Bureau of TennCare

Fiscal Year 2007-2008 Annual Report

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

Dear Tennesseans:

Once again, I'm pleased to share with you the accomplishments of the Bureau of TennCare in this annual report for the State Fiscal Year of 2007-2008.

TennCare continues to play a critical role in providing health care to Tennessee's most poor and vulnerable individuals. Our improved operational stability is not only enabling the Bureau to meet our enrollees' needs, but also allowing us to use our resources more effectively to benefit those who really need services.

Creating more choices for long-term care for our state's elderly and disabled population, selecting two new health plans for East and West Tennessee that integrate medical and behavioral care, and moving ever closer to eliminating all state audit findings – these are but a few of TennCare's ongoing accomplishments.

Looking ahead to the future, we are taking steps to move toward a return to full financial risk for the Bureau's managed care organizations statewide, and we expect the East and West transition to flow just as smoothly as it did for last year's transition to new integrated health plans in Middle Tennessee. We look forward to implementation of the Long Term Care Communities Choices Act which will allow more Tennesseans to stay in their homes while they receive long-term care services. The Bureau will also continue to look for ways to improve its operational efficiency in order to remain a responsible steward of taxpayer dollars.

In the following pages, we will provide a closer look at the Bureau of TennCare's achievements and our continued plans for success. I hope you will find this annual report useful in reflecting on the progress made in Fiscal Year 07-08.

Sincerely,

Darin Gordon
Deputy Commissioner

EXECUTIVE STAFF

Darin Gordon
Deputy Commissioner

Wendy Long, M.D.
Chief Medical Officer

Scott Pierce
Assistant Commissioner,
Chief Financial Officer

Gene Grasser
Director of Operations

Patti Killingsworth
Assistant Commissioner,
Chief of Long Term Care

Tracy Purcell
Director of Member Services

Keith Gaither
Director of Managed Care Operations

Susie Baird
Director of Policy

Brent Antony
Chief Information Officer

Terry Leve
General Counsel

Mike Cole
Director of Legislative Affairs

Kelly Gunderson
Director of Public Affairs

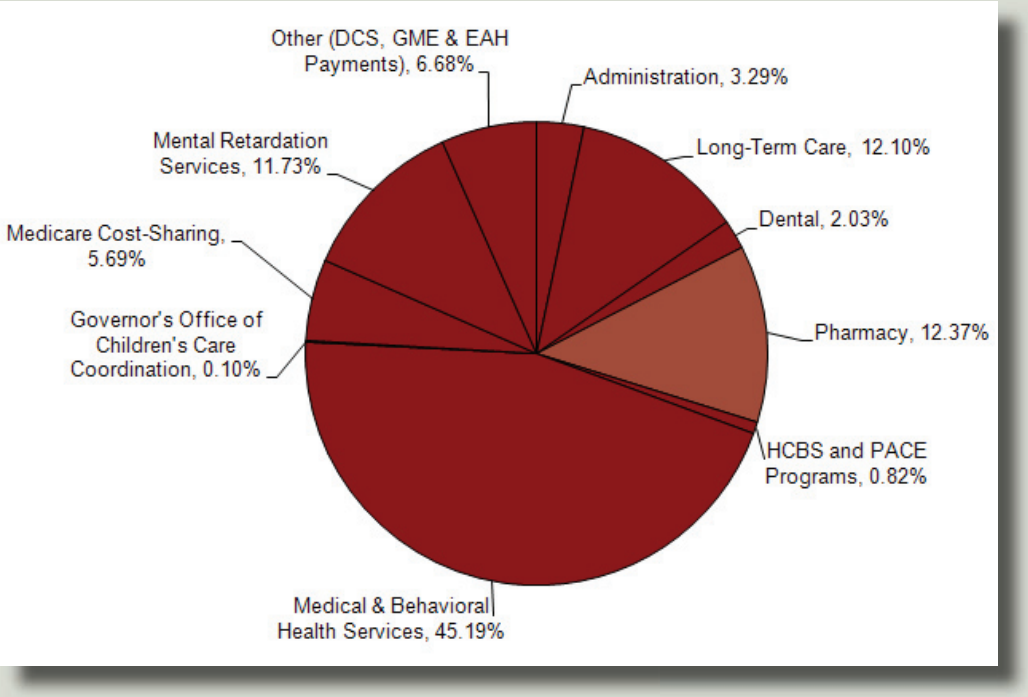
FY 08 Expenditures by Category

- **Pharmacy expenditures brought back to reasonable percentage of total TennCare expenditures**

- **Medical service costs are the largest percentage of total TennCare expenditures**

Medical & Behavioral Health Services	$3,387,993,800
Pharmacy	927,543,300
Long-Term Care	906,456,200
Mental Retardation Services	879,492,500
Medicare Cost-Sharing	426,375,300
Other (DCS, GME & EAH Payments)	501,054,300
Administration*	246,986,400
Dental	151,859,200
HCBS and PACE Programs	61,675,400
Governor's Office of Children's Care Coordination	7,553,700
Total	**$7,496,990,100**

*** Includes eligibility and outreach in addition to salaries and benefits.**



Service Delivery Network

TennCare's service delivery network is the framework by which we deliver care to our enrollee population. The network comprises physical health, mental health, pharmacy benefits and dental benefits.

Managed Care Organizations

MCO/Region*	East	Middle	Out of State**	West	Total	MCO Distribution
AmeriChoice-Middle	0	182,500	1,600	0	184,100	15.1%
Amerigroup Community Care	0	182,700	1,500	0	184,200	15.1%
Blue Care	208,500	0	1,200	0	209,700	17.2%
BHP	0	0	1,000	71,200	72,200	5.9%
John Deere (AmeriChoice-East)	85,400	0	1,100	0	86,500	7.1%
Omni	0	0	700	105,600	106,300	8.7%
PHP	103,100	0	900	0	104,000	8.5%
TennCare SELECT High	19,400	19,900	1,800	19,400	60,500	5.0%
TennCare SELECT Low	17,200	3,700	7,400	15,200	43,500	3.6%
TLC	0	0	900	167,800	168,700	13.8%
Total	433,600	388,800	18,100	379,200	1,219,700***	100.0%
Regional Distribution	35.5%	31.9%	1.5%	31.1%	100.0%	

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

** Enrollees might live out-of-state for several reasons, such as attending an out-of-state college while maintaining Tennessee residency; residents temporarily out of the state; or residing in an out-of-state medical institution for a prolonged period.

*** As of Dec. 31, 2007

In the TennCare program, managed care organizations (MCOs) coordinate health care delivery to our enrollees. This chart depicts enrollment as of December 31, 2007. The Middle Tennessee plans, AmeriChoice and Amerigroup, were selected via a competitive bid process and provide both physical and behavioral health care. In East and West Tennessee, enrollees are assigned to an MCO for their physical health services and a BHO for their behavioral health services.

TennCare Select serves as the state's backup health plan to provide services when there are MCO-capacity issues and also to provide services to certain special populations that the state has identified.

All TennCare-covered services must be medically necessary.
As of June 30, 2007, 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

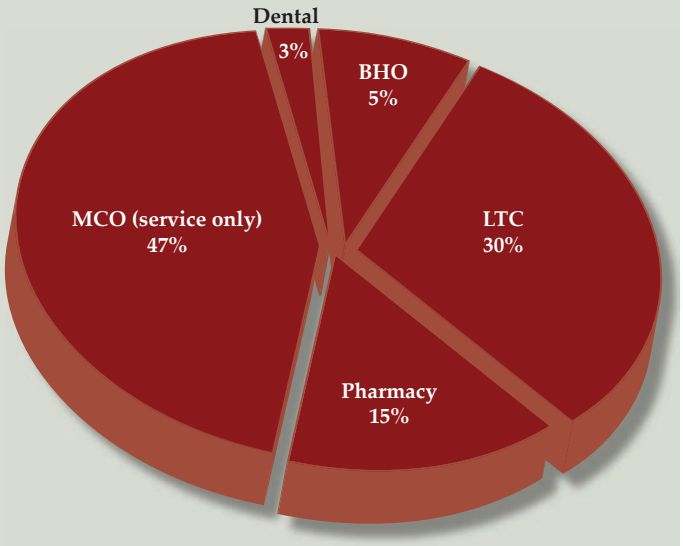
* HCBS and nursing facility services are provided outside the managed-care setting.

