Bureau of TennCare

Fiscal Year 2008-2009 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 2008-2009.

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

Creating more long-term care options for our state's elderly and disabled population, moving toward a complete medical and behavioral health integration, and eliminating all state audit findings– these are but a few of TennCare's ongoing accomplishments.

Looking ahead to the future, the Bureau will begin the federally-approved re-verification process for members of the *Daniels* class to ensure that we provide services only to those eligible for the program, while allowing us to ensure the state's limited financial resources are used appropriately. The Bureau will also continue to look for ways to improve its operational efficiency in order to be a responsible steward of tax payer dollars and remain in a position to help with the state budget as a whole during these difficult economic times.

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 08-09.

Sincerely,

Darin Gordon
Deputy Commissioner

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EXECUTIVE STAFF

Darin Gordon
Deputy Commissioner

Wendy Long, M.D.
Chief Medical Officer

Scott Pierce
Assistant Commissioner,
Chief Financial Officer

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Program Integrity and Audit

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Chief of Long Term Care

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Director of Member Services

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Director of Managed Care Operations

Susie Baird
Director of Policy

Brent Antony
Chief Information Officer

Terry Leve
General Counsel

Mike Cole
Director of Operations

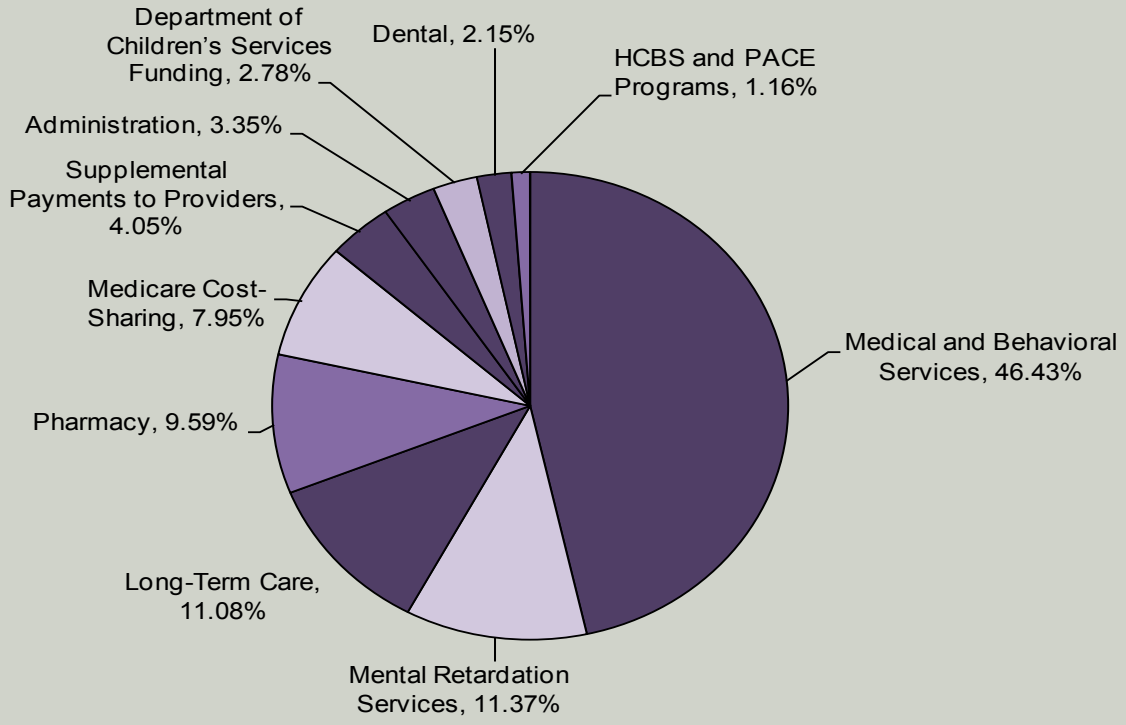
Kelly Gunderson
Director of Communications

FY 09 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 and Behavioral Services	$3,569,380,500
Mental Retardation Services (ICF/MR and HCBS)	874,218,400
Nursing Facility Services[1]	851,714,400
Pharmacy	737,585,300
Medicare Cost-Sharing[2]	611,285,600
Supplemental Payments to Providers	311,088,700
Administration[3]	257,800,900
Department of Children's Services Funding	213,815,000
Dental	165,194,400
HCBS (eldery and disabled) and PACE Programs	89,221,600
Gov.'s Office of Children's Care Coordination	7,040,900
Total	**$7,688,345,700**

[1]Does not include HCBS services. HCBS services are listed separately in this chart.
[2]Includes Medicare Part D clawback. These services are not included in the service listing on page 3.
[3]Administration includes funding for eligibility determination by DHS in all county offices and outreach in local health department.



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	West	Out of State[1]	Total	MCO Distribution
AmeriChoice-East	174,759				174,759	14.51%
AmeriChoice-Middle		183,309			183,309	15.22%
AmeriChoice-West			161,900		161,900	13.45%
Amerigroup		183,923			183,923	15.27%
Blue Care-East	238,249				238,249	19.78%
Blue Care-West			190,450		190,450	15.81%
TennCare SELECT High	18,157	20,110	19,906	2,423	60,596	5.03%
TennCare SELECT Low	1,470	2,880	602	6,292	11,244	0.93%
Total	432,635	390,222	372,948	8,715	1,204,520	100.0%
Regional Distribution	35.92%	32.40%	30.96%	0.72%	100.0%	

[1]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. Enrollment is as of January 1, 2009.

In the TennCare program, Managed Care Organizations (MCOs) coordinate health care delivery to our enrollees. This chart depicts enrollment as of January 1, 2009. 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. It also provides services to certain special populations that the state has identified like children in state custody, children receiving SSI benefits and children in an ICF-MR.

For an enrollee to receive services, the services must be medically neccessary.

As of June 30, 2009, 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.

