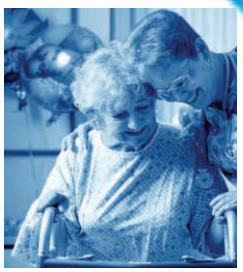
Bureau of TennCare



Annual Report 2004-05

From the Commissioner

J.D. Hickey
Deputy Commissioner

Dear Tennessean,

The past year has brought perhaps the greatest amount of change to the TennCare Bureau since the expanded Medicaid program was launched in January 1994. Much of this change was borne out of necessity – the recognition that the "status quo" in TennCare was no longer sustainable. The good news is that we have turned the corner and the program is now stable and sustainable.

Our efforts this past year, though difficult, have produced the needed results:

- The program's budget is balanced and is expected to stay that way for the foreseeable future
- Our managed care network has returned to its original risk-based model
- We have successfully won relief from several lawsuits allowing greater opportunity to run the TennCare program from the statehouse and not the courthouse

The pages of this report detail the design and operation of the TennCare program, including eligibility and enrollment information, overviews of the managed care network, budget figures and a summary of the reform initiatives that created the program Tennessee operates today. The report also highlights several notable accomplishments over the past year such as:

- Implementing dozens of pharmacy utilization control measures, expanding our drug purchasing power by joining a multi-state drug purchasing pool and increasing drug utilization review activities
- Launching five statewide disease management programs that target the most prevalent medical conditions of TennCare enrollees. These programs complement existing disease management efforts already in place within individual MCOs
- Aggressively managing the program to convert a $650 million projected budget shortfall into a balanced budget

While much energy has been dedicated to reining in the finances of the program, significant progress was also made as a result of our renewed commitment to quality. This includes new initiatives to ensure our managed care organizations and their provider networks are continually improving the quality of care delivered to those covered by TennCare.

In addition to requiring all managed care plans to become certified by the National Committee for Quality Assurance, for the first time this past year the Bureau published comparative quality data for each participating health plan. Publishing this information allows unprecedented transparency into objective, third-party evaluations of performance and quality within the TennCare program. And, we are committed to improving these baseline levels.

In the coming year we will continue refining the TennCare program with targeted initiatives that improve the operations of the Bureau, improve the quality of services delivered to our enrollees and ensure continued stability in the program. As the program continues to evolve, I encourage you to visit our web site -- http://www.tennessee.gov/tenncare -- for the latest news, information and updates.

Sincerely,

J.D. Hickey
Deputy Commissioner
Director, Bureau of TennCare

TENNCARE

Bureau of TennCare 2004-05 Annual Report
State of Tennessee

Table of Contents

Introduction..... 08

Did you know TennCare covers 23 percent of the state's population and that it represents 26.34 percent of Tennessee's tax collections? See the big picture here.

The Need for Reform..... 12

With the threat of consuming 91 percent of the State's revenue growth by 2008, the TennCare program has controlled its growth for the first time in recent history.

2004-05 Milestones..... 15

New programs, new management, court rulings and much more.

Service Delivery Network..... 22

Who provides the services that TennCare's enrollees receive? What services are provided? How much does it all cost?

Enrollment..... 32

Who comprises the TennCare population?

Looking Ahead..... 34

Reform and Grier Consent Decree implementation, a return to risk sharing, Medicare Part D and more.

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

Bureau of TennCare 2004-05 Annual Report
State of Tennessee

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Director of Policy

TENNCARE

Pursuant to the State of Tennessee's policy of non-discrimination, the Bureau of TennCare does not discriminate on the basis of race, sex, religion, color, national or ethnic origin, age, disability or military service in its policies, or in the admission to, or treatment or employment in, its programs, services or activities.

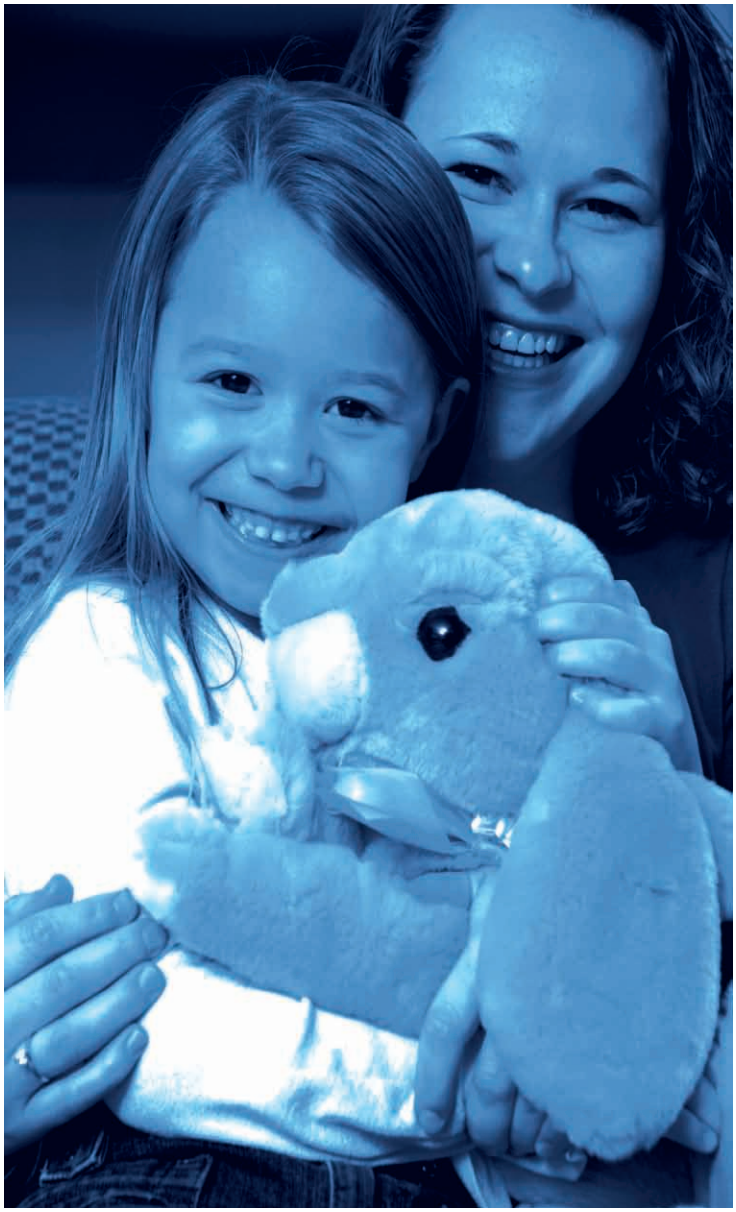
For inquiries, complaints or further information you may contact: TennCare's EEO/AA Officer at 615-507-6492 or Toll Free at 1-800-342-3145.TennCare's Director of Non-discrimination Compliance at 615-507-6474 or Toll free at 1-800-342-3145. Persons with hearing impairments should call: TDD Toll Free 1-800-772-7647 or Local 615- 313-9240. Para informacion de TennCare en Espanol llame 1-866-311-3490.

TennCare Bureau, Authorization No. 318121, copies 3,000
January 2006 - This public document was promulgated at a cost of $1.10 per copy.

TennCare is a government-operated health insurance program originally designed for low income individuals and others whose health or employment status made it difficult for them to access private insurance. The "core" population consists of individuals eligible for Medicaid. In addition to these Medicaid eligibles, TennCare has served another group of people who are not eligible for Medicaid, but who are uninsured or uninsurable (also referred to as medically eligible). This group is frequently referred to as the waiver, expansion, TennCare Standard or demonstration population. The term "demonstration population" derives from the fact that TennCare is operated as a demonstration project under an 1115(a) waiver from the federal government. The TennCare project originally sought to demonstrate that by managing the care of enrollees, the state could experience savings that would facilitate serving a larger portion of the population.

During FY 2005, these figures attest to the fact that TennCare serves a broader population than most other medicaid programs:

- TennCare covers approximately 23 percent of the state's population
- Enrollment, on December 31, 2004, was 1,357,700 with 1,113,000 of these persons being Medicaid eligible and 244,700 enrolled in the expansion population (according to U.S. Census data in 2004, Tennessee's total population was 5,748,379)
- Coverage is especially pronounced among women of childbearing age and infants and children
  In fact, one of every two babies born in Tennessee is covered by TennCare.



TennCare was created on January 1, 1994. In the beginning, all services except for long-term care and some care delivered by other state agencies were provided by Managed Care Organizations (MCOs). Every TennCare enrollee was enrolled in an MCO, making TennCare one of the largest government-operated managed care programs in the country. In 1996, behavioral health services were "carved out" from MCO responsibility and Behavioral Health Organizations (BHOs) were brought into the managed care system to deliver mental health and substance abuse treatment services. In 2002, dental services were carved out and offered by a Dental Benefits Manager (DBM).

Pharmacy services began being carved out of the other managed care programs in 1998 and offered directly by the state. In 2000, drugs for dual eligibles (individuals eligible for both TennCare and Medicare) were carved out, and in 2003, all remaining drugs were carved out. TennCare contracts with a Pharmacy Benefits Manager (PBM) to manage the drug program.

As of the 2005 fiscal year, each TennCare enrollee interacts with four Managed Care Contractors (MCCs) delivering his or her care (an MCO, a BHO, the DBM and the PBM). Long-term care services and some services for children in state custody continue to be provided outside the managed care structure.

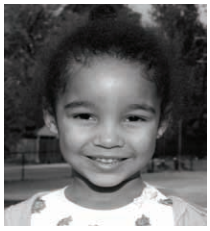
TennCare MCOs originally operated under a fully capitated risk arrangement with the state to provide medical services to TennCare enrollees. In the late 90s and early 2000, the TennCare program experienced several setbacks with some MCOs that failed and were eventually removed from the program. In an effort to stabilize the program, by July 1, 2002, all TennCare MCOs were operating under a Stabilization Plan for which time the MCOs were paid an administrative fee and were not at risk for the cost of medical service. Such was the case through the end of last fiscal year when, on July 1, 2005, the MCO network was returned to risk.

