BILL HASLAM
GOVERNOR
STATE OF TENNESSEE

June 29, 2012

The Honorable Kathleen Sebelius
Secretary of the Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Secretary Sebelius:

The TennCare program in Tennessee is now in its 19th year. All Medicaid enrollees are enrolled in Managed Care Organizations, and the service delivery model is now almost fully integrated. The MCOs provide primary care, acute care, and behavioral health services to all enrollees, and long-term services and supports to adults who are elderly or who have physical disabilities. We hope to add to the model by integrating Medicare services for persons who are dually eligible for Medicare and Medicaid, and we have recently submitted a proposal to the Medicare-Medicaid Coordination Office to do just that.

TennCare is continuing to demonstrate the cost-effective provision of quality services. We are requesting a three-year extension of the current TennCare II demonstration, which expires on June 30, 2013. We are enclosing a copy of our extension request, which has been prepared in compliance with the new regulations at 42 CFR 431, Subpart G, and the Standard Terms and Conditions.

We appreciate your attention to this matter.

Sincerely,

Bill Haslam

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Bureau of TennCare
Extension Request

TennCare II (11-W-00151/4)

June 29, 2012

Overview

TennCare is one of the longest-lasting and most comprehensive Medicaid managed care programs in the country. It has been in existence since 1994. "TennCare II," the current phase of TennCare, has been in existence since 2002.

The Bureau of TennCare is seeking a three-year extension of the current TennCare II demonstration. The extension period is July 1, 2013, through June 30, 2016. The authority under which the extension is being sought is Section 1115(f) of the Social Security Act. The Bureau is not requesting any changes in the current Special Terms and Conditions, Expenditure Authorities, or Waivers, other than updating some sections that have become obsolete during the current extension period and amending tables and text to reflect operation of the TennCare II demonstration starting on July 1, 2013.

The chapter topics that follow, with the exception of Part VIII, are taken directly from 42 CFR § 431.408(c)(2). Part VIII is required by paragraph 45(3)(i) in the current Special Terms and Conditions.

TennCare has undergone a number of changes in the past 10 years. Financial challenges have called for minor and sometimes major course corrections in order to ensure that the program remains viable and continues to be able to serve as many people as the State can afford to serve. A great deal of progress has been made in strengthening the managed care structure, with Managed Care Organizations (MCOs) today being required to be NCQA[1]-accredited and to meet rigorous standards associated with financial and programmatic integrity and stability. Significant strides have been taken toward service integration, with behavioral health services and long-term services and supports (LTSS) for Nursing Facility (NF) eligible persons being brought under the managed care program. Some of the legal issues that have played such a prominent role in the program over the years have moved toward resolution, with two examples being the 2009 ruling in the *Daniels* case regarding redetermination of eligibility for persons losing SSI benefits and the 2012 order by the Federal District Court vacating the *John B.* Consent Decree.[2]

TennCare is achieving important goals. As an example, the percentage of beneficiaries expressing satisfaction with TennCare has grown by 10 percentage points, from 85 percent in 2002, the year TennCare II started, to 95 percent in 2011.[3] EPSDT screening rates have improved, as have timeliness of prenatal care, access to care, and other measures. Budget neutrality has been maintained. (See Section VI of this document.)

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[1] National Committee for Quality Assurance.
[2] This ruling is being appealed by the plaintiffs in the case.
[3] See http://cber.bus.utk.edu/tncare/tncare11.pdf, page 8.

In recent years, the Bureau has received a number of awards and types of recognition from outside groups. These include the following:

Overall leadership:

- **June 2008:** TennCare Director Darin Gordon was named to the 12-member Executive Committee of the National Association of State Medicaid Directors (NASMD). [4]
- **June 2010:** TennCare Director Darin Gordon was selected to participate as a Fellow in the 2011 class of the Medicaid Leadership Institute, a national initiative of the Robert Wood Johnson Foundation that is managed by the Center for Health Care Strategies.
- **January 2011:** TennCare Director Darin Gordon was elected Vice President of the National Association of Medicaid Directors (NAMD).

Quality of care:

- **December 2006:** Tennessee became the first state in the nation to require its Managed Care Organizations to be NCQA-accredited.
- **April 2008:** Chief Medical Officer Dr. Wendy Long was appointed to serve on the Medicaid Accreditation Advisory Committee of NCQA.
- **December 2008:** TennCare Director Darin Gordon was appointed as the chair of the Quality Technical Assistance Group (TAG) by NASMD.[5]

Hospital services:

- **October 2010:** TennCare Director Darin Gordon received a Community Service Award for Public Service to Tennessee from the Tennessee Hospital Association.

Long-term services and supports:

- **November 2010:** Tennessee was selected for the Center for Health Care Strategies' Profiles in State Innovations, in recognition of the successful design and implementation of the CHOICES managed LTSS program.

Mental health services:

- **December 2009:** Keith Gaither, Director of Managed Care Operations, received the President's Award from the Tennessee Association of Mental Health Organizations (TAMHO).
- **August 2010:** TennCare Medical Director Dr. Jeanne James was honored by Tennessee Voices for Children with the Innovations for Children and Families award. Tennessee Voices for Children is an entity that advocates for improved mental health services for children.

Primary care:

- **December 2011:** TennCare Chief Financial Officer Casey Dungan received the William V. Corr Award of Excellence from the Tennessee Primary Care Association.

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[4] NASMD became NAMD (the National Association of Medicaid Directors) in 2010.
[5] Ibid.

Mothers and babies:

- **March 2012:** The March of Dimes and its advocacy partner the Tennessee Initiative for Perinatal Quality Care honored three members of TennCare's executive staff for their "work to protect women and babies." These three members were Director Darin Gordon, Chief Medical Officer Dr. Wendy Long, and Medical Director Dr. Jeanne James.

Services to women needing treatment for breast and/or cervical cancer:

- **November 2010:** The Tennessee Breast and Cervical Cancer Program (TBCCP) presented an award to TennCare for its assistance over an eight-year period in diagnosing breast cancer in 905 women and cervical cancer abnormalities in 2,275 women.

Information technology:

- **June 2011:** TennCare Chief Information Officer Brent Antony was named one of 11 top executives and thought leaders in the healthcare information industry. The honor was bestowed jointly by eMids Technologies, a health care information technology (IT) and consultation company, and Healthcare Payer News, an online news source dedicated to IT, finance, and policy in the field of health.

Part I: Historical Narrative Summary

The TennCare program has been in existence since 1994. It is a managed care program in which all enrollees participate. The purpose of TennCare is to demonstrate that the State can use managed care principles to serve Medicaid enrollees, as well as some individuals who are not Medicaid eligible, without compromising quality of care and without spending more than the State would have spent had it continued its fee-for-service Medicaid program.

1. Previous Waivers and Waiver Extensions.

Over the life of the TennCare program, there have been a number of previous extensions. These extensions are summarized in Table 1.

Table 1
History of the TennCare 1115 Waiver and Waiver Extensions

Waivers and Waiver Extensions	Waiver Authority	Approval Period	Comments
		TennCare I	
Original TennCare Waiver	Section 1115	January 1, 1994 – December 31, 1998	The original waiver request was quite expansive, proposing coverage for uninsured and uninsurable individuals up to a total enrollment cap of 1.775 million persons.[6]
First extension of TennCare I	Section 1115	January 1, 1999 – December 31, 2001	
One month extension of TennCare I	Section 1115(a)	January 1, 2002 – January 31, 2002	The waiver was extended for one month because of ongoing discussions regarding the budget neutrality trend rate.
One-year extension of TennCare I	Section 1115(a)	February 1, 2002 – January 31, 2003	Although this extension was "partially" approved through January 31, 2003, it ended when the TennCare II waiver began on July 1, 2002.
		TennCare II	
TennCare II	Section 1115(a)	July 1, 2002 – June 30, 2007	The new waiver outlined a more streamlined program. Persons already enrolled as uninsureds or uninsurables were allowed to remain on the program

[6] "TennCare: A New Direction in Health Care" (June 1993), page 29. This was the initial waiver request.

Waivers and Waiver Extensions	Waiver Authority	Approval Period	Comments
			subject to reverification, but new enrollment in these categories was extremely limited.
Six short extensions of TennCare II	Section 1115(a)	July 1, 2007 – October 4, 2007	At the end of June 2007 CMS introduced a new cap on pool payments, which required additional time for discussion.
First formal extension of TennCare II	Section 1115(a)	October 5, 2007 – June 30, 2010	
Second formal extension of TennCare II	Section 1115(e)	July 1, 2010 – June 30, 2013	

2. Developments in TennCare II.

Highlights of each Demonstration Year are provided below.

a. Demonstration Year 1 (July 1, 2002, through June 30, 2003).

TennCare II began on July 1, 2002, with Manny Martins as TennCare Director.

Among the changes approved for TennCare II was a two-tiered program: TennCare Medicaid (for Medicaid enrollees) and TennCare Standard (for demonstration enrollees).[7] A differentiation in benefits between TennCare Medicaid and TennCare Standard was scheduled to begin on January 1, 2003, but was stopped by a decision of the Federal Court in Middle Tennessee on December 18, 2002. These changes were re-scheduled for implementation on April 1, 2003, but then postponed indefinitely due to efforts underway to reach new agreements with the plaintiffs in four lawsuits filed against the State.

A new Medicaid category was added by TennCare II—the category for women needing treatment under the federal Breast and Cervical Cancer Prevention (BCCP) program.

The TennCare Reform Act took effect on the same day that TennCare II began. It contained a number of provisions aimed at program improvement. A temporary Stabilization Plan was implemented, changing the risk-based arrangement under which

[7] A third program, TennCare Assist, which would have been a program to help low income persons purchase employer-sponsored insurance, was envisioned but never developed.

the Managed Care Organizations (MCOs) had operated previously to an Administrative Services Only (ASO) arrangement.

On October 1, 2002, dental services were carved out to a single Dental Benefits Manager (DBM), Doral Dental of Tennessee. Pharmacy benefits for dual eligibles were also carved out and managed by Consultec (ACS).

On March 27, 2003, the State submitted Amendment 1 to the TennCare demonstration. This amendment, which requested removal of the Stabilization Neutrality Cap implemented as part of the Stabilization Plan, was approved on April 29, 2003.

On June 2, 2003, the Tennessee Department of Commerce and Insurance (TDCI) filed a petition with the Davidson County Chancery Court to liquidate Xantus, a Middle Tennessee plan that had gone through several years of rehabilitation and then receivership with the Department. Effective July 31, 2003, the TennCare Bureau terminated its contract with Xantus, and enrollees were moved to TennCare Select.[8] The Court terminated the liquidation of Xantus by order effective February 6, 2009.

The Bureau's contract with Universal Care of Tennessee, another troubled Middle Tennessee plan, ended effective June 1, 2003, and enrollees were moved to TennCare Select. On June 5, 2003, TDCI filed a petition with the Davidson County Chancery Court to liquidate Universal. The Court terminated the liquidation of Universal Care by order effective March 3, 2009.[9]

b. Demonstration Year 2 (July 1, 2003, through June 30, 2004).