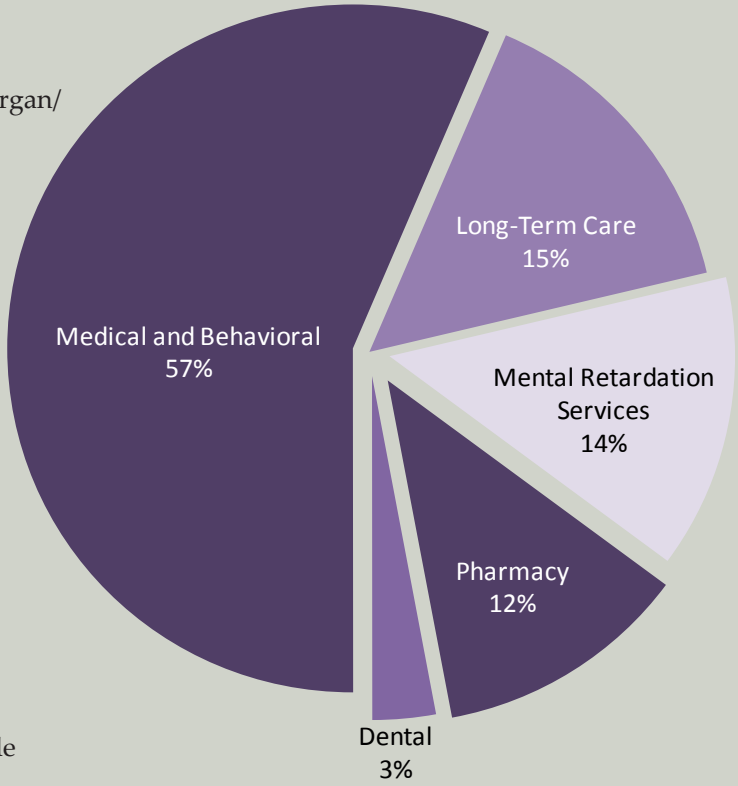
Service Listing

FY 09 Expenditures by Service Category

Program	$ Amount
Medical and Behavioral Services	$3,569,380,500
Long-Term Care/HCBS[1]	$940,936,000
Mental Retardation Services	$874,218,400
Pharmacy	$737,585,300
Dental	$165,194,400
Total – Selected Programs	$6,287,314,600

[1]Does not include Medicare cost sharing.

Service By Category



Enrollment

Enrollment by Eligibility Category and Race

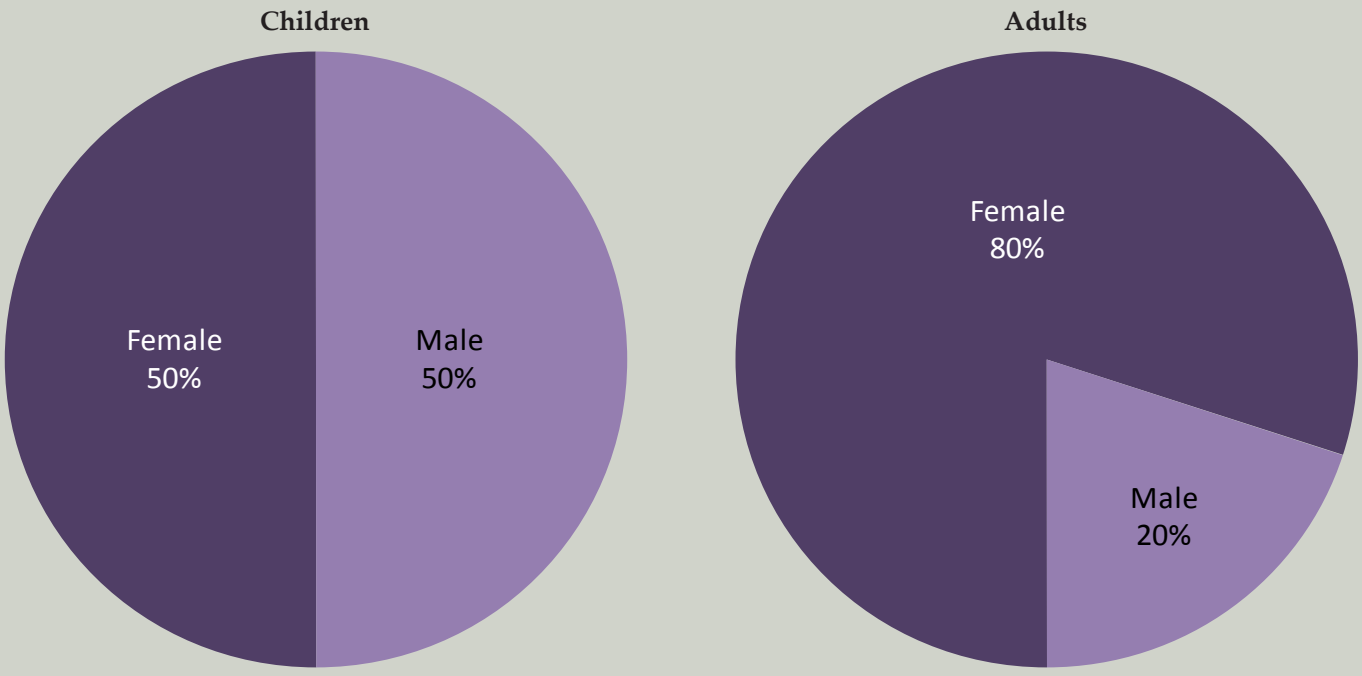
Category	White	Black	Hispanic	Other	Grand Total
Expansion Population	23,921	5,334	2,517	913	32,685
Mandatory Medicaid	667,987	358,796	50,698	63,712	1,141,193
Optional Medicaid	19,637	9,742	793	470	30,642
Grand Total	711,545	373,872	54,008	65,095	1,204,520

Enrollment by Eligibility Category and Age

Category	0 to 20	21 to 64	65+	Grand Total
Expansion Population	32,092	516	77	32,685
Mandatory Medicaid	632,181	424,820	84,192	1,141,193
Optional Medicaid	24,790	5,419	433	30,642
Grand Total	689,063	430,755	84,702	1,204,520

[1]Expansion consists for Standard enrollees, while the Optional category primarily consists of State Aid category MA T, Medical Assistance for Children Under 21 or pregnant.