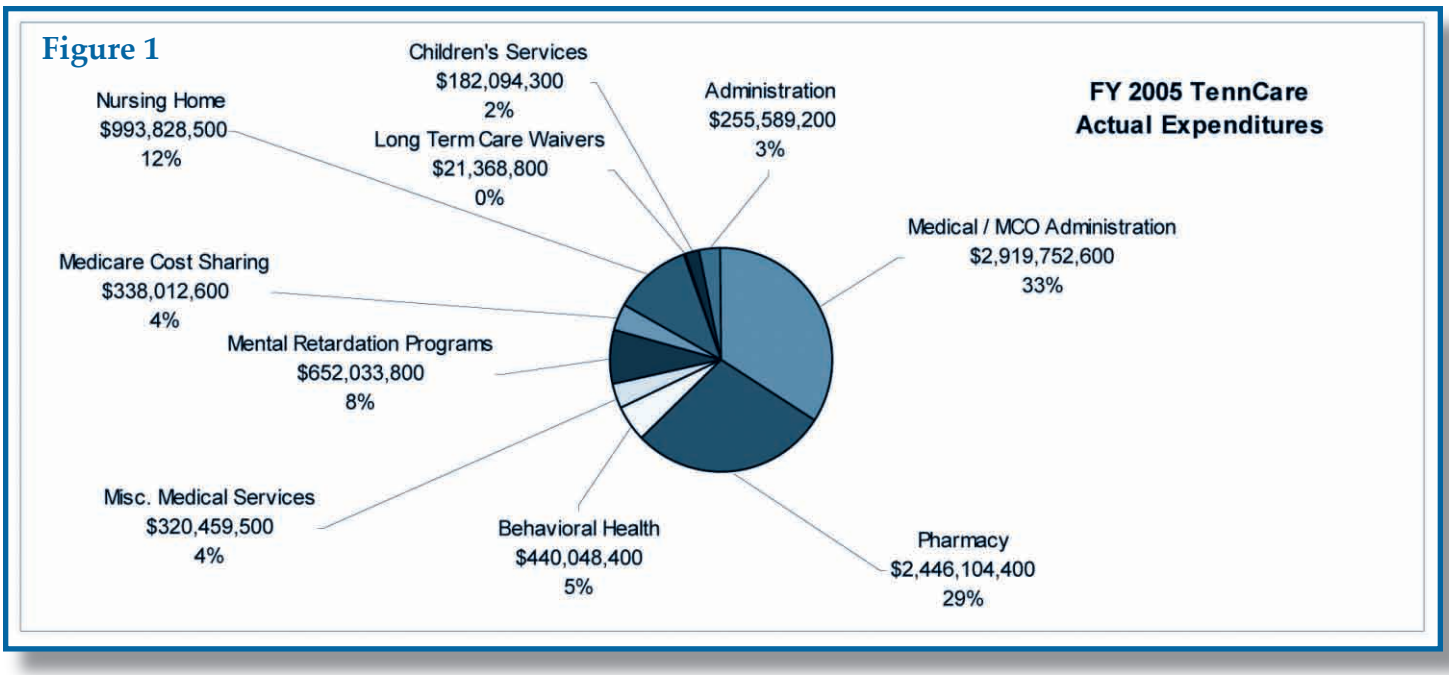
TennCare is funded through a federal match program. The match rate during Federal Fiscal Year 2005 for most services was 64.81 percent, meaning that for every $1.00 spent in the TennCare program, the federal government provides $0.6481 in reimbursement. Certain other expenditures may be funded at a higher or lower match rate depending on federal regulation.

TennCare's total expenditure in FY 2005 was over $8.5 billion. **In fact, in 2005, Tennessee's Medicaid expenditures represented 26.34 percent of Tennessee's Department of Revenue's tax collections.** A complete budget breakout follows in Table 1 and is graphically depicted in Figure 1 (next page). ■

Table 1
Total Budget with Funding Breakout

Category	FY 2005 Budget	FY 2005 Spending
Medical / MCO Administration	$2,725,131,900	$2,919,752,600
Pharmacy	$2,113,972,500	$2,446,104,400
Behavioral Health	$454,539,600	$440,048,400
Misc. Medical Services	$346,673,900	$320,459,500
Mental Retardation Programs	$664,664,400	$652,033,800
Medicare Cost Sharing	$287,511,200	$338,012,600
Nursing Home	$993,954,300	$993,828,500
Long Term Care Waivers	$47,676,000	$21,368,800
Children's Services	$180,874,000	$182,094,300
Administration	$230,073,700	$255,589,200
Total Expenditure	**$8,045,071,500**	**$8,569,292,100**
State Appropriations	$2,540,007,100	$2,538,746,900
Federal	$4,836,033,100	$4,992,233,500
Federal CPE	$207,224,300	$203,619,900
Drug Rebates	$423,304,500	$702,230,500
Premiums	$38,368,500	$40,029,100
Other funding/Carryforward	$134,000	$92,432,200





As depicted in the following table (Table 2), TennCare expenditures have a compound annual growth rate of 12.1 percent over the past five years.

TennCare spent almost $500 million more than its approved budget in FY 2005. This fact confronted state government when planning for the FY 2006 budget, and was one of the driving forces behind the need for immediate reform of the TennCare program.

Table 2

Fiscal Yr	Actual Expenditures	Growth
2000-2001	$5,430,806,600	
2001-2002	$6,105,650,500	12.43%
2002-2003	$6,864,485,100	12.43%
2003-2004	$7,631,267,100	11.17%
2004-2005	$8,569,292,100	12.29%

The Need for

R E F

Despite the successes of extending health insurance to hundreds of thousands of non-Medicaid eligible Tennesseans through TennCare over the past 11 years, 2004 represented the year the state could no longer ignore the impending fiscal crisis that TennCare threatened if left unchecked.

In August 2003, Governor Phil Bredesen secured private funding for an independent analysis of the long-term financial viability of the TennCare program.

The international business consulting firm, McKinsey & Company, spent months examining the program.

Knowing the TennCare program threatened to bankrupt the state, Governor Bredesen and the TennCare Bureau developed an initial plan to reform the program.

ORM

Its conclusion: If left unchecked, TennCare would consume 91 percent of all new revenue growth by 2008, essentially eliminating the state's ability to fund other state departments and priorities.

The plan would preserve full enrollment, and place certain service limits on some enrollees.

Thus returning the benefits package to one the state could afford to fund in the coming years.

(continued ✈✈✈✈)

The Need for Reform

However, despite near unanimous support by the General Assembly for what was widely regarded as a reasonable approach to reining in the program, the legal advocates who have kept the TennCare program in federal court for years blocked the initial reform plan.

In spite of the unwillingness of the legal advocates to support the more rational reform package, the state achieved financial stability in the TennCare program. The TennCare program is expected to have consecutive years of balanced budgets that do not require supplemental appropriations.

The 2005 state fiscal year was dominated by a focus on the TennCare reform initiative. An initial reform proposal was published in August 2004 for public comment and then submitted to the federal Centers for Medicare and Medicaid Services (CMS) in September.

This proposal outlined new benefit packages to be provided, with limitations on services to individuals other than pregnant women, children, and people with disabilities. At the time, no proposals were made with respect to closing any existing eligibility categories.

Two issues emerged later in the fall that affected the September proposal. One was an unwillingness of the Tennessee Justice Center, the organization that has functioned as the attorney for TennCare enrollees in a number of class action TennCare lawsuits, to agree to provide the state with relief from those portions of existing Consent Decrees that went beyond federal law.

The second was related to new developments discovered during closing out TennCare's FY 2004 budget - a realization that program funds were being expended even more rapidly than had been anticipated. The state learned that there had been unexpectedly high growth in the areas of pharmacy and medical utilization rates. Given these two realities, the Governor announced in November that TennCare would return to a more traditional Medicaid program. Shortly after that, he announced his intention to find an alternative approach if at all possible.

The alternative was another reform proposal, which was published in January 2005 for public comment and formally submitted to CMS in February. This proposal called for the closing of certain eligibility categories and the disenrollment of adults in those categories who were not eligible in an open Medicaid category. It also called for benefit limits and the elimination of specific benefits for certain populations.

After considerable discussion with CMS, the state divided the proposal into "phases." "Phase 1" included provisions for closing certain eligibility categories (adult uninsured, adult medically eligible, adult non-pregnant Medically Needy) and for disenrolling persons in those categories. Phase 1 was approved by CMS on March 24, 2005.

CMS began to review "Phase 2" on May 6. It included provisions for limiting pharmacy benefits for most adults and, in some cases, for eliminating them altogether. It also included proposals for eliminating certain benefits (e.g. methadone clinic services) for adults. Phase 2 was approved by CMS on June 8, 2005.

By the end of the fiscal year, implementation of these first two phases of TennCare reform were underway and so was a legal effort to gain relief from one of the consent decrees (the Grier Consent Decree) that significantly impaired the State's ability to effectively manage care and costs.

In fact, a commitment had been made by the Governor to preserve coverage for the adult non-pregnant Medically Needy population, if the state prevailed in obtaining the legal relief it sought. ■

Fiscal Year 04/05 Milestones

Favorable Ruling in Federal Appeals Court – The Rosen v. Tennessee Commissioner of Finance and Administration case was filed on behalf of persons eligible for TennCare as part of the expansion population on July 8, 1998, challenging the state's policies and procedures for determining and terminating TennCare eligibility. On May 27, 2005, the U.S. Sixth Circuit Court of Appeals reversed a federal court order that prevented the state of Tennessee from proceeding with enrollment reductions that had been announced by the Governor in November 2004. The Appeals Court decision overturned an Order by U.S. District Court Judge William Haynes. Judge Haynes had ruled that the State had a constitutional obligation to continue serving Tennessee's optional adult population.

Preparation for Disenrollment - On April 29, 2005 new enrollment was closed into the TennCare Standard program (the waiver/expansion population). The only exception is that children under age 19 can still "roll over" from Medicaid to TennCare Standard if they meet the eligibility requirements for TennCare Standard. Also on April 29, 2005, the non-pregnant adult Medically Needy (also called "Spend Down") category was closed. The Medically Needy program remains open for children up to age 21 and pregnant women who meet the eligibility requirements. All other TennCare Medicaid categories remained open to new enrollment. The Department of Human Services (DHS) conducted ex parte reviews of all persons in eligibility categories that were closing (adults, age 19 and older, in the expansion population) as a part of TennCare reform to learn if they might be eligible in an open category. Those who were eligible were moved to those categories. Those who were not eligible in an open category were sent a letter in early June 2005, with a "Request for Information" (RFI) form which they could use to send in additional information about themselves that might qualify them for an open category. Special outreach was conducted to be sure that certain groups such as people with Severe and/or Persistent Mental Illness, people with limited English proficiency, and people with other kinds of disabilities were assisted in filling out their RFIs.

Build Out of Management Team – Early in the Bredesen administration Governor Bredesen recognized the need for an enhanced senior management team to address the operational and structural changes that were necessary to stabilize the TennCare program. As a result the Bureau added several key members to its executive management team during the past year, including:

J.D. Hickey, M.D., J.D., Deputy Commissioner and TennCare Director: Dr. Hickey joined the Bureau in July 2004 after serving as the on-site project lead for the McKinsey & Company team that conducted the initial feasibility study of the TennCare program in 2003. Under Dr. Hickey's leadership, the Bureau has returned the MCO network back to a risk-sharing arrangement, balanced its budget for two consecutive fiscal years and began requiring that certain performance and quality measures are achieved.

Wendy Long, M.D., MPH, Chief Medical Officer: Dr. Long joined the Bureau in September 2004 as the senior medical officer, overseeing all clinical and quality of care initiatives. Dr. Long, a veteran public health physician, previously served as the Assistant Commissioner for the Bureau of Health Services in the Tennessee Department of Health.

Brent Antony, Chief Information Officer: Mr. Antony joined the Bureau in March 2005 and manages the Bureau's information systems division, including long-range information systems strategy development and effectively managing technology relationships with other state departments, federal agencies and private contractors. Mr. Antony's experience includes developing and implementing electronic medical records and claims processing systems for private healthcare companies during the past 17 years.

Winnie Toler, Ph.D., Chief Network Officer: Ms. Toler joined the Bureau in November 2004 to oversee the Bureau's managed care networks. Dr. Toler has more than 20 years of health care management experience and has served in upper management positions for a variety of private and public managed care groups.