Early in the year, work began on designing a new single Preferred Drug List (PDL) that would streamline the pharmacy program for prescribers and pharmacists. The new PDL was phased in over a period of months beginning on September 15, 2003, with 10 drug classes being addressed each month.

In the latter half of 2003, a coalition of groups including BlueCross BlueShield of Tennessee, the Farm Bureau, Hospital Corporation of America, Vanderbilt University, and 22 hospitals within the Tennessee Hospital Association entered into a contract with McKinsey & Company, an international consulting company, for the purpose of conducting an independent study to assess the viability of TennCare over the next five years and to identify strategic options for improving its financial sustainability.

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[8] TennCare Select is the State's plan that serves certain special populations, including persons living in parts of the State where there is insufficient capacity to serve them. See paragraph 40 of the Special Terms and Conditions. TennCare Select is managed by Volunteer State Health Plan (VSHP), a licensed HMO affiliate of its parent company BlueCross BlueShield of Tennessee.

[9] There was one more troubled Middle Tennessee plan during this period—the Tennessee Coordinated Care Network (TCCN, also known as Access MedPlus). TennCare ended its contract with TCCN prior to the start date of TennCare II. The Court terminated the liquidation of TCCN by order effective July 23, 2009.

On December 11, 2003, McKinsey & Company issued "Achieving a Critical Mission in Difficult Times—TennCare's Financial Viability" as Part 1 of a two-part report. It included the following summary statement: "Our assessment is that, even with current and planned improvement efforts and solid program management, TennCare as it is constructed today will not be financially viable. Without additional reform, the program is projected to become so costly by fiscal year 2008 [that] the state will find it difficult, if not impossible, to both support TennCare and meet its obligations in other critical programs. TennCare's costs could grow by as much as 80 percent by fiscal year 2008, and its cost growth could represent more than 80 percent of new state revenues in each of the 4 years leading up to that date." (p. ii)

On January 1, 2004, First Health replaced Consultec (ACS) as the TennCare PBM.

On February 11, 2004, McKinsey & Company issued "Achieving a Critical Mission in Difficult Times—Illustrative Strategic Options for TennCare" as Part 2 of its report. The report included 25 potential initiatives for reducing TennCare's costs and five different combinations of those initiatives as potential approaches.

On February 17, 2004, Governor Phil Bredesen addressed the Tennessee General Assembly and announced plans to reform TennCare so that it could remain financially viable. A "TennCare Transformation Team" was assembled. State workers, providers, and advocates formed four policy teams and four organization teams to develop detailed plans for "TennCare Transformation," following the Governor's directive that coverage for children, pregnant women, and individuals with disabilities be protected to the greatest extent possible.

c. Demonstration Year 3 (July 1, 2004, through June 30, 2005).

On July 1, 2004, J. D. Hickey became TennCare Director. A new Office of the Inspector General was created by statute to investigate and resolve cases of potential TennCare fraud and abuse.

On August 19, 2004, a draft of a massive waiver amendment for "TennCare Transformation" was released for public comment. Presentations and "listening sessions" were conducted in various Tennessee communities. The State received over 2,000 electronic, written, or telephone comments, and on September 24, 2004, the waiver amendment was submitted to CMS.

As part of TennCare Transformation, the State had requested relief from the plaintiffs involved in several Consent Decrees affecting the TennCare program. There were a number of discussions to this effect during this period, but these discussions were ultimately unsuccessful. In light of this development and continuing budgetary

issues, the Governor announced on November 10, 2004, that he was setting in motion a process to end TennCare and return to a traditional Medicaid program.

On January 10, 2005, the Governor announced a proposal for a "third way." This approach involved retaining TennCare and doing everything possible to keep children on the program, but closing the uninsured and uninsurable categories for adults and implementing some benefit reductions.

With respect to the September 24, 2004, waiver amendment, CMS requested that the State break this up into smaller amendments, or "phases."

The proposal for "Phase 1" (also known as Amendment 2) was submitted on February 18, 2005, and approved on March 24, 2005. It involved closing enrollment in the Medically Needy category fornon-pregnant adults and closing enrollment in the uninsured and uninsurable categories for adults age 19 and older. The 323,000 adults then enrolled in the uninsured and uninsurable categories were to be reviewed for eligibility in other Medicaid categories and moved into these categories if they qualified.

On May 6, 2005, the State submitted "Phase 2" (Amendment 3). Amendment 3 proposed to implement a limit on pharmacy coverage for non-institutionalized TennCare Medicaid adults of five prescriptions or refills per month, of which no more than two could be brand name drugs. It also proposed the implementation of a nominal copay of $3.00 per brand name prescription or refill for non-exempt TennCare Medicaid adults. Pharmacy coverage was eliminated altogether for TennCare Standard adults. Finally, Amendment 3 removed the out-of-pocket maximum applied to copays paid by TennCare Standard enrollees with incomes above poverty. Very few individuals had even come close to reaching the out-of-pocket maximum.

Amendment 3 was approved by CMS on June 8, 2005.

d. Demonstration Year 4 (July 1, 2005, through June 30, 2006).

On July 29, 2005, the Federal District Court in Nashville issued a ruling in the *Grier* Consent Decree that allowed the State to move forward with certain benefit changes. These included the new limit on prescription drug coverage for non-institutionalized adults and the new copay requirement on brand name prescriptions for non-exempt adults. On August 1, 2005, the State implemented these changes, as well as eliminating the adult dental program and coverage of methadone clinic services for adults.

On September 1, 2005, the State submitted "Phase 3" (Amendment 4) to the TennCare demonstration. This amendment proposed to re-establish an annual MCO change period and to eliminate coverage of benzodiazepines and barbiturates for adults. Amendment 4 was approved by CMS on March 31, 2006.

Amendment 4 included a proposal that CMS declined to act on, which was a request to implement a practice of suspending persons from TennCare for one year if they had been convicted of a TennCare crime such as selling drugs obtained through TennCare.

On January 11, 2006, the State submitted Amendment 5 to the TennCare demonstration. Amendment 5 outlined a plan for opening a new demonstration category patterned after the Medically Needy category for non-pregnant adults, but with an enrollment cap. This category came to be known as the "Standard Spend Down" (SSD) category. Amendment 5 was approved on November 14, 2006.

On April 7, 2006, the Bureau of TennCare issued a Request for Proposals (RFP) for new MCOs to serve the Middle Tennessee area. This was the first time that TennCare had used a competitive bid process to recruit MCOs into the program.

In June 2006 the State submitted a request to CMS for a three year extension of TennCare II under the Section 1115(e) authority.

e. Demonstration Year 5 (July 1, 2006, through June 30, 2007).

On July 7, 2006, Darin Gordon was named TennCare Director.

On July 26, 2006, after the completion of a detailed procurement process, the Bureau announced that two new MCO contracts had been awarded in the Middle Tennessee Region. The two MCOs were Amerigroup and UnitedHealthcare. The model to be used by the new MCOs was an integrated model whereby behavioral health services were coordinated with physical health services. The plans formally began operations on April 1, 2007, after completion of a series of lengthy and intensive readiness activities.

In November 2006, CMS denied the State's request for an extension of the demonstration under the Section 1115(e) waiver authority and communicated that the extension would have to be accomplished under the Section 1115(a) authority. CMS and State staff spent several months rewriting the Special Terms and Conditions of the demonstration so that they were more consistent with those approved for other states.

Earlier in the year, all MCOs had been notified that the contracts of any plans failing to obtain NCQA accreditation by December 31, 2006, would be subject to termination. All MCOs completed the NCQA survey and received their ratings. Three received an "Excellent" rating, three received a "Commendable" rating, and one received a "Provisional" rating. (The plan receiving the "Provisional" rating was already scheduled to leave the program on March 31, 2007, when the two new MCOs were scheduled to "go live" in Middle Tennessee.)

On December 1, 2006, the State promulgated a new rule on Medical Necessity. Tennessee Rule 1200-13-16 established objective definitions, clear standards for prior authorization and concurrent medical review, specific criteria for medical necessity, and detailed procedures for use in determining medical necessity.

On February 1, 2007, the State implemented "soft limits" in the pharmacy program. The process, which was later re-named the "Prescriber Attestation Process," was put in place to allow enrollees who were subject to a limit on outpatient drugs to obtain additional prescriptions in urgent situations. Over 600 medications were initially identified for this process. When an enrollee had reached his benefit limit for any given month and his prescriber contacted TennCare and attested that the enrollee had an urgent need for an otherwise covered drug that was in excess of the benefit limit, TennCare would pay for it. The State already had an "Auto Exception Process," formerly called the "Short List," which included more than 500 drugs that did not count against the limit.

On June 29, 2007, CMS notified the State that a cap on pool payments was being added to the Special Terms and Conditions for the extension that was set to begin on July 1, 2007. CMS granted the State the first in a series of short extensions of the TennCare demonstration so that this issue could be discussed.

f. Demonstration Year 6 (July 1, 2007, through June 30, 2008).

The waiver extension was approved on October 5, 2007.

Approval of the extension enabled the State to begin to address the Medically Needy program for non-pregnant adults, which was closed on April 29, 2005.[10] Persons enrolled in this program when it closed were reviewed for eligibility in the new SSD program. By agreement with CMS, the State submitted a State Plan Amendment (SPA) to remove the Medically Needy category for non-pregnant adults from the Medicaid State Plan. SPA 07-007 was approved by CMS on November 1, 2007, with an effective date of October 5, 2007.

By 2007, only a small number of TennCare Standard enrollees had premium obligations; these were children with family incomes at or above the poverty level. TennCare made the decision to end premiums for TennCare Standard enrollees effective December 1, 2007.

TennCare continued to monitor program costs closely, and in December 2007 the Bureau began public discussions of the unsustainable growth that was being experienced with respect to two services—home health and private duty nursing. In order to implement limits on these services for adults, the State submitted Amendment

[10] The Medically Needy program for pregnant women and children continued without change.

6 to the TennCare demonstration on February 29, 2008. The amendment was revised after discussions with CMS and re-submitted on May 29, 2008. It was approved by CMS on July 22, 2008.

On January 8, 2008, the Bureau released a Request for Proposals (RFP) for health plans to offer integrated medical and behavioral services in East and West Tennessee. The successful bidders were announced on April 22, 2008, and they were BlueCross BlueShield of Tennessee and UnitedHealthcare. The anticipated start date of operations for these plans was November 1, 2008, in West Tennessee, and January 1, 2009, in East Tennessee.

In the spring of 2008, the General Assembly passed the Long-Term Community Choices Act of 2008. The Act, which passed unanimously in both houses of the General Assembly, laid out the components of a proposed re-design of the TennCare long-term care program.

g. Demonstration Year 7 (July 1, 2008, through June 30, 2009).