TennCare Beneficiaries by Gender (on Jan. 1, 2009)



Medical Services

Top Five Diagnoses by Cost[1]

Inpatient Hospital

1. Liveborn	16.75%
2. Respiratory failure; insufficiency; arrest (adult)	2.89%
3. Short gestation; low birth weight; and fetal growth retardation	2.87%
4. Other perinatal conditions	2.81%
5. Septicemia (except in labor)	2.65%
Percentage of all Inpatient Expenditures	27.96%

Outpatient

1. Spondylosis; intervertebral disc disorders; other back problems	3.88%
2. Abdominal pain	3.50%
3. Chronic renal failure	3.22%
4. Other upper respiratory infections	3.05%
5. Nonspecific chest pain	2.86%
Percentage of All Outpatient Expenditures	16.51%

Physician[2]

1. Spondylosis; intervertebral disc disorders; other back problems	4.67%
2. Normal pregnancy and/or delivery	3.97%
3. Other upper respiratory infections	3.75%
4. Otitis media and related conditions	3.61%
5. Other complications of birth; puerperium affecting management of mother	2.92%
Percentage of All Physician Expenditures	18.92%

[1] Does not include behavioral health expenditures
[2] Administrative related diagnoses were excluded. They accounted for $61,801,866 in expenditures or 5.6% of total expenditures.

- Inpatient hospitalization rate was 136 admissions per 1,000 enrollees
- Average inpatient length of stay was four days per admission
- Emergency room utilization was 780 visits per 1,000 enrollees
- 83% of all TennCare enrollees visited a physician at least once during the year

MCO Medical Expenditure by Category of Service (Selected Services)

Category of Service	Providers with Paid Claims	FY 09 Recipients	Expenditures Per Recipient	FY 09 Actual Nos.
Hospital Facilities (Including care provided through hospitals (both Inpatient and Outpatient), Federally Qualified Health Centers (FQHC), Ambulatory Surgical Centers, etc.)	3,915	723,003	$2,147.58	$1,552,707,925
Physician	23,565	1,029,873	$981.31	$1,010,629,573
Durable Medical Equipment	1,848	83,258	$1,069.43	$89,038,678
Home Health	343	10,827	$25,700.44	$278,258,666
Other Services (Transportation, Lab, Hospice)	1,241	472,980	$352.03	$166,505,433

Pharmacy Services

Services Delivered through
Pharmacy Benefits Manager (PBM)

TennCare utilizes a preferred drug list (PDL) to manage the pharmacy benefit. Some drugs require prior approval. During fiscal year 2008-2009, 76 percent of TennCare-reimbursed prescriptions were generic and 24 percent were brand name.

Brand name drugs accounted for 74 percent of pharmacy expenditures, with an average cost per prescription of $178 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 09.

Providers with Paid Claims	FY 09 Recipients	Expenditures Per Recipient	FY 09 Expenditures
7,557	874,018	$843.90	$737,585,300

Note: Figures represent enrollees who utilize pharmacy services.

Top Five Drugs by Cost

Brand Name	Generic Name	Drug Type	Expenditures
Seroquel®	Quetiapine Fumarate	Antipsychotic	$30,527,658.04
Synagis®	Palivizumab	Prevent Respiratory Syncytial Virus (RSV)	$24,872,714.90
Risperdal®	Risperidone	Antipsychotic	$24.059,523.73
Singulair®	Montelukast Sodium	Asthma Medication	$23,643,095.47
Abilify®	Aripiprazole	Antipsychotic	$21,025,514.80

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	672,156
Amoxil®, A-Cillin®, various other brands	Amoxicillin Trihydrate	Antibiotics	469,391
Zithromax®	Azithromycin	Antibiotics	259,775
Prinivil® , Zestril®	Lisinopril	Blood Pressure	227,826
Singulair®	Montelukast Sodium	Asthma Medication	216,823

Dental Services

Services Delivered through the
Dental Benefits Manager (DBM)

During FY 09, medically necessary dental services were covered for enrollees under 21. Percent of enrollees age 3 - 20 receiving a dental service is 59%.

Dental Services

Providers with Paid Claims	FY 09 Recipients	Expenditures Per Recipient	FY 09 Expenditures[1]
941	329,375	$501.54	$165,194,400

[1]Does not include Health Department Dental Program

Behavioral Health Services

- 62% 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 7.3% of the entire TennCare population are SPMI/SED enrollees
- 86.9% 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, 2]
1,378	164,113	$2,091.28	$377,292,255

[1]Excludes case management services, transportation and other community services where payment to provider was a capitated arrangement.
[2]Total expenditure reflects the total proportion of administration fees paid to contracted MCOs, based on the proportion of total medical and behavioral health expenditure incurred in FY 09.

Top Five Mental Health Diagnoses by Cost

Inpatient Hospital

1. Episodic Mood Disorders	36.7%
2. Schizophrenic Disorders	20.1%
3. Drug Dependence	7.9%
4. Sexual and Gender Identity Disorders	5.6%
5. Other Non-organic Psychoses	4.0%
% of all Inpatient Expenditures	74.3%

Outpatient

1. Drug Dependence	28.0%
2. Episodic Mood Disorders	15.8%
3. Schizophrenic Disorders	14.2%
4. Pervasive Developmental Disorders	10.7%
5. Hyperkinetic Syndrome of Childhood	5.6%
% of All Outpatient Expenditures	74.3%

Physician

1. Adjustment Reaction	69.1%
2. Episodic Mood Disorders	11.6%
3. Schizophrenic Disorders	8.0%
4. Hyperkinetic Syndrome of Childhood	4.1%
5. Anxiety Dissociative and Somatoform Disorders	1.7%
% of All Physician Expenditures	94.5%

Long-Term Care Services

Category of Services	Number of Providers	Number of Recipients	Average Expenditure Per Recipient	Total Expenditure[1]
Intermediate Care - Nursing Facility[2]	291	19,379	$40,284	$780,665,800
Skilled Nursing Facility[2]	223	1,734	$47,688	$82,690,600
HCBS - Elderly and Disabled	332	3,958	$19,457	$77,012,500
PACE Program	1	325	$37,566	$12,209,100

[1]Number of recipients reflects the number of people recieving services as of Jan. 1, 2009.
[2]Includes offsets for patient liability.

