Tennessee State Health Plan

2009

Appendices C – H to the State Health Plan

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Tennessee Code Annotated Section 68-11-1625(b)

It is the policy of the state of Tennessee that:

(1) Every citizen should have reasonable access to emergency and primary care;

(2) The state's health care resources should be developed to address the needs of Tennesseans while encouraging competitive markets, economic efficiencies and the continued development of the state's health care industry;

(3) Every citizen should have confidence that the quality of health care is continually monitored and standards are adhered to by health care providers; and

(4) The state should support the recruitment and retention of a sufficient and quality health care workforce.

Appendix D. State Task Forces and Specific Issue Health Plans

The following are state planning task forces that have or are developing strategic plans concerning specific health issues. These plans will inform the development of the State Health Plan, and, through discussions with these task forces and relevant stakeholder groups, the Division of Health Planning may incorporate these plans into the State Health Plan.

Infections Task Force
The Department of Health created the Infections Task Force in response to Public Chapter 323 (2005). The Task Force studies healthcare-acquired infections and makes recommendations to the Department of Health. The latest available report from the Task Force may be found here:
http://health.state.tn.us/Downloads/MRSAreport307.pdf.

Adult Emergency Oral Health Task Force
Public Chapter 998 (2008) directed the Department of Health to convene a task force to "develop a statewide strategy for the provisions of adult emergency oral health care, utilizing public and private sector resources." The task force produced and initial report with short and long-term recommendations in early 2009 and plans to continue meeting. The report may be found here:
http://health.state.tn.us/Downloads/adultemoralhealth08.pdf.

The Tennessee Alzheimer's Disease Task Force
Public Chapter 566 (2007) created the Tennessee Alzheimer's Disease Task Force, "the public welfare requiring it." The Task Force was "directed to assess the current and future impact of Alzheimer's disease on Tennesseans; to examine the existing industries, services, and resources addressing the needs of persons with Alzheimer's disease, their families, and caregivers; and to develop a strategy to mobilize a state response to this public health crisis." The Task Force's Final Report, prepared by the Tennessee Commission on Aging and Disability, is available here:
http://www.tennessee.gov/comaging/documents/ataskforce.pdf

The Tennessee Cervical Cancer Elimination Task Force
Public Chapter 921 (2006) created the Tennessee Cervical Cancer Elimination Task Force as a subcommittee of the Tennessee Comprehensive Cancer Control Coalition. The Task Force has established a goal of eliminating cervical cancer by 2040. The group's report, the Cervical Cancer Prevention Plan, is available here:
http://health.state.tn.us/Downloads/CervicalCancerPreventionPlan.pdf.

Tennessee Veterans Task Force (TMHDD)
The Tennessee Veterans task force is a collaboration of the Tennessee Department of Mental Health and Development Disabilities and a number of veterans and mental health groups. The task force focuses on expanding and strengthening the system of care for active duty service members and returning veterans and their families by convening

trainings, compiling resources, and identifying gaps with an emphasis on building long-term system capacity. More information on the task force may be found here: http://www.tennessee.gov/mental/A&D/A_D_veterans.html.

Tennessee Obesity Task Force
In 2008 the Department of Health convened a work group to develop a strategic plan addressing obesity and related health problems in Tennessee.

Tobacco Use Prevention, Control, and Cessation Strategic Plan
In 2008, the Department of Health Tobacco Use Prevention and Control Program (TUPCP) convened stakeholders from across the state to form a Strategic Planning Work Group to establish a five-year plan for a comprehensive statewide tobacco control initiative for the period 2009-2013. The plan aims to "change social norms to reduce and eliminate the burden of tobacco-related death and illness for all people and communities of Tennessee." More information on the TUPCP may be found here: http://health.state.tn.us/healthpromotion/index.html.

Tennessee Office of eHealth Initiatives
The Tennessee Office of eHealth Initiatives under the Department of Finance and Administration serves as the single coordinating authority for the exchange of eHealth information in Tennessee. It collaborates with private and public sector health care stakeholders through the statewide eHealth Advisory Council, established by Governor Bredesen in 2006. The Advisory Council is currently transitioning into a new body as the State of Tennessee prepares for changes in the eHealth landscape brought by the federal Health Information Technology for Economic and Clinical Health (HITECH) Act of 2009.