Service Listing

07/08 *Expenditures* by Service Category

Program	$ Amount
MCO (service only)	$2,894,698,000
Pharmacy*	$927,543,300
Long-Term Care	$1,847,624,100
BHO	$306,108,900
Dental	$151,859,200
Total – Selected Programs	$6,127,833,500

* Includes Medicare Part D Clawback



Enrollment

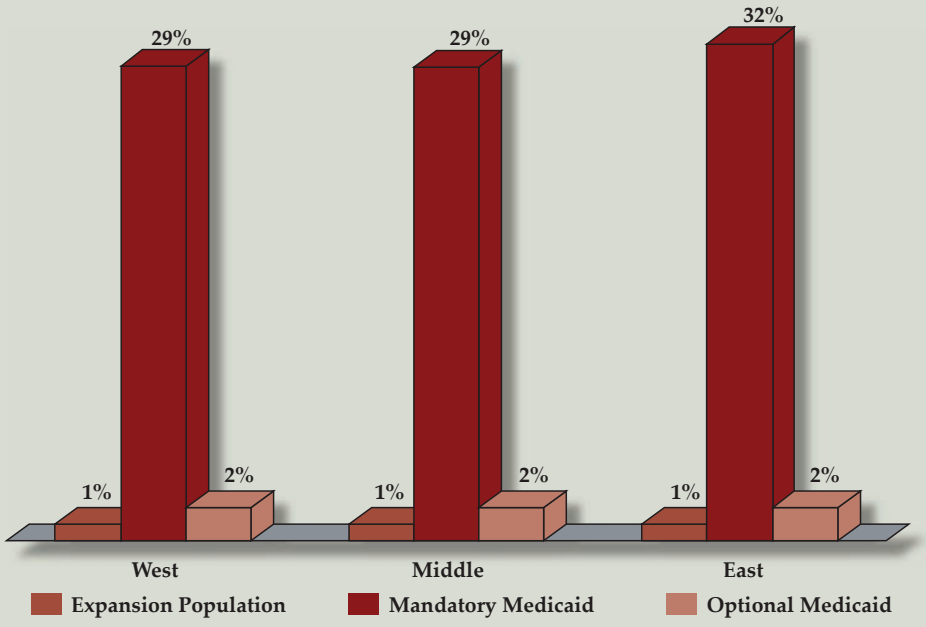
Enrollment by Eligibility Category and Race

Category	White	Black	Other	Hispanic	Grand Total
Expansion Population	2.0%	0.5%	0.1%	0.2%	2.8%
Mandatory Medicaid	52.4%	29.2%	5.7%	3.8%	91.1%
Optional Medicaid	4.4%	1.7%	0.1%	0.1%	6.3%
Grand Total	58.8%	31.4%	5.9%	4.1%	100%

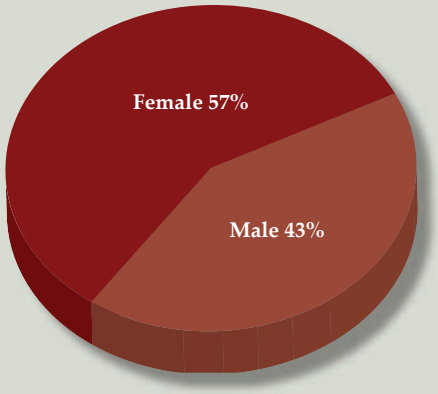
Enrollment by Eligibility Category and Age

Category	0 to 20	21 to 64	65+	Grand Total
Expansion Population	31,500	800	0	32,300
Mandatory Medicaid	618,700	408,500	83,100	1,110,300
Optional Medicaid	27,700	47,200	2,200	77,100
Grand Total	677,900	456,500	85,300	1,219,700

Enrollment by Major Eligibility Category & Grand Region (on Dec. 31, 2007)



TennCare Beneficiaries by Gender (on Dec. 31, 2007)



Medical Services

Top Five Diagnoses by Cost

Inpatient Hospital

1. Single Liveborn	14.2%
2. Short Gestation/Unspec Low Birth Weight	3.8%
3. Other Diseases of Lung	3.2%
4. Abnormality of Organs/Soft Tissues Pelvis	2.0%
5. Septicemia	1.8%
Percentage of all Inpatient Expenditures	25.0%

Outpatient

1. Respiratory Systems/Other Chest Symptoms	4.5%
2. Other Symptoms Involving Abdominal Pain	3.7%
3. General Symptoms	3.2%
4. Chronic Kidney Disease	3.0%
5. Encounter for Other/Unspec Procedure & Aftercare	2.6%
Percentage of All Outpatient Expenditures	17.0%

Physician

1. Health Supervision of Child	7.0%
2. Normal Delivery	3.1%
3. Respiratory Systems/Other Chest Symptoms	2.9%
4. General Symptoms	2.4%
5. Other Symptoms Involving Abdomen and Pelvis	2.3%
Percentage of All Physician Expenditures	17.7%

- Inpatient hospitalization rate was 136 admissions per 1,000 enrollees
- Average inpatient length of stay was 4 days per admission
- Emergency room utilization was 771 visits per 1,000 enrollees
- 87% 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 08 Recipients	Expenditures Per Recipient	FY 07-08 Actual Nos.
Hospital Facilities (Including care provided through hospitals (both Inpatient and Outpatient), Federally Qualified Health Centers (FQHC), Ambulatory Surgical Centers, etc.)	5,394	665,612	$2,141.94	$1,425,704,000
Physician	20,026	1,046,957	$835.24	$874,457,700
Durable Medical Equipment	2,534	85,469	$936.82	$80,069,100
Home Health	426	11,642	$28,756.96	$334,788,500
Other Services (Transportation, Lab, Hospice)	4,129	437,499	$410.70	$179,678,700

Pharmacy Services

Services Delivered through
Pharmacy Benefits Manager (PBM)

TennCare utilizes a preferred drug list to manage the pharmacy benefit. Some drugs require prior approval. During fiscal year 2007-2008, 73 percent of TennCare-reimbursed prescriptions were generic and 27 percent were brand name.

Brand name drugs accounted for 76 percent of pharmacy expenditures, with an average cost per prescription of $170 for a brand name prescription, compared with $21 for a generic prescription.

TennCare enrollees who utilized pharmacy services averaged 14 prescriptions per year in FY 07-08.

Providers with Paid Claims	FY 08 Recipients	Expenditures Per Recipient	FY 07-08 Expenditures
7,498	848,745	$819.67	$695,688,200

Note: Figures represent enrollees who utilize pharmacy services.

Top Five Drugs by Cost

Brand Name	Generic Name	Drug Type	Expenditures
Seroquel®	Quetiapine Fumarate	Antipsychotic	$26,871,659.68
Singulair®	Montelukast Sodium	Asthma Medication	$22,609,218.00
Synagis®	Palivizumab	Prevent Respiratory Syncytial Virus (RSV)	$22,185,012.68
Risperdal®	Risperidone	Antipsychotic	$20,386,957.13
Abilify®	Aripiprazole	Antipsychotic	$14,924,345.47

Top Five Drugs By Number of Claims

Brand Name	Generic Name	Drug Type	Number of Prescriptions
Lortab®, Vicodin®, various other Brands	Hydrocodone Bitartrate/ Acetaminophen	Narcotic	649,191
Amoxil®, A-Cillin®, various other Brands	Amoxicillin Trihydrate	Anti-infectives	313,437
Azithromycin®, Zmax® various other Brands	Azithromycin	Anti-infectives	249,084
Singulair®	Montelukast Sodium	Antiasthmatics	249,616
Zantac®	Ranitidine HCL	Gastric Acid Reducer	189,028

Dental Services

Services Delivered through the
Dental Benefits Manager (DBM)

During FY 07-08, medically necessary dental 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 08 Recipients	Expenditures Per Recipient	* FY 07-08 Expenditures
888	303,975	$473.93	$144,063,768

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

Behavioral Health Services

- 66% 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 9.3% of the entire TennCare population are SPMI/SED enrollees
- 82% 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*
1,300	169,634	$1,561	$264,874,274

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

Top Five Mental Health Diagnoses by Cost

Inpatient Hospital

1. Affective Psychoses	32.6%
2. Schizophrenic Disorder	28.3%
3. Nonorganic Psychoses	6.4%
4. Drug Dependence	4.9%
5. Depressive Disorder	4.3%
% of all Inpatient Expenditures	76.5%

Outpatient

1. Schizophrenic Disorder	34.1%
2. Affective Psychoses	17.4%
3. Drug Dependence	10.3%
4. Nondependent Abuse of Drugs	5.0%
5. Sexual Deviations and Disorders	4.3%
% of All Outpatient Expenditures	71.1%

Physician

1. Affective Psychoses	36.1%
2. Schizophrenic Disorders	13.7%
3. Hyperkinetic Syndrome of Childhood	13.4%
4. Adjustment Reaction	9.3%
5. Neurotic Disorders	8.2%
% of All Physician Expenditures	80.7%

Long Term Care Services

Category of Services	Number of Providers	Number of Recipients *	Average Expenditure Per Recipient	Total Expenditure
HCBS - MR	3***	7,227	$85,181.35	$615,605,600
HCBS - Elderly and Disabled	213	2,331	$26,458.77	$61,675,400
Intermediate Care - MR	78	1,175	$224,584.60	$263,886,900
Intermediate Care - Nursing Facility	293**	21,016	$38,195.73	$802,721,500
Skilled Nursing Facility	230**	2,073	$50,040.86	$103,734,700

*"Number of Recipients" reflects the number of people recieving services as of Dec. 31, 2007.
**Nursing Facilities that provide both Intermediate and Skilled Services are counted in "Number of Providers" for both facility types.
***The table reflects only the number of billing entities, i.e., Regional Offices for the Division of Mental Retardation Services, rather than the actual "Number of Providers" delivering services.

Behavioral Health Organizations

As of December 31, 2007, enrollees in East and West Tennessee were still assigned to one of two behavioral health organizations (BHOs), based on their MCO assignment. Tennessee Behavioral Health (TBH) is partnered with AmeriChoice East (formerly John Deere), TLC, PHP, TennCare Select in East Tennessee and Blue Care. Premier Behavioral Systems of Tennessee, LLC, is partnered with UAHC (formerly OmniCare), Unison (formerly Better Health Plan), and TennCare Select in Middle and West Tennessee. Children in state custody and enrollees temporarily living out of state are assigned to Premier. Enrollees in the new Middle Tennessee health plans receive both physical and behavioral health care from their MCO.

Effective January 1, 2007, 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.