TennCare Eligibility Chart

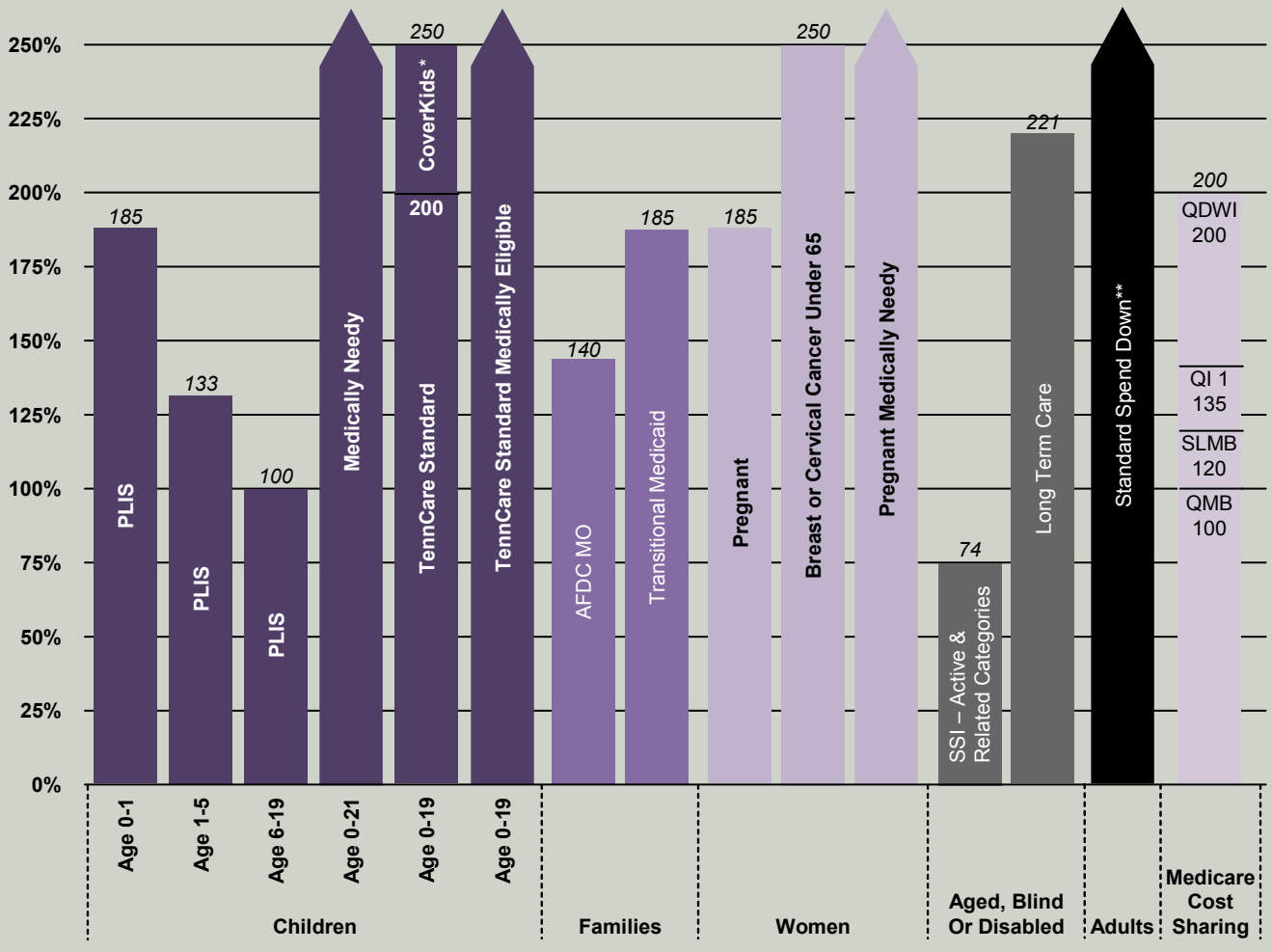
Annual and Monthly Income in Dollars

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



TennCare Eligibility Categories

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 1-Jan-09	Estimated 2009 Population	% of County on Tenncare	Total Service Expenditure[1, 2, 3]	Expenditure Per Member	% County Expenditure	% County Enrollment	% County Population
ANDERSON	14,401	74,169	19.2%	$79,750,625	$5,538	1.2%	1.2%	1.2%
BEDFORD	10,035	44,696	22.2%	$49,141,797	$4,897	0.8%	0.8%	0.7%
BENTON	3,716	16,193	22.7%	$20,980,803	$5,647	0.3%	0.3%	0.3%
BLEDSOE	3,043	13,142	22.9%	$13,109,822	$4,308	0.2%	0.3%	0.2%
BLOUNT	17,925	121,511	14.6%	$94,826,635	$5,290	1.5%	1.5%	2.0%
BRADLEY	18,049	96,472	18.5%	$93,794,646	$5,197	1.4%	1.5%	1.6%
CAMPBELL	13,172	40,936	31.9%	$64,127,240	$4,868	1.0%	1.1%	0.7%
CANNON	2,790	13,804	20.0%	$15,777,586	$5,656	0.2%	0.2%	0.2%
CARROLL	6,555	28,719	22.6%	$39,938,968	$6,093	0.6%	0.5%	0.5%
CARTER	11,932	59,492	19.9%	$61,341,859	$5,141	0.9%	1.0%	1.0%
CHEATHAM	5,448	39,396	13.7%	$29,518,588	$5,419	0.5%	0.5%	0.6%
CHESTER	3,400	16,309	20.6%	$17,252,167	$5,075	0.3%	0.3%	0.3%
CLAIBORNE	9,050	31,461	28.5%	$48,450,127	$5,353	0.7%	0.8%	0.5%
CLAY	2,099	7,794	26.7%	$12,063,259	$5,748	0.2%	0.2%	0.1%
COCKE	10,338	35,688	28.7%	$48,640,090	$4,705	0.7%	0.9%	0.6%
COFFEE	10,823	52,134	20.6%	$59,919,581	$5,536	0.9%	0.9%	0.8%
CROCKETT	3,426	14,186	23.9%	$19,782,843	$5,775	0.3%	0.3%	0.2%
CUMBERLAND	10,290	53,590	19.0%	$61,004,024	$5,928	0.9%	0.9%	0.9%
DAVIDSON	110,309	626,144	17.4%	$687,386,043	$6,231	10.5%	9.2%	10.1%
DECATUR	2,695	11,288	23.6%	$17,040,703	$6,324	0.3%	0.2%	0.2%
DEKALB	4,318	18,694	22.9%	$25,068,570	$5,806	0.4%	0.4%	0.3%
DICKSON	8,788	47,884	18.2%	$56,340,655	$6,411	0.9%	0.7%	0.8%