Dave Beshara, RPh., MBA, Chief Pharmacy Officer: Mr. Beshara joined the Bureau in March 2005 relocating to Tennessee from New Jersey where he managed pharmacy programs and formulary operations for government and private companies, including Medco Health Solutions.

New Management Information System - In August 2005, TennCare implemented a new management information system known as "TCMIS". Under contract with the state, EDS provided the TCMIS to replace the legacy system that had been in operation since 1984. Successful implementation of the new TCMIS was the result of an extensive vendor selection, system design and development process.

The new system better meets the management and information needs of TennCare. It provides enhanced support for current programs and core business processes, including:

- Recipient eligibility and enrollment
- Encounter and claims processing
- Premium management, and
- Provider enrollment

Reduced Number of Audit Findings - TennCare continued to make significant progress in reducing the number of audit findings in the annual Audit Report issued by the State of Tennessee Comptroller of the Treasury. In FY 2005, the audit report for 2004 was released with a total of 15 findings. Of these 15, seven were reduced in severity with improvement noted from the preceding year.

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

Implementation of Pharmacy Edits - TennCare's pharmacy claims processing system is an on-line, real time adjudication system. While the pharmacist is submitting a claim, the system simultaneously performs edits on the claim to ensure that TennCare's criteria for coverage and payment is met.

Many new edits were implemented in FY 2005 to enhance patient safety and low overall costs. Most notable among these are:

- Therapeutic Duplication – Denial of payment for two claims in the same therapeutic category,

Fiscal Year 04/05 Milestones

- Maximum Dose- Sets a limit on the amount of drug per day available to a patient based on guidelines of the drug manufacturer, and
- Drug to Gender - Limits certain medications to a specific gender based on the use of the drug.

Use of a Preferred Drug List (PDL) - The 2005 fiscal year represented the first full year of operation of the PDL. TennCare uses the PDL to garner better pricing while assuring enrollee access to preferred medications. A PDL is a listing of medications in a given therapeutic category where one or more drugs have a preferential status over other drugs in that category. The presence of a drug as a preferred agent can be due to:

- Higher clinical efficacy than other drugs in the class, or
- A lower net cost than other drugs in the class, when all drugs in the class are clinically equivalent

Meetings of the Pharmacy Advisory Committee were held during the latter part of the year to begin the process of expanding the number of categories of drugs included on the PDL and to reassess the status of drugs in the categories of medications already included in the PDL.

Decision to Join the National Medicaid Pooling Initiative - In an effort to assure continued maximization of supplemental rebates despite a decrease in enrollment and the upcoming implementation of Medicare Part D, Tennessee made the decision to join the National Medicaid Pooling Initiative (NMPI). NMPI is a mechanism whereby multiple states band together in order to negotiate the best possible supplemental rebates. These rebates are returned to the state each time medications on the PDL are purchased by the TennCare program.

Enhanced Retrospective Drug Utilization Review (retro DUR) Process – During fiscal year 2005, TennCare made new appointments to the retro DUR board, expanded the Pharmacy Benefit Manager's responsibilities for retro DUR and developed a process to assure that at least three reviews concerning pharmacy prescribing practices, and the associated provider educational interventions, are conducted each quarter. In addition, routine procedures were implemented for identifying enrollees who receive large numbers of controlled substances from multiple prescribers and who fill those prescriptions at multiple pharmacies. These enrollees are then "locked in" to a single pharmacy in order to improve quality and reduce the potential for fraud and abuse.

Pharmacy Bonus Payments - To encourage pharmacies to ensure that patients are utilizing cost-effective preferred drugs, TennCare instituted a Preferred Drug List (PDL) compliance bonus. The bonus payment is a check given to pharmacies that achieve a 90 percent or greater PDL compliance. If the pharmacies achieve this PDL compliance, they receive a $0.10 per claim bonus. Approximate payments for the PDL compliance bonus checks for Fiscal Year 04-05 were $1,920,000.

Essential Access Payments - TennCare makes payments to hospitals for the unreimbursed cost of providing services - including costs for TennCare-eligible individuals and charity care. These hospitals are known as Essential Access Hospitals. Allocation of funds is based an assignment of points for: (continued next page)

- TennCare adjusted days expressed as a percent of total adjusted patient days, and
- Charity, medically indigent care, and bad debt expressed as a percent of total expenses.

In Fiscal Year 2004-2005, $100,000,000 was distributed to 118 hospitals out of a total 158 evaluated Essential Access Hospitals (EAH) in the following way:

• Essential Service Safety Net	6 hospitals	$50 Million
• Children's Safety Net	3 hospitals	$ 5 Million
• Free-Standing Psychiatric hospitals	9 hospitals	$ 2 Million
• Other Essential Acute Care	100 hospitals	$43 Million

Electronic Claims Filing for Nursing Homes – TennCare significantly upgraded the claims processing system that facilitates the ability of nursing facilities to submit claims electronically. On-line claims filing is now being used by virtually 100 percent of the long term care providers.

Decision Support System RFP and Award of Contract - In FY 2005, the state of Tennessee launched the TennCare Decision Support (TCDS) project. The purpose is to provide the state with more expedient access to the information it needs for program operations and to address the critical TennCare reform initiative. The contract for TCDS was awarded in December 2004 to Medstat of Ann Arbor, Michigan. Medstat brings significant experience in the healthcare industry with specific expertise in the Medicaid market sector. Design, development and implementation activities for the TCDS project were well under way by the end of the fiscal year, with results expected in early 2006.

Improvement in EPSDT Screening Rate - Early Periodic Screening Diagnosis and Treatment (EPSDT) is a federally mandated Medicaid program for children under the age of 21 that provides for periodic screening, vision, dental, and hearing services. EPSDT also requires that any medically necessary health care service be provided to an eligible child under the age of 21 even if the service is not available under the state's Medicaid plan to the remainder of the Medicaid population. Through EPSDT, a child's health needs can be assessed through periodic evaluations, assuring that health problems are diagnosed and treated early, before they become more complex and their treatment more costly.

TennCare has operated under a Consent Decree since 1998 that mandates improvement in EPSDT screening rates. Federal Fiscal Year 1999 was the first full year after that Consent Decree was finalized. For Federal Fiscal Year 2004 (the year that is reported during the 2005 state fiscal year), TennCare reported a periodic screening percentage of 73 percent - the highest rate ever recorded. In addition, the dental screening rate increased to 51 percent - again, the highest rate in our history. Table 3 depicts the progress Tennessee has made in improving EPSDT screening rates.

Table 3
Progress on Adjusted Periodic Screening Percentage and Dental Screening Percentage

	CMS 416 screening percentage *	Results of TennCare's Division of Quality Oversight Medical Record Review **	Adjusted Periodic Screening Percentage ***	Dental Screening Percentage****
FFY 96 (baseline)	39%	56.2%	21.9%	28.2%
FFY 99	36%	55.1%	19.8%	28.5%
FFY 00	45%	69.9%	31.5%	33%
FFY 01	50%	76%	38%	38.3%
FFY 02	54%	76.97%	42%	35.7%
FFY 03	62%	90.35%	56.02%	45.8%
FFY 04	73%	92.04%	67.2%	51%

Note: "FFY" means Federal Fiscal Year. The FFY is calculated from October 1 through September 30.

*Percentage taken from the ratio reported on the CMS 416 filed each year; determined according to CMS formula. That formula involves dividing the actual number of screening services provided by the expected number of screening services that should have been provided, given the ages and numbers of children enrolled.

**Percentage obtained by TennCare Quality Oversight Unit after conducting an annual medical record review on a statistically valid sample of encounters coded as periodic screens. This review determines what percentages of

the required seven components were contained in the records.

***Percentage calculated by multiplying the figure in Column A by the figure in Column B.

****Percentage calculated by dividing the actual number of dental encounters provided for children aged 3-20 by the expected number of encounters - one (1) per year for each child enrolled in this age group.

TENNderCARE Branded – In Tennessee, the EPSDT program is known as "TENNderCARE". The goals of TENNderCARE are:

(1) To ensure that needed health care resources are both available and accessible, and

(2) To assist young TennCare enrollees and their parents or guardians in the effective use of those resources.

TennCare joined with representatives from the Governor's office, Department of Human Services, Department of Health, Department of Education, and other state agencies to unite the TennCare services offered to children under one branded set of services. Through discussions with these internal groups and several advocacy organizations, the TENNderCARE name was developed and new identity materials – brochures, posters, web sites and other products – were created to promote these preventive health and diagnostic services.

The Bureau conducted a four-week state-wide television, radio and billboard campaign to launch the program and introduce the TENNderCARE name. This initial introductory effort was immediately followed by the creation of an outbound call center, operated by the Department of Health, which contacts families of children enrolled in the program to remind them of upcoming physician appointments and assist in scheduling well-child screenings and other services.

Bureau staff also developed an online training and testing tool that was used to train staff in various state departments on the services offered under the TENNderCARE program. State employees and representatives from MCOs and other state contractors who have TENNderCARE-related responsibilities are required to complete this training session and successfully complete the follow up test to ensure program integrity.

The Bureau also conducted random telephone surveys of enrollees and primary care physician practices to assess initial awareness of these services. This awareness survey will be conducted annually to track the effectiveness of the TENNderCARE brand in increasing the screening rates of children enrolled in TennCare.

School-Based Health Program - TennCare received CMS approval to begin reimbursing school districts for medical services to certain Medicaid eligible children. To participate in this program, the service must be provided to a special education student while at school, allowing the child to receive a free and appropriate education under the Individuals with Disabilities Education Act (IDEA). This program partially reimburses districts for speech therapy, occupational therapy, physical therapy, behavioral services, nursing services and specialized transportation. In Fiscal Year 04-05, TennCare paid out approximately $1 million to the Department of Education and about 30 local school districts. By the beginning of FY 05-06, approximately 100 local school districts were signed up to participate.

Simplified Medical Eligibility Process - The paperwork and process for determining Medical Eligibility (ME) for the expansion population was streamlined as part of a collaborative effort with TennCare advocates. The revised ME application was field-tested with the public, DHS Eligibility staff, TennCare advocates and current enrollees before implementation. A Medical Eligibility outreach/assistance unit (known as the "M.E. Help Desk") was established to assist enrollees with ME questions. ■

TENNder CARE

Check In Check Up Check Back

TENNESSEE'S EPSDT PROGRAM

"Every child in Tennessee deserves to grow up healthy and happy.

TENNderCARE is the state's commitment to see that our children and teens have the best start at a healthy life."

- Phil Bredesen, Governor

Giving Children the Best Start at a Healthy Life

Good health begins at birth and continues throughout life. Providing this opportunity to Tennessee youth, TennCare has established a program of check-ups and health care coverage designed for children of all ages.

The purpose of TENNderCARE is to assure the availability and accessibility of required health care resources and to help TennCare eligible children (under the age of 21) and their parents or guardians effectively use these resources.

Who is eligible?

Every child (under 21) who is eligible for TennCare is eligible for TENNderCARE services. A child can be eligible for TennCare through Medicaid or through the Uninsured or Uninsurable guidelines. TENNderCARE screenings are well-child check-ups. Children and adolescents should receive regular screenings even if there is no apparent health problem.

