Bureau of TennCare

Healthy Families, Healthy Communities

Fiscal Year 2005-2006 Annual Report

State of Tennessee
Department of Finance and Administration
Bureau of TennCare
310 Great Circle Road
Nashville, TN 37243

Dear Friends:

It is a pleasure to share with you the accomplishments of the TennCare program in this annual report for State Fiscal Year 2005-2006.

TennCare is one of the largest Medicaid managed care programs in the nation. About one out of every five Tennesseans is enrolled in TennCare. About four out of every ten children under the age of 19 are enrolled in TennCare. TennCare plays a critical role in helping these persons get the healthcare they need.

TennCare has faced many challenges in recent years, with some of these challenges threatening the continued existence of the program. In the summer of 2004, Governor Phil Bredesen proposed the first in a series of reforms to both preserve the program and to place it on an even keel. As you will see in reading this report, these reforms have had their intended effect. I am pleased to report that TennCare is now stable and operating within its budget.

This new stability in the TennCare program is enabling us to focus on improved health outcomes for our enrollees. We were the first state in the country to require all of our managed care organizations to obtain accreditation from the National Committee for Quality Assurance. We have introduced new disease management programs in the areas of maternity care management, diabetes, congestive heart failure, and asthma; and we plan to build on these programs in the future. We are working hard to make certain that our enrollees receive quality health services.

Looking ahead to the future, we are taking steps to move many of our health plans back to full risk. We are looking forward to adding a new eligibility group to the demonstration population and thereby offering healthcare to up to 100,000 poor aged, blind, and disabled adults and caretaker relatives who have incurred unreimbursed medical bills.

This is an exciting time for TennCare. I hope you will find this annual report useful in reflecting on progress made in the program in State Fiscal Year 2005-2006.

Sincerely,

Darin Gordon
Deputy Commissioner

TENNCARE

EXECUTIVE STAFF

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Deputy Commissioner

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Director of Public Affairs

TennCare is a government-operated health insurance program designed for people who are eligible for Medicaid, as well as for some children who do not have insurance. TennCare is a Medicaid waiver, or demonstration, program. Its purpose is to demonstrate that the use of managed-care principles can generate sufficient savings to enable the state to cover more than Medicaid-eligible people.

The core population of TennCare is composed of Medicaid eligibles, most of whom are low-income children and families, pregnant women, disabled people, women needing treatment for breast or cervical cancer, or persons requiring care in a nursing facility.

The demonstration or expansion population includes children who are not eligible for Medicaid but who lack access to insurance and who meet other state criteria.

When TennCare began in 1994, the demonstration population was open to many uninsured children and adults in Tennessee. Throughout the 05/06 fiscal year, new enrollment in the demonstration program was open only to uninsured children whose Medicaid eligibility was ending. Generally, these were low-income children. However, children leaving Medicaid who have been determined to be "medically eligible," or uninsurable, may qualify at any income level.

There were 1,224,100 enrollees on TennCare as of Dec. 31, 2005: 1,173,300 Medicaid eligibles and optional enrollees, and 50,800 enrollees who largely were children who were either uninsured or uninsurable.

Some facts about TennCare:

- In 2005, about 21 percent of the Tennessee population was on TennCare.
- Pregnant women and children are a special focus of TennCare. About one in every two babies born in Tennessee is on TennCare.
- Tennessee is the only state in the country to enroll its entire Medicaid and demonstration population in managed care.
- Compared with other states, Tennessee in 2005 ranked fifth in total Medicaid managed care enrollment and 13th in the amount of Medicaid dollars spent. Only California, New York, Pennsylvania, and Florida exceeded Tennessee in the number of persons served through their respective Medicaid managed-care programs.

TennCare experienced unprecedented change during Fiscal Year 2006. While change is not always easy, one benefit has been the dramatic financial turnaround of the past 12 months. TennCare was able to control costs within the pharmacy program, live within budgeted dollars, avoid consuming all of the resources needed in other areas of state government, rebuild necessary reserves, improve business arrangements, settle long-standing financial disputes and reduce audit findings.

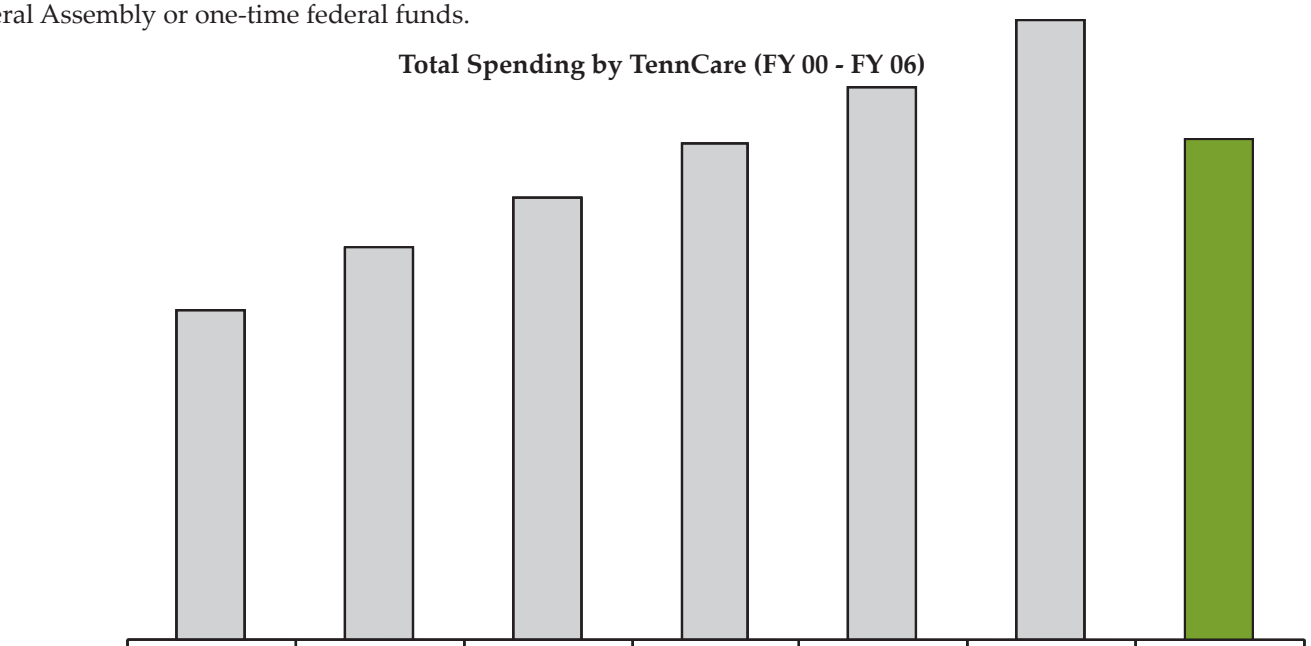
The bar graph below highlights total spending by TennCare from FY 2000 to FY 2006. Clearly, growth within the program was unsustainable. Reform implementation, along with other programmatic changes, resulted in creating a much more sustainable budget base. For the first time in years, TennCare was able to close the fiscal year without the use of reserves, supplemental appropriations from the General Assembly or one-time federal funds.

Controlling pharmacy expenditures was critical to obtaining financial stability. The second chart below highlights the reduction in pharmacy spending.

The financial strength of the Bureau is also highlighted by the reduction in audit findings. The comptroller's audit for FY 2006 resulted in four findings, a dramatic improvement from the 39 findings of FY 2003.

By achieving financial stability and by controlling costs, TennCare can focus more on the health outcomes of its enrollees. Without a looming financial crisis, the State can make investments in preventive care, health indicators, benefit expansions and targeted enrollment expansions.

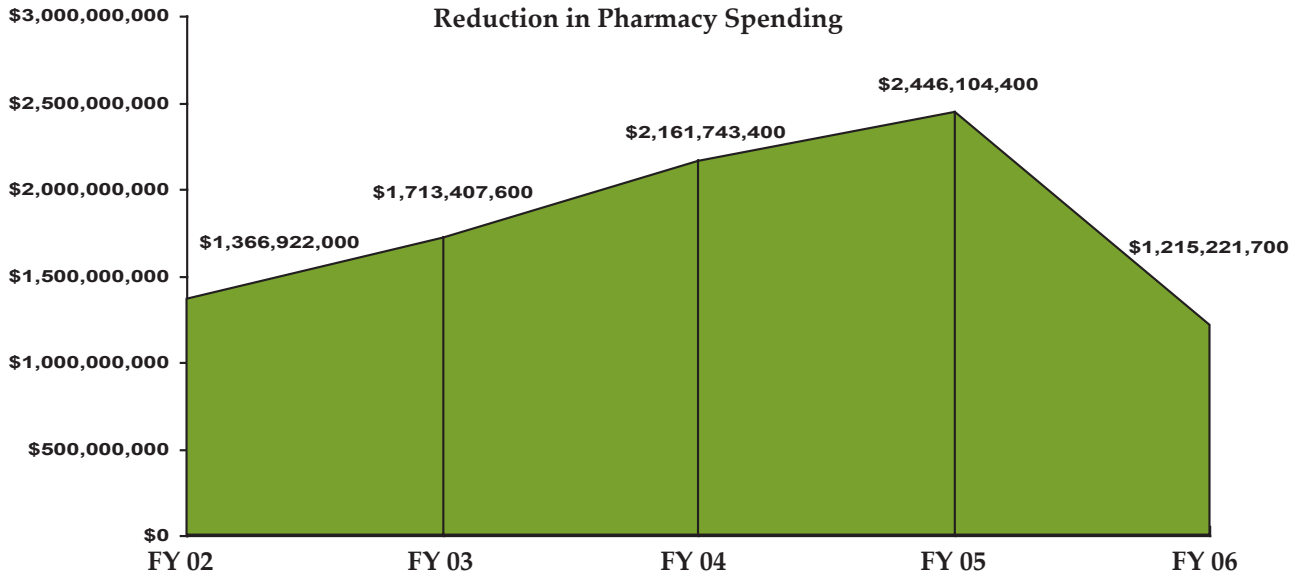
Total Spending by TennCare (FY 00 - FY 06)



	FY 00	FY 01	FY 02	FY 03	FY 04	FY 05	* FY 06
Expenditures	$4,538,526,200	$5,430,806,600	$6,105,650,500	$6,864,485,100	$7,631,268,200	$8,569,292,200	$6,918,716,800

* Reform implementation began Aug 2005 through FY 06

Reduction in Pharmacy Spending



Service Delivery Network

Managed Care Organizations

All enrollees are assigned to a managed care organization (MCO) for physical healthcare.