DYER	9,790	37,600	25.8%	$46,836,041	$4,784	0.7%	0.8%	0.6%
FAYETTE	5,826	38,173	15.1%	$26,563,911	$4,559	0.4%	0.5%	0.6%
FENTRESS	6,187	17,667	34.7%	$35,282,219	$5,703	0.5%	0.5%	0.3%
FRANKLIN	6,621	41,165	15.9%	$35,468,143	$5,357	0.5%	0.5%	0.7%
GIBSON	11,838	49,257	23.8%	$81,039,375	$6,846	1.2%	1.0%	0.8%
GILES	5,631	29,184	19.1%	$32,604,952	$5,791	0.5%	0.5%	0.5%
GRAINGER	5,034	22,708	21.9%	$22,487,882	$4,468	0.3%	0.4%	0.4%
GREENE[3]	13,626	66,157	20.4%	$174,977,599	$12,841	2.7%	1.1%	1.1%
GRUNDY	5,225	14,220	36.4%	$26,223,397	$5,019	0.4%	0.4%	0.2%
HAMBLEN	12,656	62,132	20.2%	$65,796,385	$5,199	1.0%	1.1%	1.0%
HAMILTON	54,707	332,848	16.3%	$314,020,603	$5,740	4.8%	4.5%	5.4%
HANCOCK	2,351	6,693	34.8%	$11,638,953	$4,950	0.2%	0.2%	0.1%
HARDEMAN	6,990	27,848	24.9%	$42,275,957	$6,048	0.6%	0.6%	0.4%
HARDIN	6,716	26,227	25.4%	$39,237,117	$5,842	0.6%	0.6%	0.4%
HAWKINS	12,642	57,477	21.8%	$60,165,597	$4,759	0.9%	1.0%	0.9%
HAYWOOD	5,576	19,024	29.0%	$25,983,281	$4,660	0.4%	0.5%	0.3%
HENDERSON	6,221	26,916	22.9%	$30,640,238	$4,925	0.5%	0.5%	0.4%
HENRY	7,236	31,770	22.6%	$35,445,749	$4,898	0.5%	0.6%	0.5%
HICKMAN	5,293	23,841	22.0%	$30,382,511	$5,740	0.5%	0.4%	0.4%
HOUSTON	2,023	8,137	24.6%	$12,929,612	$6,391	0.2%	0.2%	0.1%
HUMPHREYS	3,817	18,149	20.8%	$24,681,950	$6,467	0.4%	0.3%	0.3%
JACKSON	2,699	10,847	24.6%	$16,205,625	$6,005	0.2%	0.2%	0.2%
JEFFERSON	10,389	51,074	20.1%	$53,666,811	$5,166	0.8%	0.9%	0.8%
JOHNSON	4,299	18,112	23.5%	$19,282,809	$4,485	0.3%	0.4%	0.3%
KNOX	61,920	430,019	14.3%	$336,016,530	$5,427	5.1%	5.1%	6.9%
LAKE	2,093	7,323	28.3%	$12,013,715	$5,741	0.2%	0.2%	0.1%
LAUDERDALE	7,187	26,692	26.7%	$29,906,993	$4,161	0.5%	0.6%	0.4%
LAWRENCE	8,539	40,954	20.6%	$52,298,721	$6,125	0.8%	0.7%	0.7%
LEWIS	2,954	11,564	25.3%	$16,990,566	$5,751	0.3%	0.2%	0.2%