In response to the Long-Term Community Choices Act of 2008, the Bureau developed a concept paper for Amendment 7, which would bring long-term care for elderly persons and adults with physical disabilities under the managed care program and open up new opportunities for these individuals to receive Home and Community Based Services (HCBS). The concept paper was submitted to CMS on July 11, 2008, and followed by a formal submission of Amendment 7 on October 2, 2008. The new program was called CHOICES.

On October 1, 2008, SXC became the new TennCare PBM, replacing First Health.

On January 8, 2009, the Federal District Court lifted an injunction that had been in place for over 20 years in a case called *Daniels*. The issue in the case was the State's ability to properly redetermine the eligibility of individuals who had lost SSI benefits and who therefore would have to qualify in another Medicaid category in order to remain eligible for Medicaid and later TennCare. The redetermination procedures developed by the State were approved both by CMS and by the Court. As a result of this decision, the State began redetermining the eligibility of about 147,000 *Daniels* class members, some of whom had been enrolled in TennCare for years after losing SSI without having had their eligibility redetermined.

On June 15, 2009, the State requested a three-year extension of TennCare II.

h. Demonstration Year 8 (July 1, 2009, through June 30, 2010).

CMS approved Amendment 7 on July 22, 2009, and work began on the first phase of implementation. The State announced plans to start CHOICES in Middle Tennessee on

March 1, 2010, with implementation in the West and East Tennessee regions to occur soon after.

The benefit limits on home health and private duty nursing services for adults, which had been approved by CMS in Amendment 6, were implemented on September 8, 2009, following a 30-day advance notice to adult enrollees.

On September 23, 2009, the Bureau announced that Volunteer State Health Plan (VSHP) would take over the provision of behavioral health care for enrollees receiving services through TennCare Select. This announcement completed the integration of medical and behavioral health care in the managed care program, and there was no longer a need for Behavioral Health Organizations (BHOs).[11]

On September 28, 2009, the State submitted Amendment 8 to CMS. The purpose of Amendment 8 was to ensure compliance with the Mental Health Parity requirements of the Emergency Economic and Stabilization Act of 2009 by removing, effective January 1, 2010, the limits that were in place on inpatient and outpatient substance abuse treatment benefits for adults. Amendment 8 was approved on December 15, 2009.

On November 19, 2009, TennCare leaders made a presentation to a legislative committee outlining looming financial issues, with enrollment increasing due to challenging economic conditions (about 5,000 new enrollees were being added per month) and decreases occurring in State revenues. These developments led the State to submit Amendment 9 to the demonstration on February 3, 2010. Amendment 9 would have required new limits on benefits for most adults, effective July 1, 2010. On May 5, 2010, the Tennessee General Assembly passed the "Annual Coverage Assessment Act of 2010," which established a new one-year fee on hospitals.

The State quickly followed up on the potential availability of revenues from the new fee. On May 10, 2010, the Bureau of TennCare submitted a request to CMS for a waiver of the broad-based requirements related to tax programs on inpatient and outpatient hospital net patient revenues. On May 24, 2010, the Bureau submitted Amendment 10 to establish a new Unreimbursed Hospital Cost (UHC) Pool and a new Public Hospital Supplemental Payment (PHSP) pool. Both requests were approved by CMS on June 30, 2010, and Amendment 9 was withdrawn.

On December 15, 2009, CMS wrote to the State approving the requested waiver extension for the 2010-2013 period.

The CHOICES program was implemented in Middle Tennessee on March 1, 2010.

[11] BHOs had been part of the TennCare program since July 1, 1996.

i. Demonstration Year 9 (July 1, 2010, through June 30, 2011).

On July 21, 2010, the Bureau submitted Amendment 11 to CMS. The purpose of Amendment 11 was to add another hospital to the PHSP. Amendment 11 was approved on December 16, 2010.

The CHOICES program was implemented in East and West Tennessee on August 1, 2010.

On October 1, 2010, a new DBM began operations. The new DBM was Delta Dental, and its TennCare product was called "TennDent."

On October 4, 2010, after completion of reviews of eligibility for persons enrolled in the Medically Needy program for non-pregnant adults when it closed, the State conducted the first open enrollment period for new enrollment in the SSD category. The call-in enrollment process for this program, which is described in Section XIII, Part III, of the Special Terms and Conditions, is a unique process designed especially for this program. The State received 2,835 calls in just over one hour. A second open enrollment period occurred on February 22, 2011. This time, the State received 3,080 calls in just over one hour.

On January 3, 2011, Tennessee was one of 11 states to launch an Electronic Health Record (EHR) Incentive program. By the end of the first three months, 943 providers had registered for the program.

On February 1, 2011, Tennessee submitted a request to the new Medicare-Medicaid Coordination Office for one of the $1 million planning grants that were to be made to 15 states to develop a proposal for integrating care for Medicare-Medicaid dual eligibles. On April 5, 2011, the State was notified that the request was approved. The contract was signed on April 26, 2011.

On April 1, 2011, TennCare launched a new initiative to improve the dental health of enrollees who were 3 to 5 years old by offering reimbursement to non-traditional providers to conduct dental screens and apply fluoride varnish to teeth. "Non-traditional providers" were defined to include primary care physicians, pediatricians, physician assistants, nurse practitioners, and public health nurses.

Since the hospital assessment fee discussed in the section on Demonstration Year 8 was a one-year fee only, the State submitted Amendment 12, a recap of Amendment 9, in case the fee was not renewed.[12] Amendment 12 was submitted on February 28, 2011.

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[12] Paragraph 7 in the Special Terms and Conditions requires that amendments to the TennCare demonstration be submitted no later than 120 days prior to the planned date of implementation. The Tennessee General Assembly usually meets from January to May, with the annual Appropriations Bill not taken up until the end of the session.

It was substantively withdrawn on May 5, 2011, after the General Assembly passed a one-year extension of the hospital assessment fee.

j. Demonstration Year 10 (July 1, 2011, through June 30, 2012).

A third open enrollment was held for the SSD program on September 12, 2011. This time the State received 2,793 calls in just over one hour. The fourth open enrollment, held on February 21, 2012, generated 2,934 calls in just over one hour.

Amendment 13 was submitted to CMS on December 15, 2011. The purpose of Amendment 13 was to expand the enrollment cap in the CHOICES program, effective April 1, 2012. Amendment 13 was subsequently withdrawn and consolidated with Amendment 14, which had an effective date of July 1, 2012.

On February 14, 2012, a chapter ended in the 14-year long *John B.* case regarding EPSDT services for children. The District Court in Middle Tennessee ruled that TennCare had successfully established its compliance with "all the binding provisions of the Consent Decree" and, consequently, that the Consent Decree was vacated and the case dismissed. The plaintiffs filed an appeal of the decision on March 9, 2012.

Amendment 14 was submitted to CMS on March 1, 2012. This amendment was developed after several months of conversation with CMS staff regarding strategies for changing the Level of Care (LOC) criteria for NF care without violating the Maintenance of Effort (MOE) requirements contained in the Affordable Care Act. Tennessee's current LOC are among the most lenient in the country. Amendment 14 was approved on June 15, 2012, with a July 1, 2012, effective date.

Amendment 15, which was a repeat of Amendments 9 and 12, was submitted to CMS on March 1, 2012, and withdrawn on April 3, 2012, after the General Assembly passed another one-year extension of the hospital assessment fee.

Finally, the State submitted Amendment 16 to CMS on April 13, 2012. Amendment 16 was a request to remove Disproportionate Share Hospital (DSH) payments from the cap on pool payments, since the current DSH allotment for Tennessee cannot be paid out in full under the current cap. Amendment 16 was approved on June 15, 2012, with a June 15, 2012, effective date.

3. Program Component: Eligibility.

TennCare covers most Medicaid groups, including:

- Section 1931 eligibles and related groups
- SSI eligibles and related groups
- Poverty level pregnant women and children
- Children in foster care and adoption assistance programs

- Medically needy pregnant women and children
- Individuals in institutional placements and receiving HCBS as alternatives to institutional care
- Women under 65 who need treatment for breast and/or cervical cancer

Table 1a in paragraph 17 of the current Special Terms and Conditions provides a full list of Medicaid categories covered by TennCare.

There are currently six categories of demonstration eligibles, with a seventh category to be implemented as part of Amendment 14. Two of the demonstration categories were established to address particular situations when the program was in transition some years ago; today, these categories no longer have any members in them. These two categories will likely be removed in the extension.

The demonstration categories are summarized in Table 2.

Table 2
TennCare II Demonstration Categories

Group	Description	When Approved/Modified	Comments
Medically Eligible children[13]	Uninsurable children under age 19 who were already enrolled in the category or who are able to qualify as "Medicaid Rollovers"[14] when they lose Medicaid eligibility.	Amendment 2 (March 24, 2005)	
Uninsured children[15]	Children under age 19 who lack access to insurance and whose family incomes are below 200 percent of poverty; must be already enrolled in the category or able to qualify as "Medicaid Rollovers" when they lose Medicaid eligibility.	Amendment 2 (March 24, 2005)	
Transition Group	Persons who were eligible in the Medically Needy category as aged,	Amendment 2 (March 24, 2005)	There are no longer any individuals left in

[13] At the beginning of TennCare II, the word "Uninsurable" was replaced with the term "Medically Eligible." Persons already enrolled as "Uninsurables" continued on the program as long as they continued to meet eligibility criteria. New "Medically Eligible" persons were covered with incomes below 100 percent of poverty. Amendment 2 removed coverage of Medically Eligible adults and replaced it with coverage of Medically Eligible children at any income level.

[14] A "Medicaid Rollover" is a person who moves from Medicaid to the Uninsured Children or Medically Eligible Children category.

[15] The category for newly enrolling Uninsured children was closed for many children during TennCare I. Children already enrolled who continued to meet the criteria for the category or who qualified as "Medicaid Rollovers" remained on the program.

Group	Description	When Approved/Modified	Comments
	blind, or disabled individuals, or as caretaker relatives of Medicaid-eligible children, at the time this category was closed in April 2005.		this category.
Discontinued Demonstration Group	Persons in the closed adult uninsured and uninsurable categories who were awaiting a determination that they might be eligible in a Medicaid category.	Amendment 2 (March 24, 2005)	There are no longer any individuals left in this category.
Standard Spend Down	Persons who meet the criteria associated with the Medically Needy category for aged, blind, or disabled individuals, or as caretaker relatives of Medicaid-eligible children, and who enroll during designated enrollment periods.	Amendment 6 (November 14, 2006)	
CHOICES 217-Like Group	Elderly or disabled adults who meet the Nursing Facility Level of Care (LOC), who are receiving HCBS, and who would qualify for TennCare if the HCBS they are receiving were provided under a 1915(c) waiver.	Amendment 7 (July 22, 2009)	
At Risk Demonstration Group	Persons who, without HCBS, are "At Risk" for Nursing Facility placement.[16]	Amendment 14 (June 15, 2012)	

One question that is often asked is which eligibility groups are exempt from managed care. The answer is that none of them is exempt. All TennCare enrollees participate in the managed care program and have done so since the beginning of the program in 1994. There are about 325 people who participate in a PACE program, which is treated separately from the rest of the managed care program, as of this writing. Everyone else, including persons enrolled in one of the State's three HCBS waivers for persons with intellectual disabilities and including dually eligible Medicare-Medicaid beneficiaries, chooses or is assigned to an MCO. Children under 21 and adults who are not Medicare beneficiaries are assigned to the PBM. Children under 21 are also assigned to the DBM.