Most of the eight MCOs are contracted to provide services in a designated Grand Region of the state – with the exception of VHP, which operates only in Davidson County, and TennCare Select, which operates statewide. TennCare Select serves as the State's "backup" health plan, in order to accept enrollment from failed health plans or in areas that may be underserved, as well as the plan that provides medical services to certain specialized populations as defined by the State.

The MCOs provide a full range of services, except for those delivered by other entities: behavioral health, pharmacy, dental and long-term care services.

Distribution of TennCare Enrollment by Grand Region

MCO/ Region*	East	Middle	Out of State**	West	Total	MCO Distribution
Unison	0	0	0	54,500	54,500	4.5%
BlueCare	220,600	0	0	0	220,600	18.0%
AmeriChoice	81,400	0	0	0	81,400	6.7%
UAHC	0	0	0	123,800	123,800	10.1%
PHP	111,600	0	0	0	111,600	9.1%
TennCare Select	35,200	341,622	3,578	34,400	414,800	33.9%
TLC	0	0	0	174,000	174,000	14.2%
VHP	0	43,400	0	0	43,400	3.5%
Total	448,800	385,022	3,578	386,700	1,224,100***	100.0%
Regional Distribution	36.7%	31.2%	0.5%	31.6%	100.0%	

* Individuals in counties bordering Grand Regions may show up differently when segregating between region by MCO & BHO assignment.

** Enrollees may live out of state for several reasons such as: attending an out of state college while maintaining Tennessee residency; physically living in a Tennessee border county with a contiguous out-of-state address; or residing in an out-of-state medical institution for a prolonged period.

*** Effective Dec. 31, 2005

Behavioral Health Organizations

All enrollees are assigned to one of two behavioral health organizations (BHOs), based on their MCO assignment. Tennessee Behavioral Health (TBH) is partnered with AmeriChoice (formerly John Deere), TLC, PHP, TennCare Select in East Tennessee and Blue Care. Premier Behavioral Systems of Tennessee, LLC. (Premier) is partnered with UAHC (formerly OmniCare), Unison (formerly Better Health Plan), VHP and TennCare Select in Middle and West Tennessee. Children in state custody and enrollees living out-of-state-are assigned to Premier.

Effective January 1, 2006, both BHOs executed risk-based contracts with the state of Tennessee:

- TBH East – a full-risk contract serving enrollees in the East Tennessee Grand Region.
- TBH Middle/West – a shared-risk agreement for the Middle and West Grand Regions.
- Premier – a shared-risk contract serving enrollees statewide.

A single management company, Advocare of Tennessee, provides management to both TBH and Premier.

Distribution of TennCare Enrollees by BHO and Grand Region

Region / BHO*	Premier	TBH	Total	Percentage
West	212,685	174,015	386,700	31.59%
Middle	381,172	3,850	385,022	31.45%
East	4,488	444,312	448,800	36.66%
Out-of-State	3,363	215	3,578	0.29%
Total	601,708	622,392	1,224,100	100%
Percentage	49.4%	50.6%	100%	

* Individuals in counties bordering Grand Regions may show up differently when segregating between region by MCO & BHO assignment.

Pharmacy Benefits Manager

First Health Services Corporation is the Pharmacy Benefit Manager (PBM) for TennCare. As TennCare's PBM, First Health processes drug claims for TennCare enrollees, manages the preferred drug list and point-of-sale edits, and conducts the retrospective drug utilization (retro DUR) program for the Bureau of TennCare.

Dental Benefits Manager

In TennCare, Doral Dental of Tennessee, LLC, is the dental benefits manager. As such, Doral administers the dental program and contracts with providers.

Service Listing

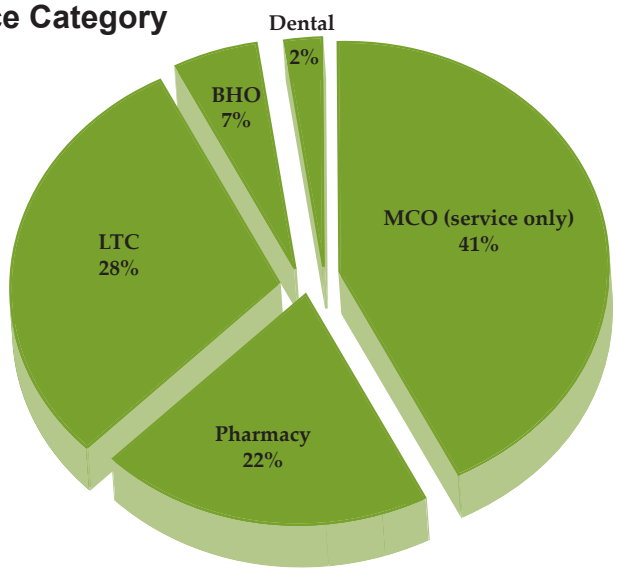
All TennCare-covered services must be medically necessary. As of June 30, 2006, TennCare covered the following services:

- Community health services
- Dental services for enrollees under 21; for enrollees 21 and older, services are limited to the completion of certain orthodontic treatments initiated before enrollees turn 21.
- Durable medical equipment
- Emergency ambulance transportation – air and ground
- EPSDT services for Medicaid enrollees under 21; preventive, diagnostic and treatment services for TennCare Standard enrollees under 21
- Home- and Community-Based Services (HCBS) for certain persons with mental retardation or persons determined to be elderly or disabled*
- Home health care
- Hospice care
- Inpatient and outpatient substance abuse benefits (lifetime limit of $30,000 for adults 21 and older)
- Inpatient hospital services
- Lab and X-ray services
- Medical supplies
- Mental health case management services
- Mental health crisis services
- Non-emergency transportation
- Nursing facility services (including Level 1, Level 2 and ICF/MR services)*
- Occupational therapy
- Organ- and tissue-transplant services and donor organ/tissue-procurement services
- Outpatient hospital services
- Outpatient mental health services
- Pharmacy services
- Physical therapy
- Physician services
- Private duty nursing
- Psychiatric inpatient services
- Psychiatric rehabilitation services
- Psychiatric residential treatment services
- Reconstructive breast surgery
- Rehabilitation services
- Renal dialysis clinic services
- Speech therapy
- Vision services for enrollees under 21

*HCBS and nursing facility services are provided outside the managed-care setting.

05/06 Budget by Service Category

Program	$ Amount
MCO (service only)	$2,295,167,900
Pharmacy	$1,215,221,700
Long-Term Care	$1,595,846,900
BHO	$391,382,700
Dental	$139,265,800
Total – Selected Programs	$5,636,885,000



Medical Services 05/06

Services Delivered through MCOs

Top Five Diagnoses by Cost

Inpatient Hospital

1. Single Liveborn	11.7%
2. Short Gestation/Unspec Low Birth Weight	3.6%
3. Other Diseases of Lung	2.9%
4. Heart Failure	2.3%
5. Other Forms of Chronic Ischemic Heart Disease	2.1%
Percentage of all Inpatient Expenditures	22.6%

Outpatient

1. Respiratory Systems/Other Chest Symptoms	4.2%
2. Other Symptoms Involving Abdominal Pain	3.6%
3. General Symptoms	3.4%
4. Chronic Renal Failure	2.8%
5. Encounter for Other/Unspec Procedure & Aftercare	2.7%
Percentage of All Outpatient Expenditures	16.7%

Physician

1. Health Supervision of Child	4.9%
2. General Symptoms	3.0%
3. Respiratory Systems/Other Chest Symptoms	3.0%
4. Normal Delivery	3.0%
5. Other and Unspecified Disorders of Back (724)	2.3%
Percentage of All Physician Expenditures	16.2%

- Inpatient hospitalization rate was 132 admissions per 1,000 enrollees
- Average inpatient length of stay was 4.5 days per admission
- Emergency room utilization was 743 visits per 1,000 enrollees
- 80% of all TennCare enrollees visited a physician at least once during the year

MCO Medical Expenditure by Category of Service

Category of Service	Providers With Paid Claims	FY 06 Recipients	Expenditures Per Recipient	FY 05-06 Actual Closing Nos.
Hospital Facilities (Including care provided through hospitals (both Inpatient and Outpatient), Federally Qualified Health Centers (FQHC), Ambulatory Surgical Centers, etc.)	5,541	616,902	$1,842	$1,136,108,100
Physician	22,190	1,013,022	$748	$757,405,400
Durable Medical Equipment	2,533	82,021	$895	$73,445,400
Home Health	406	11,465	$14,414	$165,252,100
Other Services (Transportation, Lab, Hospice)	6,699	530,223	$307	$162,956,900

Pharmacy Services

Services Delivered through PBM

TennCare utilizes a preferred drug list to manage the pharmacy benefit. Some drugs require prior approval. During calendar year 2005-2006, 71 percent of TennCare-reimbursed prescriptions were generic and 29 percent were brand-name.

Brand-name drugs accounted for 81 percent of pharmacy expenditures, with an average cost per prescription of $105 for a brand-name prescription, compared with approximately $19 for a generic prescription. TennCare enrollees who utilized pharmacy services averaged 41.30 prescriptions per year in FY 05-06.

Providers with Paid Claims	FY 06 Recipients	Expenditures Per Recipient	FY 05-06 Expenditures
7,149	1,153,419	$958	$1,105,126,400

Note: Figures represent enrollees who utilize pharmacy services.

Top Five Drugs by Cost

Brand Name	Generic Name	Drug Type	Cost of Drug
Seroquel®	Quetiapine Fumarate	Antipsychotic	$34,971,544.10
Zocor®	Simvastatin	Cholesterol-Lowering Agent	$28,293,346.31
Risperdal®	Risperidone	Antipsychotic	$24,295,869.56
Synagis®	Palivizumab	Prevent Respiratory Syncytial Virus (RSV)	$23,417,308.61
Zyprexa®	Olanzapine	Antipsychotic	$22,900,731.41

Top Five Drugs By Number of Claims

Brand Name	Generic Name	Drug Type	Number of Prescriptions
Vicodin®, Lortab®, various other Brands	Hydrocodone Bitartrate/ Acetaminophen	Narcotic	636,486
Proventil®, Ventolin®, various other Brands	Albuterol	Asthmatic	254,999
Lasix®	Furosemide	Diuretic	254,558
Prinivil®, Zestril®	Lisinopril	Blood Pressure	249,616
Singulair®	Montelukast Sodium	Asthmatic	234,295

Dental Services

Services Delivered through the DBM

During FY 2006, medically necessary services were covered for enrollees under 21. For TennCare-eligible children age 3 and over, 51 percent received dental services.