County	Enrollment on 1-Jan-09	Estimated 2009 Population	% of County on Tenncare	Total Service Expenditure[1, 2, 3]	Expenditure Per Member	% County Expenditure	% County Enrollment	% County Population
LINCOLN	6,308	33,116	18.9%	$36,724,451	$5,822	0.6%	0.5%	0.5%
LOUDON	6,751	46,445	14.4%	$39,431,141	$5,841	0.6%	0.6%	0.7%
MACON	5,492	21,838	24.9%	$30,349,266	$5,526	0.5%	0.5%	0.4%
MADISON	21,287	96,376	21.9%	$120,178,646	$5,646	1.8%	1.8%	1.6%
MARION	6,615	28,247	23.2%	$34,015,636	$5,142	0.5%	0.5%	0.5%
MARSHALL	5,356	29,731	17.8%	$28,753,428	$5,369	0.4%	0.4%	0.5%
MAURY	14,753	81,938	17.8%	$98,511,747	$6,677	1.5%	1.2%	1.3%
MCMINN	10,669	52,511	20.1%	$57,375,150	$5,378	0.9%	0.9%	0.8%
MCNAIRY	7,283	25,724	28.0%	$38,141,005	$5,237	0.6%	0.6%	0.4%
MEIGS	3,048	11,790	25.6%	$12,887,981	$4,228	0.2%	0.3%	0.2%
MONROE	10,025	45,648	21.7%	$48,022,338	$4,790	0.7%	0.8%	0.7%
MONTGOMERY	21,776	154,756	13.9%	$123,841,537	$5,687	1.9%	1.8%	2.5%
MOORE	837	6,195	13.4%	$5,379,301	$6,425	0.1%	0.1%	0.1%
MORGAN	4,642	20,404	22.5%	$23,875,233	$5,144	0.4%	0.4%	0.3%
OBION	6,822	31,375	21.5%	$32,224,794	$4,723	0.5%	0.6%	0.5%
OVERTON	4,863	20,975	23.0%	$27,886,533	$5,734	0.4%	0.4%	0.3%
PERRY	1,581	7,753	20.2%	$10,431,619	$6,600	0.2%	0.1%	0.1%
PICKETT	1,169	4,801	24.1%	$7,684,515	$6,576	0.1%	0.1%	0.1%
POLK	3,849	15,671	24.3%	$16,737,217	$4,349	0.3%	0.3%	0.3%
PUTNAM	13,962	71,160	19.4%	$90,631,188	$6,491	1.4%	1.2%	1.1%
RHEA	7,882	30,781	25.4%	$42,707,686	$5,419	0.7%	0.7%	0.5%
ROANE	10,229	53,430	19.0%	$65,633,073	$6,416	1.0%	0.8%	0.9%
ROBERTSON	10,646	64,898	16.2%	$58,169,618	$5,464	0.9%	0.9%	1.0%
RUTHERFORD	32,038	249,270	12.7%	$178,581,603	$5,574	2.7%	2.7%	4.0%
SCOTT	7,784	22,039	35.0%	$40,795,489	$5,241	0.6%	0.6%	0.4%
SEQUATCHIE	3,216	13,580	23.4%	$16,508,557	$5,134	0.3%	0.3%	0.2%
SEVIER	14,606	84,835	17.0%	$67,362,463	$4,612	1.0%	1.2%	1.4%
SHELBY	230,522	906,825	25.2%	$1,022,436,425	$4,435	15.7%	19.1%	14.6%
SMITH	3,779	19,107	19.6%	$21,325,076	$5,643	0.3%	0.3%	0.3%
STEWART	2,448	13,226	18.3%	$15,379,044	$6,282	0.2%	0.2%	0.2%
SULLIVAN	27,946	153,900	18.0%	$143,226,178	$5,125	2.2%	2.3%	2.5%
SUMNER	21,069	155,474	13.4%	$120,050,991	$5,698	1.8%	1.7%	2.5%
TIPTON	11,697	58,706	19.7%	$51,923,652	$4,439	0.8%	1.0%	0.9%
TROUSDALE	1,665	7,822	21.1%	$9,539,388	$5,728	0.1%	0.1%	0.1%
UNICOI	3,854	17,718	21.5%	$22,936,716	$5,951	0.4%	0.3%	0.3%
UNION	4,608	19,008	24.0%	$21,100,172	$4,579	0.3%	0.4%	0.3%
VAN BUREN	1,337	5,481	24.2%	$8,600,359	$6,432	0.1%	0.1%	0.1%
WARREN	9,608	39,842	23.9%	$57,941,674	$6,031	0.9%	0.8%	0.6%
WASHINGTON	19,021	118,639	15.9%	$115,985,937	$6,098	1.8%	1.6%	1.9%
WAYNE	3,125	16,614	18.6%	$22,505,434	$7,202	0.3%	0.3%	0.3%
WEAKLEY	6,365	33,375	18.9%	$35,926,443	$5,645	0.6%	0.5%	0.5%
WHITE	5,661	25,129	22.3%	$36,823,606	$6,505	0.6%	0.5%	0.4%
WILLIAMSON	7,949	171,452	4.6%	$50,530,769	$6,357	0.8%	0.7%	2.8%
WILSON	12,981	109,803	11.7%	$78,110,974	$6,017	1.2%	1.1%	1.8%
OTHER[4]	8,715			$14,010,077	$1,608	0.2%	0.7%	0.0%
TOTAL	1,204,520	6,214,888	19.4%	$6,527,514,000	$5,419	100.0%	100.0%	100.0%

[1]Service Expenditures include medical, pharmacy, LTC, dental, behavioral health services, 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 $240,199,400. ASO administration and Part D payments were allocated across counties relative to the county's proportion of total expenditure.

[2]Service Expenditures do not include Medicare Cost Sharing (except for Part D), Supplemental Payments to Providers, TennCare Administration, DCS funding and GOCCC

[3]This category reflects recipients who are Tennessee residents for which their domicile is temporarily located outside of the state.

[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.

Milestones

Always Striving for Quality Care and Operational Excellence

Federal Court Grants TennCare Relief from Long-Standing Court Order

The state of Tennessee received relief from the U.S. District Court in January 2009, resolving a long-standing court order that will ensure everyone enrolled in the TennCare program is actually eligible for the program. The court granted the state permission to check the eligibility of 147,000 TennCare members, some of whom may no longer be eligible for the program. They are all members of a class of enrollees subject to a 21-year old court order known as *Daniels*.

"We appreciate that the court ruled quickly and fairly, allowing us to move forward in determining which of these individuals are still eligible for TennCare," TennCare Director Darin Gordon said. "By allowing TennCare to remove those individuals who are no longer eligible, the court's ruling will enable the state to reduce or avoid some of the budget reductions we otherwise would have had to make in the state's effort to balance its budget during this difficult economic period."

All *Daniels* class members were once eligible for Supplemental Security Income (SSI), a package of federal benefits that includes Medicaid. Due to the *Daniels* court order, the state was barred from re-determining their eligibility, effectively allowing non-eligible individuals to remain on the program. Although some of *Daniels* class members may remain eligible for TennCare, some will not for a variety of reasons, including those who no longer live in Tennessee, make too much money, or are not now disabled. For example, an individual who was injured in a car accident but through rehabilitation is able to return to work now may not still be considered disabled by the Federal government's standards and would no longer qualify.

The state will begin identifying *Daniels* class members in TennCare and start a review process. For those who are no longer eligible for SSI, and have not filed an SSI appeal, the state will move to determine whether they meet other qualifications to be eligible for Medicaid.

"This gives us hope that we may be able to realize savings that will help minimize cuts we will have to make," Gordon said. "It's simply a matter of fairness that we are allowed to take people off the program who no longer qualify to minimize the budget reductions we will have to make that will impact TennCare's truly eligible members."

Daniels class members will keep their benefits with no lapse in coverage during the determination process. The process is similar to one the court approved in 2005 for other TennCare members, which meets full approval of the federal Centers for Medicare and Medicaid Services (CMS), TennCare's federal partner.

Preparing for CHOICES Implementation

TennCare is currently awaiting federal approval of changes to Tennessee's long-term care program, which will help bring the state one step closer to full implementation of the Long-Term Care Community Choices Act of 2008. The Bureau has been working with the Centers for Medicare and Medicaid Services (CMS) since the summer of 2008 on this proposal, which will integrate nursing facility services and home and community based services (HCBS) for the elderly and adults with physical disabilities into the existing managed care delivery system, expanding access to HCBS and improving coordination and quality of care.