APPENDIX E. CoverRx Co-Pay Sliding Scale Based on Income

CoverRx Co-Pay Sliding Scale Based on Income			
Persons in Household	**At or Below FPL**	**101% to 150% FPL**	**151% to 250% FPL**
1	$10,830	$10,831 - $16,245	$16,246 - $27,075
2	$14,570	$14,571 - $21,855	$21,856 - $36,425
3	$18,310	$18,311 - $27,465	$27,466 - $45,775
4	$22,050	$22,051 - $33,075	$33,076 - $55,125
5	$25,790	$25,791 - $38,685	$38,686 - $64,475
6	$29,530	$29,531 - $44,295	$44,296 - $73,825
7	$33,270	$33,271 - $49,905	$49,906 - $83,175
8	$37,010	$37,011 - $55,515	$55,516 - $92,525
Co-Pay Structure			
Generics: 30 day supply	$3	$5	$8
Generics: 90 day supply*	$3	$10	$16
Brand/Insulin/Diabetic Supplies: 30 day supply or up to covered limit	$5	$8	$12
All Others	Lesser of Discount, MAC or U&C	Lesser of Discount, MAC or U&C	Lesser of Discount, MAC or U&C

*90 day supplies available only through mail order and select retail pharmacies that have chosen to participate. Check with your local pharmacy to see if 90 day supplies are available at that location.

APPENDIX F. Comparison of Tennessee Health System Performance with Top-Performing Systems in Other States

Indicator	If Tennessee's performance improved to the level of the best-performing state for this indicator, then:	
Insured Adults	279,990	more adults (ages 18-64) would be covered by health insurance (public or private), and therefore would be more likely to receive health care when needed.
Insured Children	61,304	more children (ages 0-17) would be covered by health insurance (public or private), and therefore would be more likely to receive health care when needed.
Adult Preventive Care	184,252	more adults (ages 50 and older) would receive recommended preventive care, such as colon cancer screenings, mammograms, pap smears, and flu shots at appropriate ages.
Diabetes Care	75,699	more adults (ages 18 and older) with diabetes would receive three recommended services (eye exam, foot exam, and hemoglobin A1c test) to help prevent or delay disease complications.
Childhood Vaccinations	12,220	more children (ages 19-35 months) would be up-to-date on all recommended doses of five key vaccines.
Adults with a Usual Source of Care	299,823	more adults (ages 18 and older) would have a usual source of care to help ensure that care is coordinated and accessible when needed.
Children with a Medical Home	157,360	more children (ages 0-17) would have a medical home to help ensure that care is coordinated and accessible when needed.
Preventable Hospital Admissions	34,929	fewer preventable hospitalizations for ambulatory care sensitive conditions would occur among Medicare beneficiaries (age 65 and older) and
	$153,503,000	dollars would be saved from the reduction in hospitalizations.
Hospital Readmissions	5,156	fewer hospital readmissions would occur among Medicare beneficiaries (age 65 and older) and
	$49,769,000	dollars would be saved from the reduction in readmissions.
Hospitalization of Nursing Home Residents	3,363	fewer long-stay nursing home residents would be hospitalized and
	$28,361,000	dollars would be saved from the reduction in hospitalizations.

Indicator	If Tennessee's performance improved to the level of the best-performing state for this indicator, then:	
Mortality Amenable to Health Care	3,276	fewer premature deaths (before age 75) might occur from causes that are potentially treatable or preventable with timely and appropriate health care.

Source: "Tennessee: Estimated Impact of Improving State Performance," Commonwealth Fund, Accessed on 1/7/09 at:
http://www.commonwealthfund.org/improvemenTennessee Code Annotatedlcs/improvemenTennessee Code Annotatedlcs_show.htm?doc_id=501809

APPENDIX G. State Health Plan Advisory Committee Members

State Government Members:

- Chair of the Senate General Welfare, Health, and Human Resources Committee – Senator Rusty Crowe
- Chair of the House Health and Human Resources Committee – Representative Joe Armstrong
- Comptroller of the Treasury – Justin P. Wilson
- Commissioner of Finance and Administration – Dave Goetz
- Commissioner of Health – Susan R. Cooper, MSN, RN
- Commissioner of Mental Health and Developmental Disabilities – Virginia Trotter Betts
- Deputy Commissioner of Finance and Administration and Director of the Bureau of TennCare – Darin J. Gordon
- Executive Director, Health Services and Development Agency – Melanie Hill

Non-State Government Members:

- American Health Planning Association – Arthur Maples, president; Baptist Memorial Hospital (Memphis)
- Long term care – Bruce Duncan, Assistant Vice President, National HealthCare Corp. (Murfreesboro)
- Health Insurance – David Locke, BlueCross BlueShield of Tennessee (Chattanooga)
- Tennessee Hospital Association – Mary Layne Van Cleve, COO (Nashville)
- Tennessee Medical Association – Albert J. Grobmyer, III, MD (Memphis)
- Public Policy – Rita Geier, Senior Fellow for Public Health, the Howard H. Baker Center for Public Policy, UT-Knoxville (Knoxville)
- Business – Cristie Travis, Memphis Business Coalition on Health (Memphis)