Dental Services

Providers with Paid Claims	FY 06 Recipients	Expenditures Per Recipient	* FY 05-06 Expenditures
785	297,724	$449	$133,921,300

* Does not include Health Department Dental Program or administrative costs.

Long Term Care Services

TennCare's Long Term Care services consist of traditional "institutional" care such as nursing homes and intermediate care facilities for persons who have mental retardation (ICFs/MR or "Developmental Centers"), as well as the at-home service delivery model known as Home and Community Based Services. In order to receive any kind of long term care paid for by TennCare, a person must establish Medicaid eligibility through the local office of the Department of Human Services. In addition, the person must meet applicable "level of care" or medical criteria for the type of care for which reimbursement is requested. This is called a "Pre-Admission Evaluation" or "PAE." The PAE or level of care decision is made by TennCare within eight working days of receipt.

Nursing Facility Care

TennCare offers two levels of nursing home care. Level 1, or intermediate care, is provided for individuals who require inpatient nursing care such as assessing and monitoring the person's medical condition, administering medication, and supervising nurses' aides who assist with activities of daily living. Level 2, or skilled nursing, is available for persons who need require skilled medical services that can only be performed by a registered or licensed practical nurse.

There are approximately 300 nursing homes participating in the Medicaid program. On any given day, there are approximately 29,500 nursing home patients receiving TennCare assistance. Nursing home services include room and board, nursing services and routine medical equipment and supplies necessary to support the enrollee. The remainder of an enrollee's medical care, such as hospitalization, physician, lab and x-ray, and hospice are provided by a TennCare managed care organization.

Nursing homes are paid on a per diem basis and each nursing home has its own specified reimbursement rate established annually by the Comptroller of the Treasury. Nursing home residents may be required to pay a portion of the cost of their care (called "Patient Liability") with TennCare supplementing the enrollees' payments to make up the per diem rate established by the Comptroller.

HCBS for Persons who are Elderly and/or who have Disabilities

Home and Community Based Services (HCBS) are available for persons who are elderly and/or who have disabilities that qualify for Level 1 nursing home care but who choose to remain at home. As with nursing home care, HCBS is limited to persons who qualify for Medicaid. However, unlike with nursing home care, participants in HCBS waivers for the elderly and/or disabled must be at least 21 years of age.

HCBS services are provided based on an individualized plan of care. Services that may be covered include:

- Personal Care Services
- Homemaker Services
- Home-Delivered Meals
- Minor Home Modifications
- Personal Emergency Response System
- Inpatient Respite
- Case Management

As with nursing home care, enrollees in HCBS programs for the elderly and/or disabled with incomes above a certain level are required to pay a portion of the cost of their care. However, the enrollee is allowed to keep an amount of money each month to pay for living expenses such as rent, utilities, and food since the enrollee is living at home. This is called the Personal Needs Allowance.

Currently, TennCare's statewide waiver program has funding to support 3,700 persons who qualify for skilled nursing care but who want to receive services at home. TennCare has more than 1,500 open HCBS slots statewide with no waiting list to apply. Point of entry is through local Area Agencies on Aging and Disability (AAADs), who assist enrollees interested in applying for these services.

As with nursing home residents, enrollees in HCBS programs receive the remainder of their medical care, such as home health and private duty nursing services along with hospitalization, physician, pharmacy, and lab and x-ray services from TennCare's managed care organizations. The one exception is with persons participating in the PACE program, which is operated only in Hamilton County. PACE is an "all-inclusive" HCBS model, meaning that the enrollees receive all of their medical care – including hospitalization, physician services, pharmacy and even nursing home care – through or at the expense of the PACE program. Currently, PACE can serve up to 325 individuals each year.

HCBS for Persons with Mental Retardation

TennCare contracts with the Division of Mental Retardation Services to operate three (3) HCBS waiver programs for persons with mental retardation, as an alternative to institutionalization in an MR facility. Only mentally retarded people may qualify.

Funding is available for about 8,000 people who have mental retardation, are Medicaid eligible and who meet level-of-care criteria. Point of entry is through Regional Offices of the Division of Mental Retardation Services.

Long Term Care Services

Category of Services	Number of Providers	Number of Residents	Average Expenditure Per Resident	Total Expenditure
HCBS - MR	* 2	6,741	$59,933	$404,010,700
HCBS - Elderly	59	1,379	$18,202	$25,101,400
Intermediate Care - MR	78	1,304	$203,742	$265,679,600
Intermediate Care - Nursing Facility	293	25,138	$32,231	$810,231,700
Skilled Nursing Facility	233	2,519	$36,055	$90,823,500

U.S. Census data as of Dec. 31, 2005
* Number of providers does not total because some entities provide more than one kind of service. Also, this table reflects only the two billing providers for MR; actual MR HCBS providers number more than 400.

Behavioral Health Services

Services Delivered through BHOs

Top Five Mental Health Diagnoses by Cost

Inpatient Hospital

1. Affective Psychoses	45.6%
2. Schizophrenic Disorder	17.9%
3. Depressive Disorder	6.1%
4. Sexual Deviations and Disorders	4.4%
5. Other Nonorganic Psychoses	4.0%
% of all Inpatient Expenditures	78.0%

Outpatient

1. Schizophrenic Disorder	26.5%
2. Affective Psychoses	21.2%
3. Drug Dependence	8.2%
4. Disturbance of Conduct	7.4%
5. Sexual Deviations and Disorders	7.2%
% of All Outpatient Expenditures	70.5%

Physician

1. Affective Psychoses	37.4%
2. Hyperkinetic Sydrome of Childhood	12.9%
3. Schizophrenic Disorder	12.1%
4. Adjustment Reaction	11.7%
5. Neurotic Disorders	7.0%
% of All Physician Expenditures	81.1%

- 68% of enrollees receiving mental health care are either adults designated as SPMI (Seriously and Persistently Mentally Ill) or children designated as SED (Seriously Emotionally Disturbed)
- Approximately 7.6% of the entire TennCare population are SPMI/SED enrollees
- 82.5% of dollars spent on mental health care is for SPMI/SED enrollees

Mental Health Clinics and Institutional Services

Providers with Paid Claims	Recipients	Expenditures Per Recipient	Expenditures**
1,279	165,155	$1,686	$278,381,294

** Case management services, transportation and other community services are not included.

The core TennCare population includes people eligible for Medicaid. To be eligible for Medicaid, people must meet the criteria for a Medicaid category. Medicaid categories are established by federal law. Some of them are mandatory categories that states must cover in their Medicaid programs, and some are optional categories that states may elect to cover in their Medicaid programs. States do not have the latitude to design their own Medicaid categories apart from those named in federal regulations.

TennCare covers all mandatory Medicaid categories and most optional Medicaid categories. Income levels vary among categories, but low income is a prerequisite for most categories.

Major categories include the following:

- Children
- Pregnant women
- Families receiving public assistance (Families First)
- People with disabilities or chronic illnesses who qualify for Supplemental Security Income (SSI)
- People who require care in nursing facilities and
- Women needing treatment for breast and/or cervical cancer

Some people with Medicare also qualify for assistance from TennCare. They may be eligible in a Medicaid category, in which case they are eligible for full TennCare benefits. Or they may have incomes below certain levels, in which case TennCare assists them with their Medicare cost-sharing. Medicare beneficiaries who are not eligible in a Medicaid category do not get any other services from TennCare.

In addition to the Medicaid categories, TennCare covers categories under the demonstration, or expansion, program. As of July 1, 2006, there were two demonstration categories. Persons in both categories either had to be enrolled in those categories prior to Dec. 31, 2001, or they had to have lost eligibility for Medicaid since July 1, 2002. The categories are as follows:

- Uninsured children under age 19 with family incomes below 200% poverty
- Uninsurable ("Medically Eligible") children under age 19 with family incomes at any level

On January 11, 2006, the state submitted a request to CMS to add another demonstration category. That category would include 100,000 non-pregnant adults meeting criteria similar to those for the Medically Needy, or Spend-down, program. As of June 30, 2006, CMS had not yet approved the request.

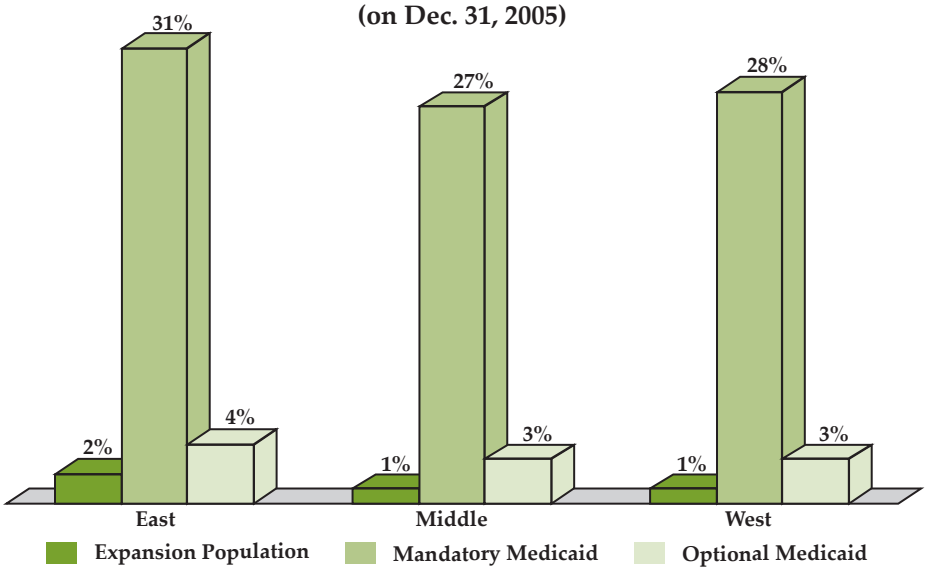
Enrollment by Eligibility Category and Race

Category	White	Black	Other	Hispanic	Grand Total
Expansion Population	3.3%	0.6%	0.1%	0.1%	4.1%
Mandatory Medicaid	49.5%	28.4%	5.3%	2.9%	86.1%
Optional Medicaid	7.6%	1.9%	0.2%	0.1%	9.8%
Grand Total	60.4%	30.9%	5.6%	3.1%	100%

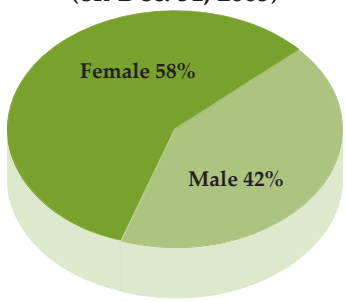
Enrollment by Eligibility Category and Age