The state formally submitted Amendment #7 to the TennCare waiver to CMS on October 2, 2008. Members who are currently receiving TennCare-reimbursed nursing facility care or who are receiving services under Tennessee's HCBS waiver for persons who are elderly or have physical disabilities are already enrolled in Managed Care Organizations (MCOs). However, they currently get their long-term care services outside of managed care. Under the proposed amendment, these individuals will get all of their TennCare services in a coordinated and comprehensive manner from the MCOs.

TennCare has designed models for care coordination and consumer direction, developed a quality management strategy, begun drafting amendments for MCO Contractor Risk Ag- reements and is working to define MMIS system change requirements, which can be finalized once Amendment #7 is approved.

At the same time, TennCare has moved ahead with things that do not require CMS approval, including efforts to streamline eligibility determination processes. TennCare has been working with the Department of Human Services to make it faster and easier for people to enroll in HCBS programs. A process that used to take up to several weeks now happens almost immediately for a significant percentage of HCBS applicants who also receive SSI. TennCare has also started assisting nursing facilities in transitioning to the new integrated service delivery system.

Changes made so far have proven to be a great success As the state gets closer to the full implementation of the Long-Term Care CHOICES program, TennCare will begin the process of working closely with the MCOs to ensure a smooth transition to coordinated care for members' long-term care needs.

TennCare Expansion in Home and Community Based Services Approved by Feds

TennCare announced in September of 2008 the approval of a planned expansion of home and community based services (HCBS). The Centers for Medicare and Medicaid Services (CMS) approved an expansion that will allow TennCare to serve 2,300 more people in its HCBS program for the elderly and adults with physical disabilities. With the expansion, TennCare will provide these services to up-to 6,000 individuals this year ensuring HCBS options will continue to be available while awaiting federal approval of the CHOICES program.

TennCare has special permission from the federal government that allows Medicaid members who qualify for nursing home care to get help at home instead as long as it can be done safely and the cost is the same or less than a non-skilled nursing home.

"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 wrap around that care with help like personal care, homemaker services, respite and home-delivered meals."

Like the TennCare CHOICES in Long-Term Care Program, this expansion in HCBS is part of the Long-Term Care Community Choices Act of 2008, which was recently unanimously passed by the Tennessee General Assembly.

CMS Approves Changes to Home Health and Private Duty Nursing Coverage

By working with federal officials at the Centers for Medicare and Medicaid Services (CMS), TennCare has now gained approval to implement changes to adult home health and private duty nursing coverage.

The state's proposed Amendment #6 to the TennCare waiver, originally submitted to CMS on February 29, 2008, was designed to address the dramatic growth in spending on home health and private duty nursing for adults in the TennCare program in order to better balance the benefits the Bureau provides with the resources available. Total spending on these two services had grown from $54 million in FY 04 to $243 million in FY 07 and was projected to grow to $320 million in FY 08. There were previously no limits on these two benefits other than medical necessity.

CMS approved Amendment #6 on July 22, 2008. TennCare immediately began the process of mailing notices to enrollees to inform them that the changes would take effect. The Bureau had previously initiated a good deal of work with MCOs to identify the persons who would be most affected by these changes and to develop alternative plans of care when appropriate.

With the approval of Amendment #6, certain limits on home health and private duty nursing for adults will became effective on September 8, 2008, including:

- Home health – Enrollees can get as much as one nursing visit and two home health aide visits per day, as long as the combined total number of hours involved in these visits does not exceed 8 hours per day and 35 hours per week, with up to 40 hours per week allowed in some situations. These limits can be exceeded when medically necessary for children under 21.

- Private duty nursing – This service is to be provided for children under 21 as medically necessary and for adults requiring more than 8 hours of continuous care per day as medically necessary to support the use of ventilator equipment or other life-sustaining medical technology when constant nursing supervision, visual assessment, and monitoring of both equipment and patient are required.

Even with these new limits, TennCare's home health and private duty nursing benefits remain among the most generous for state Medicaid programs.

American Reinvestment and Recovery Act's Impact on TennCare

On February 17, 2009, President Obama signed into law the American Reinvestment and Recovery Act (ARRA), which allocated about $1.1 billion additional federal dollars to Tennessee over a the nine-quarter "recession adjustment period" spanning the time between October 2008 and December 2010. These funds will be used to avoid immediate budget reductions and adjust to the changing economic climate over a period of time as well as financially assisting the state as a whole.

The funds will be provided solely through an increased federal match on medical assistance payments made by TennCare. These are payments TennCare makes directly related to providing health care services to our enrollees. TennCare operates on a "reimbursement" model, meaning TennCare must spend state money and then the federal government will reimburse the state for a portion of the expense. Previously, for every dollar TennCare spent on medical assistance payments, the federal government paid about 65 cents, and the state of Tennessee paid about 35 cents.

Under ARRA, the match rate will increase to 74 percent. ARRA funds cannot be used to add new people to the TennCare program or to add benefits. The funds are "non-recurring," which means that they will not be available once the recession adjustment period has ended and thus cannot be used to fund the continuation of any services or eligibility expansions that might be initiated during this period.

The Act also outlines grants to be used in implementing new Health Information Technology Extension Programs and incentive funds to help encourage providers to transition to electronic health records. TennCare is currently awaiting guidance from federal officials before it is certain how that program will be designed.

New Managed Care Organizations Begin Serving Members in East and West Tennessee

Following the successful implementation of new Managed Care Organizations (MCOs) in Middle Tennessee in 2007, two new MCOs began serving TennCare enrollees in West Tennessee on November 1, 2008. These MCOs, AmeriChoice and BlueCross/BlueShield, were both selected by the state through a competitive bid process in the spring and are operating in a full-risk capitated arrangement.

The Bureau coordinated transition data transfers from the exiting health plans to the new ones, which included authorizations for services and transportation, encounter files, and names of enrollees participating in disease management programs. Bureau staff conducted daily status calls during the week prior to November 1 and for three weeks afterward to review the status of specific cases, call center performance, and network development.

Work was also done to implement these same MCOs in East Tennessee on January 1, 2009, marking the Bureau's return to full financial risk for the program's MCOs statewide and improving the program's operational control and financial capability.