We anticipate the addition of a new Medicaid expansion population in January 1, 2014, as required by the Affordable Care Act. Information about this population is presented in Part VIII of this extension request.

[16] "Interim CHOICES 3" is a new category proposed in Amendment 14.

4. Program Component: Benefits.

TennCare covers a long list of benefits, including all mandatory Medicaid benefits and many optional benefits, such as:

- Speech, occupational, and physical therapy
- Private duty nursing services
- Psychiatric residential treatment services
- Clinic services
- Prescription drugs
- Durable medical equipment

When the CHOICES program was approved in Amendment 7, a list of HCBS was added for CHOICES participants. This list includes, for specified groups, community-based residential alternatives, personal care visits, attendant care, home-delivered meals, Personal Emergency Response Systems, adult day care, in-home and inpatient respite care, assistive technology, minor home modifications, and pest control. It appears in Table 2b in paragraph 30(h) of the current Special Terms and Conditions.

In accordance with paragraph 7(c) of the Special Terms and Conditions, TennCare has requested a change in the description of the homemaker, attendant care, and personal care benefits in Attachment D. That request was approved on May 8, 2012.

For much of its existence, TennCare has operated with very few benefit limits. There are still relatively few, with the major ones being a limit on prescription drug coverage for most adults, approved in Amendment 3, and limitations on coverage of home health and private duty nursing services for adults, approved in Amendment 8.

Two factors have been useful in making benefit decisions. One is the clarification we have provided in State rules regarding "Medical Necessity." This clarification was required by State law in 2004 and effectuated in State rules in 2006. See http://www.tn.gov/sos/rules/1200/1200-13/1200-13-16.20111128.pdf.

The other factor has been the development of a list of exclusions, meaning services that are never covered. This list was first put into State rules at the beginning of TennCare II and has been modified on several occasions since then. Although some of the items on the list appear extreme, almost all of them are items or services that have been requested from TennCare at one time or another. See Rule 1200-13-13-.10 at the following web address: http://www.tn.gov/sos/rules/1200/1200-13/1200-13-13.20120129.pdf.

5. Program Component: Service Delivery.

Almost all TennCare services are delivered by Managed Care Contractors (MCCs).

Table 3 presents a configuration of the current MCCs serving the TennCare program.

Table 3
TennCare Managed Care Contractors (MCCs)

	West Tennessee	Middle Tennessee	East Tennessee
Managed Care Organizations (MCOs)	BlueCare[17] UnitedHealthcare Community Plan[18] TennCare Select[19]	Amerigroup UnitedHealthcare Community Plan TennCare Select	BlueCare UnitedHealthcare Community Plan TennCare Select
Pharmacy Benefits Manager (PBM)	SXC Health Solutions Corp.		
Dental Benefits Manager (DBM)	TennDent[20]		

One of the areas of TennCare where change is most apparent is in the number of MCCs At the beginning of TennCare II, MCCs included MCOs, BHOs, and a DBM. The PBM was added across the board in 2003.[21] As is evident in Table 4, the overall number of TennCare MCCs has declined dramatically over time.

Table 4
Number of Managed Care Contractors During TennCare II

Year	MCOs[22]	BHOs	DBM	PBM	Total
2002	9	2	1	0	12
2003	9	2	1	1	13
2004	7	2	1	1	11
2005	7	2	1	1	11
2006	7	2	1	1	11
2007	9	2	1	1	13

[17] BlueCare is operated by Volunteer State Health Plan, Inc. (VSHP), which is an independent licensee of the BlueCross BlueShield Association and a licensed HMO affiliate of its parent company BlueCross BlueShield of Tennessee.
[18] UnitedHealthcare Community Plan, formerly known as "AmeriChoice," is operated by UnitedHealthcare Plan of the River Valley, Inc.
[19] TennCare Select is operated by Volunteer State Health Plan, Inc. (VSHP).
[20] TennDent is operated by DentaQuest and assumed responsibilities as TennCare's Dental Benefits Manager on October 1, 2010.
[21] Earlier, the PBM had had some responsibilities for certain populations, such as dual eligibles.
[22] One of the MCOs serving TennCare offers two plans: an at-risk plan in East and West Tennessee, and a partial risk plan known as TennCare Select.

Year	MCOs[22]	BHOs	DBM	PBM	Total
2008	7	2	1	1	11
2009	3	1	1	1	6
2010	3	0	1	1	5
2011	3	0	1	1	5
2012	3	0	1	1	5

Interestingly, none of the MCOs and BHOs operating in TennCare prior to 2007 was acquired through a competitive procurement process. The two BHOs were statewide, but the MCOs varied greatly in size, ranging from statewide to county-specific.

All of that began to change in 2006, when TennCare started thinking about "right-sizing" the MCOs and "re-visioning" what they could do. "Right sizing" meant that the State would contract with two MCOs to serve each of the three grand regions of the State (West, Middle, and East Tennessee). MCOs would be selected through a competitive procurement process to be managed, in part, by an outside contractor and that would involve painstaking attention to a multitude of details. The new vision for MCOs included integration of behavioral health services, thereby ending the artificial divisions that occurred when a person's mental health care was managed by one entity and his physical health care by another. BHOs were no longer needed.

The result of the MCO procurement process was that the MCOs currently providing TennCare services are strong, well-capitalized, experienced entities. During the October-December 2011 quarter, they reported a collective net worth of nearly seven times the statutorily required amount.

Once the new MCOs were chosen, a lengthy readiness review process was put in place prior to their beginning operations. The "go live" dates for the new MCOs were as follows:

- April 1, 2007: Middle Tennessee
- November 1, 2008: West Tennessee
- January 1, 2009: East Tennessee

After the last integration effort occurred in East Tennessee, there was still one BHO remaining as a partner to TennCare Select. That BHO was phased out in September 2009, when physical and behavioral health services were blended in TennCare Select just as in the other health plans.

The next target for service integration was LTSS. Beginning with the approval of the CHOICES program in Amendment 7, LTSS for adults who are elderly or physically disabled, as well as NF care for children, was brought under the MCOs. CHOICES was phased in on the following dates:

- March 1, 2010: Middle Tennessee
- August 1, 2010: East and West Tennessee

CHOICES has been instrumental in helping TennCare meet goals of rebalancing LTSS so that there is more access to HCBS for people who need them and more targeted utilization of NFs as providers of care to persons with the most acute needs.

At the inception of the TennCare program, 17 percent of all elderly persons and adults with physical disabilities receiving LTSS got their care in home and community settings, with the remaining 83 percent receiving care in an institution. As of April 2012, the percentage of members receiving care in home and community settings had nearly doubled, to 33.5 percent, with only 66.5 percent receiving care in institutions. While the vast majority of changes in enrollment are attributable to successful diversion efforts achieved through expanded access to HCBS and improved coordination of care, hundreds of TennCare members have also successfully transitioned from institutions to community-based living, both before and after the State's Money Follows the Person Rebalancing Demonstration, which is also administered by MCOs through the managed care program.

Each of the Bureau's expectations regarding MCC performance is carefully laid out in the MCC contracts, which are usually amended twice a year. All contracts are monitored closely.

As an example, there are several hundred deliverables included in the MCO contracts. The Bureau has established an electronic database for tracking these deliverables and assigned a business owner within the Bureau for each one. The system identifies when items are due and triggers reminders to business owners, as well as follow-up messages if the reminders are not acted upon. Business owners must enter their responses into the system, showing that they have followed up on the items that are their responsibility. Sometimes this process reveals that a particular report is no longer needed, in which case it may be removed from the contract the next time it is amended. The Bureau seeks to avoid requesting items from the MCOs that no one at the Bureau is reviewing or using. This electronic contract monitoring process promotes regular, systematic, and timely reports on all required deliverables and helps make sure that these items are reviewed and responded to as intended. Additional monitoring activities have been established since implementation of the CHOICES program, including specific monitoring of care coordination processes through audits and other on-site monitoring activities.

An important participant in the monitoring process is the Tennessee Department of Commerce and Insurance (TDCI). TDCI maintains a TennCare Oversight Division that carries out a number of critical functions such as collecting and analyzing MCO financial reports and assuring compliance with prompt pay requirements.

6. Progress on Project Objectives.

A detailed Interim Evaluation Report, which is required by paragraph 71 of the Special Terms and Conditions, is presented in Part VI of this application. This report shows improvements over time in a number of indicators such as EPSDT screening rates, child/adolescent access to PCPs, adult and adolescent well-care visits, timeliness of prenatal care, control of high blood pressure, and HbA1c (diabetes) testing. Over 90 percent of TennCare enrollees report that they

go to a doctor or clinic, rather than a hospital emergency room, when initially seeking care.[23] Satisfaction with TennCare remains extremely high at 95 percent, which is a full 10 percentage points above the level reported at the beginning of TennCare II in 2002.[24]

In addition to the positive effects on enrollee health, the TennCare program has demonstrated important outcomes of an economic nature—efficiency, stability and viability. During the course of the demonstration, budget neutrality has been successfully maintained. TennCare MCOs exhibit a high rate of claims payment accuracy and timeliness.

In the few areas where progress has lagged, measures have been taken to improve the trend. When breast cancer screening rates failed to improve, TennCare instituted pay-for-performance incentives for MCOs that hit target rates. Similar initiatives are currently being considered to improve cervical cancer screening rates as well. MCOs are required to do performance improvement projects each year, and they are currently working together in collaborative workgroups that focus on diabetes and maternity-related issues.

A major new program that is now under the demonstration's umbrella, the CHOICES LTSS program, has shown remarkable progress so far in rebalancing the system so that NF care is reserved for those with the most acute needs and those with lesser levels of need can be offered cost-effective HCBS.

Due to these favorable results, we have seen significant achievements so far in our overall demonstration goals:

- Assuring appropriate access to care for enrollees
- Providing quality care to enrollees
- Assuring enrollees' satisfaction with services
- Improving health care for enrollees
- Using a managed care approach to provide services to Medicaid State Plan and demonstration eligibles at a cost that does not exceed what would have been spent in a Medicaid fee-for-service system
- Assuring that health plans maintain stability and viability while meeting all contract and program requirements

We envision making additional progress toward these goals during the new waiver period.

7. Future Goals of the Program.

[23] HEDIS/CAHPS Report: Comparative Analysis of Audited Results from TennCare MCOs, State of Tennessee, Department of Finance and Administration, Bureau of TennCare (produced yearly-last report August 2011, prepared by Qsource).

[24] The Impact of TennCare: A Survey of Recipients, The University of Tennessee Center for Business and Economic Research (produced yearly-last report November 2011).