Screenings are the initial step in identifying children with needs requiring more in-depth testing and diagnostic procedures. Screenings are provided to initially identify problems in a general area requiring further assessment/evaluation (such as behavioral or developmental) while diagnostic procedures should identify or rule out specific problems (such as ADHD or mental retardation). Screening instruments are also designed for use with all children during a well-child visit.

TennCare requires that TENNderCARE screenings be performed according to the standards of the Periodicity Schedule that is recommended by the American Academy of Pediatrics. The required seven components are as listed:

- Comprehensive Health (Physical and Mental) and Developmental History
- Comprehensive Unclothed Physical Exam
- Health Education/ Anticipatory Guidance
- Vision Screening
- Hearing Screening
- Laboratory Tests
- Immunizations

What TENNderCARE provides

- Free check ups
- Dental check up and services
- Medical treatment
- Behavioral health services

Contact Information

Contact the Family Assistance Service Center at 1-866-311-4287. Or, find us on the internet at: *http://www.state.tn.us/tenncare/child.html*

Service Delivery Network

- *MCOs*
- *BHOs*
- *PBM*
- *DBM*

MCOs

All TennCare enrollees are assigned to a Managed Care Organization (MCO) for their physical health care needs. Each of the eight MCOs are contracted to provide services to enrollees in a designated Grand Region of the state, with the exception of VHP which operates only in Davidson County and TennCare Select which operates statewide. TennCare Select serves as the state's "back-up" health plan in order to accept enrollment from failed health plans or in areas that may be underserved as well as the plan that provides medical services to vulnerable and specialized populations as defined by the state. Table 4 illustrates the distribution of TennCare enrollment by MCO and by grand division.

The MCOs are responsible for providing a full range of health care services for each enrollee except that the following services are carved out and delivered by other entities: behavioral health, pharmacy, dental and long term care services.

Table 4

Distribution of TennCare Enrollment by MCO by Grand Region

Eligible recipients on December 31, 2004

MCO / Region*	East	Middle	West	Out of State**	Total	MCO Distribution
BHP	0	0	49,300	0	49,300	3.6%
BlueCare	259,900	0	0	0	259,900	19.1%
John Deere	87,200	0	0	0	87,200	6.4%
PHP	129,900	0	0	0	129,900	9.6%
TennCare Select	36,200	388,600	34,100	7,600	466,500	34.4%
UAHC	0	0	133,200	0	133,200	9.9%
TLC	0	0	193,300	0	193,300	14.2%
VHP	0	38,400	0	0	38,400	2.8%
Total	513,200	427,000	409,900	7,600	1,357,700	100.0%
Regional Distribution	37.8%	31.4%	30.2%	0.6%	100.0%	

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

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

BHOs

All enrollees are assigned to one of two Behavioral Health Organizations (BHOs) for their behavioral health needs. Generally, enrollees are assigned to a BHO based on their MCO assignment. Tennessee Behavioral Health (TBH) is partnered with John Deere, TLC, PHP, TennCare Select in East Tennessee and BlueCare in East Tennessee and Knox County. Premier Behavioral Systems of Tennessee, L.L.C. (Premier) is partnered with OmniCare, Better Health Plan, and VHP. TennCare Select in Middle and West Tennessee is also partnered with Premier. Children in state custody and enrollees living out-of-state are automatically assigned to Premier.

Effective July 1, 2004, TBH executed two separate contracts and/or amendments with the state of Tennessee.

1. TBH East – a full risk contract serving all enrollees in the East Tennessee Grand Region.
2. TBH Middle and West – a partial risk agreement for the remainder of the state.

Premier Behavioral Systems of Tennessee, L.L.C., has a no-risk contract serving enrollees in Middle and West Tennessee. A single management company, Advocare of Tennessee, provides management to both TBH and Premier.

Table 5 provides the information concerning the distribution of enrollees across BHOs, by grand division of the state.

Table 5

Distribution of TennCare Enrollees by BHO and Grand Region
(Eligible recipients on 12/31/2004)

Region \ BHO*	Premier	TBH	Total	Percentage
West	215,600	193,600	409,200	30.1%
Middle	422,600	6,100	428,700	31.6%
East	8,100	504,100	512,200	37.7%
Out-of-State	5,000	2,600	7,600	0.6%
Total	651,300	706,400	1,357,700	100.0%
Percentage	48.0%	52.0%	100.0%	

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

PBM

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

DBM

Doral Dental is the Dental Benefits Manager (DBM) for TennCare. All dental claims are processed by Doral and all dental care is provided to enrollees through their provider network.

FY 2005 Network Concerns:

- **DBM** - TennCare exercised its prerogative not to renew its contract with the dental benefits manager (DBM), Doral Dental of Tennessee, LLC at the end of SFY 04/05. Although Doral Dental had performed well in managing dental benefits for TennCare enrollees over the three-year contract term, the State made the determination that it would re-bid the DBM contract through the RFP process. At the completion of that RFP process, Doral Dental was selected as the winning bidder. The new DBM agreement reduces state costs by $3 million compared to the original contract.

- **MCOs** - One of the TennCare MCOs, OmniCare [now operating as United American Health Care (UAHC)], was placed under Administrative Supervision by Tennessee Department of Commerce & Insurance (TDCI) on April 5. 2005. Both TennCare and TDCI continue to monitor the company's performance.

TennCare Services

All TennCare-covered services must be medically necessary. As of July 1, 2004 TennCare covered services included the following:

- Community health services
- Convalescent care
- Dental services for enrollees under age 21 as medically necessary. Enrollees age 21 and over are eligible for dental benefits if they have a life-threatening infection, prosthetic heart valve, were severely immunocompromised, had a tumor of the oral cavity, had impacted wisdom teeth or an accidental injury to the oral cavity or teeth.
- Durable medical equipment
- Emergency ambulance transportation - air and ground
- EPSDT services for enrollees under age 21
- Home health care
- Home and Community-based Services (HCBS) for the developmentally disabled, mentally retarded, and/or elderly*
- Hospice care
- Inpatient and outpatient substance abuse benefits
- Inpatient hospital services
- Lab and X-ray services
- Medical supplies
- Non-emergency ambulance transportation
- Non-emergency transportation
- Nursing facility services (including Level I, Level II and ICF-MR facilities)
- Occupational therapy
- Organ transplants and donor organ procurements
- Outpatient hospital services
- Outpatient mental health services (including physician services)

- Outpatient substance abuse treatment programs
- Pharmacy services
- Physical therapy services
- Physician inpatient services
- Physician outpatient services/community health clinics/other clinic services
- Private duty nursing
- Psychiatric inpatient services
- Psychiatric physician inpatient services
- Psychiatric rehabilitation services
- Reconstructive breast surgery
- Renal dialysis services
- Sitter services
- Speech therapy
- 24-hour psychiatric residential treatment services
- Vision services for enrollees under age 21 as medically necessary

* HCBS and Nursing Facility services are provided outside the managed care setting.

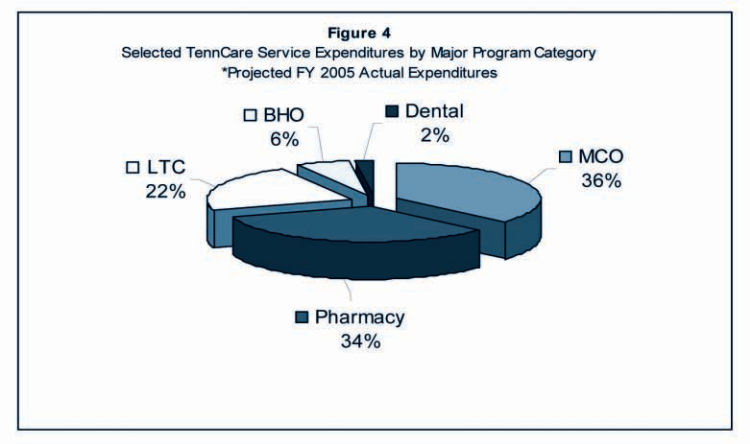


Table 8
Selected TennCare Service Expenditures by Major Program Category

MCO (Services Only)	$2,647,097,700
Pharmacy	$2,446,104,400
LTC	$1,619,486,300
BHO	$440,048,400
Dental	$ 141,661,000
Total – Selected* Programs	**$7,294,397,800**

* MCO Expenditure does not include MCO Administrative costs. Other costs not included are supplemental payments to hospitals, Medicare Crossover, educational costs, Bureau administrative costs and payments to the Dept. of Children's Services. The addition of these items, totaling $1,274,894,300, would reflect the total cost of the TennCare program at $8,569,292,100.

Pharmacy Services – Services Delivered Through the PBM

- TennCare utilizes a preferred drug list to manage the pharmacy benefit. Some drugs require prior approval.
- During FY 2005, 52 percent of TennCare-reimbursed prescriptions were generic and 48 percent were brand.
- Brand name drugs accounted for 84 percent of pharmacy expenditures, with an average cost per prescription of nearly $100 for a brand name prescription, compared to approximately $17 for a generic prescription.
- TennCare enrollees who utilized pharmacy services averaged 35.91 prescriptions per year in FY 04-05.

Table 9

Category of service	Providers with paid claims	FY 2005 recipients	Expenditures per recipient	FY 2004-2005 Expenditures
Pharmacy	1834	1,210,848	$2020.16	$2,446,104,400

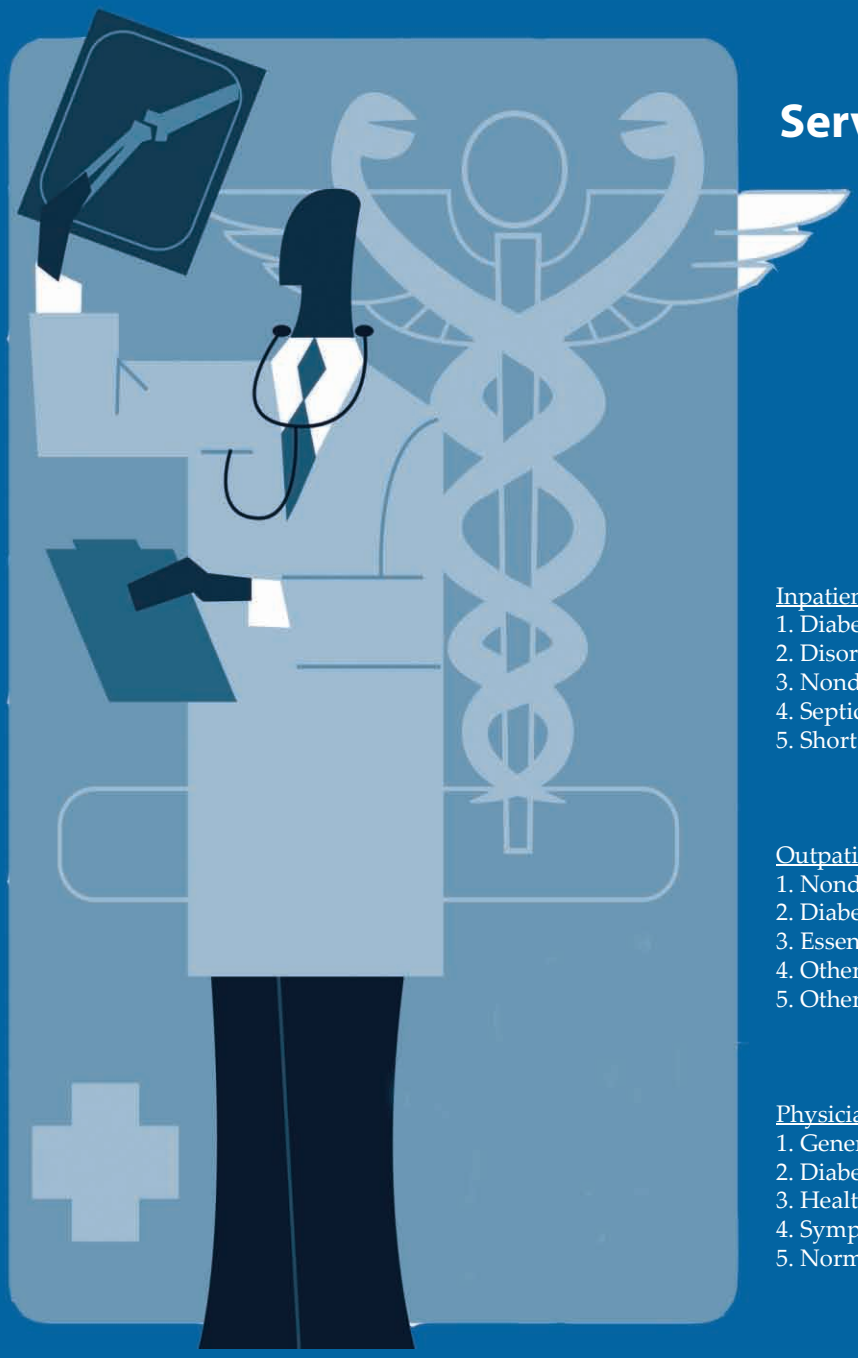
* An adjustment reflecting the difference between accrual and cash-basis measures was made.