Appendix H. Tennessee Environment Scan of Uninsured, FQHC, CAH, and Rural Health Clinics

Information prepared by the Vanderbilt Center for Better Health

Summary

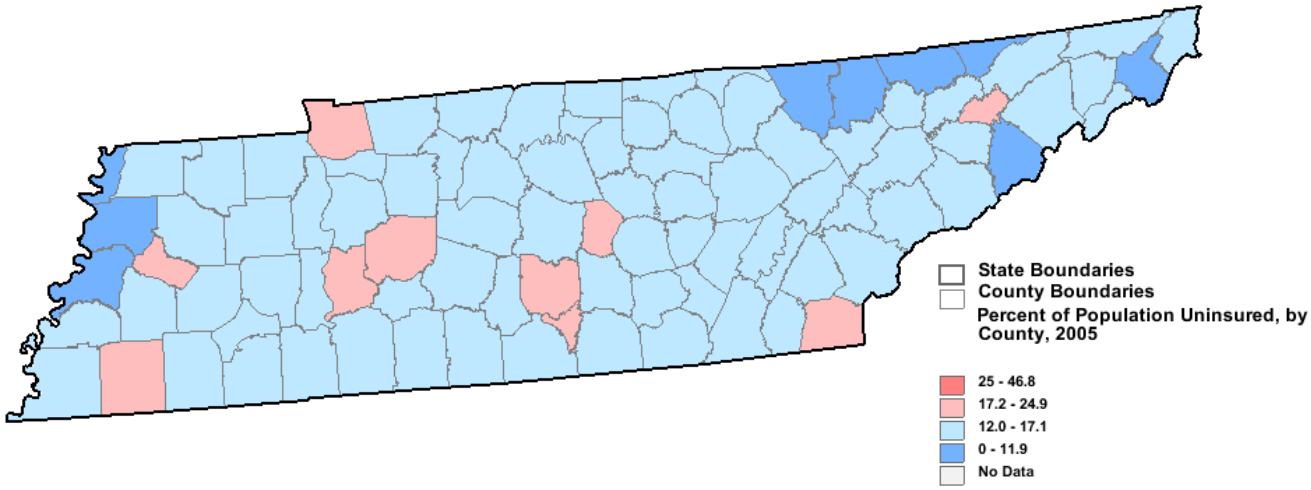
In Tennessee there are:

- 774,563 uninsured people
- 108 Federally Qualified Health Centers
- 15 Critical Access Hospitals
- 60 Rural Health Clinics

Uninsured and Underinsured

Data source: U.S. Census Bureau, Annual Social and Economic Supplement, 2004

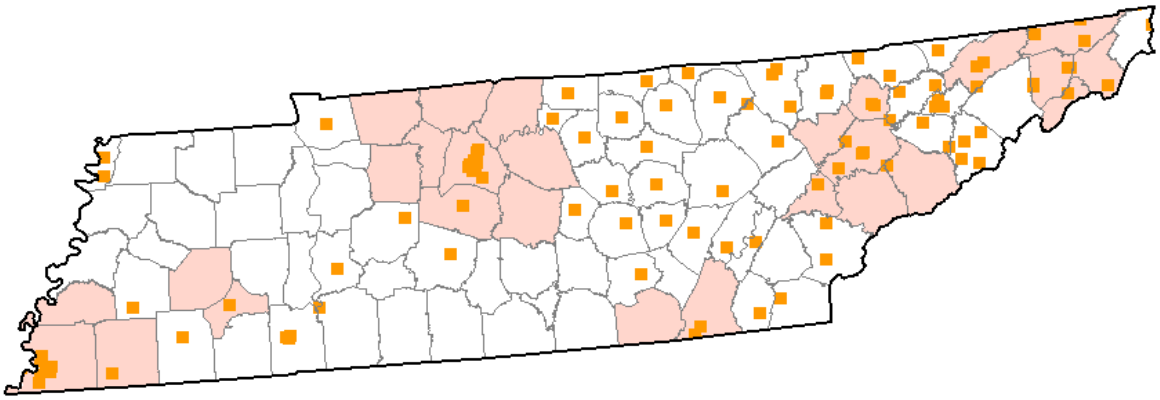
For reporting purposes, the Census Bureau broadly classifies health insurance coverage as private coverage or government coverage. Private health insurance is a plan provided through an employer or a union or purchased by an individual from a private company. Government health insurance includes the federal programs Medicare, Medicaid, and military health care; the Children's Health Insurance Program (CHIP); and individual state health plans. People were considered "insured" if they were covered by any type of health insurance for part or all of the previous calendar year. They were considered "uninsured" if they were not covered by any type of health insurance at any time in that year.