Category	0 to 21	21 to 64	65+	Grand Total
Expansion Population	31,000	18,100	1,700	50,800
Mandatory Medicaid	588,000	383,500	82,300	1,053,800
Optional Medicaid	35,800	58,000	25,700	119,500
Grand Total	654,800	459,600	109,700	1,224,100

Enrollment by Major Eligibility Category & Grand Region (on Dec. 31, 2005)



TennCare Beneficiaries by Gender (on Dec. 31, 2005)



TennCare Expenditures and Recipients by County

Bureau of TennCare

County	Enrollment on 12/31/2005	Estimated 2006 Population	% of County on TennCare	Total Service Expenditures	Expenditure Per Member	% County Expenditure	% County Enrollment	% County Population
ANDERSON	15,138	72,033	21.02%	$64,440,333.87	$4,256.86	1.2%	1.2%	1.20%
BEDFORD	8,736	41,641	20.98%	$36,015,420.31	$4,122.64	0.7%	0.7%	0.69%
BENTON	4,513	16,869	26.75%	$19,344,434.59	$4,286.38	0.4%	0.4%	0.28%
BLEDSOE	2,969	12,940	22.94%	$9,566,723.59	$3,222.20	0.2%	0.2%	0.22%
BLOUNT	18,427	113,274	16.27%	$74,103,554.60	$4,021.47	1.4%	1.5%	1.89%
BRADLEY	17,292	93,538	18.49%	$70,847,836.36	$4,097.15	1.4%	1.4%	1.56%
CAMPBELL	13,994	41,017	34.12%	$53,089,895.78	$3,793.76	1.0%	1.1%	0.68%
CANNON	2,832	13,555	20.89%	$12,404,099.69	$4,379.98	0.2%	0.2%	0.23%
CARROLL	7,442	30,176	24.66%	$34,736,448.88	$4,667.62	0.7%	0.6%	0.50%
CARTER	12,710	57,582	22.07%	$52,919,075.73	$4,163.58	1.0%	1.0%	0.96%
CHEATHAM	5,310	39,237	13.53%	$23,011,378.71	$4,333.59	0.4%	0.4%	0.65%
CHESTER	3,357	16,562	20.27%	$13,444,079.19	$4,004.79	0.3%	0.3%	0.28%
CLAIBORNE	10,158	31,160	32.60%	$43,646,558.16	$4,296.77	0.8%	0.8%	0.52%
CLAY	2,363	8,120	29.10%	$10,818,213.89	$4,578.17	0.2%	0.2%	0.14%
COCKE	11,196	35,309	31.71%	$43,354,296.00	$3,872.30	0.8%	0.9%	0.59%
COFFEE	10,809	50,875	21.25%	$51,867,444.52	$4,798.54	1.0%	0.9%	0.85%
CROCKETT	3,601	15,183	23.72%	$15,343,163.76	$4,260.81	0.3%	0.3%	0.25%
CUMBERLAND	10,394	50,681	20.51%	$48,637,449.18	$4,679.38	0.9%	0.9%	0.84%
DAVIDSON	109,492	595,832	18.38%	$524,226,395.85	$4,787.81	10.0%	8.9%	9.92%
DECATUR	2,964	11,851	25.01%	$14,957,374.81	$5,046.35	0.3%	0.2%	0.20%
DEKALB	4,341	18,502	23.46%	$20,113,479.24	$4,633.37	0.4%	0.4%	0.31%
DICKSON	8,535	46,312	18.43%	$46,518,946.91	$5,450.37	0.9%	0.7%	0.77%
DYER	10,409	38,290	27.18%	$36,404,539.02	$3,497.41	0.7%	0.9%	0.64%
FAYETTE	6,137	31,720	19.35%	$22,130,188.54	$3,606.03	0.4%	0.5%	0.53%
FENTRESS	6,591	17,399	37.88%	$33,693,536.45	$5,112.05	0.6%	0.5%	0.29%
FRANKLIN	6,766	40,977	16.51%	$29,865,713.96	$4,414.09	0.6%	0.6%	0.68%
GIBSON	12,206	48,715	25.06%	$62,747,588.13	$5,140.72	1.2%	1.0%	0.81%
GILES	5,843	30,267	19.30%	$27,504,553.17	$4,707.27	0.5%	0.5%	0.50%
GRAINGER	5,392	22,022	24.48%	$20,426,923.88	$3,788.38	0.4%	0.4%	0.37%
GREENE**	13,906	65,176	21.34%	$152,646,239.25	$10,977.01	2.9%	1.1%	1.09%
GRUNDY	5,168	14,814	34.89%	$19,604,873.86	$3,793.51	0.4%	0.4%	0.25%
HAMBLEN	12,748	60,707	21.00%	$56,111,479.43	$4,401.59	1.1%	1.0%	1.01%
HAMILTON	55,549	313,194	17.74%	$245,978,551.19	$4,428.14	4.7%	4.5%	5.22%
HANCOCK	2,575	6,858	37.55%	$10,587,449.73	$4,111.63	0.2%	0.2%	0.11%
HARDEMAN	7,369	29,907	24.64%	$29,700,285.33	$4,030.44	0.6%	0.6%	0.50%
HARDIN	7,444	26,635	27.95%	$32,860,719.65	$4,414.39	0.6%	0.6%	0.44%
HAWKINS	12,500	56,234	22.23%	$44,304,203.90	$3,544.34	0.8%	1.0%	0.94%
HAYWOOD	5,970	19,920	29.97%	$19,796,677.28	$3,316.03	0.4%	0.5%	0.33%
HENDERSON	6,430	26,767	24.02%	$25,884,340.05	$4,025.56	0.5%	0.5%	0.45%
HENRY	7,404	31,872	23.23%	$28,977,309.23	$3,913.74	0.6%	0.6%	0.53%
HICKMAN	5,402	24,550	22.00%	$23,319,757.05	$4,316.87	0.4%	0.4%	0.41%
HOUSTON	2,046	8,236	24.84%	$10,302,377.19	$5,035.38	0.2%	0.2%	0.14%
HUMPHREYS	3,918	18,554	21.12%	$20,445,730.01	$5,218.41	0.4%	0.3%	0.31%
JACKSON	2,962	11,524	25.70%	$14,628,501.84	$4,938.72	0.3%	0.2%	0.19%
JEFFERSON	10,518	48,457	21.71%	$44,234,632.40	$4,205.61	0.8%	0.9%	0.81%
JOHNSON	4,826	18,308	26.36%	$16,357,512.07	$3,389.46	0.3%	0.4%	0.30%
KNOX	63,376	399,254	15.87%	$270,474,607.31	$4,267.78	5.2%	5.2%	6.65%
LAKE	2,251	7,952	28.31%	$11,362,823.33	$5,047.90	0.2%	0.2%	0.13%
LAUDERDALE	7,914	28,709	27.57%	$25,969,725.27	$3,281.49	0.5%	0.6%	0.48%

County	Enrollment on 12/31/2005	Estimated 2006 Population	% of County on TennCare	Total Service Expenditures	Expenditure per Member	% County Expenditure	% County Enrollment	% County Population
LEWIS	3,087	11,972	25.79%	$13,682,311.76	$4,432.24	0.3%	0.3%	0.20%
LINCOLN	6,625	32,717	20.25%	$29,641,346.64	$4,474.17	0.6%	0.5%	0.54%
LOUDON	6,998	42,026	16.65%	$32,002,187.44	$4,573.05	0.6%	0.6%	0.70%
MACON	5,099	21,799	23.39%	$21,543,902.54	$4,225.12	0.4%	0.4%	0.36%
MADISON	21,968	96,205	22.83%	$86,651,252.52	$3,944.43	1.7%	1.8%	1.60%
MARION	6,830	28,440	24.02%	$30,316,751.49	$4,438.76	0.6%	0.6%	0.47%
MARSHALL	5,007	28,709	17.44%	$21,900,067.18	$4,373.89	0.4%	0.4%	0.48%
MAURY	13,664	74,841	18.26%	$74,428,792.31	$5,447.07	1.4%	1.1%	1.25%
MCMINN	10,768	51,614	20.86%	$42,571,269.54	$3,953.50	0.8%	0.9%	0.86%
MCNAIRY	7,807	25,249	30.92%	$32,471,659.56	$4,159.30	0.6%	0.6%	0.42%
MEIGS	3,146	11,816	26.63%	$10,331,715.64	$3,284.08	0.2%	0.3%	0.20%
MONROE	10,115	42,178	23.98%	$36,435,806.77	$3,602.16	0.7%	0.8%	0.70%
MONTGOMERY	22,321	146,487	15.24%	$90,151,275.29	$4,038.85	1.7%	1.8%	2.44%
MOORE	816	6,011	13.58%	$4,440,314.93	$5,441.56	0.1%	0.1%	0.10%
MORGAN	5,226	20,637	25.32%	$19,770,373.60	$3,783.08	0.4%	0.4%	0.34%
OBION	6,772	33,004	20.52%	$26,224,306.87	$3,872.46	0.5%	0.6%	0.55%
OVERTON	4,885	20,765	23.53%	$20,443,460.29	$4,184.95	0.4%	0.4%	0.35%
PERRY	1,522	7,742	19.66%	$8,488,840.10	$5,577.42	0.2%	0.1%	0.13%
PICKETT	1,362	5,157	26.41%	$6,761,750.64	$4,964.57	0.1%	0.1%	0.09%
POLK	3,817	16,517	23.11%	$14,225,165.86	$3,726.79	0.3%	0.3%	0.28%
PUTNAM	13,841	66,880	20.70%	$65,956,260.22	$4,765.28	1.3%	1.1%	1.11%
RHEA	7,587	29,803	25.46%	$30,752,601.46	$4,053.33	0.6%	0.6%	0.50%
ROANE	11,025	53,534	20.59%	$52,575,093.15	$4,768.72	1.0%	0.9%	0.89%
ROBERTSON	9,572	60,446	15.84%	$46,946,127.49	$4,904.53	0.9%	0.8%	1.01%
RUTHERFORD	28,539	208,017	13.72%	$116,287,223.94	$4,074.68	2.2%	2.3%	3.46%
SCOTT	8,504	22,548	37.72%	$36,674,493.93	$4,312.62	0.7%	0.7%	0.38%
SEQUATCHIE	3,103	12,352	25.12%	$12,939,528.05	$4,170.01	0.2%	0.3%	0.21%
SEVIER	14,802	78,724	18.80%	$50,901,626.22	$3,438.83	1.0%	1.2%	1.31%
SHELBY	234,375	933,955	25.09%	$792,746,986.11	$3,382.39	15.1%	19.1%	15.55%
SMITH	3,555	19,039	18.67%	$15,584,629.78	$4,383.86	0.3%	0.3%	0.32%
STEWART	2,354	13,460	17.49%	$11,117,560.09	$4,722.84	0.2%	0.2%	0.22%
SULLIVAN	29,058	154,374	18.82%	$114,016,945.90	$3,923.77	2.2%	2.4%	2.57%
SUMNER	20,863	142,619	14.63%	$90,194,077.26	$4,323.16	1.7%	1.7%	2.38%
TIPTON	11,590	56,699	20.44%	$35,672,999.18	$3,077.91	0.7%	0.9%	0.94%
TROUSDALE	1,792	7,716	23.22%	$7,866,381.73	$4,389.72	0.2%	0.1%	0.13%
UNICOI	4,344	17,917	24.25%	$22,224,422.15	$5,116.12	0.4%	0.4%	0.30%
UNION	5,096	19,714	25.85%	$18,131,526.73	$3,557.99	0.3%	0.4%	0.33%
VAN BUREN	1,347	5,665	23.78%	$6,843,157.63	$5,080.30	0.1%	0.1%	0.09%
WARREN	9,537	40,308	23.66%	$45,571,106.44	$4,778.35	0.9%	0.8%	0.67%
WASHINGTON	19,313	112,908	17.11%	$92,120,904.30	$4,769.89	1.8%	1.6%	1.88%
WAYNE	3,531	17,516	20.16%	$19,900,998.90	$5,636.08	0.4%	0.3%	0.29%
WEAKLEY	6,524	35,723	18.26%	$28,790,493.88	$4,413.01	0.5%	0.5%	0.60%
WHITE	5,973	24,137	24.75%	$30,048,509.65	$5,030.72	0.6%	0.5%	0.40%
WILLIAMSON	7,275	147,382	4.94%	$37,347,725.78	$5,133.71	0.7%	0.6%	2.45%
WILSON	11,908	98,549	12.08%	$58,757,099.24	$4,934.25	1.1%	1.0%	1.64%
OTHER	11,370			$121,422,787.31	$10,679.23	2.3%	0.9%	0.00%
TOTAL	1,224,100	6,004,724	20.39%	$5,245,502,300	$4,285.28	100%	100%	100%