Table 10 - Top 5 Drugs By Number of Claims

Brand Name	Generic Name	Drug Type	Number of Prescriptions
Vicodin, Lortab, Various Other Brands	Hydrocodone Bitartrate/ Acetaminophen	Narcotic	1,652,312
Protonix	Pantroprazole Sodium	Gastric acid reducer	1,278,470
Zocor	Simvastatin	Cholesterol lowering agent	851,414
Lasix	Furosemide	Diuretic	698,414
Xanax	Alprazolam	Anti-anxiety agent	661,693

Table 11 - Top 5 Drugs By Cost

Brand Name	Generic Name	Drug Type	Cost of Drug
Protonix	Pantoprazole Sodium	Gastric acid reducer	$144,874,881
Zocor	Simvastatin	Cholesterol lowering agent	$104,507,152
Seroquel	Quetiapine Fumarate	Antipsychotic	$ 61,156,544
Zyprexa	Olanzapine	Antipsychotic	$ 57,498,152
Neurontin	Gabapentin	Pain and seizure drug	$ 45,241,645



Medical Services -
Services Delivered Through MCOs

- Inpatient hospitalization rate was 132 per 1000 enrollees
- Average inpatient length of stay was 4.5 days
- Emergency room utilization was 750 per 1000 enrollees
- 80 percent of all TennCare enrollees visited a physician a least once during the year

Table 13 - Top 5 Diagnoses by Cost

Inpatient Hospital
1. Diabetes Mellitus
2. Disorders of fluid, electrolyte, and acid-base balance
3. Nondependent Drug Abuse
4. Septicemia
5. Short Gestation/Low Birth Weight

= 30.2 percent of all Inpatient Expenditures

Outpatient Hospital
1. Nondependent Drug Abuse
2. Diabetes Mellitus
3. Essential Hypertension
4. Other and unspecified disorders of joint
5. Other and unspecified disorders of back

= 18.2 percent of all Outpatient Expenditures

Physician
1. General Symptoms
2. Diabetes Mellitus
3. Health Supervision of infant or child
4. Symptoms involving respiratory system and other chest symptoms
5. Normal Delivery

= 14.7 percent of all Physician Expenditures

Table 12 - MCO Medical Expenditure by Category of Service*

Category of service	Providers with paid claims	FY 2005 recipients	Expenditures per recipient	FY 2004-2005 Expenditures
Hospital Facilities (Including care provided through hospitals (both Inpatient and Outpatient), Federally Qualified Health Centers (FQHC), Ambulatory Surgical Centers, etc.)	4,300	833,000	$1,572	$1,309,296,200
Physician	22,500	1,273,000	$785	$ 999,404,700
DME	2,200	115,000	$670	$ 77,000,000
Home Health	300	13,400	$5,097	$ 68,299,000
Other Services (Transportation, Lab, Hospice)	5,400	604,000	$320	$ 193,097,800
Total MCO Services**	31,000	1,184,300	$2,235	$ 2,647,097,700

* Expenditure adjusted to reflect services rendered but not yet recorded.
** Total amounts represent unduplicated counts and may not be the mathematical total of the column. Expenditures per recipient may not total due to rounding.

Long Term Care Services

Long term care services are "carved-out" from the remainder of the TennCare managed care program and are managed and reimbursed directly by the State.

- 32,000 Pre-Admission Evaluations are processed each year
- 48 nursing homes in the state are certified as Level 1 (Intermediate Care only); 12 are certified as Level 2 (Skilled Nursing Care) only
- 245 nursing homes are dually certified as both Level 1 and Level 2
- 17 nursing homes are certified as ICF/MR (Intermediate Care Facility for the Mentally Retarded)

Home and community based services (HCBS) are available in limited quantities for those people who are developmentally delayed, mentally retarded and/or elderly who would qualify for ICF admission, but wish to remain in their homes and receive services that are less costly than admission to a long term care center. HCBS plans are operated through waivers with CMS.

Table 14

Category of service	Number of Providers	FY 2004-2005 Institutional Residents	Average Expenditure per enrollee	Total FY 2004-2005 Expenditures
Home and Community-Based Services (HCBS) – Mental Retardation	2*	5,002	$75,880	$379,552,500
Home and Community-Based Services (HCBS) – Elderly	68	859	$24,876	$21,368,800
Intermediate Care: MR Facility (ICF-MR)	78	1,371	$198,746	$272,481,300
Intermediate Care Nursing Facility (Level 1 Facility)	296	26,478	$31,681	$946,083,700
Skilled Nursing Facility (Level 2 Facility)	238	2,462	$43,554	
Total	447	36,172	$44,772	$1,619,486,300

Census Data as of December 31, 2004

*Number of providers does not total because some entities provide more than one kind of service. Also, this table reflects only the two billing providers for MR; actual providers of MR HCBS services are in excess of 400.

Mental Health Services

Services Delivered through BHOs

- 68 percent 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 10 percent of the entire TennCare population are SPMI/SED enrollees
- 78 percent of dollars spent on mental health care are for SPMI/SED enrollees

Category of service	Providers with paid claims	FY 2004-2005 recipients	Expenditures per enrollee	FY 2004-2005 Expenditures
Mental Health Clinic and Institutional Services	1,205	202,004	$2,178	$440,048,400

Table 15

Top 5 Mental Health Diagnoses by Cost

Inpatient

1. Affective Psychosis
2. Schizophrenic Disorders
3. Depressive Disorders
4. Drug Dependence
5. Disturbance of Conduct

= 83.6 percent of all Inpatient Expenditures

Outpatient

1. Affective Psychosis
2. Schizophrenic Disorders
3. Disturbance of Conduct
4. Drug Dependence
5. Sexual Disorders

= 71.2 percent of all Outpatient Expenditures

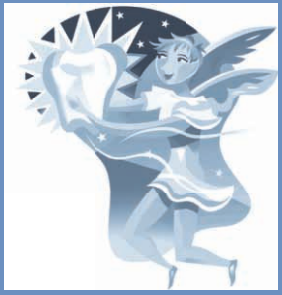
Physician

1. Affective Psychosis
2. Schizophrenic Disorders
3. Hyperkinetic Syndrome
4. Adjustment Reaction
5. Neurotic Disorders

= 77.8 percent of all Physician Expenditures

Dental Services

Services Delivered Through the DBM



- During FY 2005, medically necessary services were covered for enrollees under age 21. Enrollees age 21 and over were eligible for dental benefits if they had a life threatening infection, prosthetic heart valve, were severely immunocompromised, had a tumor of the oral cavity, had impacted wisdom teeth or an accidental injury to the oral cavity or teeth.
- 99 percent of dental services provided were for children under age 21.
- 51 percent of TennCare-eligible children received a dental service in FFY 2004.

Table 17

Category of service	Providers with paid claims	FY 2005 recipients	Expenditures per recipient	FY 2004-2005 Expenditures
Dental Services	741	318,283	$445	$141,661,000

Table 18

TennCare Expenditures and Recipients by County – State Fiscal Year 04/05*

County	TennCare Enrollment on 12/31/2004	Estimated 2005 Tennessee Population	Total TennCare Service Expenditures	Expenditure per Member	% County Expenditure as TennCare Total	% County Enrollment as TennCare Total	% County Population as Tennessee Total
ANDERSON	17,169	71,975	$96,101,169	$5,597	1.4%	1.3%	1.2%
BEDFORD	9,309	40,945	$44,302,553	$4,759	0.6%	0.7%	0.7%
BENTON	5,363	16,838	$27,990,252	$5,219	0.4%	0.4%	0.3%
BLEDSOE	3,414	12,868	$16,230,244	$4,754	0.2%	0.3%	0.2%
BLOUNT	21,165	112,074	$115,113,061	$5,439	1.7%	1.6%	1.9%
BRADLEY	18,623	92,686	$104,140,687	$5,592	1.5%	1.4%	1.6%
CAMPBELL	16,333	40,860	$88,470,691	$5,417	1.3%	1.2%	0.7%
CANNON	3,291	13,440	$17,394,936	$5,286	0.3%	0.2%	0.2%
CARROLL	8,476	30,066	$49,789,650	$5,874	0.7%	0.6%	0.5%
CARTER	15,659	57,464	$87,624,315	$5,596	1.3%	1.2%	1.0%
CHEATHAM	5,993	38,768	$30,678,299	$5,119	0.4%	0.4%	0.7%
CHESTER	3,843	16,426	$22,242,517	$5,788	0.3%	0.3%	0.3%
CLAIBORNE	11,999	30,989	$66,767,489	$5,564	1.0%	0.9%	0.5%
CLAY	2,906	8,106	$16,422,256	$5,651	0.2%	0.2%	0.1%
COCKE	13,172	35,064	$66,824,305	$5,073	1.0%	1.0%	0.6%
COFFEE	11,893	50,414	$61,300,545	$5,154	0.9%	0.9%	0.8%
CROCKETT	4,045	15,068	$23,375,880	$5,779	0.3%	0.3%	0.3%
CUMBERLAND	12,355	50,127	$70,518,002	$5,708	1.0%	0.9%	0.8%
DAVIDSON	118,178	592,446	$593,563,870	$5,023	8.7%	8.7%	9.9%
DECATUR	3,611	11,850	$23,337,564	$6,463	0.3%	0.3%	0.2%
DEKALB	5,040	18,350	$26,931,878	$5,344	0.4%	0.4%	0.3%
DICKSON	9,532	45,826	$52,719,918	$5,531	0.8%	0.7%	0.8%
DYER	11,661	38,129	$55,278,857	$4,740	0.8%	0.9%	0.6%
FAYETTE	7,017	31,295	$29,579,499	$4,215	0.4%	0.5%	0.5%
FENTRESS	8,098	17,300	$44,099,035	$5,446	0.6%	0.6%	0.3%
FRANKLIN	7,850	40,714	$40,684,265	$5,183	0.6%	0.6%	0.7%
GIBSON	13,472	48,640	$89,030,710	$6,609	1.3%	1.0%	0.8%
GILES	6,781	30,170	$35,483,562	$5,233	0.5%	0.5%	0.5%
GRAINGER	6,769	21,840	$35,040,093	$5,177	0.5%	0.5%	0.4%
GREENE**	15,991	64,841	$166,859,941	$10,435	2.4%	1.2%	1.1%
GRUNDY	6,284	14,759	$32,024,141	$5,096	0.5%	0.5%	0.2%
HAMBLEN	14,443	60,310	$82,771,435	$5,731	1.2%	1.1%	1.0%
HAMILTON	62,117	312,491	$333,671,441	$5,372	4.9%	4.6%	5.2%
HANCOCK	3,197	6,853	$15,974,381	$4,997	0.2%	0.2%	0.1%
HARDEMAN	8,211	29,618	$39,491,385	$4,810	0.6%	0.6%	0.5%
HARDIN	8,857	26,501	$53,336,346	$6,022	0.8%	0.7%	0.4%
HAWKINS	14,469	55,817	$74,221,388	$5,130	1.1%	1.1%	0.9%
HAYWOOD	6,636	19,920	$27,004,541	$4,069	0.4%	0.5%	0.3%
HENDERSON	7,104	26,591	$37,627,115	$5,297	0.5%	0.5%	0.4%
HENRY	8,370	31,761	$42,616,430	$5,092	0.6%	0.6%	0.5%
HICKMAN	6,211	24,186	$32,741,327	$5,272	0.5%	0.5%	0.4%
HOUSTON	2,327	8,223	$13,861,325	$5,957	0.2%	0.2%	0.1%
HUMPHREYS	4,400	18,469	$24,676,803	$5,608	0.4%	0.3%	0.3%
JACKSON	3,653	11,441	$20,703,977	$5,668	0.3%	0.3%	0.2%
JEFFERSON	11,958	47,809	$68,897,913	$5,762	1.0%	0.9%	0.8%