A major goal of the future is to continue the progress made to date on integration of benefits. The State is applying to the Medicare-Medicaid Coordination Office for a separate Section 1115 waiver to be layered on top of the TennCare demonstration. The new program, to be called TennCare PLUS, would allow the State to offer a coordinated package of TennCare and Medicare benefits to Full Benefit Dual Eligibles (FBDEs). The projected start date is January 1, 2014. Although this project is outside the TennCare demonstration, it is certainly complementary to it and dependent upon continuation of TennCare as it currently exists.

a. Future goals and desired outcomes.

Each year, the Bureau of TennCare goes through a process of updating program goals, objectives, and performance measures. This involves determining whether the current goals, objectives, and performance measures are still appropriate, given any program changes that have occurred during the year or are likely in the near future.

We anticipate that goals, objectives, and performance measures will remain relatively unchanged during 2013. The major addition will likely be adding/enhancing measures for the relatively new CHOICES LTSS population. We doubt we will need to make many changes to accommodate the new expansion population in 2014, however, since this population is likely to be similar to the adult 1931 population and to uninsured adult populations that we have served in the past.

b. Plans for quality of care activities under the extension.

TennCare currently carries on a wide variety of process-related quality of care activities, in addition to the collection and analysis of outcome measures. It is anticipated that all of these activities will continue into 2013. The process indicators that have been developed for the CHOICES LTSS population will continue to be incorporated into the quality plan. As 2014 approaches, the activities will need to be enhanced in order to encompass the Medicaid expansion population. We are now making plans for just what that enhancement will look like. For example, it is possible that TennCare's External Quality Review Organization (EQRO), Qsource, will take on additional roles and responsibilities.

c. Plans for evaluation activities under the extension.

We will continue with the present outcome evaluation, with a couple of additions. First, the outcome indicators for the CHOICES LTSS population will be incorporated into the evaluation. Next, an analysis plan for the Medicaid expansion in 2014 will need to be developed. Since the characteristics of this population will be different from the characteristics for our current TennCare population, targets for our current goals and objectives may need to be revised. Additional goals and objectives for the expansion population may be needed as well.

Part II: Narrative of Changes Being Requested

The State is not requesting any changes in the current Special Terms and Conditions of the demonstration other than those mentioned below.

We are aware that certain changes will need to be made to reference the new ACA eligibility group, effective January 1, 2014. It is our intention to consult with CMS about how best to incorporate these references.

CMS may wish to update certain items in the Special Terms and Conditions that are out-of-date. These items include references to demonstration categories that are now obsolete and references to CHOICES that are obsolete now that the program has been fully implemented. See Table 5.

Table 5
Major Out-of-Date Items in Current STCs

Out-of-Date Item	Why Out-of-Date	References
The "Transition Group"	This group was established as a transition group at the time Amendment 2 was approved in 2005. There are no longer any persons in the group.	Paragraph 17 (Table 1a) Paragraph 22
The "Discontinued Demonstration Group"	This group was established as a transition group at the time Amendment 2 was approved in 2005. There are no longer any persons in the group.	Paragraph 17 (Table 1a) Paragraph 23
Readiness review for implementation of CHOICES	CHOICES was implemented in 2010.	Paragraph 34(h)(ii)
Table 8	This table is entitled "Projected PMPM Costs Before CHOICES Implementation." CHOICES was implemented in 2010.	Paragraph 64(c)

Also, we want the new STCs to clarify that enrollment into the "At Risk Demonstration Group" and Interim CHOICES 3 will be closed as of December 31, 2013. The State had requested this end date in Amendment 14 and was told that it could not be approved as part of Amendment 14 because December 31, 2013, is outside the time period for the current extension, which ends on June 30, 2013. Individuals enrolled in the At Risk Demonstration Group and in Interim CHOICES 3 as of December 31, 2013, may continue to qualify in this demonstration eligibility category and in this CHOICES group so long as the following criteria are met:

- They continue to meet Nursing Facility eligibility and the Level of Care (LOC) criteria in place when they enrolled; and
- They remain continuously enrolled in the At Risk Demonstration Group and in CHOICES Group 3.

Finally, certain Special Terms and Conditions contain tables that may need to be extended. The State's proposals for extending these tables are shown below.

1. **Table 4, paragraph 34(e)(i).** Proposed continuation numbers are provided in red font.

Table 4—Enrollment Targets

Demonstration Year	Lower Limit	Upper Limit
DY 8	6,000	8,000
DY 9	7,500	9,500
DY 10	8,500	11,000
DY 11	11,000[25]	15,000[26]
DY 12	12,000	16,000
DY 13	13,500	17,500
DY 14	15,000	18,500

2. **Table 9, paragraph 64(c).** Continuation numbers are provided in red font.

Table 9—Projected PMPM Costs After CHOICES Implementation

	Trend	DY 8	DY 9	DY 10	DY 11
EG1 Disabled	5.82%	$1,253.79	$1,326.76	$1,403.98	$1,485.69
EG2 Over 65	5.01%	$843.92	$886.20	$930.60	$977.22
EG3 Children	6.24%	$377.82	$401.40	$426.45	$453.06
EG 4 Adults	6.05%	$733.56	$777.94	$825.01	$874.92
EG 5 Duals	5.54%	$531.03	$560.45	$591.50	$624.27
EG6 Med Exp Child	6.24%	$377.82	$401.40	$426.45	$453.06

	Trend	DY 12	DY 13	DY 14
EG1 Disabled	5.82%	$1,572.16	$1,663.65	$1,760.48
EG2 Over 65	5.01%	$1,026.18	$1,077.58	$1,131.57
EG3 Children	6.24%	$481.33	$511.36	$543.27
EG 4 Adults	6.05%	$927.85	$983.98	$1,043.51
EG 5 Duals	5.54%	$658.86	$695.36	$733.88
EG6 Med Exp Child	6.24%	$481.33	$511.36	$543.27

3. **Table 10, paragraph 64(d).** Continuation numbers are provided in red font.

[25] Lower limit requested in Amendment 14.
[26] Upper limit requested in Amendment 14.

Table 10—DSH Adjustments for DY 1 through DY 14

	DSH Adjustment (total computable)	DSH Adjustment (Federal share)
DY 1	$413,700,907	$268,409,148
DY 2	$479,893,052	$310,106,890
DY 3	$479,893,052	$310,538,794
DY 4	$479,893,052	$308,091,339
DY 5	$479,356,649	$305,451,928
DY 6 (preliminary)	$479,657,638	$305,451,928
DY 7 (preliminary)	$485,299,094	$311,270,839
DY 8 (preliminary)	$488,969,517	$319,052,610
DY 9 (preliminary)	$470,369,327	$309,408,043
DY 10 (preliminary)	$463,996,853	$305,451,928
DY 11 (preliminary)	$463,996,853	$305,451,928
DY 12 (preliminary)	$463,996,853	$305,451,928
DY 13 (preliminary)	$463,996,853	$305,451,928
DY 14 (preliminary)	$463,996,853	$305,451,928

Part III: Waivers and Expenditure Authorities

The State is requesting the same waiver and expenditure authorities as those approved in the current demonstration.

Part IV: Summaries of EQRO Reports, MCO and State Quality Assurance Monitoring, and Other Documentation of the Quality of and Access to Care Provided Under the Demonstration

1. Overview of Reports Used to Assess Quality and Access.

a. The EQRO.

The Balanced Budget Act of 1997 required that an EQRO monitor TennCare's health plans. The federally mandated activities are the Annual Quality Survey (AQS), Performance Measure Validation (PMV), Performance Improvement Project (PIP) Validation, Technical Report, and an Annual Provider Network Adequacy and Benefit Delivery Review (ANA).

The other activities of the EQRO are activities requested by TennCare: EPSDT Summary Report, HEDIS/CAHPS Report, Impact Analysis Report, and Provider Data Validation.

TennCare's current EQRO contractor is Qsource. Qsource monitors the MCOs and the DBM; it does not monitor the PBM.

Reports prepared regularly by the EQRO are described in Table 6 below.

Table 6
Overview of Quality Monitoring Activities in Tennessee

a. EQRO Reports

Activity	Description	Frequency
Annual Provider Network Adequacy and Benefit Delivery Review (ANA)	The EQRO completes a review of each health plan regarding the adequacy of the provider network and the completeness of the communication with enrollees and providers about TennCare-covered services. This includes credentialing and recredentialing information. The EQRO completes this report at the direction of TDCI[27] with support from TennCare. The EQRO submits an individual report for each MCO and the DBM. The reporting period is the previous calendar	Annually

[27] Tennessee Department of Commerce and Insurance.

Activity	Description	Frequency
	year (for instance, January 1- December 31, 2011 was the reporting period for the 2012 ANA).[28]	
Annual Quality Survey (AQS)	The EQRO conducts an AQS of each MCO and DBM in order to determine the extent to which each MCO and the DBM is in compliance with the following: ▪ Contractor Risk Agreements with the State of Tennessee, Bureau of TennCare ▪ 42 CFR Parts 417.106, 430, 433, 434 and 438 ▪ Quality standards and State mandates that include the *John B. Consent Decree* and the *Grier Revised Consent Decree* The EQRO submits an individual report for each MCO and DBM and a summary report for the MCOs. The reporting period is the previous calendar year (for instance, January 1- December 31, 2009 was the reporting period for the 2010 AQS).[29]	Annually
Early, Periodic, Screening, Diagnosis and Treatment (EPSDT) Summary Report	Using data from EPSDT-related assessments conducted through the AQS and ANA processes, the EQRO compiles this single report documenting the EPSDT-specific activities conducted during the review period (the previous calendar year).[30]	Annually
Performance Improvement Project (PIP) Validation	Based on requirements set forth in the EQRO's contract with TennCare, the EQRO validates PIP(s) for each MCO and documents the findings in individual MCO reports. The EQRO utilizes the CMS publication entitled *Validating Performance Improvement Projects: A Protocol for Use in Conducting Medicaid External Quality Review Activities, final protocol, Version 1.0, May 1, 2002* in order to assess each PIP's compliance with the requirements set forth in 42 CFR § 438.240(b)(1).[31]	Annually
Performance Measure Validation	For each MCO, the EQRO conducts PMV(s) and submits MCO-specific reports detailing the findings. To conduct	Annually

[28] Annual Provider Network Adequacy and Benefit Delivery Review Reports (MCC-specific), State of Tennessee, Department of Finance and Administration, Bureau of TennCare (produced yearly-last report May 2011, prepared by Qsource).

[29] Annual Quality Survey Reports (MCC-specific and summary reports), State of Tennessee, Department of Finance and Administration, Bureau of TennCare (produced yearly-last report August 2011, prepared by Qsource).

[30] EPSDT Summary Report, State of Tennessee, Department of Finance and Administration, Bureau of TennCare (produced yearly-last report August 2011, prepared by Qsource).