TennCare conducted a number of activities during the months leading up to implementation to assure that the MCOs were ready for the transition in each area. These activities included weekly status calls, weekly reviews of network files to assess progress toward compliance with access standards, and reviews of policies and procedures in key areas to make certain that the MCOs understood the contract requirements and were prepared to comply with these requirements.

The MCOs have accepted 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 of the state. The implementation of these MCOs also establishes an integrated behavioral health care system for members in those regions, which allows for improved focus on disease management and preventive care.

TennCare Mental Health Services Integrated into Managed Care Structure – "State-Only's" Relocated

When services for persons with mental illness were brought under the TennCare managed care program in 1996, there was a group of people whom the Department of Mental Health and Developmental Disabilities (TDMHDD) had been serving who were not eligible for TennCare. These people had been assessed as being Severely and/or Persistently Mentally Ill (SPMI) and as having incomes below poverty. Even though they were not eligible for TennCare, TDMHDD asked TennCare to provide services to them through the Behavioral Health Organizations (BHOs). TennCare agreed to pick up the costs of their mental health services, using state-only dollars for which no federal matching funds were available. Over the years TennCare continued to absorb the costs for this group, even though they were not a TennCare responsibility.

The Bureau began integrating behavioral and medical health care delivery for Middle Tennessee members in 2007 with the implementation of two new managed care organizations. TennCare continued the process with the execution of new MCO contracts in West Tennessee in November 2008 and in East Tennessee the following January.

On January 1, 2009, TennCare completed a process of phasing mental health services into the Managed Care Organizations. Because behavioral health services are no longer delivered separately from medical services, there was no longer a need for separate BHOs. Accordingly, the responsibility for the State-Only's was moved back to TDMHDD. There are about 11,000 persons in this group, and they now receive services through the Mental Health Safety Net.

TennCare Implements New Pharmacy Benefits Manager

In October 2008, First Health was replaced by SXC Health Solutions Corporation as TennCare's new Pharmacy Benefits Manager (PBM). The PBM is responsible for providing a state-of-the-art online Point of Sale (POS) pharmacy claims processing system with prospective drug utilization review (Pro-DUR) and retrospective drug utilization review (Retro-DUR) capabilities, along with a 24-hour, 7 days a week call center to handle prior authorization requests and pharmacy technical assistance questions.

SXC was awarded the TennCare contract in April 2008. Some key differences with the new PBM contract include SXC's responsibility for managing the pharmacy network and assuming some financial risk for supplemental rebates.

The pharmacy network now consists of a specialty pharmacy network in addition to a retail/ambulatory pharmacy network. The specialty pharmacy network agrees to accept more favorable reimbursement rates on designated specialty products and must possess unique clinical monitoring and distribution capabilities. In addition, specialty pharmacy services may be provided through the mail.

SXC also guaranteed a certain percentage of supplemental rebates to the state. If they exceed this expected savings number by over 1 percent, they receive a financial reward up to $1.2 million. If they fall short of this expected savings number by more than 1 percent, they will owe the state money up to the guaranteed amount.

Illinois-based SXC has also provided pharmacy benefits management support to Medicaid programs in Alabama, Georgia, Vermont and Washington.

Zero Audit Findings for TennCare

For Fiscal Year 2008, the Office of the Comptroller's annual TennCare audit revealed no findings, demonstrating the Bureau's continued improvement – from 39 audit findings in FY 2002 to three audit findings in FY 2007.

This milestone is the result of a great deal of work that has been done to address past audit findings and to improve administrative processes within the Bureau. TennCare staff has made concentrated efforts to effectively manage the program, including early identification and quick resolution of problems in order to make sure the Bureau is providing the highest quality of care to enrollees while being responsible stewards of taxpayer dollars.

TennCare will continue to monitor the prior audit findings since FY 2002 to avoid their reoccurrence and will also monitor potential finding areas that have been identified to ensure these issues do not become future audit findings.

Nursing Facility Diversion Grants

In an effort to help nursing homes respond to the changing needs and wishes of Tennesseans who need long-term care services, TennCare announced in July 2008 it would offer up to $5 million in grants to nursing facilities (NFs) that want to begin providing home and community based services (HCBS).

In accordance with the Long-Term Care Community Choices Act of 2008, the Bureau of TennCare sent out Requests for Proposals (RFPs) to TennCare-participating NFs to solicit proposals for projects they could undertake to diversify their businesses and thereby be better prepared to respond to the changes that are likely to occur when the TennCare CHOICES program is implemented.

One purpose of CHOICES is to revise the overall balance of long-term care funds that are spent on home and community based services versus institutional care. The state wants to assist NFs in being able to respond to these changes, as well as to build relationships that would help them provide more seamless transitions for individuals and their families as care needs change.

Nursing Facility diversion grant awards were announced in December. The grants are outcomes-based and funded with only state dollars. NFs may request up to half of their funding upon execution of a grant contract, but may request the remaining funds only upon: (1) completion of and payment by the nursing facility for activities specified in the proposal for which funding was awarded; and (2) approval of a TennCare Provider Agreement for the specific HCBS in counties specified in the proposal. So far, more than $2.7 million has been awarded to 26 nursing facilities for services such as adult day care, personal care and homemaker services.

Gordon Appointed to Chair Quality Technical Assistance Group

In December 2008, TennCare Director Darin Gordon was appointed chair of the Quality Technical Assistance Group (TAG) by the National Association of State Medicaid Directors (NASMD), a group on which he serves as an executive committee member. The Quality TAG provides ongoing information and technical advice to the states on issues relating to the quality of service provided in managed care settings. Gordon chaired his first meeting December 10, 2008, and meetings will continue throughout 2009.

TennCare Chief Medical Officer Appointed to Medicaid Accreditation Advisory Committee of the National Committee for Quality Assurance (NCQA)

In April 2009, TennCare Chief Medical Officer Dr. Wendy Long was appointed to serve on NCQA's Medicaid Accreditation Advisory Committee, which is organized to provide expert and industry advice on developing quality standards, metrics, and scoring guidelines. This Committee acts as a sounding board for NCQA in reviewing proposed standards and its general approach to evaluation and is assisting NCQA in evaluating the existing Health Plan Accreditation process for adaptations that focus on the Medicaid population's special needs.