Federally Qualified Health Centers (FQHC)

Data source: Centers for Medicare and Medicaid Services (CMS), Quarter 4, 2008

Federally qualified health centers (FQHCs) include all organizations receiving grants under section 330 of the Public Health Service Act, certain tribal organizations, and FQHC Look-Alikes. FQHCs qualify for enhanced reimbursement from Medicare and Medicaid, as well as other benefits. FQHCs must serve an underserved area or population, offer a sliding fee scale, provide comprehensive services, have an ongoing quality assurance program, and have a governing board of directors.



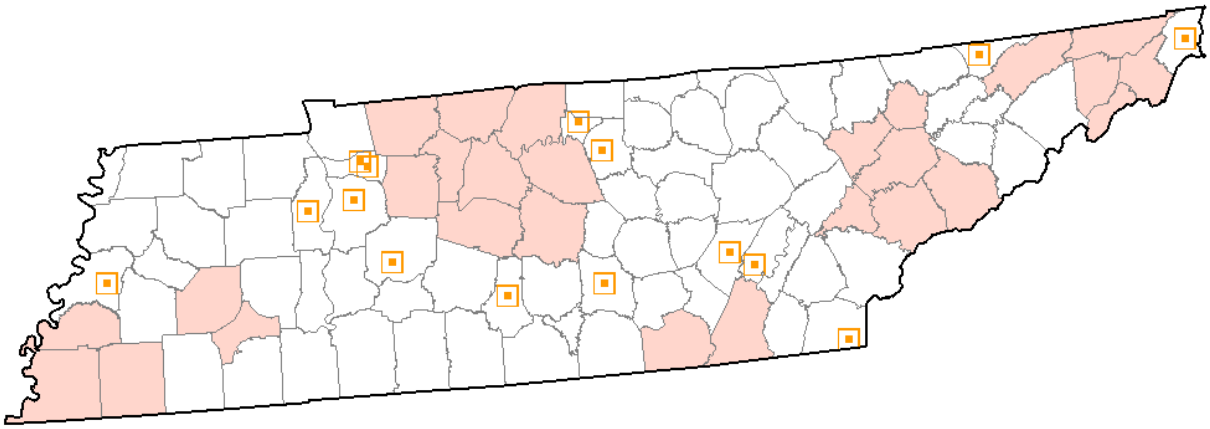
Metropolitan counties are shaded. Rural counties are non-shaded.

Critical Access Hospitals

Data source: Centers for Medicare and Medicaid Services (CMS), Quarter 4, 2008

The Critical Access Hospitals (CAH) program was designed to improve rural health care access and reduce hospital closures. Critical Access Hospitals provide essential services to a community and are reimbursed by Medicare on a "reasonable cost basis" for services provided to Medicare patients.

A Critical Access Hospital (CAH) is a hospital that is certified to receive cost-based reimbursement from Medicare. The reimbursement that CAHs receive is intended to improve their financial performance and thereby reduce hospital closures. Each hospital must review its own situation to determine if CAH status would be advantageous. CAHs are certified under a different set of Medicare Conditions of Participation (CoP) that are more flexible than the acute care hospital CoPs.



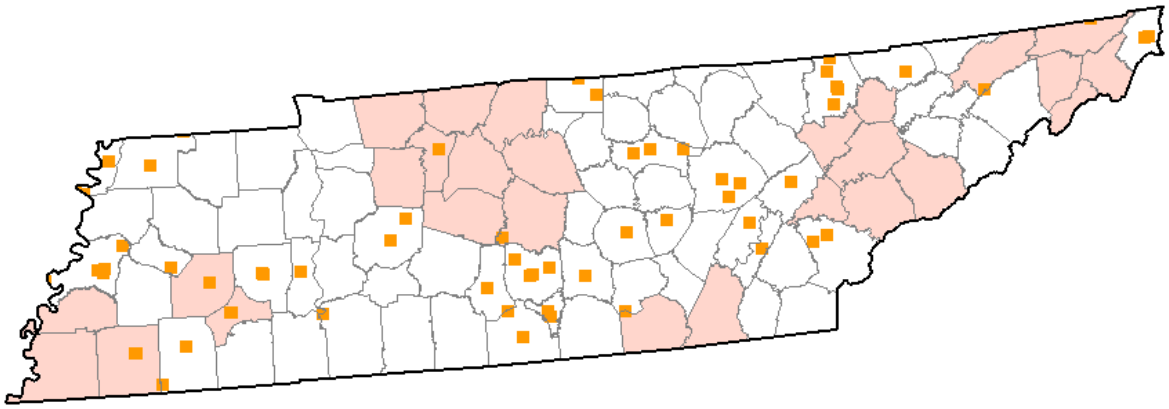
Metropolitan counties are shaded. Rural counties are non-shaded.