[31] PIP Validation Reports (MCO-specific and summary reports), State of Tennessee, Department of Finance and Administration, Bureau of TennCare (produced yearly-last report September 2011, prepared by Qsource).

Activity	Description	Frequency
(PMV)	the PMV, the EQRO utilizes the most current volume of the National Committee for Quality Assurance's (NCQA) *HEDIS Compliance Audit: Standards, Policies, and Procedures.*[32]	
EQRO Technical Report	CMS requires the EQRO to summarize the quality, timeliness and access to care furnished by the TennCare MCOs and the DBM. This report utilizes the guidelines and specifications set forth by CMS to summarize the results of the federally mandated EQRO activities (ANA, AQS, PIP, and PMV).[33]	Annually
Provider Data Validation (PDV)	TennCare's contract with the EQRO requires the EQRO to conduct a provider data validation survey and submit a report documenting its findings. The purpose of this activity is to determine the accuracy of the provider data files submitted by the TennCare MCOs and the DBM and to use the results as an indication of the extent to which providers are available and accessible to TennCare enrollees. The EQRO conducts this activity and develops this report under the direction of TennCare's Office of Provider Services with support from Quality Oversight.[34]	Quarterly
Healthcare Effectiveness Data and Information Set (HEDIS)/Consumer Assessment of Healthplan Providers and Systems (CAHPS) Summary Report	The EQRO summarizes the results of the HEDIS/CAHPS data reported by TennCare MCOs. In addition to the data summary, the report includes an overview of MCO performance using the calculated weighted average of scores alongside national averages and comparisons across the State's MCOs. Starting in 2011, the EQRO will also produce a HEDIS/CAHPS Report for Consumers.[35]	Annually
Impact Analysis	This report examines federal and state activity that could impact the Bureau of TennCare and inform State policy.[36]	Annually

[32] Annual Performance Measure Validation Reports (MCO specific), State of Tennessee, Department of Finance and Administration, Bureau of TennCare (produced yearly-last report September 2011, prepared by Qsource).

[33] Annual EQRO Technical Report, State of Tennessee, Department of Finance and Administration, Bureau of TennCare (produced yearly-last report September 2011, prepared by Qsource).

[34] Provider Data Validation Reports, State of Tennessee, Department of Finance and Administration, Bureau of TennCare (produced quarterly-last report 2012 quarter 1, April 2012, prepared by Qsource).

[35] HEDIS/CAHPS Report: Comparative Analysis of Audited Results from TennCare MCOs, State of Tennessee, Department of Finance and Administration, Bureau of TennCare (produced yearly-last report August 2011, prepared by Qsource). http://www.tn.gov/tenncare/forms/hedis11.pdf.

[36] Impact Analysis Report, State of Tennessee, Department of Finance and Administration, Bureau of TennCare (produced yearly-last report 2011).

b. **Annual Beneficiary Survey.**

Activity	Description	Frequency
The Impact of TennCare: A Survey of Recipients	This survey is used to capture satisfaction/access data beyond what is covered by CAHPS. TennCare contracts with the University of Tennessee Center for Business and Economic Research to survey approximately 5,000 Tennesseans each year, with most questions posed to the subset of that group who are TennCare members. The survey has been conducted since 1993, thereby allowing for long-term tracking of trends.[37]	Annually

c. **EPSDT Medical Record Review.**

Activity	Description	Frequency
Report of Annual EPSDT Medical Record Review	All children and youth under age 21 are eligible to receive EPSDT screens, and providers have been required to carry out and document the seven components of each EPSDT screen. Nursing consultants from TennCare's Division of Quality Oversight conduct the record reviews.[38]	Annually

d. **CMS-416 Reports.**

Activity	Description	Frequency
Annual EPSDT Participation Report Form CMS-416	This is a report compiled by CMS for each state and the nation as a whole. Tennessee completes its form CMS-416 in excel format and e-mails it to CMS on an annual basis. CMS collects basic information on Medicaid and CHIP programs to assess the effectiveness of EPSDT. Information on the number of individuals eligible for EPSDT services is collected as well as the number of children provided screening services, the number of	Annually

[37] The Impact of TennCare: A Survey of Recipients, The University of Tennessee Center for Business and Economic Research (produced yearly-last report November 2011) http://cber.bus.utk.edu/tncare/tncare11.pdf.

[38] Report of Annual EPSDT Medical Record Review, Bureau of TennCare Division of Quality Oversight, July 2011.

Activity	Description	Frequency
	children referred for medical treatment, and the number of children receiving dental services.[39]	

e. **CHOICES Studies.**

A new component to our Quality Improvement Strategy has been added for the CHOICES program (required by STC 45c) in addition to a CHOICES Special Study (required by STC 69).

Activity	Description	Frequency
CHOICES Quality Improvement Strategy	A number of measures were added to the 2011 Quality Assessment and Improvement Strategy to assure quality in the CHOICES program. These measures seek to assure that CHOICES 2 members have a level of care determination indicating the need for institutional services prior to enrollment in CHOICES and receipt of HCBS; members are offered a choice between institutional services and HCBS; plans of care are reviewed/updated at least annually; providers meet minimum qualifications; CHOICES 2 members/family members receive education at least annually about how to identify and report abuse, neglect and exploitation; critical incidents are reported within timeframes specified in Contractor Risk Agreement; MCO provider agreements meet uniform requirements; members are informed of and afforded rights to request a Fair Hearing when services denied, reduced, suspended or terminated. The CHOICES 3 group will be added when the strategy is updated in 2013.[40]	Annually

[39] http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Early-Periodic-Screening-Diagnosis-and-Treatment.html

[40] 2011 Quality Assessment and Performance Improvement Strategy and Quality Strategy: Annual Update Report, State of Tennessee Bureau of TennCare, 2011, pgs. 14-21. Implementation of the CHOICES program occurred in 2010. Group 1 is for individuals receiving services in a NF. These individuals are enrolled in TennCare Medicaid. Group 2 is for individuals who meet the NF level-of-care and are receiving HCBS as an alternative to Medicaid, if they are eligible for SSI, or TennCare Standard, if they are not SSI eligible but would qualify in the demonstration group for persons receiving HCBS who meet institutional income standards. A waiver amendment was submitted to CMS on March 1, 2012 to make certain changes to CHOICES Group 3, for those "at-risk" of NF care. CHOICES Group 3 was approved as part of the original program design, but the State has been prohibited from implementing this group due to federal maintenance of effort provisions of the ARRA and ACA.

Activity	Description	Frequency
CHOICES Special Study	The CHOICES Special Study seeks to answer the question: *What is the effect of CHOICES on the use of institutional versus home- and community-based care?* It looks at the rebalancing of the long-term care system including impacts on utilization and cost. The study indicators include utilization-based measures and expenditure-based measures in order to determine the share of member months and expenditures in both CHOICES 1 and CHOICES 2 and the amount of movement in between the two groups. As with the Quality Strategy, this study will be altered in 2013 to include CHOICES Group 3.[41]	Annually

f. Pharmacy.

Activity	Description	Frequency
Pharmacy Audits	In the PBM contract that went into effect October 1, 2008, TennCare included a contractual requirement for the PBM to perform regular pharmacy audits. The PBM is responsible for performing desk audits on a quarterly basis, along with 10 field audits per quarter. The goal of these audits is to identify prescriptions that are incorrectly billed or that suggest fraud or abuse. Patterns identified during the audits can then be used to create new quantity limits aimed at preventing fraud and abuse.	Quarterly

2. Summaries of Reports Used to Assess Quality and Access.

See Table 7 below.

[41] CHOICES Special Study for TennCare Health Plans, TennCare Division of Quality Oversight, Revised January 26, 2011.

Table 7
Summaries of Report Findings on Quality and Access

Report	Date of Most Recently Completed Report	Summary	Follow up by the State, if Indicated
ANA	2011	Network Adequacy: MCOs scored between 99.5% and 99.9%; TennDent scored 100%. Benefit Delivery: One MCO scored 99%; all the other MCOs scored 100%; TennDent scored 80.9%.	The Bureau required a Corrective Action Plan from TennDent to address its score.
AQS	2011	No plan rated fewer than 4 out of 5 stars on any standard or activity, with 5 being the highest rating.	Less than 100% compliance necessitates corrective action plan, which all plans submitted.
EPSDT Summary Report	2011	Strengths and Areas of Need were identified for each MCC in areas that include: member communication/outreach, tracking system, and program coordination. Several strengths identified, but areas of need also noted for Amerigroup, UnitedHealthcare and TennDent	Corrective action plans submitted as part of AQS and ANA (where EPSDT Summary Report data originate).
PIP Validation Report	2011	PIPs carried out during 2010: Follow-up for children prescribed ADHD medication (Amerigroup), Behavioral health postpartum depression screening (Volunteer State Health Plan), Improving compliance with continuing treatment for major depressive disorders (UnitedHealthcare). United had a validation status of "Met," Other MCOs had validation status of "Not Met."	Those with "Not Met" status required to submit corrective action plans. MCOs also given extensive technical assistance by TennCare quality staff.
Performance Measure Validation	2011	This is a report documenting the EQRO's yearly validation of two HEDIS measures. In 2010 these measures	

Report	Date of Most Recently Completed Report	Summary	Follow up by the State, if Indicated
Report		were Breast Cancer Screening and Follow-up Care for Children Prescribed ADHD Medication (initiation phase). MCOs were in full compliance with all standards.	
EQRO Technical Report	2011	This is a summary document containing information for many of the specific measures collected by the EQRO that are noted in this table.	
Provider Data Validation	2012	This quarterly report documents accuracy rate for each audited provider data element: contract status, address, whether provider credentialed, panel status (open or closed), provides services to patients under 21/21+, provides primary care services, provides prenatal care services. Overall ratings for the most recent audit (first quarter 2012) ranged from 90.6% to 99.2%.	In the case where more than 10% of listed providers had incorrect data for a particular element, damages were assessed and/or a corrective action plan was required.
HEDIS/CAHPS Report	2011	This yearly report details NCQA-specified measures (by health plan) used to assess quality and effectiveness of health services. A number of these measures are discussed in the Interim Evaluation Report, most with very positive results over time.	Indicators needing improvement may be chosen by TennCare for use in Pay-for-Performance incentive payments (e.g. breast cancer screening), MCC may do PIP or they may be the focus of MCC Collaborative (where MCCs work jointly to address particular issues).
Impact Analysis Report	2011	The most recent report focuses on three major national and state-related issues with consequences for the TennCare program: healthcare reform, EHRs and ICD-10, and disparities in	

Report	Date of Most Recently Completed Report	Summary	Follow up by the State, if Indicated
		health/healthcare services.	
UT Beneficiary Survey	2011	This is a statewide, not MCC-specific yearly survey, which found, for example, high rates of beneficiary satisfaction and high rates of beneficiaries first seeking care at doctor office/clinic rather than E.R.	
EPSDT Medical Record Review	2011	This record review was conducted with a statewide sample of medical records to ascertain provider compliance with carrying out and documenting seven components of each EPSDT screen. Statewide compliance rate for 2010 was 91.27%.	Although the rate is not calculated at the level of the individual provider, TennCare quality oversight staff educates providers in the sample with regards to elements that were found to be deficient during the medical record review. Corrective action plans are required from MCOs that are two or more standard deviations below the State average for any of the required seven components.
CMS-416 Reports	2012	These CMS-generated tables show that for fiscal year 2010, the screening ratio for Tennessee (total number of screens/expected number of screens for the eligible population) is nearly perfect at 0.99. (A ratio of 1.00 means that the total number of screens are identical to the number of screens that actually occurred). In comparison, the ratio for the nation as a whole is just 0.83.	
CHOICES Quality Improvement	2011	This data is currently being analyzed by TennCare's Long Term Services and	N/A

Report	Date of Most Recently Completed Report	Summary	Follow up by the State, if Indicated
Strategy (contained in 2011 Quality Assessment and Performance Improvement Strategy document)		Supports Division and Quality Oversight Division.	
Choices Special Study for TennCare Health Plans (methodology document)	2011	This data is currently being analyzed by TennCare's Long Term Services and Supports Division and Quality Oversight Division.	N/A

Part V: Financial Data

With respect to Budget Neutrality assumptions and projections for the waiver extension, we have largely continued the trends as defined in the current extension.