Region / BHO*	AmeriChoice Middle	Amerigroup	Premier	TBH	Total	Percentage
West	0	0	214,200	165,000	379,200	31.1%
Middle	182,500	182,700	21,300	2,300	388,800	31.9%
East	0	0	7,500	426,100	433,600	35.5%
Out-of-State	1,600	1,500	10,200	4,800	18,100	1.5%
Total	184,100	184,200	253,200	598,200	1,219,700	100%
Percentage	15.1%	15.1%	20.8%	49.0%	100%	

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

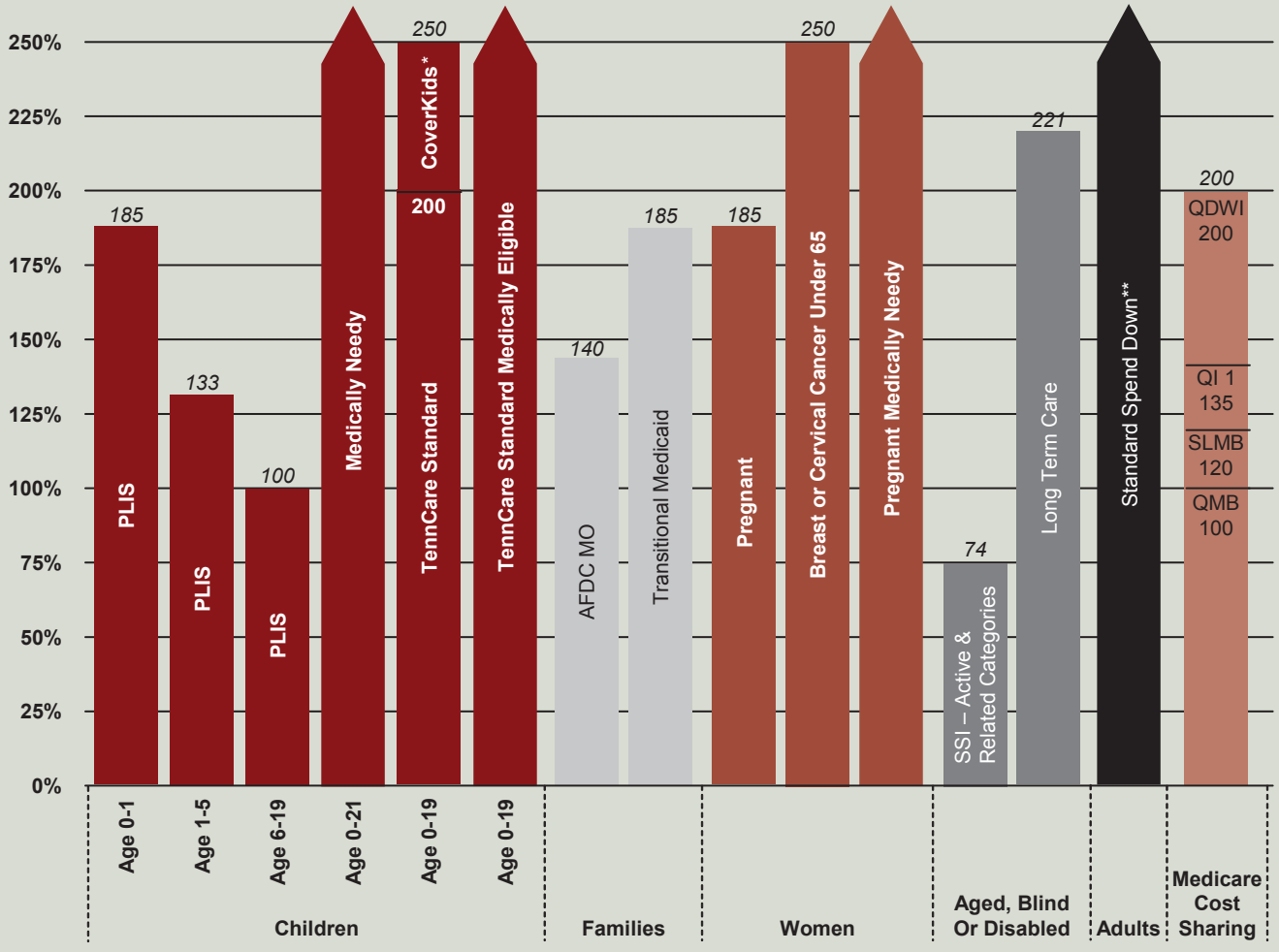
Annual and Monthly Income in Dollars

These two charts set forth the income and resource levels that applicants must meet before they can be determined eligible for TennCare.

Family Size		65%	75%	100%	120%	133%	135%	185%	200%	250%
1	Mo	$563	$650	$867	$1,040	$1,153	$1,170	$1,603	$1,733	$2,167
	Yr	6,760	7,800	10,400	12,480	13,832	14,040	19,240	20,800	26,000
2	Mo	758	875	1,167	1,400	1,552	1,575	2,158	2,333	2,917
	Yr	9,100	10,500	14,000	16,800	18,620	18,900	25,900	28,000	35,000
3	Mo	953	1,100	1,467	1,760	1,951	1,980	2,713	2,933	3,677
	Yr	11,440	13,200	17,600	21,120	23,408	23,760	32,560	35,200	44,000
4	Mo	1,148	1,325	1,767	2,120	2,350	2,385	3,268	3,533	4,417
	Yr	13,780	15,900	21,200	25,440	28,196	28,620	39,220	42,400	53,000
5	Mo	1,343	1,550	2,067	2,480	2,749	2,790	3,823	4,133	5,167
	Yr	16,120	18,600	24,800	29,760	32,984	33,480	45,880	49,600	62,000
6	Mo	1,538	1,775	2,367	2,840	3,148	3,195	4,378	4,733	5,917
	Yr	18,460	21,300	28,400	34,080	37,772	38,340	52,540	56,800	71,000
7	Mo	1,733	2,000	2,667	3,200	3,547	3,600	4,933	5,333	6,667
	Yr	20,800	24,000	32,000	38,400	42,560	43,200	59,200	64,000	80,000
8	Mo	1,928	2,225	2,967	3,560	3,946	4,005	5,488	5,933	7,417
	Yr	23,140	26,700	35,600	42,720	47,348	48,060	65,860	71,200	89,000

Note: For each additional person add $3,600 annually or $300 monthly

Tennessee Medicaid Coverage Groups and Eligibility Requirements



Category	Program	Description	Income Limit
Children	PLIS (Poverty Level Income Standard)	Low income children age 0 up to 1st birthday	185% of poverty - No resource test
		Low income children age 1 to 6th birthday	133% of poverty - No resource test
		Low income children age 6 to 19th birthday	100% of poverty - No resource test
	Medically Needy	Children up to age 21. Must either have low income or have sufficient unreimbursed medical bills to spend down to requisite income limits.	Monthly spend-down levels of $241 (1), $258 (2), $317 (3), $325 (4), $392 (5), $408 (6), or $467 (7), depending upon family size - Resource: $2,000 (1), $3,000 (2), add $100 per additional individual ***
	Standard Rollover	Children under age 19 who do not have access to insurance. Category is only open to children who lose Medicaid eligibility and rollover into Standard.	Below 200% of poverty - No resource test
	Standard Medically Eligible	Children under age 19 who do not have access to insurance and who have health conditions that make the child uninsurable. Category is only open to children who lose Medicaid eligibility and rollover into Standard.	No income or resource test
	AFDC MO	Individuals who meet basic Families First criteria for Title XIX, but do not qualify for certain technical components of Families First.	Monthly income levels of $1217 (1), $1574 (2), $1837 (3), $2011 (4), $2257 (5), $2379 (6), or $2518 (7) depending upon family size, subject to disregards - Resource: $2,000 (1)
	Transitional Medicaid	Individuals who lose Families First due to earned income or increased work hours may receive 12 months of Medicaid.	185% of poverty during months 7 - 12
Women	Pregnant	Low income pregnant women. NOTE: Newborns born to Medicaid –eligible women are deemed eligible for one year.	185% of poverty - No resource test
	Breast or Cervical Cancer	Women under 65 who are not eligible for any other category of Medicaid and have been diagnosed as the result of a screening at a Centers for Disease Control and Prevention (CDC) site with breast or cervical cancer, including pre-cancerous conditions and who are in need of treatment for the cancer.	250% of poverty - No resource test
	Pregnant Medically Needy	Pregnant women. Must have sufficient unreimbursed medical bills to spend down to requisite income limits.	Monthly spend-down levels of $241 (1), $258 (2), $317 (3), $325 (4), $392 (5), $408 (6), or $467 (7), depending upon family size - Resource: $2,000 (1), $3,000 (2), add $100 per additional individual
Aged, Blind & Disabled	SSI (Supplemental Security Income)	Active: Low income aged, blind, or disabled recipients of federal SSI cash payments as determined by SSA	74% of poverty Resource: $2,000 (1), $3,000 (2)
	Long Term Care	Low income individuals who require care in a nursing facility or intermediate care facility for the mentally retarded or who receive Home and Community-Based Services in their home	$2,022/month (300% of the SSI benefit rate) - Resource: $2,000
Adults	Standard Spend Down	Non-pregnant adults who are aged, blind, disabled or caretaker relatives and who have too much income and have sufficient unreimbursed medical bills to spend down to requisite income limits. This category is not currently open to new enrollees.	Monthly spend-down levels of $241 (1), $258 (2), $317 (3), $325 (4), $392 (5), $408 (6), or $467 (7), depending upon family size - Resource: $2,000 (1), $3,000 (2), add $100 per additional individual
Medicare Cost Sharing	QMB	**Qualified Medicare Beneficiary** - TennCare pays Medicare premiums, deductibles and co-insurance for those eligible for Medicare Part A	100% of poverty - Resource: $4,000 (1), $6,000 (2)
	SLMB	**Specified Low Income Medicare Beneficiaries** - TennCare pays Medicare Part B premiums only	Between 100% and 120% of poverty - Resource: $4,000 (1), $6,000 (2)
	QI 1	**Qualified Individuals** - TennCare pays Medicare Part B premiums only	Between 120% and 135% of poverty - Resource: $4,000 (1), $6,000 (2)
	QDWI	**Qualified Disabled Working Individual** - TennCare pays Medicare Part A buy-in for non-aged individuals who lost SSI disability benefits and premium free Part A	200% of poverty - Resource: $2,000 (1), $3,000 (2)

* CoverKids is a state of Tennessee SCHIP program managed by Cover Tennessee and is not part of the Medicaid TennCare program.