Table 18 continued

County	TennCare Enrollment on 12/31/2004	Estimated 2005 Tennessee Population	Total TennCare Service Expenditures	Expenditure per Member	% County Expenditure as TennCare Total	% County Enrollment as TennCare Total	% County Population as Tennessee Total
JOHNSON	5,776	18,203	$29,496,785	$5,107	0.4%	0.4%	0.3%
KNOX	71,326	396,741	$380,509,842	$5,335	5.6%	5.3%	6.7%
LAKE	2,507	7,967	$15,012,055	$5,988	0.2%	0.2%	0.1%
LAUDERDALE	8,737	28,449	$37,554,859	$4,298	0.5%	0.6%	0.5%
LAWRENCE	10,820	41,329	$56,093,514	$5,184	0.8%	0.8%	0.7%
LEWIS	3,645	11,890	$18,876,835	$5,179	0.3%	0.3%	0.2%
LINCOLN	7,761	32,510	$40,153,384	$5,174	0.6%	0.6%	0.5%
LOUDON	8,219	41,610	$50,936,515	$6,197	0.7%	0.6%	0.7%
MACON	6,040	21,568	$31,297,130	$5,182	0.5%	0.4%	0.4%
MADISON	23,859	95,487	$117,140,544	$4,910	1.7%	1.8%	1.6%
MARION	8,039	28,395	$39,723,593	$4,941	0.6%	0.6%	0.5%
MARSHALL	5,542	28,380	$28,011,732	$5,054	0.4%	0.4%	0.5%
MAURY	15,563	74,003	$89,165,603	$5,729	1.3%	1.1%	1.2%
MEIGS	3,726	11,718	$21,074,316	$5,656	0.3%	0.3%	0.2%
MONROE	11,786	41,669	$62,117,794	$5,270	0.9%	0.9%	0.7%
MONTGOMERY	23,655	144,724	$106,076,361	$4,484	1.5%	1.7%	2.4%
MOORE	958	5,968	$5,906,597	$6,166	0.1%	0.1%	0.1%
MORGAN	6,329	20,523	$31,124,218	$4,918	0.5%	0.5%	0.3%
MCMINN	12,379	51,196	$70,235,616	$5,674	1.0%	0.9%	0.9%
MCNAIRY	9,211	25,165	$47,484,544	$5,155	0.7%	0.7%	0.4%
OBION	7,526	32,921	$37,268,331	$4,952	0.5%	0.6%	0.6%
OVERTON	5,956	20,669	$33,205,694	$5,575	0.5%	0.4%	0.3%
PERRY	1,870	7,734	$10,930,552	$5,845	0.2%	0.1%	0.1%
PICKETT	1,738	5,125	$9,777,097	$5,625	0.1%	0.1%	0.1%
POLK	4,361	16,469	$24,370,707	$5,588	0.4%	0.3%	0.3%
PUTNAM	15,343	66,235	$85,086,068	$5,546	1.2%	1.1%	1.1%
RHEA	8,414	29,580	$44,558,944	$5,296	0.7%	0.6%	0.5%
ROANE	12,822	53,326	$78,876,307	$6,152	1.2%	0.9%	0.9%
ROBERTSON	10,745	59,487	$57,652,189	$5,365	0.8%	0.8%	1.0%
RUTHERFORD	30,005	203,987	$155,584,029	$5,185	2.3%	2.2%	3.4%
SCOTT	9,759	22,345	$54,621,490	$5,597	0.8%	0.7%	0.4%
SEQUATCHIE	3,609	12,201	$18,817,306	$5,214	0.3%	0.3%	0.2%
SEVIER	17,832	77,553	$88,601,265	$4,969	1.3%	1.3%	1.3%
SHELBY	240,613	928,648	$871,980,479	$3,624	12.7%	17.7%	15.6%
SMITH	4,078	18,846	$23,217,201	$5,693	0.3%	0.3%	0.3%
STEWART	2,745	13,292	$13,724,325	$5,000	0.2%	0.2%	0.2%
SULLIVAN	33,567	154,295	$176,676,821	$5,263	2.6%	2.5%	2.6%
SUMNER	23,956	140,685	$121,447,700	$5,070	1.8%	1.8%	2.4%
TIPTON	12,715	55,867	$50,543,554	$3,975	0.7%	0.9%	0.9%
TROUSDALE	2,189	7,651	$13,102,741	$5,986	0.2%	0.2%	0.1%
UNICOI	5,302	17,894	$35,434,172	$6,683	0.5%	0.4%	0.3%
UNION	6,180	19,431	$29,478,119	$4,770	0.4%	0.5%	0.3%
VAN BUREN	1,748	5,651	$10,078,742	$5,766	0.1%	0.1%	0.1%
WARREN	10,816	39,977	$60,354,191	$5,580	0.9%	0.8%	0.7%
WASHINGTON	22,211	112,102	$129,549,060	$5,833	1.9%	1.6%	1.9%
WAYNE	4,328	17,436	$26,420,455	$6,105	0.4%	0.3%	0.3%
WEAKLEY	7,351	35,642	$40,263,252	$5,477	0.6%	0.5%	0.6%

Table 16 continued

County	TennCare Enrollment on 12/31/2004	Estimated 2005 Tennessee Population	Total TennCare Service Expenditures	Expenditure per Member	% County Expenditure as TennCare Total	% County Enrollment as TennCare Total	% County Population as Tennessee Total
WHITE	7,038	23,981	$39,586,724	$5,625	0.6%	0.5%	0.4%
WILLIAMSON	8,666	144,222	$51,236,201	$5,912	0.7%	0.6%	2.4%
WILSON	13,576	97,010	$73,399,874	$5,407	1.1%	1.0%	1.6%
OTHER	7,586		$13,008,783	$1,715	0.2%	0.6%	0.0%
Total/Average	1,357,768	5,958,085	$6,854,360,200	$5,048	100.0%	100.0%	100.0%

* Expenditures include MCO, Pharmacy, LTC and Dental; does not include BHO Services or MCO Administrative costs (reference Table 8).

** Greene County expenditures include costs associated with the Greene Valley Developmental Center, causing the per member cost to appear higher when comparing it to the other counties.

Enrollment

The core TennCare population is based on federally established criteria and is comprised of individuals who qualify for Medicaid by virtue of having a low income and falling into one of the following categories:

- Children
- Pregnant women
- Families receiving public assistance (Families First)
- People with disabilities or chronic illnesses
- People who require care in nursing facilities, or
- Women with breast or cervical cancer

The Medicaid program operates under federal regulations and includes certain groups that the federal government requires that all states cover (the mandatory population) and other groups that states may elect to cover at their own discretion (the optional population).

In addition to the Medicaid population, during FY 04/05, TennCare served a sizeable expansion population including previously uninsured and uninsurable individuals.

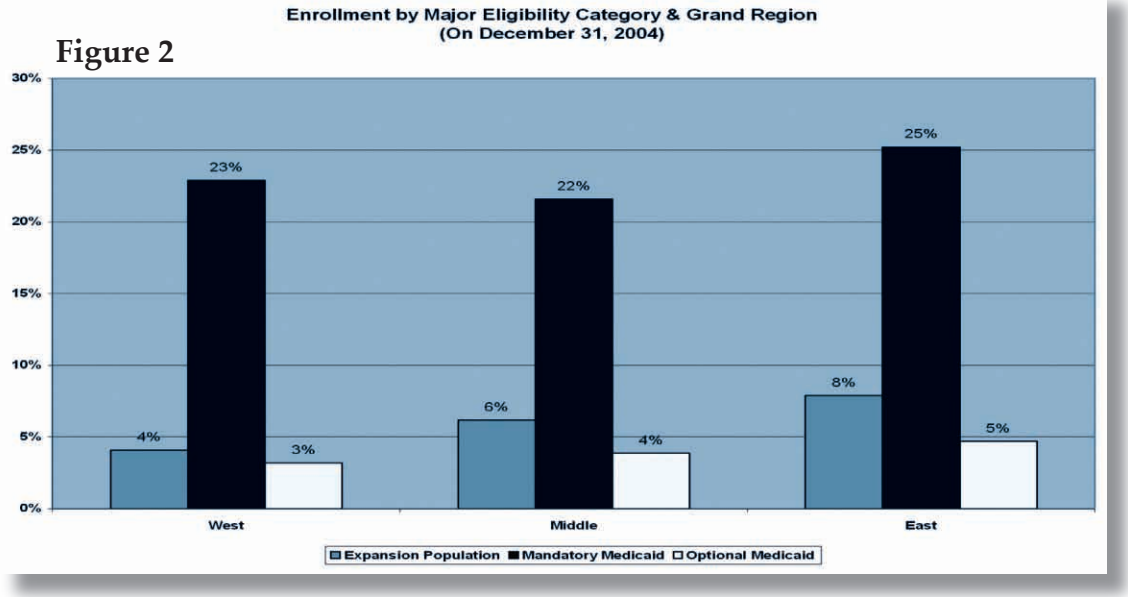
Medicare beneficiaries with low incomes were also eligible for TennCare in both the core and expansion population.