* Expenditures include MCO, Pharmacy, LTC and Dental; they do not include BHO Services or MCO Administrative costs.
** Greene County expenditures include costs associated with the Greene Valley Developmental Center, causing the per-member cost to appear higher when comparing it with those of the other counties.

TENNder CARE

Check In Check Up Check Back

TENNESSEE'S EPSDT PROGRAM

TennCare continues to invest in the future of Tennessee's children through a partnership with the Department of Health

TENNderCARE is Tennessee's Early, Periodic, Screening, Diagnosis, and Treatment program (EPSDT), a federally mandated service under Medicaid's comprehensive and preventive child health program for individuals under 21.

The EPSDT program consists of two operational components: (1) assuring the availability and accessibility of required healthcare resources; and (2) helping Medicaid recipients and their parents or guardians effectively use these resources. Tennessee includes TennCare children who are not Medicaid eligible in these goals.

"Every child in Tennessee deserves to grow up healthy and happy," says Governor Phil Bredesen. "TENNderCARE is the State's commitment to see that our children and teens have the best start at a healthy life."

Through the TENNderCARE program, Tennessee is committed to promoting good health for more than 654,000 children from birth to 21. The program allows for assessment of children's health needs through initial and periodic examinations and evaluations, and assures that the health problems found are diagnosed and treated early, before they become more complex and their treatment more costly.

The number of children receiving a TENNderCARE exam has continued to rise each year for the past 6 years, with the 2005 federal fiscal year screening rate reaching 75 percent. A key element to increasing the number of children receiving TENNderCARE exams is the provision of outreach services. To strengthen outreach efforts, the TennCare Bureau entered into an agreement with the Tennessee Department of Health (DOH) for the development of a comprehensive outreach program designed to inform families of the benefits of preventive health services, encourage families to utilize TENNderCARE services and to assist families with the scheduling of appointments. In January 2005, the state-wide TENNderCARE outreach program became operational, with two core elements: (1) a child enrollee call center and (2) a community-based outreach program.

The Call Center employs 28 service representatives and is staffed from 9 a.m. to 8 p.m., to accommodate the schedules of working families. The representatives, with bilingual capabilities, are responsible for outbound telephone contact to all new TennCare child enrollees and those enrollees whose eligibility recently has been re-certified. The representatives inform enrollees of

TENNderCARE services, discuss the benefit of preventive healthcare, encourage families to schedule appointments for all EPSDT-eligible family members, offer assistance with scheduling appointments, and, if needed, coordinate transportation to appointments. During the 2005 federal fiscal year, representatives attempted phone calls to 265,330 families with children – calls that resulted in 103,246 contacts with families. The service representatives assisted families with the scheduling of 6,968 TENNderCARE appointments.

The TENNderCARE Call Center recently expanded its focus to include outreach to at-risk populations with prenatal or post-partum needs and to families with infants younger than 1. There are three registered nurse positions available to make outbound calls to families who meet these criteria, to offer prenatal, post-partum and infant care education and assist with appointment scheduling. The nursing staff also responds to any calls related to conditions that may cause infant deaths. The new nursing enhancement includes a call-in line that enables enrollees with questions related to prenatal and infant care to speak to a member of the nursing staff.

TENNderCARE Community Based Outreach Programs operate in all 95 Tennessee counties, either through the Regional or Metropolitan Health Departments. Local health department staff conducted community assessments to identify audiences of TennCare families and potential partnerships based on available community resources. Programs target the general EPSDT eligible membership but also include specific outreach for special populations such as adolescents, children with special healthcare needs, and pregnant women.

Because teens represent a group that can be difficult to influence, special programs have been developed to gain their attention. "Health Rocks" are health-focused events coordinated especially for teens through activities, education and incentives relevant to their interest level. Posters with teen-specific messages are distributed through middle and high schools, sporting events, employers and other sites where teens congregate. A teen page added to the TennCare website features information directed at this age group, as well. The MCOs have collaborated on a quarterly newsletter for teens with articles of interest to this age group. By reading these articles, teens might be inclined to schedule visits with their primary care providers, resulting in completion of a TENNderCARE exam.

The community outreach staffers employ a mixture of approaches in their efforts to interact with TennCare enrollees. They distribute TENNderCARE educational materials that have been developed by the TennCare Outreach Workgroup that emphasize the importance of preventive care. Attendance at health fairs and other community events provides an opportunity for face-to-face discussions with TennCare enrollees. Collaboration with community-based organizations is essential for broadening enrollee contact. There are a multitude of agencies that are experienced in providing services to this population and that assist the outreach workers in tailoring activities for optimal benefit. Family Resource Centers, GED programs, public housing sites, day care centers, Head Start programs, schools, and community recreation centers are a few of the settings where enrollees assemble. Particular attention is focused on groups that serve enrollees who are illiterate, blind, deaf, or have limited English proficiency.

Outreach workers have collaborated with primary care physicians to reach those enrollees who are not up-to-date on their exams. Phone calls, home visits, and special events have been scheduled to encourage enrollees to undergo their exams. MCOs have collaborated on activities, providing enrollee and provider incentives for participation. Community Partner Packets have been developed to inform potential partners about the TENNderCARE program and the need for their involvement. Staffers also have instituted an effort to reach employers with low wage earners whose children may be TennCare-eligible. At the work site, paycheck inserts, presentations, posters, and exhibits are used to disseminate TENNderCARE information. Outreach teams also have spread the message through billboards, electronic message boards, radio talk shows, television interviews, public service announcements and newspaper articles.

TENNderCARE also recognizes the importance of oral health in the overall wellness of children. Poor oral health can lead to decreased school attendance, the inability to concentrate when in school, and serious medical conditions. The TennCare Bureau has partnered with the Department of Health to address oral health disease by providing dental services to children in public school settings.

The School Based Dental Prevention Program is a statewide, school-based dental program for children in kindergarten through the eighth grade, and is available in schools with a free- and reduced-lunch enrollment of 50 percent or more. Portable equipment is used by dental staff to provide dental screenings, referrals and follow-up to dental providers to address unmet dental needs. Health education and preventive sealants are provided to the target school population as well as information regarding TennCare eligibility, the application process, and TENNderCARE medical exams.

The School Based Dental Prevention Program is operating in all 13 regions of the state. Comprehensive preventive services were provided in a total of 353 schools in the fiscal year 2005-06. These services include:

- dental screenings for 152,680 children,
- referrals for care for 40,148 children,
- dental sealants for 56,418 children,
- comprehensive oral evaluations by a licensed dentist were provided to 35,478 TennCare children,
- oral health education programs reaching 192,970 children,
- TennCare outreach activities to 162,706 children and
- follow-up for 100 percent of children with priority unmet dental needs.

EPSDT services to TennCare children continue to grow at a steady rate. As a result, medical, dental, and behavioral services can be accessed across the state. For those enrollees who are unfamiliar with the TENNderCARE benefit, outreach activities will continue in order to raise awareness of the need for preventive services.

TENNderCARE
Check In Check Up Check Back
TENNESSEE'S EPSDT PROGRAM

TennCare Reform

Continuation of Closed Enrollment/Disenrollment

As a part of the TennCare reform initiative discussed at length in the previous year's annual report, enrollment into the TennCare Standard program (the waiver/expansion population) continued to be closed throughout the 05/06 fiscal year. The only exception was for children under 19 who still could "roll over" from Medicaid to TennCare Standard if they met the eligibility requirements of TennCare Standard. The Medically Needy (also called "Spend Down") TennCare Medicaid category also remained closed to non-pregnant adults, but was open for children up to 21 and pregnant women who met the eligibility requirements. All other TennCare Medicaid categories remained fully open to new enrollment.

The Department of Human Services (DHS) managed the process of disenrolling adults 19 and older in TennCare Standard. This process began with ex parte reviews designed to determine if any of these enrollees were eligible in an open Medicaid category. Those who were eligible were moved to those categories.

Those who were not eligible in an open category were sent a letter with a "Request for Information" (RFI) form, which they could use to send in additional information about themselves that might qualify them for an open category. Special outreach was conducted to be sure that certain groups – such as people with severe and/or persistent mental illness, people with limited English proficiency, and people with other kinds of special circumstances – were assisted in filling out their RFIs.

Through the disenrollment process, approximately 18,000 adults gained Medicaid eligibility. Approximately 170,000 adults were disenrolled from TennCare Standard.