** (aged, blind, disabled & caretaker relatives) not currently open to new enrollees

*** Numbers in parentheses refer to the number of members within a family.

TennCare Expenditures and Recipients by County

County	Enrollment on 31-Dec-07	Estimated 2007 Population	% of County on Tenncare	Total Service Expenditure[1, 2, 3]	Expenditure per Member	% County Expenditure	% County Enrollment	% County Population
ANDERSON	14,453	73,471	19.7%	$71,533,866	$4,949	1.16%	1.2%	1.2%
BEDFORD	9,756	44,062	22.1%	$43,511,690	$4,460	0.71%	0.8%	0.7%
BENTON	4,036	16,267	24.8%	$21,915,365	$5,430	0.36%	0.3%	0.3%
BLEDSOE	3,036	13,084	23.2%	$12,204,658	$4,020	0.20%	0.2%	0.2%
BLOUNT	17,933	119,855	15.0%	$83,704,330	$4,668	1.36%	1.5%	1.9%
BRADLEY	17,904	95,443	18.8%	$79,975,838	$4,467	1.30%	1.5%	1.6%
CAMPBELL	13,371	40,771	32.8%	$59,730,799	$4,467	0.97%	1.1%	0.7%
CANNON	2,795	13,432	20.8%	$13,964,836	$4,996	0.23%	0.2%	0.2%
CARROLL	7,001	28,919	24.2%	$36,956,542	$5,279	0.60%	0.6%	0.5%
CARTER	12,170	59,198	20.6%	$56,795,461	$4,667	0.92%	1.0%	1.0%
CHEATHAM	5,250	39,112	13.4%	$24,973,563	$4,757	0.41%	0.4%	0.6%
CHESTER	3,475	16,142	21.5%	$16,556,051	$4,764	0.27%	0.3%	0.3%
CLAIBORNE	9,406	31,270	30.1%	$47,183,163	$5,016	0.77%	0.8%	0.5%
CLAY	2,054	7,870	26.1%	$10,385,384	$5,056	0.17%	0.2%	0.1%
COCKE	10,792	35,337	30.5%	$44,796,666	$4,151	0.73%	0.9%	0.6%
COFFEE	10,991	51,741	21.2%	$52,591,636	$4,785	0.85%	0.9%	0.8%
CROCKETT	3,553	14,233	25.0%	$20,552,249	$5,784	0.33%	0.3%	0.2%
CUMBERLAND	10,292	53,040	19.4%	$54,323,991	$5,278	0.88%	0.8%	0.9%
DAVIDSON	111,121	619,626	17.9%	$661,490,292	$5,953	10.74%	9.0%	10.1%
DECATUR	2,839	11,339	25.0%	$17,827,863	$6,280	0.29%	0.2%	0.2%
DEKALB	4,357	18,436	23.6%	$22,212,846	$5,098	0.36%	0.4%	0.3%
DICKSON	8,632	47,366	18.2%	$48,296,539	$5,595	0.78%	0.7%	0.8%
DYER	9,878	37,684	26.2%	$48,032,942	$4,863	0.78%	0.8%	0.6%
FAYETTE	5,988	37,193	16.1%	$26,675,379	$4,455	0.43%	0.5%	0.6%
FENTRESS	6,304	17,420	36.2	$31,905,726	$5,061	0.52%	0.5%	0.3%
FRANKLIN	6,713	41,207	16.3%	$34,558,794	$5,148	0.56%	0.5%	0.7%
GIBSON	12,287	48,553	25.3%	$76,459,120	$6,223	1.24%	1.0%	0.8%
GILES	5,821	29,024	20.1%	$29,046,008	$4,990	0.47%	0.5%	0.5%
GRAINGER	5,047	22,546	22.4%	$19,716,270	$3,907	0.32%	0.4%	0.4%
GREENE[4]	13,670	65,971	20.7%	$166,201,912	$12,158	2.70%	1.1%	1.1%
GRUNDY	5,165	14,275	36.2%	$24,241,861	$4,693	0.39%	0.4%	0.2%
HAMBLEN	12,662	61,829	20.5%	$61,944,573	$4,892	1.01%	1.0%	1.0%
HAMILTON	55,398	330,168	16.8%	$316,349,170	$5,710	5.14%	4.5%	5.4%
HANCOCK	2,395	6,733	35.6%	$13,653,807	$5,701	0.22%	0.2%	0.1%
HARDEMAN	7,272	27,834	26.1%	$38,586,180	$5,306	0.63%	0.6%	0.5%
HARDIN	7,004	26,061	26.9%	$39,181,165	$5,594	0.64%	0.6%	0.4%
HAWKINS	12,968	57,054	22.7%	$55,248,836	$4,260	0.90%	1.1%	0.9%
HAYWOOD	5,755	19,126	30.1%	$24,200,281	$4,205	0.39%	0.5%	0.3%
HENDERSON	6,378	26,749	23.8%	$28,172,952	$4,417	0.46%	0.5%	0.4%
HENRY	7,434	31,630	23.5%	$34,627,018	$4,658	0.56%	0.6%	0.5%
HICKMAN	5,379	23,768	22.6%	$26,588,938	$4,943	0.43%	0.4%	0.4%
HOUSTON	2,065	8,075	25.6%	$12,341,320	$5,976	0.20%	0.2%	0.1%
HUMPHREYS	3,981	18,173	21.9%	$22,338,735	$5,611	0.36%	0.3%	0.3%
JACKSON	2,768	10,791	25.7%	$13,737,451	$4,963	0.22%	0.2%	0.2%
JEFFERSON	10,499	50,221	20.9%	$51,249,010	$4,881	0.83%	0.9%	0.8%
JOHNSON	4,546	18,107	25.1%	$18,144,861	$3,991	0.29%	0.4%	0.3%
KNOX	63,126	423,874	14.9%	$321,812,277	$5,098	5.23%	5.1%	6.9%
LAKE	2,061	7,411	27.8%	$12,166,349	$5,903	0.20%	0.2%	0.1%
LAUDERDALE	7,502	26,700	28.1%	$25,739,459	$3,431	0.42%	0.6%	0.4%
LAWRENCE	8,838	40,887	21.6%	$45,870,861	$5,190	0.75%	0.7%	0.7%
LEWIS	3,092	11,591	26.7%	$15,935,646	$5,154	0.26%	0.3%	0.2%

