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Opinion No. 05-103

TennCare Reforms

QUESTIONS

1. Does any agreement clear the way for the administration to implement TennCare reforms, adjustments or administrative actions?

2. If so, please list the TennCare reforms for which such an agreement clears the way.

3. If any of the consent decrees relating to the TennCare program have prevented change, please cite which decree and provisions therein have prevented the administration from pursuing and/or enacting the following reforms, adjustments or administrative actions, and provide a citation for each such prohibition:

A. Drug utilization review (DUR)
B. Disease management
C. Use of preferred drug lists (PDLs)
D. Use of therapeutic, bioequivalent, or generic drugs
E. Multi-state drug-purchasing pool
F. Requiring MCOs to manage care and take back risk
G. Reducing payments to MCOs for not managing care and taking back risk
H. Federal government grants, or increase in dollars to TennCare
I. Revenue increases (e.g., cigarette taxes, fees)
J. Alternatives to nursing home care (e.g., home health, attendant care, assisted living)
K. Co-payments

OPINIONS

1-2. There is no agreement that "clears the way" for the implementation of TennCare reforms. An agreement has been reached among some of the parties in *Grier, et al. v. Goetz, et al.*, under the terms of which the signatories have agreed to support a forthcoming motion by the State to modify the *Grier* Revised Consent Decree in certain specified respects, as necessary to allow the State to implement reforms to TennCare. The *Grier* plaintiffs have not joined in that agreement.

Any modifications of the *Grier* Revised Consent Decree are dependent on Court approval.

3. There is no consent decree that, by its express terms, prohibits the measures listed in your question. In fact, some of these measures are currently utilized in the TennCare program.[1] However, there are provisions of the Revised Consent Decree in *Grier, et al. v. Goetz, et al.* that operate to impede the effective implementation of certain of those measures.

ANALYSIS

1-2. A Memorandum of Understanding was entered into on April 26, 2005, among some, but not all, of the parties to the case of *Grier, et al. v. Goetz, et al.,* No. 79-3107, U. S. District Court (M.D. Tenn.). In that Memorandum of Understanding, the State has agreed to initiate a new Waiver-Based Spend Down program that would provide TennCare coverage for the neediest and most medically fragile enrollees currently slated for disenrollment. The State's agreement to initiate this program is expressly contingent upon the satisfaction of certain conditions, including the State obtaining modifications and/or clarifications of the *Grier* Revised Consent Decree that would provide that, notwithstanding anything to the contrary in the Revised Consent Decree, the State may implement any of a number of reforms to TennCare that are specified in the Memorandum of Understanding. Under the terms of that Memorandum of Understanding, the plaintiffs-intervenors, the defendants-intervenors Tennessee Hospital Association and Hospital Alliance of Tennessee, and a group of TennCare providers participating in the case as *amici curiae*, have agreed to urge the *Grier* Court to adopt the modifications sought by the State by joining the State's forthcoming motion to modify the consent decree. The *Grier* plaintiffs have not agreed to the Memorandum of Understanding. In any event, any changes to the Revised Consent Decree are ultimately dependent upon the approval of the federal court that has jurisdiction over the *Grier* litigation.

3. While there is no consent decree that, by its express terms, prohibits the measures listed in your question, there are provisions of the Revised Consent Decree in *Grier, et al. v. Goetz, et al.* (Doc. No. 908) that operate to impede the effective implementation of certain of those measures and blunt their usefulness as potential tools to achieve cost containment.

The primary provisions of the *Grier* consent decree that operate in this manner are set out at paragraphs C.14, containing special provisions relating to pharmacy services, and C.7, dealing with issues of burden of proof and deference to an enrollee's treating physician in all appeals of adverse action affecting TennCare benefits. Paragraph C.14.a.i - iv provides, in pertinent part:

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[1]For example, TennCare currently has in place a preferred drug list and a drug utilization review program. Enrollee cost-sharing obligations, including co-payments, are imposed on some segments of the TennCare population, as approved by the Centers for Medicare and Medicaid Services (CMS). It is also our understanding that the State has recently joined the National Medicaid Pooling Initiative for drug purchasing.

> a. When a provider with prescribing authority . . . prescribes a medication for a beneficiary, and the prescription is presented at a pharmacy that participates in the TennCare program, the beneficiary is entitled to either:
>
> > i. The drug as prescribed, if the drug is on the TennCare preferred drug list (PDL) and prior authorization is either unnecessary or, if required, has been obtained; or
> >
> > ii. The drug as prescribed, if the prescribing provider has obtained prior authorization or established the medical necessity of the medication; or
> >
> > iii. An alternative medication on the TennCare PDL, if the pharmacist consults the prescribing provider when the beneficiary presents the prescription to be filled, and the provider prescribes the substituted drug; or
> >
> > iv. An interim supply of three days . . . of the prescribed drug if the pharmacist is unable, when the enrollee presents the prescription to be filled, to obtain either authorization to fill the prescription as written or the prescribing provider's authorization to substitute an alternative medication on the TennCare PDL. . . . [U]pon receipt of an interim supply, the enrollee need do nothing more than return to the pharmacy later to receive either (1) the balance of the prescription as originally written, if the prescribing provider's authorization to substitute an alternative PDL medication has not been obtained, or (2) the alternative medication authorized by the prescribing provider. . . .

Paragraph C.7 of the consent decree provides that, in any appeal by an enrollee of an adverse action affecting his TennCare services, the State has the burden of obtaining from the enrollee and his prescribing provider all medical records that support the appeal, and may not overrule the decision or opinion of the prescribing provider unless there is substantial and material medical evidence, documented in the enrollee's medical records, to justify such action.

In the context of pharmacy services, the operation of C.14.a.iv requires that, even in instances in which an enrollee's provider has prescribed a medication that is not on the TennCare preferred drug list (PDL) and/or for which the provider has not obtained the required prior authorization, the enrollee will receive that medication, as prescribed, if his provider simply does not respond to the pharmacist's attempted contact or declines to change the prescription to an alternative drug that is on the PDL. The fact that, under the terms of paragraph C.14.a.iv, a TennCare enrollee will receive whatever medication his provider prescribes, even if the drug is not on the TennCare PDL or has not received required prior authorization, inhibits the State's ability to implement effectively a preferred drug list, prospective drug utilization review, programs addressing the use of therapeutic substitution or generic drugs, and aspects of disease management.

Similarly, the provisions of paragraph C.7 of the *Grier* consent decree may operate to make

the ability of a managed care organization (MCO) and/or the TennCare Bureau to overrule the opinion of an enrollee's prescribing provider dependent on that provider supplying the enrollee's medical records. In the event that enrollee medical records are not supplied by the prescribing provider, or are not supplied in a timely manner, that circumstance effectively impedes the ability of the MCO and TennCare to deny prescribed services, thereby impacting their ability to manage care, both with respect to pharmacy and non-pharmacy services.

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