Benefit Changes Implemented

On August 1, 2005, also as part of the comprehensive reform plan to deal with a projected $650 million deficit in state funding for the TennCare program, the following benefits were eliminated from coverage for adult enrollees:

- Methadone clinic services
- Over-the-counter drugs
- Sitter services
- Convalescent care services
- Dental care

A co-payment of $3 became effective on August 1, 2005, for most brand-name medications; and it affects adult Medicaid enrollees and children in the TennCare Standard population with incomes more than 100 percent of the federal poverty level. Pregnant women, adults receiving hospice care, institutionalized individuals, and emergency services are exempt from the co-pay requirements.

In addition, a monthly limit of five prescriptions, of which no more than two may be for brand-name medications, was implemented for non-institutionalized adult enrollees. A list of medications that do not count against the limit and that continue to be available to adult enrollees even after a limit has been hit was developed and put into place before the prescription limits were implemented.

Grier Ruling

In spring 2005, the State petitioned the U.S. Federal District Court for modifications to the Grier Consent Decree. This decree sets forth the due-process rights of TennCare members (i.e., the rights to notice and to request a fair hearing) when Managed Care Contractors (MCCs) deny, delay, reduce or terminate TennCare services. The State requested the changes to improve quality and to control TennCare costs, by permitting the State and its MCCs to more effectively manage the health care delivered to enrollees.

Although the State was not granted the comprehensive relief it sought, beginning in August 2005 and continuing into 2006, the Court granted a considerable number of the requested changes. These modifications made it possible for the State to preserve coverage for non-pregnant adults in the Medically Needy category and paved the way for the design of a new TennCare Standard eligibility category to provide enrollment opportunities for 100,000 "spend down" adults in the future.

Submission of Standard Spend Down Proposal to CMS

On January 11, 2006, TennCare submitted a proposed waiver amendment to the Centers for Medicare and Medicaid Services (CMS). This amendment would allow the State to enroll up to 100,000 non-pregnant adults in the TennCare expansion program (TennCare Standard) if they meet criteria patterned after those criteria used in the Medically Needy (Spend Down) program. The new eligibility group would be called the "Standard Spend Down" group, or "SSD." As of the end of the state fiscal year, CMS had not yet approved the amendment.

Decision Not to Move Forward with Other Benefit Limits

The reform plan submitted to CMS in February 2005 was implemented with a phased-in approach that began in June 2005 with the process for disenrolling adults in the TennCare Standard population.

It was followed in August 2005 with a first round of benefit changes that included the elimination of certain services for adults and the implementation of prescription drug limits for adults.

A second round of benefit changes – which would have included placing limits on the number of covered inpatient hospital days, outpatient facility visits, outpatient physician visits and lab and X-ray services for adult enrollees – was planned for early calendar year 2006. Ultimately, the decision was made to withdraw the request pending before CMS to implement these additional limits and to focus instead on efforts to enhance MCO case management and disease management activities.

Quality Initiatives

NCQA Accreditation

With a July 1, 2005, amendment to the Managed Care Organizations contract, Tennessee became the first state in the country to mandate that all Medicaid MCOs become accredited by the National Committee for Quality Assurance (NCQA).

NCQA is an independent, 501(c)(3) nonprofit organization that assesses and scores MCO performance in the areas of quality improvement, utilization management, provider credentialing and member rights and responsibilities. The contracts of those MCOs that fail to obtain NCQA accreditation by Dec. 31, 2006, may be terminated by TennCare. This process will leave only those MCOs providing the highest quality of care and service to enrollees.

As of this writing, all MCOs have been accredited by NCQA, with three plans achieving an "Excellent" accreditation status, three plans receiving "Commendable" status and one plan receiving a "Provisional" accreditation. NCQA recognizes five levels of accreditation: Excellent, Commendable, Accredited, Provisional and Denied.

AmeriChoice, BCBS and TLC received an Excellent accreditation. Unison, UAHC and PHP received Commendable. And, VHP received a Provisional accreditation.

MCOs Report HEDIS and CAHPS

As a part of a requirement that all MCOs achieve NCQA accreditation by Dec. 31, 2006, all MCOs were required to submit a full set of HEDIS and CAHPS data to the State in June 2006. HEDIS refers to the Health Plan Employer Data and Information Set and is a nationally recognized set of standardized measures of MCO performance.

CAHPS refers to the Consumer Assessment of Health Plan Survey and is a nationally recognized set of standardized surveys used to measure member satisfaction with their MCOs. Selected HEDIS and CAHPS measures are evaluated and scored by NCQA as a part of the accreditation process.

This first complete set of data represents a wealth of information concerning MCO performance and member satisfaction with MCO performance and will serve as a baseline for evaluating MCO quality improvement efforts.

A summary report is available on TennCare's Website at www.tn.gov/tenncare. Last year, MCOs were required to submit a limited set of HEDIS measures, thus enabling the State to compare performance over the past two years for a small group of measures. The State level results demonstrated improvement in every indicator and are presented in the following table:

Measure	HEDIS 2005	HEDIS 2006
Childhood Immunization Status: Combo 2	73.0%	73.4%
Adolescent Immunization Status: Combo 2	19.6%	25.0%
Breast Cancer Screening	40.7%	50.2%
Cervical Cancer Screening	54.1%	60.9%
Comprehensive Diabetes Care - HbA1c testing	67.4%	70.7%
Prenatal and Postpartum Care - Timeliness of Prenatal Care	70.6%	75.6%
Prenatal and Postpartum Care - Postpartum Care	54.7%	58.2%

MCO Disease and Case Management Programs Expanded

In July 2005, TennCare began amending the MCO contracts to set clear expectations for the statewide provision of disease/care management programs targeting asthma, diabetes, congestive heart failure and maternity care.

These conditions were selected because of their prevalence in the TennCare population and the significant potential that exists to improve quality of care through the use of disease management interventions.

The MCO disease management programs must be operated in accordance with NCQA standards with the goals of improving patient outcomes by promoting health care provider adherence to best practice guidelines, and of educating and engaging patients in the important role they play in managing their own health care.

In addition to the enhanced focus on disease management, a variety of utilization indicators have been identified to serve as triggers for potential enrollment in MCO case management, with particular emphasis on enrollees who appear to be over-utilizing emergency department services.

Shared Health Pilot

During the 05/06 fiscal year, the Bureau of TennCare worked extensively with Shared Health, a wholly owned subsidiary of BlueCross BlueShield of Tennessee, to develop and deploy a Web-based clinical health record in a pilot project among a select group of TennCare clinicians.

The Shared Health Clinical Health Record (CHR) provides comprehensive patient information, including patient demographic information, medical diagnoses and procedures, medications and other pertinent clinical information and forms, to give clinicians a global view of a patient's medical history and to facilitate better coordination of care.

An additional ePrescribe module enables authorized physicians to securely order medications for their patients directly from their personal computers, eliminating traditional paper prescriptions and improving safety and accuracy.

The pilot project has gone very well and the Bureau expects to deploy the CHR for the entire TennCare population in October 2006.

Pharmacy Changes

Pharmacy Prior Authorization Process

As a result of court rulings in the Grier case, the State was able to implement a pharmacy prior authorization (PA) process with significant potential to both improve quality of care and reduce unnecessary/inappropriate health care costs. Beginning on Jan. 1, 2006, for drugs requiring PA, the enrollee's physician must obtain such PA from the State's Pharmacy Benefit Manager (PBM) before the drug can be paid for by TennCare. If a prescription is presented at the pharmacy without the requisite PA, the pharmacist attempts to contact the provider to encourage the provider either to seek PA or to change the prescription to one that does not require PA. If the pharmacist is unable to reach the provider or the provider fails to obtain PA, the prescription will not be filled.

An exception to the aforementioned process would be made if, in the judgment of the dispensing pharmacist, an emergency situation existed. In such a case, the pharmacist dispenses an emergency, 72-hour supply of the prescribed drug. The patient does not receive any more than an emergency, 72-hour supply of the prescribed drug unless PA is subsequently granted.

Policies and procedures have been developed to ensure that members for whom a request for PA has been denied are mailed written notices explaining why PA was denied and how to appeal. Those who are unable to fill a prescription because PA has not been sought are handed a pre-printed notice at the pharmacy that advises the member to contact the provider regarding the need for PA. Members who are unsuccessful in that regard may seek assistance from the PBM in contacting the provider to initiate the PA process.

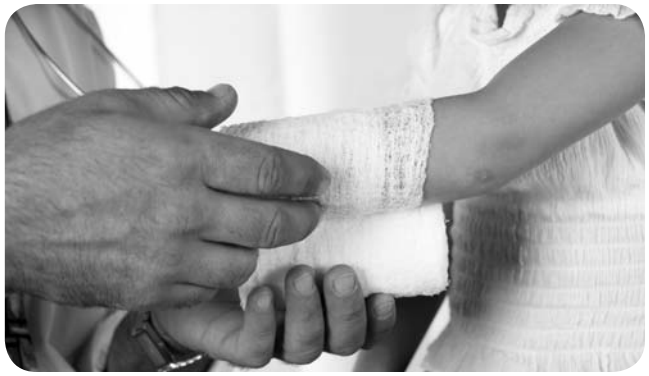
Medicare Part D Implementation

On January 1, 2006, CMS began offering a prescription drug benefit to individuals enrolled in the federal Medicare program. As a result, enrollees dually eligible for both TennCare and Medicare no longer receive their prescriptions through TennCare. At the time of implementation of Medicare Part D, 225,000 dual eligibles were enrolled in TennCare. Implementation of Part D and TennCare's new prior authorization program occurred simultaneously and resulted in an approximate 48 percent decrease in the numbers of prescriptions processed each month. The State continues to be financially responsible for the cost of the Part D benefit for TennCare dual eligibles via a federal "clawback" provision.

National Medicaid Pooling Initiative

In an effort to assure continued maximization of supplemental rebates despite a decrease in enrollment and the implementation of Medicare Part D, on July 1, 2005, Tennessee joined the National Medicaid Pooling Initiative (NMPI). NMPI is a mechanism whereby multiple states band together in order to negotiate the best possible supplemental rebates. These rebates are returned to the state each time medications on the preferred drug list (PDL) are purchased by the TennCare program. Participation in the NMPI has allowed

TennCare to lock in drug prices for a three-year period, resulting in price protection.



Preferred Drug List Improvements

Meetings of the Pharmacy Advisory Committee were held quarterly during state fiscal year 06 to facilitate the process of expanding the number of categories of drugs included on the PDL and to reassess the status of drugs in the categories of medications already included on the PDL.