County	Enrollment on 31-Dec-07	Estimated 2007 Population	% of County on Tenncare	Total Service Expenditure[1, 2, 3]	Expenditure per Member	% County Expenditure	% County Enrollment	% County Population
LINCOLN	6,593	32,731	20.1%	$34,253,967	$5,196	0.56%	0.5%	0.5%
LOUDON	6,886	45,448	15.2%	$38,403,409	$5,577	0.62%	0.6%	0.7%
MACON	5,307	21,561	24.6%	$25,573,889	$4,819	0.42%	0.4%	0.4%
MADISON	21,790	96,518	22.6%	$116,266,471	$5,336	1.89%	1.8%	1.6%
MARION	6,750	28,138	24.0%	$32,007,214	$4,742	0.52%	0.5%	0.5%
MARSHALL	5,311	29,179	18.2%	$24,386,312	$4,592	0.40%	0.4%	0.5%
MAURY	14,529	79,966	18.2%	$86,548,404	$5,959	1.41%	1.2%	1.3%
MCMINN	10,817	52,131	20.7%	$51,569,754	$4,770	0.84%	0.9%	0.2%
MCNAIRY	7,503	25,595	29.3%	$34,287,862	$4,570	0.56%	0.6%	0.7%
MEIGS	3,130	11,657	26.9%	$12,422,150	$3,969	0.20%	0.3%	2.5%
MONROE	10,084	44,848	22.5%	$43,593,755	$4,323	0.71%	0.8%	0.1%
MONTGOMERY	22,489	154,460	14.6%	$111,211,472	$4,945	1.81%	1.8%	0.3%
MOORE	852	6,119	13.9%	$4,364,853	$5,123	0.07%	0.1%	0.8%
MORGAN	4,988	20,365	24.5%	$22,614,922	$4,534	0.37%	0.4%	0.4%
OBION	6,913	31,633	21.9%	$31,615,084	$4,573	0.51%	0.6%	0.5%
OVERTON	5,039	20,975	24.0%	$26,063,750	$5,172	0.42%	0.4%	0.3%
PERRY	1,541	7,671	20.1%	$8,976,491	$5,825	0.15%	0.1%	0.1%
PICKETT	1,246	4,762	26.2%	$6,001,161	$4,816	0.10%	0.1%	0.1%
POLK	3,662	15,678	23.4%	$14,820,660	$4,047	0.24%	0.3%	0.3%
PUTNAM	14,237	69,916	20.4%	$80,928,066	$5,684	1.31%	1.2%	1.1%
RHEA	7,843	30,328	25.9%	$39,993,951	$5,099	0.65%	0.6%	0.5%
ROANE	10,400	53,399	19.5%	$63,186,731	$6,076	1.03%	0.8%	0.9%
ROBERTSON	10,663	63,333	16.8%	$52,143,338	$4,890	0.85%	0.9%	1.0%
RUTHERFORD	31,613	241,462	13.1%	$161,855,489	$5,120	2.63%	2.6%	3.9%
SCOTT	8,151	21,973	37.1%	$38,762,596	$4,756	0.63%	0.7%	0.4%
SEQUATCHIE	3,153	13,369	23.6%	$16,018,420	$5,080	0.26%	0.3%	0.2%
SEVIER	14,727	83,527	17.6%	$58,795,104	$3,992	0.95%	1.2%	1.4%
SHELBY	236,170	910,100	25.9%	$1,007,916,334	$4,268	16.37%	19.2%	14.8%
SMITH	3,766	18,845	20.0%	$18,492,930	$4,910	0.30%	0.3%	0.3%
STEWART	2,479	13,087	18.9%	$14,386,942	$5,804	0.23%	0.2%	0.2%
SULLIVAN	28,282	153,519	18.4%	$127,798,269	$4,519	2.08%	2.3%	2.5%
SUMNER	21,160	152,721	13.9%	$104,368,807	$4,932	1.70%	1.7%	2.5%
TIPTON	11,728	57,686	20.3%	$50,011,306	$4,264	0.81%	1.0%	0.9%
TROUSDALE	1,697	7,727	22.0%	$9,121,338	$5,375	0.15%	0.1%	0.1%
UNICOI	4,003	17,699	22.6%	$21,243,955	$5,307	0.35%	0.3%	0.3%
UNION	4,657	18,877	24.7%	$18,915,260	$4,062	0.31%	0.4%	0.3%
VAN BUREN	1,345	5,437	24.7%	$7,925,533	$5,893	0.13%	0.1%	0.1%
WARREN	9,707	39,690	24.5%	$49,582,152	$5,108	0.81%	0.8%	0.6%
WASHINGTON	19,123	116,657	16.4%	$107,959,837	$5,646	1.75%	1.6%	1.9%
WAYNE	3,299	16,657	19.8%	$20,781,997	$6,299	0.34%	0.3%	0.3%
WEAKLEY	6,485	33,227	19.5%	$33,461,239	$5,160	0.54%	0.5%	0.5%
WHITE	5,759	24,895	23.1%	$33,043,262	$5,738	0.54%	0.5%	0.4%
WILLIAMSON	7,743	166,128	4.7%	$47,871,128	$6,183	0.78%	0.6%	2.7%
WILSON	12,823	106,356	12.1%	$69,743,586	$5,439	1.13%	1.0%	1.7%
OTHER[5]	6,091			$12,270,798	$2,015			
TOTAL	1,219,749	6,156,719	19.8%	$6,127,833,500	$5,024	100%	100%	100%

1. Service Expenditures include Medical, Pharmacy, LTC, Dental, Behavioral Health Services, partial MCO administrative costs and Part D payments on behalf of Dual eligible members. Payments on behalf of Dual eligible members for Part D drug coverage totaled $231,851,100.
2. Administration and Part D payments are allocated across counties relative to the county's proportion of total expenditure, excluding Admin and Part D.
3. Total service expenditure is not comparable to previous years because it contains additional expenditure categories.
4. Greene County expenditures include costs associated with the Greene Valley Department Center, causing the per-member cost to appear higher when comparing it with those of the other counties.
5. This category reflects recipients who are Tennessee residents whose domicile is temporarily located outside of the state.

Milestones

Always Striving for Quality Care and Operational Excellence

TennCare Begins New Process for Managed Care Plans in East and West Regions

TennCare announced plans to partner with well-qualified health plans to deliver quality services to enrollees in East and West Tennessee in January 2008 by releasing a request for proposal (RFP) for health care plans to offer both medical and behavioral health services in these remaining regions of the state. TennCare conducted a similar process for Middle Tennessee members in July 2006.

The East and West competitive bid process completes TennCare's return to full financial risk for the program's managed care organizations (MCOs) statewide, improving the program's operational control and financial capability. The RFP was designed to help ensure potential bidders were aware of the unique needs of enrollees in the individual regions and the distinct delivery systems of the two areas. TennCare provided region-specific demographic and utilization data, and set new requirements that obligated interested bidders to meet with community providers in each region to gain insight into unique market conditions.

In April 2008, the Bureau announced that Blue Cross Blue Shield of Tennessee (BCBST) and UnitedHealth Plan of River Valley, Inc. (United) were the prevailing bidders in both the East and West grand regions of the state for TennCare's MCO contracts. The competitive bid process for MCO contracts produced a strong field of possible candidates, however, both of the prevailing plans have not only extensive managed care experience, but also have direct experience with the state's Medicaid program. Existing knowledge of the program can help shorten the learning curve for new MCOs and help ensure a smooth transition for members and providers.

BCBST, a Chattanooga, Tenn.-based corporation, serves more than five million people nationwide with approximately $2.2 billion in assets. Through its BlueCare product, BCBST operates a TennCare MCO in East Tennessee currently. The bid award does not affect TennCare's statewide administrative services organization (ASO), TennCare Select, also currently operated by BCBST.

United, headquartered in Minnesota, operates health plans in 14 states serving more than 1.7 million members with revenues in excess of $4.5 billion. In 2006, United acquired John Deere Healthplan, an existing TennCare MCO in the East region. In 2007, United was one of the two prevailing MCO bidders in TennCare's Middle region competitive bid process and currently serves all three regions as AmeriChoice by United Healthcare.

This bid process allowed managed care companies to compete in either the East or West regions or in both. The state awarded the regional contracts by independently selecting two companies in each region with the highest combination of technical evaluation, in-person plan interview and cost proposal scores.

The MCOs will accept full financial risk to participate in Tennessee's Medicaid program and will be paid set monthly rates, or capitated payments, to manage and deliver care to TennCare members in the East and West regions. The new contracts also establish an integrated behavioral health care system for members in those regions, following the same integration strategy established in the Middle region in 2007.

Behavioral and medical health care integration combined with a return to full financial risk for MCOs means TennCare members in these regions can expect greater focus on case and disease management with an emphasis on preventative care. TennCare will examine each plan's implementation activities closely, including provider network building, to be sure they are ready to serve members before any enrollee is assigned to one of the MCOs under the new contracts.

Before the new plans will be allowed to serve TennCare members, they must complete a readiness review to ensure the plans have operationalized the contract requirements for each region. The readiness review covers claims administration, information systems testing, financial audits, medical management and customer services processes and workflows, and provider network development.

TennCare will stagger each region's member transition and start-up dates. The plans will begin serving West region members on November 1, 2008 and will begin serving members in the East region January 1, 2009.

Lengthy Negotiations Lead to Waiver Renewal

TennCare received the necessary approval from the federal government to continue operating its managed care Medicaid program in its current form for three more years in October 2007.

TennCare's waiver is an agreement between the state and CMS that allows TennCare to 'waive' specific federal Medicaid rules in order to operate a managed care program. TennCare is the only Medicaid program in the country to enroll its entire population in managed care. The waiver also stipulates specific financial boundaries under which TennCare must operate, including how supplemental payments to hospitals are calculated and distributed to help offset some uncompensated care costs borne by hospitals.

The federal Centers for Medicare and Medicaid Services must issue a new approval when the state's waiver ends. TennCare's original agreement with CMS expired June 30, 2007, however, CMS granted six short-term extensions while financial negotiations were finalized.

Although the approval process took more time than anticipated, the additional time for negotiation proved productive in that TennCare was able to secure an agreement that allows the Bureau to pay $115 million more to hospitals over the next three years to help offset uncompensated care than CMS' original proposal would have allowed.

In the past three years, TennCare has paid more than $1.7 billion to hospitals to assist with uncompensated care costs through certified public expenditures, essential access payments, critical access payments, payments to Meharry Medical College and two additional one-time supplemental payments. These combined funding sources make up TennCare's uncompensated care pool of money designated to assist hospitals with charity care and Medicaid losses. The new waiver places a cap on these supplemental payments to hospitals. The fact that the majority of the cap's impact occurs at the end of the three-year period gives the state time to incorporate this financing change into its budget in order to protect TennCare's operational and financial stability.

Progress in Daniels Litigation

A 21-year-old court order known as the Daniels Injunction has prevented Tennessee's Medicaid program from checking the eligibility of enrollees who at one time received Supplemental Security Income (SSI) and then were determined ineligible for those benefits. SSI is money the federal government provides to certain people over the age of 65, people with disabilities and people who are blind based on need. Those who receive SSI cash automatically qualify for TennCare.

