mail Stop: Room 315-H
Washington, DC 20201

RE: Letter of Support for TennCare PLUS

Dear Ms. Bella:

The First Tennessee Area Agency on Aging and Disability (FTAAAD) is pleased to support the efforts of the Bureau of TennCare in its proposal to implement an integrated program of care for full benefit dual eligibles in Tennessee, "Response to RFP CMS-2011-0009."

We feel this is a wonderful opportunity to align the Medicare and Medicaid programs for one of the most complex and expensive populations served across both programs. In addition, we understand this program is aimed at improving the quality of care while also delivering care in a more efficient manner.

FTAAAD fully supports TennCare's proposal and appreciate your consideration.

Sincerely,

Kathy T. Whitaker, Director

Phone: 731- 587-4213
1-800-750-6866
Fax: 731-588-5833

Northwest Tennessee Development District
Area Agency on Aging & Disability

Susan Hill, Director
P.O. Box 963
124 Weldon Dr.
Martin, TN 38237-0963
susan.hill@nwtdd.org

May 16, 2012

Ms. Melanie Bella, Director
Medicare-Medicaid Coordination Office
Centers for Medicare and Medicaid Services
200 Independence Avenue, SW
Mail Stop: Room 315-H
Washington, DC 20201

RE: Letter to Support for TennCare PLUS

Dear Ms. Bella:

The Northwest Tennessee Area Agency on Aging and Disability is pleased to support the efforts of the Bureau of TennCare in its proposal to implement an integrated program of care for full benefit dual eligibles in Tennessee, "Response to RFP CMS-2011-0009."

Tennessee is uniquely positioned to successfully implement an integrated care demonstration for dual eligibles due to having 18 years of managed care experience. All full benefit dual eligibles in Tennessee are already enrolled in TennCare managed care for their Medicaid services. Physical health and behavioral health services, as well as long term care services are already integrated into the managed care program.

We therefore offer this letter of support and appreciate your consideration of TennCare's proposal.

Sincerely,

Susan Hill

Susan Hill, Director
Northwest Tennessee Area Agency on Aging and Disability

Southeast Tennessee Area Agency on Aging and Disability

A program of the Southeast Tennessee Development District
P. O. Box 4757 • 1000 Riverfront Parkway • Chattanooga, TN 37405
Phone (423) 266-5781 • Fax (423) 424-4225 • 866-836-6678
www.setaaad.org

May 15, 2012

Ms. Melanie Bella, Director
Medicare-Medicaid Coordination Office
Centers for Medicare and Medicaid Services
200 Independence Avenue, SW
Mail Stop: Room 315-H
Washington, DC 20201

RE: Letter of Support for TennCare PLUS

Dear Ms. Bella:

The Southeast Tennessee Area Agency on Aging and Disability is pleased to support the efforts of the Bureau of TennCare in its proposal to implement an integrated program of care for full benefit dual eligibles in Tennessee, "Response to RFP CMS-2011-0009."

We have had a positive experience of partnering with TennCare in the CHOICES Program which provides Home and Community Based Services as well as nursing home care through the managed care model. Tennessee's proposal is aimed at improving the quality of care while delivering care in a more efficient manner. This certainly falls in line with the federal demonstration by the Centers for Medicare and Medicaid Services.

It is notable that all full benefit dual eligibles in Tennessee are already enrolled in TennCare managed care for their Medicaid services. Physical health, behavioral health services as well as long term services and supports are already integrated in to the managed care program.

We therefore offer this letter of support and appreciate your consideration of TennCare's proposal.

Sincerely,

Steve Witt

Steve Witt
Director

C: Darin J. Gordon, TennCare Director

South Central Tennessee
Area Agency on Aging & Disability
101 Sam Watkins Boulevard
Mount Pleasant, TN 38474
Main Phone: 931-379-2929
Main Fax: 931-379-2685
Web: www.sctaaad.org

May 14, 2012

Ms. Melanie Bella, Director
Medicare-Medicaid Coordination Office
Centers for Medicare and Medicaid Services
200 Independence Avenue, SW
Mail Stop: Room 315-H
Washington, DC 20201

Re: Letter of Support for TennCare PLUS

Dear Ms. Bella:

The South Central Tennessee Area Agency on Aging and Disability is pleased to support the efforts of the Bureau of TennCare in its proposal to implement an integrated program of care for full benefit dual eligibles in Tennessee, "response to RFP-CMS-2011-0009."

This project is a historic opportunity to align the Medicare and Medicaid programs for one of the most complex and expensive populations served across both programs. Tennessee's proposal is aimed at improving the quality of care while also delivering care in a more efficient manner.

Tennessee has 18 years of managed care experience which makes it uniquely positioned to successfully implement an integrated care demonstration for dual eligibles. Also, physical health and behavioral health services, as well as long term care services are already integrated into the managed care program.

The State has ongoing dialogue with key stakeholders which will help ensure the success of this program.

We therefore offer this letter of support and appreciate your consideration of TennCare's proposal.

Sincerely,

Joe Evans
Director of Aging and Disability Programs
South Central Tennessee Development District

ALEXIAN BROTHERS
Community Services
Program of All-inclusive Care for the Elderly PACE

5/17/12

Ms. Melanie Bella, Director
Medicare-Medicaid Coordination Office
Centers for Medicare and Medicaid Services
200 Independence Avenue, SW
Mail Stop: Room 315-H
Washington, DC 20201

RE: Letter of Support for TennCare PLUS

Dear Ms. Bella:

Alexian Brothers PACE is pleased to support the efforts of the Bureau of TennCare in its proposal to implement an integrated program of care for full benefit dual eligibles in Tennessee, "Response to RFP CMS-2011-0009."

PACE is a proven model of care and we stand ready with our extensive experience in integrating and coordinating care to assist TennCare with implementation. Ongoing dialogue will help to ensure that the desired goals of quality, cost efficiency, continuity of care, stable provider networks and most importantly, a positive experience for members are achieved.

We believe Tennessee is uniquely positioned to successfully implement an integrated care demonstration for dual eligibles.

- Tennessee has 18 years of managed care experience.
- All full benefit dual eligibles in Tennessee are already enrolled in TennCare managed care for their Medicaid services.
- Physical health, behavioral health services and most recently long term supports and services are already integrated into the managed care program

We, therefore, offer this letter of support and appreciate your consideration of TennCare's proposal.

Sincerely,

Viston Taylor

Viston Taylor, M.P.H., FACHE
Chief Executive Officer

C: Darin J. Gordon, TennCare Director

425 Cumberland Street, Suite 110, Chattanooga, Tennessee 37404
423.698.0802 fax 423.622.6048