A preferred drug list is a listing of medications in a given therapeutic category where one or more drugs have a preferential status over the other drugs in that category. Designation as a preferred agent can be due to the drug having greater clinical efficacy than other drugs in the class, or to a lower net cost, when all drugs in the class are clinically equivalent.

The 2006 fiscal year represented the second full fiscal year of operation of the Preferred Drug List. TennCare uses the PDL to garner better pricing while assuring enrollee access to medically necessary medications.

Reduced Number of Audit Findings

TennCare continued to make significant progress in reducing the number of findings in the Annual Audit Report issued by the State of Tennessee Comptroller of the Treasury. In 2006, the audit report for 2005 was issued with a total of nine findings. Of these nine, four were reduced in severity, with improvement noted from the preceding year.

- SFY 2002 audit = 39 total findings
- SFY 2003 audit = 29 total findings
- SFY 2004 audit = 15 total findings
- SFY 2005 audit = 9 total findings

Notice and Appeal Process Improvements

A number of modifications to the Grier Consent Decree resulting from the court orders during fiscal year 05/06 pertain to notice and appeal processes.

The State now may require a member who appeals a service without a valid prescription to exhaust an administrative process before the appeal can proceed. The administrative process ensures timely access to a qualified provider to evaluate the member's need for the requested service before a fair hearing is granted.
The new orders also clarified that, while under Grier a patient may appeal any adverse action, pursuant to federal regulations, members are entitled to a fair hearing only when the appeal is based on an underlying valid factual dispute and not when the sole dispute is a challenge to the State's policy.

Other modifications address when a member can request that his/her medical appeal be processed as an emergency, i.e., on an expedited timeline (generally 31, rather than 90, days). In this context, an "emergency" means that, if the member does not receive the requested care or medicine sooner than 90 days, s/he will be at risk of:

- Serious health problems or death,
- Serious dysfunction of an organ or body part, or
- Hospitalization.

Under certain circumstances, even when an expedited timeline is granted, the State may be able to extend such a timeline up to 45 days when necessary to obtain medical records needed to process the appeal. Further, while a member may request an emergency appeal, the State may ask the treating physician to provide written certification whether such appeal is, in fact, an emergency and if not, complete processing on a standard 90-day timeline.

One of the most significant changes regarding medical appeals processes pertains to situations in which an MCC 1) issues a notice that fails to meet Grier's enhanced notice content requirements; or 2) misses one of the specified timelines for processing a medical appeal set forth in the Grier Consent Decree. In the event of such an administrative error, the State is no longer required to automatically overturn the MCC and direct the requested service regardless of medical necessity. Instead, the MCC may issue a single, corrected notice that addresses the deficiencies of the original notice, or the State may remedy the missed timeline early in the appeals process.

A final, noteworthy area of modification pertaining to appeal processes permits the State to comply with federal law and regulations that require the Single State Medicaid Agency to retain the authority to review and/or overturn the decisions of non-agency hearing officers when those decisions are contrary to applicable law, regulations or agency policy interpretations.

Taken together, these modifications have improved the quality of services provided to TennCare members, have maximized the State's resources and have facilitated more efficient processing of medical appeals while ensuring full due-process protections.

Systems/Data Accomplishments

Certification of TCMIS

Following an on-site visit in September 2005, the Bureau received full federal certification of the TennCare Management Information System (TCMIS) from the Centers for Medicare & Medicaid Services (CMS). Certification of the system was granted retroactive to the implementation date of August 2004, without reservation.

Based on prior approval of the contract with EDS to implement and operate the system, CMS will cover 90 percent of the cost for design, development and implementation of the system and 75 percent of the cost of ongoing system operations, now that the system has been fully certified, bringing a significant amount of additional federal funding to the program.

The TennCare Encounter Data Initiative

The TennCare Encounter Data Initiative (TEDI) is a continuous data quality improvement project that was implemented in the first quarter of 2006. TennCare depends on the encounter data for a number of purposes. The data is needed to substantiate the care delivered to enrollees and the payment for that care. A number of parties, including the state auditors, actuaries and Bureau management, use the data for financial and utilization analysis. The Bureau also uses the data for various operational reporting requirements. As such, it is critical that the submitted data is accurate, complete and consistent in format and content.

By collaborating with internal and external stakeholders, TEDI has been successful. This is proven by the following improvements:

- Provided structure to the encounter data quality management process
- Implemented quality controls
- Improved encounter data quality
- Enhanced data delivery system
- Developed policies and procedures
- Improved compliance
- Established work group concept

TEDI leveraged existing resources; therefore, no additional costs were incurred.

Major Changes in Middle Tennessee

05/06 Milestone

Release of an RFP for a New Managed Care Model

As part of the transition to increased fiscal responsibility and the commitment to continuously improve the quality of care delivered through the program, in April 2006, the Bureau of TennCare released a Request for Proposal (RFP) to accept competitive bids from Managed Care Organizations for provision of TennCare services in the Middle Tennessee Region.

This RFP was the first time TennCare has used the competitive bid process to recruit MCOs to its service delivery network.

The RFP included:

- A requirement for an integrated behavioral health model with the MCO managing both physical health and behavioral health services, in order to improve coordination of care for our enrollees and deliver services more efficiently,
- the opportunity for additional bid points at higher levels of financial risk. The lowest level of financial risk available to bidders was greater than the current level of financial risk assumed by TennCare MCOs,
- requirements for additional disease management programs above and beyond the current disease management programs already required by MCOs,
- detailed requirements that all children in the new MCOs will receive outreach and screening services to assure preventive health care delivery,
- clear provider network requirements to give enrollees access to needed primary and specialty care, and
- an aggressive timeline for accreditation from NCQA, including a requirement to produce data that allows for an objective assessment of quality of care.

The Bureau of TennCare received six proposals for the Middle Tennessee Region, one each from the two existing MCOs operating in the Middle Tennessee region and four additional proposals from other large managed care companies operating in multiple states throughout the country. Proposals were evaluated with a particular focus on experience in other markets with Medicaid managed care – thereby favoring candidates with established track records for stably and consistently administering healthcare. The Bureau also focused on how physical and behavioral services care would be managed and coordinated on an integrated basis.

Looking Ahead to 06/07

New MCOs Selected and Scheduled to Begin Operation

As a result of the competitive bid process, contracts were awarded in July 2006 to two new managed care organizations that are scheduled to begin serving TennCare enrollees effective April 1, 2007. Each of the two successful bidders elected to accept full financial risk to participate in Tennessee's Medicaid program.

Amerigroup is a Virginia-based company that manages more than 1 million Medicaid lives in nine states and has assets worth $1.2 billion. AmeriChoice (United Healthcare Plan) is based in Minnesota. It manages more than 1.2 million Medicaid lives in 13 states and has assets of $45 billion. United recently acquired John Deere Healthplan, a TennCare MCO in the eastern part of the state.

Representatives from TennCare, the Department of Mental Health and Developmental Disabilities and the Department of Commerce and Insurance are conducting an extensive "readiness review" of the new Middle Tennessee MCOs.

Desk audits, the first component of these reviews, have involved review and approval of all required policies, procedures and deliverables. In addition, on-site reviews have been conducted, focusing on claims administration, information systems testing, financial audits, medical management and customer services processes and workflows, and provider network development and network adequacy.

The addition of these two, nationally proven companies to the TennCare network is emblematic of the efforts the Bureau is taking to bring stable MCOs into our network. This helps ensure not only more choices for our enrollees but also a smooth transition to MCOs who are experienced in providing high-quality care to similar populations in other states.

* TennCare is returning to a fully capitated, managed-care delivery system

* TennCare will contract with MCOs who will assume full risk to participate

* Contracts to the MCOs are to be awarded July 2006

* The new MCOs are to start serving TennCare enrollees April 1, 2007

Waiver Extension

TennCare is a Section 1115 demonstration waiver. Through TennCare, the State of Tennessee is allowed to waive certain federal regulations relating to the Medicaid program in order to demonstrate a managed care approach to healthcare delivery. The design of the program enables the State to cover more people and services than it is able to cover under Medicaid, while keeping spending to a level that does not exceed what would have been spent under Medicaid. The current TennCare waiver, which has been in place since 2002, expires on June 30, 2007. The State is in the process of seeking a waiver extension from CMS, which would be effective July 1, 2007, through June 30, 2010. It is not envisioned that the waiver extension would involve any substantial changes in the programmatic aspects of the original waiver.

Implementation of Standard Spend Down Program

Pending CMS approval, TennCare anticipates implementing the new Standard Spend Down Program (SSD) as early as February 2007. The Department of Human Services is establishing a new enrollment process for SSD. Open enrollment periods will be established to control enrollment to a specific number of individuals. When the open enrollment period is announced, individuals will be able to call a toll-free number to express interest in the program.

When the State has received calls from the specified number of interested individuals, enrollment will be closed and those interested individuals will be sent an application and instructions on how to apply for the program. Total enrollment is capped at 100,000.

There are several important criteria to be eligible in the new SSD category. The new category will be open only for individuals who are age 21 and over and not pregnant (today, these children and pregnant women are eligible for Medicaid in another category). An individual must also be over 65, blind, disabled or the caretaker relative of a TennCare eligible child. Applicants must also have enough medical bills to "spend down" their gross income below the income standard.

TennCare plans to follow federal guidelines and provide a "look back" period of 90 days for unpaid medical bills. Once eligible for TennCare's SSD category, the enrollee receives a full year of coverage.

Upon CMS approval, TennCare will also begin verifying eligibility for those non-pregnant adults who are currently eligible in the old Medically Needy category. As enrollees in this category are re-verified, they will be given the opportunity to apply for SSD without going through the call-in process. If they complete the application process and are determined eligible, this group of individuals will move into the SSD program without a break in coverage.

TennCare also operates a Medically Needy Spend Down category for pregnant women and children that is currently open for new enrollment. Financial eligibility criteria and the eligibility time period are the same as SSD but without an enrollment cap on this Medicaid category.

Home and Community Based Services (HCBS) Waiver Expansion

In addition to the Section 1115 demonstration waiver under which the bulk of the TennCare program falls, TennCare operates several home and community based services (HCBS) waivers. These waivers serve two distinct population groups:

- Children and adults with mental retardation who would qualify for ICF-MR admission, but wish to remain in their homes and receive services, and
- Elderly and disabled adults who would qualify for admission to a nursing home but who wish to remain in the community with appropriate services and supports.

Federal regulations associated with these waivers require that the services needed and received by the patient must be less costly than admission to a long-term care facility.