Sometimes the federal government finds that a person no longer qualifies for SSI money for reasons such as the person is no longer considered disabled due to re-habilitation or the person now makes too much money to qualify. However, due to the Daniel's ruling, once any of those enrollees stopped receiving the SSI benefit, the Bureau was forced to keep that person on TennCare without being able to verify that he or she still qualifies for the program. TennCare believes it is only fair to re-verify the eligibility of the Daniels class just as the Bureau does annually with all other enrollees. If the person qualifies for TennCare in another eligibility category, he or she would continue to receive benefits.

The Daniels Injunction also prevented the state from disenrolling those who had received SSI and were now incarcerated even though people who are incarcerated in a state penitentiary or as a state prisoner in county jail are never eligible for TennCare.

On February 1, 2008, the state entered a motion asking permission of the federal court to implement a process for re-determining the eligibility of Daniels class members and disenrolling those who are found to be ineligible for TennCare. An Agreed Order was entered by the Court at the end of February 2008 allowing the state to begin terminating the eligibility of Daniels class members who are, or who become, either incarcerated in a state penitentiary or incarcerated as a state prisoner in a county jail.

While TennCare is now able to remove incarcerated individuals from the program, the state will continue to seek further relief from the Daniels Injunction. This is to ensure that only those who are eligible for the program remain on the program in order to provide the highest quality care for our members and to continue being good stewards of tax payer money.

TennCare Awards Pharmacy Benefits Contract

The Bureau looks to build on its success in the efficient management of its pharmacy benefit through a new contract with SXC Health Solutions Corp. awarded in April 2008. Through a competitive bid process, SXC has been awarded the Pharmacy Benefits Manager (PBM) contract with the Bureau of TennCare. The three-year, $35 million contract will begin October 1, 2008.

The TennCare PBM administers the pharmacy claims system, an online system that processes all pharmacy transactions. The PBM also helps administer TennCare's Preferred Drug List, manages the pharmacy network, provides pharmacists with weekly payments for their services, and generates weekly encounter data and reconciliation services for the TennCare Bureau. For the first time in TennCare's history, this new PBM contract includes a partial risk contract. Through its $650 million annual pharmacy program, TennCare fills about one million claims per month.

Illinois-based SXC provides pharmacy benefits management support to Medicaid programs in such states as Alabama, Georgia, Vermont and Washington. The publicly traded company reported more than $93.1 million in 2007 revenue from its U.S. and Canadian operations.

First Health is the current PBM for the Bureau. The transition to SXC will start June 1, 2008 and take approximately four months to complete.

TennCare Ceases Premium Payments

In December 2007, TennCare stopped charging and collecting premium payments from TennCare enrollees. When the expansion population was added to TennCare in 1994, the Bureau charged premiums for some enrollees. The payments ranged from approximately $20 to $1,325 per month.

Premium costs were calculated using several factors such as income, family size and poverty level. Services were never denied even if an enrollee did not pay his or her premium. Due to the fact that majority of TennCare enrollees were not required to pay premiums, TennCare determined that it was no longer cost effective to maintain a premium program. As a result, in December 2007, notices were mailed to all enrollees with premium obligations informing them future payments were no longer required, however, enrollees would continue to remain responsible for any past-due payments.

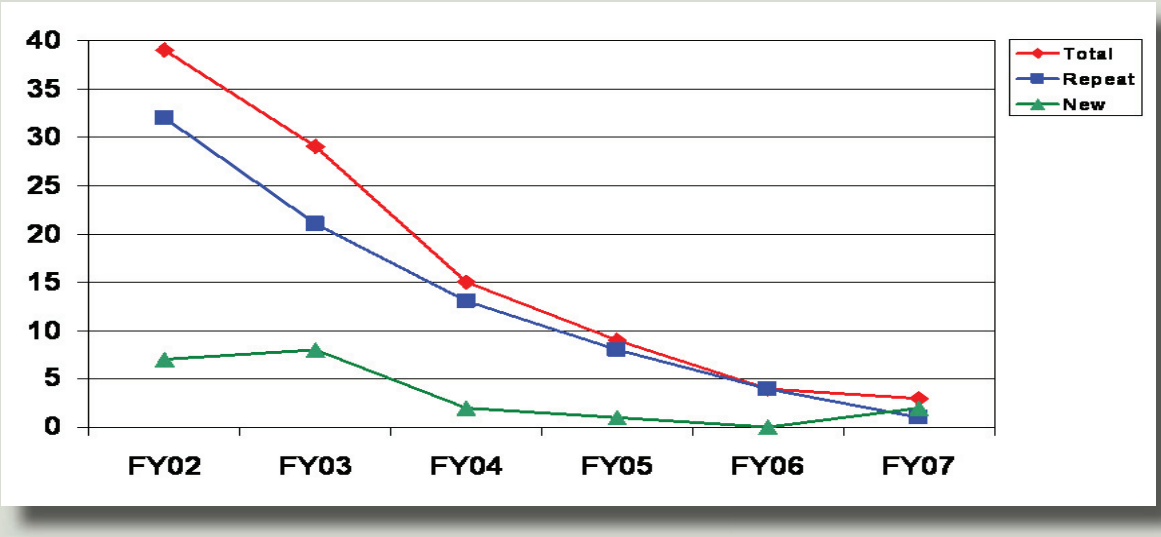
Record Low Number of Audit Findings

For the second year in a row, TennCare received a record-low number of audit findings from the Comptroller of the Treasury. For Fiscal Year 2007, auditors reported only three findings within the Bureau. This latest news comes on the heels of record low findings the previous year. In FY06, the report produced only four findings.

This is a drastic change from previous years when the auditors identified multiple findings. In 2002, this audit yielded 39 findings. Since 2002, the dramatic reduction in findings and the severity of the findings are a direct result of improved practices and management within the Bureau.

In recent years, TennCare staff has made a concentrated effort to effectively manage the Bureau including early identification and quick resolution of potentional problems in order to make sure the Bureau is providing the highest quality of care to enrollees while being responsible stewards of taxpayer dollars.

In order to reduce findings, teams were developed within the Bureau to analyze and correct past findings. The goal of the Bureau is to continue to work closely with the Comptroller's auditing team to quickly resolve any potential future audit findings.



More Freedom for Tennesseans with Long-Term Care Needs

The Long-Term Care Community Choices Act of 2008

The Tennessee General Assembly unanimously passed landmark legislation that will streamline access to Home and Community Based Services (HCBS) and increase the number of people who will be able to stay in their own homes for long-term care needs instead of being cared for away from home in a nursing facility. The act will allow more choices when it comes to long-term care so long as the cost of the services provided do not exceed that of nursing home care

The Long-Term Care Community Choices Act of 2008 was presented by Governor Phil Bredesen at the start of the legislative session. TennCare is the state's largest single payer of long-term care services, and Governor Breseden is committed to making sure TennCare enrollees have the choices available that best fit their needs, an easy system in place to find the care to match their needs, and the standards that ensure the highest quality of care.

"What this means for so many Tennesseans and their families is more freedom—freedom to chose where it is they feel most comfortable receiving their long-term care," said Governor Bredesen. "I am pleased with the collaborative efforts of the legislators, TennCare officials, and other stakeholders that ensured the success of this Act."

TennCare worked closely with the Governor's office, lawmakers, the AARP and other stakeholders to make sure the Act would be able to meet the needs of TennCare members by providing quality care while offering more options to members without spending more taxpayer dollars.

"We all know that care at home, as long as it can be safe and effective, is the kind of care we want for ourselves and our family members," said Darin Gordon, TennCare Director. "TennCare can serve more people with the same amount of dollars because family members and other caregivers step in to provide basic care for their loved ones. The state can then wrap around that care with help like personal care, homemaker services, respite and home-delivered meals."

The basic premise of the Long-Term Care Community Choices Act of 2008 is to make it easier to find care and more convenient to access it by allowing people to determine whether they can get the care they need at home with HCBS or if they require care at a nursing facility. Key components of the act include:

- By providing for the expansion of HCBS, TennCare is given the ability to offer more kinds of home care options and serve more people using existing long-term care funds.

- By integrating LTC within the existing managed care system, a single entity will help TennCare members access all of the different types of Medicaid benefits they need—medical, behavioral, nursing facility and home care services. This will help ensure that the right care is provided in the right place at the right time.

Ensuring that the right care is provided in the right place at the right time

- The bill includes certain cost controls to help ensure that the state doesn't make promises beyond its ability to pay.

- It provides a "Single Point of Entry" to help people who need LTC and their families find out about the options that are available and how to best access them.

- By streamlining eligibility, the Act will change the system to help make it easier and faster to access LTC services.

- It provides for the development of more kinds of cost-effective community-based residential alternatives to nursing facility care for persons who can no longer live alone, but do not want to go to a nursing home. This includes Adult Care Homes that offer 24-hour supervision to no more than five persons in a small, homelike setting.

- It provides for the development and implementation of a new reimbursement method that would allow TennCare to pay nursing facilities based on the level of need of the members they serve.

- It provides assistance to nursing homes for diversifying their businesses so they can begin to offer the same kinds of services they provide in their facilities today in people's homes.

- It provides for more options and choices for people receiving HCBS. This may include the ability to select, direct and even employ staff who will deliver care with careful controls in place to ensure accountability for taxpayer funds.

- It provides for some additional funding for things like meals on wheels, homemaker services and personal care to be provided through the state-funded Options program for people who are not eligible for Medicaid and are currently on a waiting list for those services.

- It changes the licensure requirements for Assisted-Care Living Facility Services, allowing the benefit to be more flexible so people will not be forced out of their "home" at an assisted-care living facility in order to receive medical services that could safely be provided there, just as they could in a private residence.