The growth rate trends for each of the five eligibility groups included in the Baseline Per Member Per Month (PMPM) calculations are continued from the current waiver, using DY 11 as the base. Member months for Demonstration Year (DY) 12 for each of the five eligibility groups in Groups I and II are projected with a 1 percent increase over the member months projected for DY 10, the current DY, with no additional change projected for DY 13 and DY 14. The funding for the Disproportionate Share (DSH) adjustment is held constant with the DY10 level across DY 12, DY 13, and DY 14.

Section 2001 of the Affordable Care Act (ACA) requires the enrollment of many new Medicaid eligibles, beginning on January 1, 2014, which is six months into the new extension period. The State has discussed this issue with CMS, and no decision has yet been reached as to when or how to show the effects of this change. At such time as CMS and the State reach a mutually agreeable decision on this issue, we will provide an update that reflects the impact of ACA implementation on our Budget Neutrality assumptions and projections.

TennCare Budget Neutrality (2003-2016)
(Note: Premiums have been subtracted)

I. The Baseline 2003-2007

Baseline PMPM

	FY 2003	FY 2004	FY 2005	FY 2006	FY 2007
Disabled (can be any ages)	$730.05	$787.29	$849.01	$915.57	$987.35
2-Child<=18	$230.19	$248.56	$268.40	$289.82	$312.95
3-Adult>=65	$317.64	$337.27	$358.11	$380.24	$403.74
4-Adult<=64	$455.09	$490.36	$528.36	$569.31	$613.43
Duals(17)				$83.17	$89.82

Member Months of Groups I and II

Groups I & II	FY 2003	FY 2004	FY 2005	FY 2006	FY 2007
1-Disabled (can be any ages)	1,995,204	2,050,765	2,078,035	2,006,317	1,981,596
2-Child <=18	6,618,606	6,607,161	6,685,162	7,039,017	7,100,528
3-Adult >=65	58,522	53,656	46,049	34,826	30,648
4-Adult<=64	2,146,506	2,519,172	2,720,294	3,082,138	3,041,436
Duals (17)				1,206,933	2,279,536
Total	**10,818,838**	**11,230,754**	**11,529,540**	**13,369,231**	**14,433,744**

Ceiling without DSH

	FY 2003	FY 2004	FY 2005	FY 2006	FY 2007
1-Disabled (can be any ages)	$1,456,598,680	$1,614,546,777	$1,764,272,495	$1,836,923,656	$1,956,528,811
2-Child <=18	$1,523,536,915	$1,642,275,938	$1,794,297,481	$2,040,047,907	$2,222,110,238
3-Adult >=65	$18,588,928	$18,096,559	$16,490,607	$13,242,238	$12,373,824
4-Adult<=64	$976,853,416	$1,235,301,182	$1,437,294,538	$1,754,691,985	$1,865,708,085
Duals (17)				$100,380,618	$204,747,924
Total	**$3,975,577,939**	**$4,510,220,456**	**$5,012,355,121**	**$5,745,286,403**	**$6,261,468,881**

DSH

DSH Adjustment	FY 2003	FY 2004	FY2005	FY 2006	FY 2007
Total	$413,700,907	$479,893,052	$479,893,052	$479,893,052	$479,893,052

Total Ceiling

Budget Neutrality Cap	FY 2003	FY 2004	FY2005	FY 2006	FY 2007
Total w/DSH Adj.	$4,389,278,846	$4,990,113,508	$5,492,248,173	$6,225,179,455	$6,741,361,933

I. The Baseline 2008-2010

Note: CHOICES PMPM for Middle Region is included in FY2010 (Mar-June)

Baseline PMPM

	FY 2008	FY 2009	FY 2010 (July-Feb)	FY 2010 (March-June)
Disabled (can be any ages)	$1,055.48	$1,128.31	$1,206.16	$1,253.79
2-Child<=18	$333.23	$354.82	$377.81	$377.82
3-Adult>=65	$428.69	$455.18	$483.31	$843.92
4-Adult<=64	$651.03	$690.94	$733.29	$733.56
Duals(17)	$95.81	$102.20	$109.02	$531.03

Member Months of Groups I and II

Groups I & II	FY 2008	FY 2009	FY 2010 (July-Feb)	FY 2010 (March-June)
1-Disabled (can be any ages)	1,946,150	1,944,260	1,103,020	489,276
2-Child <=18	7,043,034	7,310,961	4,865,391	2,538,340
3-Adult >=65	23,843	19,148	8,117	5,103
4-Adult<=64	3,054,558	2,895,697	2,214,292	1,130,748
Duals (17)	2,351,021	2,367,131	1,341,198	539,186
Total	**14,418,606**	**14,537,197**	**9,532,017**	**4,702,653**

Ceiling without DSH

	FY 2008	FY 2009	FY 2010 (July-Feb)	FY 2010 (March-June)
1-Disabled (can be any ages)	$2,054,122,402	$2,193,728,001	$1,330,418,000	$613,449,356
2-Child <=18	$2,346,950,220	$2,594,075,182	$1,838,193,468	$959,035,619
3-Adult >=65	$10,221,256	$8,715,787	$3,923,027	$4,306,524
4-Adult<=64	$1,988,608,895	$2,000,752,885	$1,623,717,997	$829,471,503
Duals (17)	$225,251,322	$241,920,788	$146,217,351	$286,323,942
Total	**$6,625,154,094**	**$7,039,192,643**	**$4,942,469,844**	**$2,692,586,943**

DSH

DSH Adjustment	FY 2008	FY 2009	FY2010
Total	$479,657,658	$485,299,094	$488,969,517

Total Ceiling

Budget Neutrality Cap	FY 2008	FY 2009	FY 2010
Total w/DSH Adj.	$7,104,811,752	$7,524,491,737	$8,124,026,304

I. The Baseline 2011-2013

Baseline PMPM

	FY 2011	FY 2012	FY 2012 Projected	FY 2013 Projected
Disabled (can be any ages)	$1,326.76	$1,403.98	$1,403.98	$1,485.69
2-Child<=18	$401.40	$426.45	$426.45	$453.06
3-Adult>=65	$886.20	$930.60	$930.60	$977.22
4-Adult<=64	$777.94	$825.01	$825.01	$874.92
Duals(17)	$560.45	$591.50	$591.50	$624.27

Member Months of Groups I and II

Groups I & II	FY 2011	FY 2012 Actual	FY 2012 Projected	FY 2013 Projected
1-Disabled (can be any ages)	1,504,522	767,336	1,534,672	1,786,250
2-Child <=18	8,026,649	4,022,195	8,044,390	6,943,137
3-Adult >=65	14,895	7,025	14,050	5,232
4-Adult<=64	3,432,624	1,732,807	3,465,614	3,396,483
Duals (17)	1,640,349	821,633	1,643,266	2,557,814
Total	**14,619,039**	**7,350,996**	**14,701,992**	**14,688,916**

Ceiling without DSH

	FY 2011	FY 2012 Actual	FY 2012 Projected	FY 2013 Projected
1-Disabled (can be any ages)	$1,996,139,609	$1,077,324,397	$2,154,648,795	$2,653,813,763
2-Child <=18	$3,221,896,909	$1,715,265,058	$3,430,530,116	$3,145,657,649
3-Adult >=65	$13,199,949	$6,537,465	$13,074,930	$5,112,815
4-Adult<=64	$2,670,375,515	$1,429,583,103	$2,859,166,206	$2,971,650,906
Duals (17)	$919,333,597	$485,995,920	$971,991,839	$1,596,766,546
Total	**$8,820,945,578**	**$4,714,705,943**	**$9,429,411,885**	**$10,373,001,679**

DSH

DSH Adjustment	FY 2011	FY 2012 Actual	FY2012 Projected	FY2013 Projected
Total	$470,369,327	$231,998,427	$463,996,853	$463,996,853

Total Ceiling

Budget Neutrality Cap	FY 2011	FY 2012 Actual	FY 2012 Projected	FY 2013 Projected
Total w/DSH Adj.	**$9,291,314,905**	**$4,946,704,369**	**$9,893,408,738**	**$10,836,998,532**

I. The Baseline 2014-2016

Annual Trends Used in Baseline PMPM Projections, FY 2014 – FY 2016	
Disabled (can be any ages)	5.82%
2-Child<=18	6.24%
3-Adult>=65	5.01%
4-Adult<=64	6.05%
Duals(17)	5.54%

Baseline PMPM

	FY 2014 Projected	FY 2015 Projected	FY 2016 Projected
Disabled (can be any ages)	$1,572.16	$1,663.65	$1,760.48
2-Child<=18	$481.33	$511.36	$543.27
3-Adult>=65	$1,026.18	$1,077.58	$1,131.57
4-Adult<=64	$927.85	$983.98	$1,043.51
Duals(17)	$658.86	$695.36	$733.88

Member Months of Groups I and II

Groups I & II	FY 2014 Projected	FY 2015 Projected	FY 2016 Projected
1-Disabled (can be any ages)	1,550,019	1,550,019	1,550,019
2-Child <=18	8,124,834	8,124,834	8,124,834
3-Adult >=65	14,191	14,191	14,191
4-Adult<=64	3,500,270	3,500,270	3,500,270
Duals (17)	1,659,699	1,659,699	1,659,699
Total	**14,849,012**	**14,849,012**	**14,849,012**

Ceiling without DSH

	FY 2014 Projected	FY 2015 Projected	FY 2016 Projected
1-Disabled (can be any ages)	$2,436,870,342	$2,578,693,357	$2,728,770,305
2-Child <=18	$3,910,729,828	$4,154,754,967	$4,414,007,001
3-Adult >=65	$14,561,944	$15,291,449	$16,057,500
4-Adult<=64	$3,247,723,434	$3,444,198,479	$3,652,559,524
Duals (17)	$1,093,501,604	$1,154,083,256	$1,218,021,225
Total	**$10,703,387,151**	**$11,347,021,508**	**$12,029,415,555**