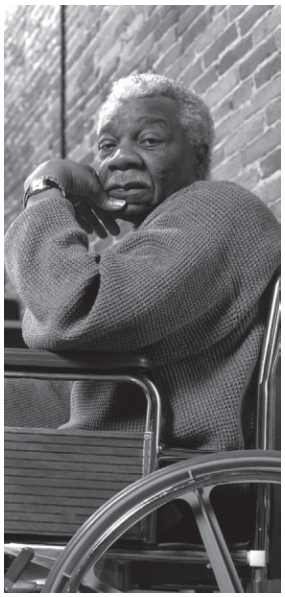
Key statistics – The following tables and charts provide enrollment information at mid-point in the fiscal year: December 31, 2004.

Table 6 - Enrollment by Major Eligibility Category and Age

		By Age Group		
Category	All	0 - < 21	21-64	65+
Mandatory Medicaid	952,900	528,200	343,800	80,900
Optional Medicaid	160,100	63,500	68,600	28,000
Expansion Population	244,700	44,900	177,500	22,300
Totals	**1,357,700**	**636,600**	**589,900**	**131,200**

Figure 2





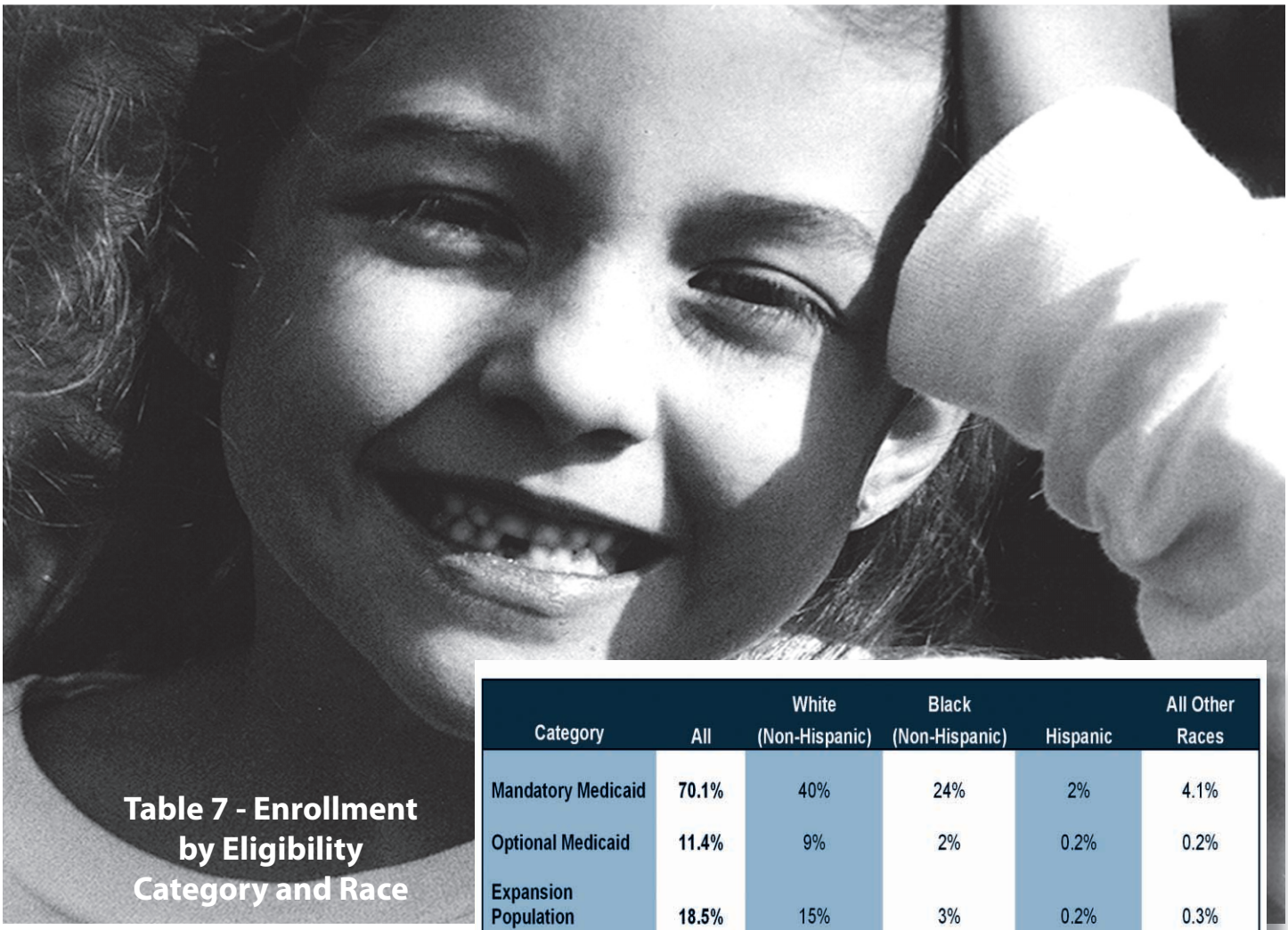


Table 7 - Enrollment by Eligibility Category and Race

Category	All	White (Non-Hispanic)	Black (Non-Hispanic)	Hispanic	All Other Races
Mandatory Medicaid	**70.1%**	40%	24%	2%	4.1%
Optional Medicaid	**11.4%**	9%	2%	0.2%	0.2%
Expansion Population	**18.5%**	15%	3%	0.2%	0.3%
Totals	**100%**	**64%**	**29%**	**2.4%**	**4.6%**

Data as of December 31, 2004

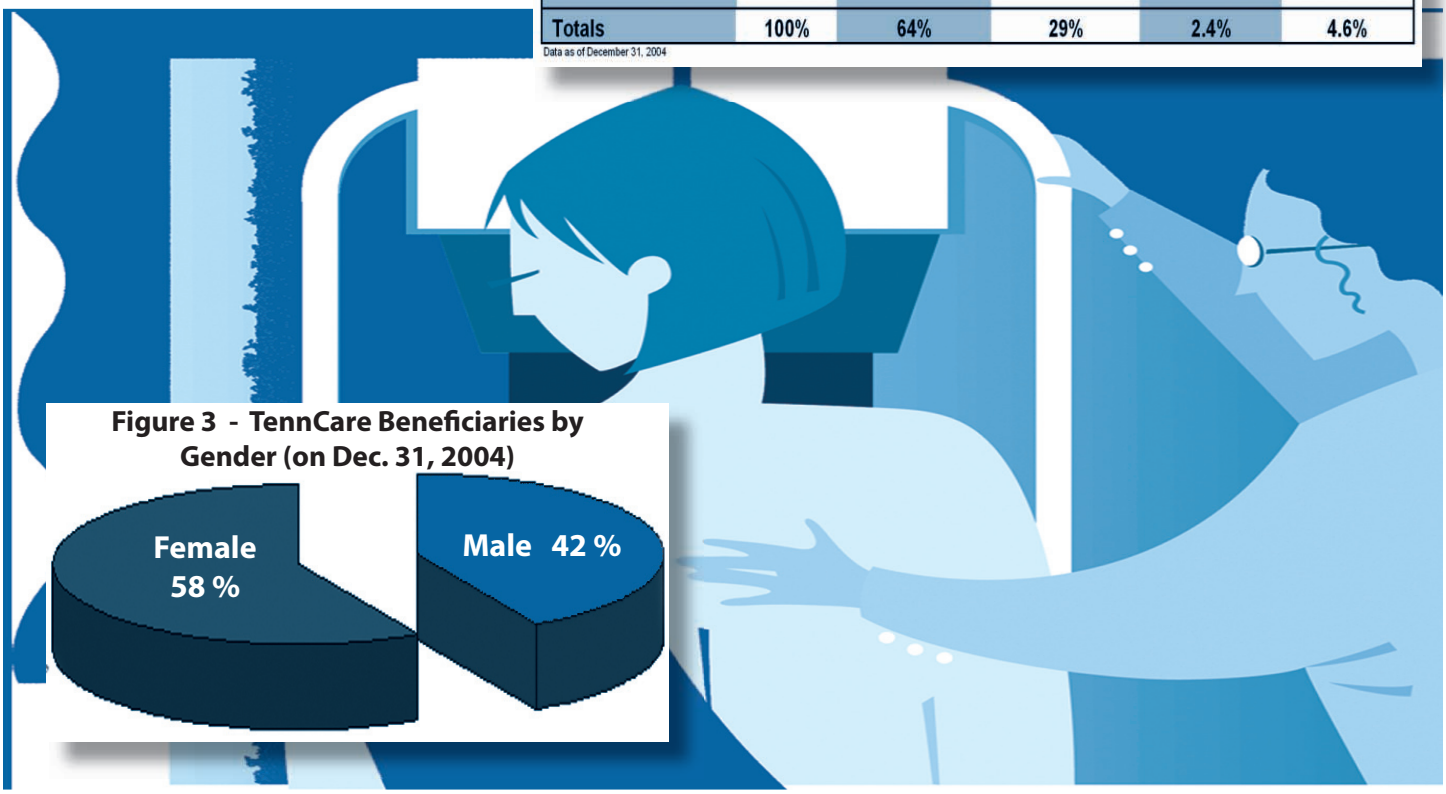


Figure 3 - TennCare Beneficiaries by Gender (on Dec. 31, 2004)

Looking Ahead

FY 05/06 Plans & Challenges

Reform Implementation – Phase 1: Disenrollments

The 05/06 fiscal year began with the disenrollment of the adult expansion population. The disenrollment process, including the associated appeals, is managed by the Department of Human Services (DHS).

Several state departments are working together to "soften the landing" for those being disenrolled from TennCare by funding and implementing Safety Net services.

Reform Implementation – Phase 2: Benefit Changes

As of August 1, 2005, the following changes took place for all enrollees age 21 and over:

- Convalescent care and sitter services are no longer covered.
- No prescription coverage for adults age 21 and older in the expansion population.
- Over-the-counter medication is no longer covered, except for prenatal vitamins by prescription for a pregnant enrollee.
- Prescription drug coverage for Medicaid-eligible adults who are not institutionalized is limited to no more than five prescriptions per calendar month, only two of which can be brand-name drugs. Approximately 28.5 percent of the program's 1.2 million enrollees are subject to this limit.
- Pharmacy co-pays begin for all Medicaid-eligible adults age 21 and older and TennCare Standard enrollees under age 21 with incomes at or above 100 percent FPL.
- No pharmacy co-pays charged for:
  - Generic drugs within the monthly limit
  - Birth control
  - Drugs given in a medical emergency
  - Drugs for enrollees in hospice care
  - Drugs for pregnant women
- A "pharmacy short list" of certain drugs and supplies was created for enrollees who continue to be eligible for a pharmacy benefit, listing those specific drugs and supplies that do not count against prescription limits and that continue to be available even after the prescription limits have been hit.
- No coverage for adult (age 21 and up) dental services.
- Methadone clinic services – both detox and maintenance services – will not be covered.
- No out-of-pocket maximum for any TennCare-eligible individual.