- It establishes a LTC Oversight Committee to continue to oversee the development and implementation of the managed LTC system.

TennCare will begin working on implementing aspects of the program that do not require federal approval by the Centers for Medicare and Medicaid Services (CMS). This includes speeding up the eligibility determination process, changes to provider enrollment and payment processes, and establishing a "Single Point of Entry" for LTC information. TennCare estimates, once approved by CMS, it should take about six to nine months to fully implement the program.

- More freedom and more choices
- Quicker determination of eligibilty
- Single point of entry for LTC services
- Would cost taxpayers the same as current program

TennCare Proposes Changes to Home Health and Private Duty Nursing Coverage

Currently, Tennessee has one of the most generous programs in the country when it comes to coverage of home health and private duty nursing benefits. While home health and private duty nursing can allow for quality care for an individual at home, the expense of such care is increasing at an alarming rate—such that it has become the fastest-growing cost driver in the TennCare program. Spending on home health and private duty nursing skyrocketed from $18 million in Fiscal Year 2000 to an estimated $313 million in FY2008. That is an annual growth rate of 53 percent, which is unsustainable in a taxpayer funded program.

Unsustainable 53% annual growth rate

Costs increased in some cases because paid care was used to replace natural support systems like family, friends and community members. In many cases, paid care was provided 24 hours per day, seven days per week. In such situations, frequently in-home health aides and private duty nurses have "down-time" where they are not actually providing the needed home health services or medical care for the enrollee. This is not an effective or responsible use of taxpayer dollars. The cost of keeping a 24-hour health care worker in a home for one-on-one care greatly exceeds the cost of nursing home care. The average cost for nursing home care is about $53,000 per year, while the annual cost of round-the-clock home health and private duty nursing coverage ranges from $190,000 to $350,000.

In order to better balance the benefits it provides with the resources available, TennCare proposed changes to adult home health and private duty nursing coverage that will allow the Bureau to reign in out-of-control cost increases by placing new limits on benefits for adults age 21 and older. However, no changes would be made to benefits for children.

The proposed adult home health and private duty nursing limits are as follows:

Changes to Private Duty Nursing

The proposed changes would limit private duty nursing to individuals who:

1. Are ventilator dependent (for at least 12 hours per day), OR
2. Have a functioning tracheostomy requiring suctioning AND need other specified types of nursing care.*

* Patient must require all of the following: 1) oxgen, 2) nebulizer or cough assist, 3) medication via G-tube, PICC line or central port and 4) TPN or nutrition via G-tube.

Changes to Home Health

For most other adult patients, the following home health (HH) coverage limits will apply:

Home Health Aide Care
- Up to 35 hours per week
  - o No more than 8 hours/day
  - o No more than 2 visits/day
  - o HH aide and nurse care combined cannot exceed 35 hours per week
- For example, 35 hours/week =
  - o 7 hours, 5 days/week
  - o 5 hours, 7 days/week

Home Health Nurse Care
- Up to 27 hours per week
  - o Each visit must be < 8 hours
  - o No more than 1 visit/day
  - o HH nurse and aide care combined cannot exceed 35 hours per week
- For example, 27 hours/week =
  - o 5 hours, 5 days/week
  - o 3.5 hours, 7 days/week

Limits for TennCare Adults Who Qualify for Level 2 (Skilled) Nursing Facility Care:

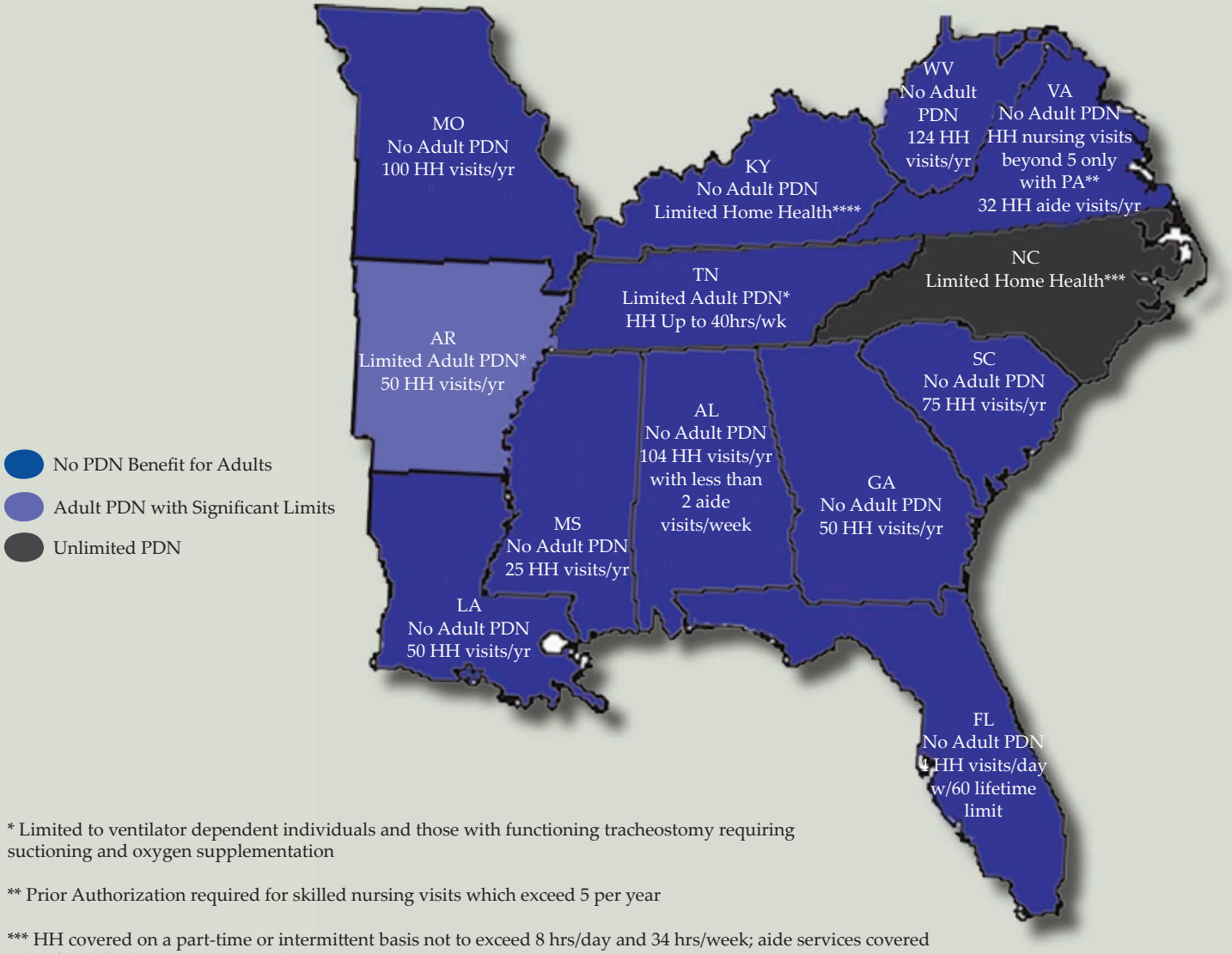
Home Health Aide Care
- Up to 40 hours per week
  - o No more than 8 hours/day
  - o No more than 2 visits/day
  - o HH aide and HH nurse care combined cannot exceed 40 hours per week
- For example, 40 hours/week =
  - o 8 hours, 5 days a week
  - o 5.5 hours, 7 days a week

Home Health Nurse Care
- Up to 30 hours per week
  - o Each visit must be < 8 hours
  - o No more than 1 visit/day
  - o HH nurse and HH aide care combined cannot exceed 40 hours per week
- For example, 30 hours/week =
  - o 6 hours, 5 days/week
  - o 4 hours, 7 days/week

Even with the new limits, TennCare's home health and private duty nursing benefits will remain extremely generous. In fact, Tennessee's benefits will exceed those in almost every other state in the Southeast. The proposed plan is also more generous than the federal Medicare plan which limits home health to a maximum of 35 hours per week and does not cover private duty nursing at all. It is also far more generous than the pre-TennCare state Medicaid plan, which limited home health to 60 visits per year and did not offer private duty nursing coverage for adults. TennCare is currently working with federal officials at the Centers for Medicare and Medicaid Services to gain approval to implement these much needed cost-effective changes.

Tennessee would still have one of the most generous home health and private duty nursing benefits in the Southeast.

How TN Would Compare to Surrounding States if Changes are Approved



* Limited to ventilator dependent individuals and those with functioning tracheostomy requiring suctioning and oxygen supplementation

** Prior Authorization required for skilled nursing visits which exceed 5 per year

*** HH covered on a part-time or intermittent basis not to exceed 8 hrs/day and 34 hrs/week; aide services covered only if a skilled service is required

**** Kentucky has 4 separate Medicaid benefit plans. Comprehensive Choices, for persons who are elderly and/or disabled and who meet Nursing Facility level of care, covers no more than 2 intermittent skilled nursing visits per day. Home Health Aide services are available as separate personal care and housekeeping services (up to 4 hours per week) through a 1915c waiver program where services cannot exceed the cost of institutional care. All services must be prior authorized.

Bureau Awarded Medicaid Emergency Room Diversion Grant

The federal government awarded TennCare more that $4.4 million through a Medicaid Emergency Room Diversion Grant. These funds will help to develop alternative non-emergency service providers, primarily in rural or underserved areas, and as a result, reduce the use of hospital emergency rooms for the treatment of non-emergent medical conditions.