In FY 06/07, the three waiver programs serving the elderly and disabled will be consolidated into a single program, which will then be significantly expanded in terms of the total number of enrollees eligible to participate and the number of services available to eligible enrollees. New services available through the waiver will include in-home respite, assistive technology, personal care attendant services, adult day care, pest control and care in an assisted living facility (excluding the cost of room and board). This expansion is representative of TennCare's commitment to offering more choices for our enrollees by providing community supports that enable enrollees to receive care at home instead of at nursing homes.

Litigation Concerning the John B. (EPSDT) Consent Decree

In 1998, the State entered into a Consent Decree in the John B. case. The decree details the State's responsibilities with regard to the provision of healthcare services to enrollees under age 21. The Tennessee Justice Center represents the plaintiff class and has alleged that the State has not complied with the terms of the Consent Decree. The State disputes this allegation, and it is expected that the matter will be heard in federal court in the spring or summer of 2007.

Continued Focus on Quality

New Medical Necessity Rules

During the 2004 session of Tennessee's General Assembly, a bill including a new definition of medical necessity for the TennCare program was passed into law. The new definition specifies that to be medically necessary, a medical item or service must satisfy each of the following criteria:

- It must be recommended by a licensed physician who is treating the enrollee or by another licensed healthcare provider practicing within the scope of his or her license who is treating the enrollee;
- It must be required in order to diagnose or treat an enrollee's medical condition;
- It must be safe and effective;
- It must not be experimental or investigational; and
- It must be the least costly alternative course of diagnosis or treatment that is adequate for the enrollee's medical condition.

The new definition was not immediately put into effect, because of a federal court Consent Decree that would have prevented effective implementation. However, in summer 2005, the State went to court for relief from certain provisions of the Grier Consent Decree and eventually obtained enough relief to begin planning to move forward with implementation of the new definition.

Rules have been developed to provide a framework for putting the definition into practice and to facilitate evidence-based decision-making by the managed care contractors. Temporary rules will be implemented Dec. 1, 2006, with the opportunity for public comment before final rules were promulgated.

Initiative to Reduce Emergency Department Overuse

Recent data indicate that TennCare enrollees utilize emergency department (ED) services at a rate of approximately 743 visits per 1,000 enrollees per year. This compares with a national rate among the general population of 382 visits per 1,000 people per year. Further analysis demonstrates that approximately 40 percent of visits among TennCare enrollees are for non-emergent healthcare conditions. Reliance upon EDs for primary care services represents a problem for TennCare in that it results in poor utilization of limited financial resources; it is a problem for hospitals, in that it detracts from the mission and purpose of the ED and contributes to reimbursement challenges; and it is a problem for patients who might experience long waits.

To address this shared problem, TennCare is partnering with the Tennessee Hospital Association on a pilot project intended to reduce inappropriate utilization of EDs. Hospitals electing to participate in the pilot will implement a triage-and-screening process to identify patients who do not have urgent or emergent medical conditions. These patients then will be referred to alternate, more cost-effective settings for care. TennCare is supporting this initiative by assuring that TennCare managed care organizations will be available 24 hours a day, seven days a week, to assist enrollees who need help making appointments with their primary care provider or accessing care in another, more appropriate setting.

Pay for Performance - Quality Incentive Measures

In order to encourage continuous improvement in the quality of care provided through TennCare's managed care organizations, TennCare has developed a pay-for-performance initiative focused on improvements in indicators associated with MCO disease management programs. In 2006, the identified performance measures included emergency department visit rates for congestive heart failure and asthma, and HEDIS indicators related to prenatal care and diabetes. HEDIS, the Health Plan Employer Data and Information Set, is a nationally recognized set of standardized measures of MCO performance.

Beginning in 2007, TennCare intends to move to an annual Quality Incentive assessment and payment process, with payments tied to performance in the preceding calendar year.

Performance measures may vary from year to year, but it is anticipated that the 2007 Quality Incentive measures will include the following HEDIS measures:

- Hemoglobin A1C (HbA1C) testing
- Controlling high blood pressure
- Rating of the health plan (CAHPS measure)
- Timeliness of prenatal care
- Post-partum care
- Adolescent immunizations (combo2)
- Childhood immunizations (combo 2)
- Cervical cancer screening

Shared Health Expansion

In September 2006, in anticipation of expanding the Shared Health Clinical Health Record to cover the entire TennCare population, the Bureau will provide notice to all affected enrollees regarding their privacy rights, sensitive data that will be hidden from view and their option to be excluded from the CHR.

Beginning in October 2006, the Shared Health CHR will became available for all TennCare enrollees. With concurrent implementation of several commercial groups, the utility of the CHR is dramatically increased and provider adoption is expected to grow substantially as a result.

The Bureau and Shared Health will work jointly to drive adoption of the CHR and ePrescribe to improve coordination and quality of care for the TennCare population. During the course of the year, the Bureau also will explore the potential of a consumer view of the CHR, or a personal health record (PHR) for the TennCare enrollee population.

Continued Focus on Pharmacy

Soft Pharmacy Limits

As part of the TennCare Reform effort, a "hard" pharmacy benefit limit was implemented for most adult enrollees in August 2005. Hard limits are limits that cannot be exceeded for any reason. Because the Grier Consent Decree did not allow Tennessee to implement an effective prior authorization system, hard limits were believed to be the only way to effectively control utilization.

In reality, certain exceptions were built into the initial phase of reform, in the form of the pharmacy "short list." The pharmacy short list includes certain drugs that do not count against the monthly five-prescription, two brand-name limit, and are available to enrollees even after a limit has been hit.

Despite the existence of these short-list exceptions, there was a desire to expand the ability to make exceptions to the pharmacy benefit limit, if relief could be obtained from the requirements of the Grier Consent Decree that prevented the State from running an effective prior authorization program. As discussed earlier in this report, substantial relief was granted by the court via a series of court orders issued in 2005 and 2006. As a result, on Feb. 1, 2007, TennCare intends to implement a process whereby a prescriber may obtain authorization for a drug in excess of the prescription limits if the drug is on a list specified by TennCare and if the prescriber attests that without the medication the patient is at significant risk for serious health consequences.

Experience operating under the existing pharmacy limits has shown that a very small percentage of enrollees are hitting the benefit limit. This special exemption process is intended to address the unique needs of a small group of enrollees with especially complex healthcare problems.

Increased Generic Dispensing Fee

On July 1, 2006, in an effort to continue to encourage utilization of generic drugs, TennCare intends to increase the dispensing fee paid to pharmacists for generic medications from $2.50 to $3. The dispensing fee for brand name medications remains at $2.50 per prescription.

On average, each generic prescription costs the TennCare program $22, compared with $150 for each brand-name prescription. The percent of total prescriptions that were generic increased from 56 percent in calendar year 2005 to 71 percent in calendar year 2006, as a result of a multifaceted set of interventions designed to promote generic drug prescribing.

The decision to increase the dispensing fee for generic medications was made in recognition of the crucial role pharmacists play in educating patients and physicians regarding prescribed medications and in driving utilization to the most cost-effective medications.

Pharmacy Benefits Manager Request for Proposal

TennCare contracts with a pharmacy benefits manager (PBM) to administer the pharmacy benefit for TennCare enrollees. Key functions of the PBM include processing pharmacy claims, administering the prior authorization process, negotiating and managing supplemental rebates, educating providers and conducting prospective and retrospective drug utilization review.

First Health became the PBM for TennCare on Jan. 1, 2004, as a result of a competitive bid process. The contract was for a three-year term running through Dec. 31, 2006, with the option for two, one-year extensions.

TennCare exercised its option to extend the contract through Dec. 31, 2007, with the intent to competitively bid the PBM functions again in 2007. Work on the RFP is under way.

Medical Appeals Changes

Consolidation of Functions

During FY 2007, as part of the State's continuing efforts to improve the quality and efficiency of medical appeals processing, all medical appeals functions will be consolidated into a single medical appeals division: the Division of Member Eligibility and Medical Appeals Services. Key units will include:

- ASU (Administrative Solutions Unit) – The intake unit for all medical appeals.
- TSU (TennCare Solutions Unit) – The primary processing unit for all medical appeals.
- LSU (Legal Solutions Unit) – Represents the State in the fair-hearing process.
- DSU (Directives Solutions Unit) – Ensures implementation of appeal directives.
- SSAU (Single State Agency Unit) – Screens decisions of non-agency hearing officers to identify those which are contrary to applicable law, regulations, or agency policy interpretations and which require further review by the TennCare Commissioner or his Designee.

To round out a seasoned management team for the medical appeals division, the Bureau will hire a director of compliance, who also will serve as special counsel regarding Grier litigation matters.

RFP for Medical Appeals Call Center

Pursuant to the Grier Consent Decree, the State is required to maintain a 24-hour call center through which members may file and seek resolution of TennCare medical appeals. Such a call center should specialize in providing information regarding TennCare services. It also should gather information from callers regarding medical issues and appeals for follow-up and resolution by TennCare staff.

During fiscal year 2007, the State will complete the bid process and award a three-year contract for medical appeals call center operations. The call center will be on-site in Nashville, to better facilitate training, technical assistance, and quality assurance activities. The vendor will begin training activities Dec. 1, 2006, and is expected to go live Jan. 1, 2007.

Phone Numbers

Family Assistance Service Center: 1-866-311-4287

Call this number for general information regarding TennCare, including:

- Applying for TennCare
- Disenrollment & Benefit Changes
- Reporting a change (such as a new address, or change in jobs)
- Establishing or changing an appointment with your DHS case worker

TennCare Solutions: 1-800-878-3192

- Call this number to file an appeal about medical or prescription problems.

Tennessee Health Options: 1-888-486-9355

- Call this number if you do not have health insurance or are losing TennCare.

TennCare Partners Advocacy: 1-800-758-1638

- Call this number if you require help with mental health care or alcohol treatment.

TennCare Advocacy Program: 1-800-722-7474

- Call this number if you need help with any other health-related care?

TTY or TDD Phone Calls: 1-800-772-7647

- If you use a TTY or TDD machine, use this number. Call ONLY if you use require this service.

Foreign Language Phone Lines

- Para información sobre de TennCare en español, llame al 1-866-311-4290
- Arabic/Kurdish Line: 1-877-652-3046
- Bosnian Line: 1-877-652-3069
- Somali Line: 1-877-652-3054

Phone Numbers for Providers

- TennCare Provider Services: 1-800-852-2683
- TennCare Pharmacy Program: 1-888-816-1680
- TennCare Bldg. Front Desk: 1-800-342-3145
- TennCare Bldg. Fax: 1-615-741-0882

For more information on TennCare, please visit our web site at:

- http://www.tennessee.gov/tenncare/

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