Rural Health Clinics

Data source: Centers for Medicare and Medicaid Services (CMS), Quarter 4, 2008

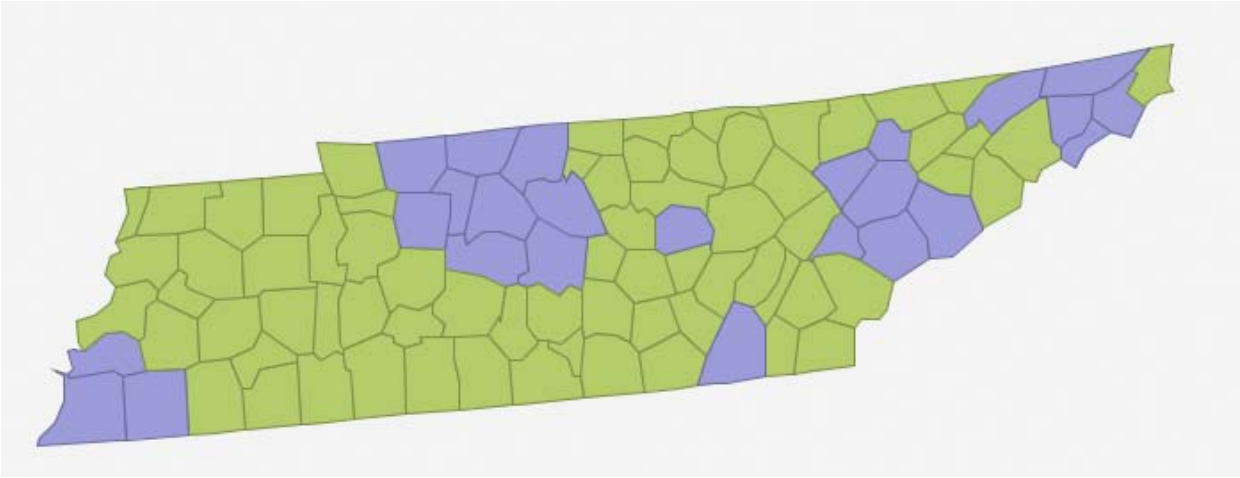
See Appendix X for a definition of "rural." The Rural Health Clinics (RHCs) program is intended to increase primary care services for Medicaid and Medicare patients in rural communities. RHCs can be public, private, or non-profit. The main advantage of RHC status is enhanced reimbursement rates for providing Medicaid and Medicare services in rural areas. RHCs must be located in rural, underserved areas and must use midlevel practitioners.

A Rural Health Clinic is a clinic certified to receive special Medicare and Medicaid reimbursement. The purpose of the RHC program is improving access to primary care in underserved rural areas. RHCs are required to use a team approach of physicians and midlevel practitioners such as nurse practitioners, physician assistants, and certified nurse midwives to provide services. The clinic must be staffed at least 50% of the time with a midlevel practitioner.



Metropolitan counties are shaded. Rural counties are non-shaded.

Defining Rural

The United States Census Bureau has taken the lead in creating a working definition of rural by defining what is urban or metropolitan, then defining rural by exclusion. The Bureau defines an urbanized area (UA) as consisting of adjacent, densely settled census block groups (BGs) and census blocks that meet minimum population density requirements along with adjacent densely settled census blocks where together they encompass a population of at least 50,000 people. Urban clusters (UC) have a similar definition; however, the overall population can be 2,500 to less than 50,000. These categories are based on definitions adopted by the U.S. Department of Health and Human Services Office of Rural Health Policy (ORHP/HHS). Counties are first classified as either rural or urban depending on the MSA in which they are located.

- Rural: Non-metropolitan counties, as designated by the MSA method, shall be considered rural. However, portions of urban metropolitan counties may be classified as rural if their census block or tract number is identified by "Goldsmith Modification" methodology. The "Goldsmith Modification" identified rural "pocket" areas within larger urban metropolitan counties.
- Urban: Metropolitan counties, as measured by the U.S. Office of Management and Budget's MSA method, shall be designated as urban, except for metropolitan counties identified by census block or tract in the "Goldsmith Modification."