The funds came to TennCare through the Deficit Reduction Act of 2005 which provided $50 million in Federal grant funds for state Medicaid agencies. The Centers for Medicare and Medicaid Services (CMS) asked Medicaid agencies to apply for the funds through a competitive application process, and on April 15, 2008, CMS announced that the grant funds would be distributed to 20 state Medicaid programs over a two-year period.

Based on the merit of the Bureau of TennCare's application, Tennessee received a total of $4,472,240 for the implementation of one Medicaid Emergency Room Diversion initiative in each Grand Region of the state—West, Middle, and East Tennessee. TennCare will forward the entire award directly to communities so local hospitals and clinics can provide TennCare enrollees with the opportunity to access health care services at the most appropriate point of service, resulting in improved health for TennCare enrollees and overall cost savings.

Through partnerships with TennCare managed care contractors (MCCs), Federally Qualified Health Centers, and health care service providers, this grant award will be used to implement unique initiatives in Haywood, Hamilton and Davidson Counties that collectively include establishing new health clinics; extending the hours of operation for existing clinics; coordinating care through effective referral and health information exchange processes; and educating TennCare enrollees about establishing or revitalizing a health care home, effectively accessing routine medical services, and utilizing available TennCare-related information and resources to facilitate access to care.

Beginning July 1, 2008, the Haywood County Clinic, Nashville Medical Home Connection and the Volunteer State Health Plan Partnership initiatives will lay the groundwork for expanded access to non-emergent health care services for TennCare enrollees at times when traditional provider offices are not available for care; within 18 months, the alternative non-emergency service provider settings will be fully operational.

Autism Grant

TennCare is now leading the country's other Medicaid agencies in addressing the issue of timely autism diagnosis by helping community-based pediatricians evaluate young children for autism.

In November of 2007, TennCare granted $492,000 to the Tennessee chapter of the American Academy of Pediatrics (TNAAP), part of which will be used to enable the Vanderbilt Kennedy Center's Treatment and Research Institute for Autism Spectrum Disorders (TRIAD) to train community pediatricians in assessment of children suspected to have autism so those children receive specialized intervention as soon as possible.

The new program is called START ED, which stands for Screening Tools and Referral Training - Evaluation and Diagnosis. Five Middle Tennessee pediatricians are set to participate in the six-month pilot. They will learn how to access the children and interview their parents to make a diagnostic determination. They will also videotape autism assessments from their own practices to gather feedback from TRIAD experts (with appropriate parental consent).

Autism is a highly prevalent developmental disorder—the latest estimates are that one in every 150 children falls somewhere on the autism spectrum. According to TRIAD, autism is part of a group of complex neurodevelopmental disorders which can often be characterized by varying degrees of impairment in language and communication, social abilities and unusual patterns of activities and interests. This grant will help the health care community in Tennessee better identify, understand and treat autism.

Medicaid Transformation Grant

The Bureau received a special CMS grant for a program designed to assist physicians who practice in rural areas and who lack access to e-prescription technology. TennCare had already received $450,950 in Fiscal Year 2007 from the Medicaid Transformation Grant for an Electronic Prescription Pilot Project, and in Fiscal Year 2008 was granted an additional $223,254 for the program. The e-prescribing pilot program consists of 50 rural physician practices in 13 counties.

TennCare Director Named to NASMD Executive Committee

TennCare Director Darin Gordon was named to the 12-member Executive Committee of the National Association of State Medicaid Directors. NASMD is a bipartisan, professional, non-profit organization consisting of representatives from state Medicaid agencies. NASMD plays an active role in discussing issues with the Centers for Medicare and Medicaid Services (CMS) and in fostering communication among states about matters of concern. As a member of the committee, Director Gordon will be able to ensure that Tennessee has a voice in policy development at the federal level.

Bureau Recognized for Health Care Technology Innovation

Due to progress in the implementation of electronic health initiatives, the U.S. Office of the Inspector General for the Department of Health and Human Services lauded TennCare in a report released in August 2007. The report found that TennCare is among only a few state Medicaid agencies implementing electronic health initiatives. Of the 52 agencies surveyed, TennCare was one of only 12 found to be using innovative health information technology in its day-to-day operations and one of only five state agencies to have developed e-prescribing initiatives for their providers.

TennCare, in partnership with Shared Health, has implemented a claims-based electronic health record that contains diagnoses, procedure or visit information, and prescription histories. It contains non-claims information from other sources, such as lab results from participating labs and immunization records provided by the Department of Health. It also allows providers to maintain other pertinent information such as vital signs, allergies and documentation of early periodic screening, diagnosis, and treatment (EPSDT) screenings.

TennCare also offers e-prescribing to its providers through the secure TennCare EHR Web portal. The e-prescribing application includes information about TennCare's drug formulary, dosing instructions and side effects, and it offers a tool to alert providers about potential drug interactions based on a patient's prescription history or allergies.

These innovative health information technology and health information exchange initiatives have been identified by Governor Bredesen and federal officials as having the potential to reduce health care costs that arise from inefficiency, medical errors, inappropriate care and incomplete information.

Looking Ahead

As TennCare builds on its accomplishments, the Bureau looks to improve its operations in accountability, efficiency, fairness and innovation.

TennCare Tackles Daniels Legal Constraint

The Bureau will continue to seek relief from the long-standing court order known as the Daniels Injunction by appealing to the federal court to allow TennCare to re-verify the eligibility of 147,000 individuals in the class.

After the Bureau appealed to the Court in early February 2008, an Agreed Order was entered by the end of the month allowing the state to begin terminating eligibility for incarcerated enrollees in the Daniels class. This Order signified great progress in ensuring fairness in eligibility determination for all enrollees; however, the Bureau will continue to seek relief from the Daniels injunction in order to re-verify the remaining individuals in the class.

Once the federal court has lifted the injunction, the Bureau will be able to confirm that all persons receiving coverage under TennCare are actually eligible for the program and will be better able to ensure resources are directed to those who really need them.

Bureau Seeks CMS Approval for Long Term Care Waiver Amendment

While TennCare will begin implementing aspects of the Long Term Care Community Choices Act of 2008, the Bureau must secure federal approval by the Centers for Medicare and Medicaid Services (CMS) in order to implement several key aspects of the program, including:

- Having a single entity responsible for coordinating all of the care a TennCare member needs, including medical, behavioral and long term care;
- Expanding the number of persons who can access home-based care;
- And allowing those who need long-term care and their families to choose to hire friends and neighbors to deliver certain kinds of needed care (called Consumer Direction).

Once CMS approves the amendment, it will take approximately six months to implement the new CHOICES in Long Term Care Program. However, once up and running, it will fundamentally restructure how long term care is handled in TennCare, providing a richer set of choices and options and better coordiantion of care for elderly and disabled Tennesseans who need long-term care services today, and thousands more who will need them in the future.

TennCare Looks toward Complete Medical and Behavioral Health Integration Statewide

Following the successful implementation of two new MCOs serving TennCare enrollees in Middle Tennessee in 2007, the Bureau requested competitive bids for managed care contracts to offer both medical and behavioral health services to enrollees in the East and West regions of the state in January 2008. This bid process allowed managed care companies to compete in either the East or West regions or both, and the prevailing bidders in both grand regions were announced in April 2008—Blue Cross Blue Shield of Tennessee and UnitedHealth Plan of River Valley, Inc.

In Fiscal Year 08/09, the Bureau will look toward total implementation of these MCOs and a return to full financial risk for the Bureau's MCOs statewide, solidifying TennCare's operational strength and financial viability. These plans will begin serving West region members in November 2008 and East region members in January 2009.

Bureau Will Build on Strong Improvements to Prescription Program

In recent years, the efficient management of TennCare's pharmacy benefit has resulted in savings of more than $1 billion of taxpayer funds.

In FY 08/09, the Bureau looks to build on that success by contracting with a new Pharmacy Benefits Manager (PBM). The PBM administers the pharmacy claims system, an online system that processes all pharmacy transactions. The PBM also helps administer TennCare's Preferred Drug List, manages the pharmacy network, provides pharmacists with weekly payments for their services and generates weekly encounter data and reconciliation services for the Bureau.

Through a competitive bid process, SXC Health Solutions Corp. was awarded the PBM contract with TennCare in April 2008. For the first time in TennCare's history, the PBM contract includes a risk component designed to ensure incentives are properly aligned. The three-year, $35 million contract will begin October 1, 2008, and the Bureau anticipates a smooth transition with as little impact on providers and enrollees as possible. This contract represents another step forward in appropriately aligning the incentives in TennCare's program.

Continued Focus on Reducing Audit Findings

The Bureau of TennCare continues to make solid gains in its operational efficiency, as evidenced by a State Comptroller audit report released in February 2008. The audit showed a significant decrease in the number and severity of findings—down to only three from 39 findings in 2002.

The progress TennCare continues to experience in reducing audit findings points to the Bureau's commitment to fiscal responsibility and sound operations. As an example, one of the three findings noted in the audit relates to TennCare's inability to check the eligibility of 154,000 due to the Daniels injunction. The Bureau has already taken steps to address this final recurring audit finding and to move this long-standing case to resolution.

TennCare is committed to continuing to work with the Comptroller's office to aggressively address any outstanding or future issues and to build on the Bureau's operational success.

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

TennCare Fraud: 1-800-433-3982

For more information on TennCare, please visit our web site at: http://www.tn.gov/tenncare/