Phase 3: Non-Pharmacy Benefit Limits

TennCare continues to await approval from CMS for reform elements slated for July 2006 implementation including limits for adults on the following services:

- Inpatient hospital services,
- Outpatient facility services,
- Treatment for substance abuse: 10 days detox covered, regardless of SPMI status, with a lifetime limit of $30,000 for inpatient, residential and outpatient treatment,
- Physician outpatient services, and
- Lab and X-ray services.

Implementation of the August 2005 Grier Order

Implementation of the new Grier Order took effect January 1, 2006 and involves comprehensive changes in the prior authorization process for pharmacy services, as well as significant changes in the way Tennessee processes medical appeals. In addition, the State plans to promulgate new regulations that will govern medical necessity determinations.

Implementation of the MOU – The New Medically Needy Program

Prior to the Grier hearing, the Governor entered into a Memorandum of Understanding (MOU) with one group of the lawyers representing TennCare enrollees (the plaintiff's intervenors) in which he agreed that the State would not proceed with the planned disenrollment of the Medically Needy population if the State was granted the relief it sought from the Grier consent decree.

Although the State was not granted the comprehensive relief it sought, enough relief was granted for the Governor to elect to move forward with the provisions of the MOU. This will involve creation of a new Medically Needy program during the current fiscal year. The State has already filed necessary documents with the federal government to gain authority to launch the program.

Return to Risk

Effective July 1, 2005, TennCare staff developed and negotiated a shared risk arrangement with the MCOs. TennCare's challenge to return MCOs to a risk-based arrangement was finding an appropriate level of risk while maintaining a balance so that MCOs are not placed in financial difficulties that could adversely affect the program. Adding to the difficulty of this task, TennCare decreased MCO administrative payment rates on an average of 15 percent at the same time new risk arrangements were implemented.

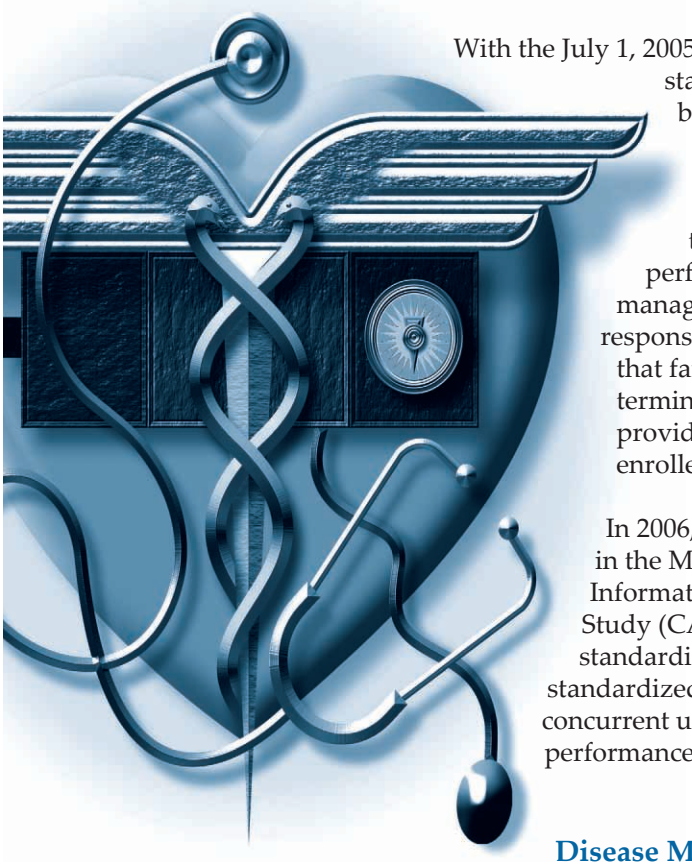
Table 19

Shared Risk Initiative	Contribution to Risk	Contribution to Bonus
Medical Services Budget Target	2.0%	5.0%
Usage of Generic Drugs	2.0%	2.0%
Completion of Major Milestone for NCQA	2.0%	Not Applicable
EPSDT Compliance	2.0%	2.0%
Non-Emergency ER Visits per 1,000	1.0%	2.0%
Inpatient Admissions per 1,000	1.0%	4.0%

The terms of this arrangement include a risk and bonus component, placing 10 percent of the administrative fee at risk and providing a bonus potential to earn 15 percent of the administrative fee for maintaining and/or meeting specified performance measures. The performance measures and percentages of risk or bonus associated with each are found in *Table 19* (above).

The cost of providing MCOs a bonus payment would be offset by the savings Tennessee would incur if the MCOs were to hit the highest performance standards. The net effect of such a payment would result in a $100 million savings for the State. The performance measures are primarily benchmarked against each individual MCO's previous experience, and failure to maintain or improve will impact the MCO financially. Should an MCO meet benchmarks that achieve bonus payouts, the savings realized by TennCare will more than pay for the bonus payouts. TennCare's intent is to return to a fully capitated risk arrangement in the future.

NCQA Accreditation



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

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

In 2006, as part of the accreditation process, the MCOs will participate in the Medicaid version of the Health Plan Employer Data and Information Set (HEDIS) and the Consumer Assessment of Health Plans Study (CAHPS Survey). HEDIS is a nationally recognized set of standardized performance measures while CAHPS is a set of standardized surveys used to measure member satisfaction. The concurrent use of these measures will allow reliable comparison of the performance of TennCare MCCs to other managed Medicaid health plans.

Disease Management

Last summer, TennCare began amending the MCO contracts to set clear expectations for the statewide provision of disease management programs targeting a minimum of five (5) health conditions: high risk pregnancy, diabetes, asthma, congestive heart failure and obesity. These conditions were selected because of their prevalence in the TennCare population and the significant potential that exists to improve quality of care through the use of disease management interventions. These efforts represent a substantial step toward improved patient outcomes by promoting health care, provider adherence to best practice guidelines, and educating and engaging patients in the important role they play in managing their own health.

"Soft" Benefit Limits

With the implementation of reform, TennCare implemented "hard" benefit limits. Hard limits refer to limits that cannot be exceeded for any reason. Because the Grier Consent Decree did not allow Tennessee to implement an effective prior authorization system, hard limits were felt to be the only way to control costs by reducing the numbers of services delivered. In reality, certain exceptions were built into the initial phase of reform, in the form of "short lists". The pharmacy short list includes certain drugs that do not count against the 5 prescription / 2 brand limit and are available to enrollees even after the limit has been hit. A similar list exists for non-pharmacy services. Despite the existence of these short list exceptions, there is a desire to expand the ability to make exceptions to the benefit limits for enrollees with extraordinary medical needs. If and when legal conditions permit, TennCare will pursue implementation of "soft" limits.

NMPI and Preferred Drug List

On July 1, 2005, TennCare joined the National Medicaid Pooling Initiative (NMPI). In comparison to the supplemental rebate contracts negotiated in late 2003, the NMPI significantly increases the number of therapeutic classes with supplemental rebates, resulting in the potential for additional cost savings for the TennCare program. In addition, the supplemental rebate contracts negotiated through the NMPI lock in prices for a three-year period, resulting in price protection.

As a result of the expanded therapeutic classes with available rebates, the Preferred Drug List (PDL) has been expanded and an updated PDL was rolled out during the months of July-December, 2005. Select classes of medications were

gradually grandfathered each month through the end of December 2005. This allowed time for physicians to evaluate their patients, change treatment to a preferred agent, or apply for prior authorization. As market share shifts to the preferred agents on the PDL, additional cost savings are expected to be seen as a result of contracted supplemental rebates for these medications.

Home and Community Based Services (HCBS) Waiver Changes

Home and community based services (HCBS) are available in limited quantities for those people with developmental delays, mental retardation and/or elderly who would qualify for ICF admission, but wish to remain in their homes and receive services. The services needed and received by the patient must be less costly than admission to a long term care center. HCBS plans are operated through waivers with CMS.

For both programs, a $291,000 Real Choice grant will be used to re-design the current Pre-Admission Evaluation (PAE) intake form, with the goal to develop an intake document that is useful for both institutional and non-institutional placements. Plans are also underway to pilot a HCBS program to integrate HCBS services into TennCare's managed care program in an effort to promote continuity of care.

In addition to the PAE intake process improvements listed above, the TennCare Bureau has launched several initiatives to improve the existing HCBS program, including:

- Petitioning the federal government to expand the number of HCBS slots available to enrollees
- Creating greater flexibility in our HCBS rules to encourage expansion of the program
- Creating a presumptive eligibility process to make it easier for enrollees to become enrolled in an HCBS program
- Recommending increased funding for HCBS programs by $6.4 million total new dollars

The TennCare program will continue its commitment to improving HCBS programs across the state in the coming year to ensure proper services are available to enrollees in home and community-based settings.

Medicare Part D

Medicare Part D took effect on January 1, 2006, giving all Medicare eligibles a drug benefit. With the implementation of Part D, the federal government has assumed responsibility for drug benefits for the Medicaid/ Medicare dual eligibles.

Medicaid Reform at the National Level

Medicaid spending has been growing exponentially. In the four years between 2000 and 2004, federal Medicaid spending increased by nearly $60 billion - an increase from $117.9 billion to $176.2 billion. The federal Congressional Budget Office estimates that federal Medicaid spending will reach $193 billion in 2006.

States are attempting to keep up with spiraling costs. Medicaid spending is now the largest component of state budgets, having passed education spending for the first time in history in 2003. In fact, in 2005, Tennessee's Medicaid expenditures represented 26.34 percent of Tennessee's Department of Revenue's tax collections. Most reform efforts around the country have taken place at the state rather than the federal level. The primary reform efforts that have

occurred at the national level to date have been introduction of new waiver options for states, such as HIFA waivers.

The most recent Congressional budget agreement called for a $10 billion slowing of the Medicaid rate of growth over the next five years and established a Medicaid Commission to make recommendations for how to achieve these savings. The Secretary of Health and Human Services signed a charter for the Commission on May 19, 2005, and shortly thereafter appointed the members. The purpose of the Commission is to produce two reports:

- The first report, due on September 1, 2005, was submitted containing a detailed proposal for achieving $10 billion in reductions in the rate of federal Medicaid spending over the next five years. Several of the recommendations from this report were approved as part of the Budget Reconciliation Act passed by Congress and later signed by the president in early 2006.
- By December 31, 2006, the Commission will complete a report containing a detailed proposal and recommendations for modernizing the Medicaid program on a long-term basis.

Move to New Building

The downtown Nashville building that has housed TennCare, and the state's Medicaid program prior to the creation of TennCare for decades was acquired by the federal government last year to make room for a new federal courthouse.

Having been displaced by the federal government, the state contracted for the construction of an office building to house all TennCare staff. More than 500 staff and major contractors relocated to the 200,000 square foot facility during the summer of 2005, representing the single largest facility relocation in the state's history.

Conclusion

The past year has included difficult, but necessary decisions, in the TennCare program. The year also included several notable milestones – moving the managed care network back to risk sharing, preserving coverage for 100,000 enrollees, winning the battle over runaway pharmacy costs and fighting for and achieving relief from long-standing consent decrees – to name a few. The willingness to tackle these difficult challenges and make the difficult decisions has resulted in a program that is financially viable and remains among the most generous in the nation.

The Bureau will take this momentum forward next year and continue to improve the operation of the program while every day meeting the health care needs of our enrollees and acting as effective stewards of taxpayer dollars. ■

TENNCARE

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