DSH

DSH Adjustment	FY 2014 Projected	FY 2015 Projected	FY2016 Projected
Total	$463,996,853	$463,996,853	$463,996,853

Total Ceiling

Budget Neutrality Cap	FY 2014 Projected	FY 2015 Projected	FY 2016 Projected
Total w/DSH Adj.	**$11,167,384,004**	**$11,811,018,361**	**$12,493,412,408**

II. Actual Experience

2003-2007

Schedule C Reports	FY 2003	FY 2004	FY 2005	FY 2006	FY 2007
Schedule C - Services (including drug rebates & premiums)	$2,918,489,924	$4,767,439,313	$3,515,173,372	$3,553,329,225	$3,774,856,521
Schedule C - Pool payments and Admin	$670,147,871	$765,484,916	$860,964,598	$731,067,879	$682,605,192
Schedule C -- TOTAL (both FMAP and admin)	$3,588,637,795	$5,532,924,229	$4,376,137,970	$4,284,397,104	$4,457,461,713
Premium Collections Reported on CMS-64 Summary, Line 9E	$51,078,297	$37,017,558	$28,173,531	$10,497,520	$5,654,183
Schedule C Net of Premium Collections, Total Computable	**$3,537,559,498**	**$5,495,906,671**	**$4,347,964,439**	**$4,273,899,584**	**$4,451,807,530**

2008-2012

Group 1 and 2	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012 Q1-Q2	FY 2012
1-Disabled (can be any ages)	$1,431,705,596	$1,543,027,265	$1,549,907,539	$1,761,238,295	$885,893,490	$1,771,786,980
2-Child <=18	$1,158,903,371	$1,294,467,233	$1,434,117,751	$1,381,469,818	$746,334,590	$1,492,669,180
3-Adult >=65	$9,608,405	$9,495,474	$43,683,766	$36,874,554	$14,904,570	$29,809,140
4-Adult<=64	$1,059,521,141	$1,015,532,446	$1,198,014,788	$1,187,599,744	$624,577,094	$1,249,154,188
Duals (17)	$331,585,163	$389,298,464	$507,472,557	$1,494,242,311	$757,243,350	$1,514,486,700
Total	**$3,991,323,676**	**$4,251,820,882**	**$4,733,196,401**	**$5,861,424,722**	**$3,028,953,094**	**$6,057,906,188**

Group 3	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012 Q1-Q2	FY 2012
1-Disabled (can be any ages)	$0	$0	$0	$0	$0	$0
2-Child <=18	$11,060,683	$3,066,409	$3,285,240	$3,153,048	$2,364,001	$4,728,002
3-Adult >=65	$0	$0	$0	$0	$0	$0
4-Adult<=64	$3,278,887	$1,859,013	$804,766	$1,027,139	$425,528	$851,056
Duals (17)	$0	$0	$0	$0	$0	$0
Total	**$14,339,570**	**$4,925,422**	**$4,090,006**	**$4,180,187**	**$2,789,529**	**$5,579,058**

Pool Payments and Admin	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012 Q1-Q2	FY 2012
Total Pool Payments	$563,755,906	$607,735,588	$583,184,390	$574,357,772	$236,426,239	$574,357,772

Quarterly Premium Collections	$983,165.68	$116,389.00	$116,389.00			
Total Net Quarterly Expenditures	$4,568,435,986	$4,864,365,503	$5,320,354,408	$6,439,962,681	$3,268,168,862	$6,637,843,018

III. Surplus
2003-2007

Surplus/ (Deficit)	FY 2003	FY 2004	FY 2005	FY 2006	FY 2007
Surplus/ (Deficit) – per FY	$851,719,348	($505,793,163)	$1,144,283,734	$1,951,279,871	$2,289,554,403
Surplus/ (Deficit) - Cumulative	N/A	$345,926,185	$1,490,209,919	$3,441,489,790	$5,731,044,193

2008-2012

Surplus/ (Deficit)	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012 Q1-Q2	FY 2012
Surplus/ (Deficit) – per FY	$2,536,375,766	$2,660,126,234	$2,803,671,896	$2,851,352,224	$1,678,535,507	$3,255,565,720
Surplus/ (Deficit) - Cumulative	$8,267,419,959	$10,927,546,193	$13,731,218,089	$16,582,570,313		$19,838,136,033

Part VI: Interim Evaluation Report

The heart of TennCare's program evaluation involves outcome measures designed to determine whether program goals and objectives contained in the TennCare Evaluation Plan submitted to CMS and approved on March 31, 2008 have been met. Performance measures are those specified in the Quality Improvement Strategy (QIS).

We first discuss our medical and behavioral health measures. Then we discuss measures related to program efficiency, stability and viability. Finally, we speak to new measures being introduced for the TennCare CHOICES program.

1. Medical and behavioral health measures.

Goals	Objectives	Progress to Date
1. Assure appropriate access to care for enrollees.	1.1 By 2013, the statewide weighted HEDIS rate for adults' access to preventive/ambulatory health services will increase to 75% for enrollees 20-44 years old and the rate for enrollees 45-64 years old will be maintained at 79% or above.[42] *(2007 baseline=70% for ages 20-44; 74% for ages 45-64)*	In 2010, the rate was 79.50% for enrollees 20-44 years old and 79.89% for enrollees 45-64 years old. **Better than baseline** **2013 objective met**
	1.2 By 2013, the statewide weighted HEDIS rate for children and adolescents' access to PCPs will increase to 90% for enrollees 7-11 years old and 86% for enrollees 12-19 years old.[43] *(2007 baseline=87% for ages 7-11, 82% for ages 12-19)*	In 2010, the rate was 91.43% for enrollees 7-11 years old and 87.22% for enrollees 45-64 years old. **Better than baseline** **2013 objective met**

[42] HEDIS/CAHPS Report: Comparative Analysis of Audited Results from TennCare MCOs, State of Tennessee, Department of Finance and Administration, Bureau of TennCare (produced yearly-last report August 2011, prepared by Qsource). See http://www.tn.gov/tenncare/forms/hedis11.pdf.
[43] Ibid.

Goals	Objectives	Progress to Date
	1.3 By 2013, 97% of TennCare heads of household and 98% or greater of TennCare children will go to a doctor or clinic when they are first seeking care rather than a hospital (emergency room).[44] *(2007 baseline=94% for heads of household, 97% for children)*	In 2010, the rate was 92% for heads of household and 97% for children. **Same as baseline (children)** **Not better than baseline (heads)** **2013 objective not yet met**
2. Provide quality care to enrollees.	2.1 By 2013, the statewide weighted HEDIS rate for adolescent well-care visits will increase to 41%.[45] *(2007 baseline=35%)*	In 2010, the rate was 41.1% **Better than baseline** **2013 objective met**
	2.2 By 2013, the statewide weighted HEDIS rate for timeliness of prenatal care will be maintained at 82% or above.[46] *(2007 baseline=78%)*	In 2010, the rate was 81.06% **Better than baseline** **2013 objective not yet met**
	2.3 By 2013, the statewide weighted HEDIS rate for breast cancer screening will increase to 50%.[47] *(2007 baseline=44%)*	In 2010, the rate was 38.45% **Not better than baseline** **2013 objective not yet met**
	2.4 By 2013, the statewide weighted HEDIS rate for cervical cancer screening will increase to 68%.[48] *(2007 baseline=63%)*	In 2010, the rate was 61.30% **Not better than baseline** **2013 objective not yet met**
	2.5 By 2013, providers of EPSDT screening services will document the delivery of 95% of the required seven components of an EPSDT screen.[49] *(2007 baseline=89%)*	In 2010, the rate was 94%. **Better than baseline** **2013 objective not yet met**

[44] The Impact of TennCare: A Survey of Recipients, The University of Tennessee Center for Business and Economic Research (produced yearly-last report November 2011). See http://cber.bus.utk.edu/tncare/tncare11.pdf.
[45] HEDIS/CAHPS Report: Comparative Analysis of Audited Results from TennCare MCOs, State of Tennessee, Department of Finance and Administration, Bureau of TennCare (produced yearly-last report August 2011, prepared by Qsource). See http://www.tn.gov/tenncare/forms/hedis11.pdf.
[46] Ibid.
[47] Ibid.
[48] Ibid.
[49] Report of Annual EPSDT Medical Record Review, Bureau of TennCare Division of Quality Oversight, July 2011.

Goals	Objectives	Progress to Date
3. Assure enrollees' satisfaction with services.	3.1 By 2013, 95% of TennCare enrollees will be satisfied with TennCare.[50] *(2007 baseline=90%)*	In 2010, the rate was 94%. **Better than baseline** **2013 objective not yet met**
	3.2 By 2013, the statewide average for adult CAHPS getting needed care-always or usually-will increase to 82%.[51] *(2007 baseline=78%)*	In 2010, the rate was 76.6% **Not better than baseline** **2013 objective not yet met**
	3.3 By 2013, the statewide average for child CAHPS getting care quickly-always or usually-will increase to 81%.[52] *(2007 baseline=79%)*	In 2010, the rate was 88.78% **Better than baseline** **2013 objective met**
4. Improve health care for program enrollees.	4.1 By 2013, the statewide weighted HEDIS rate for HbA1c testing will be maintained at 73% or above.[53] *(2007 baseline=68%)*	In 2010, the rate was 77.93% **Better than baseline** **2013 objective met**
	4.2 By 2013, the statewide weighted HEDIS rate for controlling high blood pressure will increase to 55%.[54] *(2007 baseline=50%)*	In 2010, the rate was 53.67% **Better than baseline** **2013 objective not yet met**
	4.3 By 2013, the statewide weighted HEDIS rate for follow-up after hospitalization for mental illness will be maintained at 51% for follow-up within 7 days of discharge and 72% for follow-up within 30 days of discharge.[55]	In 2010, the 7-day rate was 37.93% and the 30-day rate was 61.24% **2010 is baseline** **2013 objective not yet met**

[50] The Impact of TennCare: A Survey of Recipients, The University of Tennessee Center for Business and Economic Research (produced yearly-last report November 2011). See http://cber.bus.utk.edu/tncare/tncare11.pdf.
[51] HEDIS/CAHPS Report: Comparative Analysis of Audited Results from TennCare MCOs, State of Tennessee, Department of Finance and Administration, Bureau of TennCare (produced yearly-last report August 2011, prepared by Qsource). See http://www.tn.gov/tenncare/forms/hedis11.pdf.
[52] Ibid.
[53] Ibid.
[54] Ibid.
[55] Ibid.

Goals	Objectives	Progress to Date
	4.4 By the end of each demonstration year, the state will achieve a total statewide EPSDT screening rate of at least 80%.[56] *(2007 baseline=77%)*	In 2010, the rate was 99% **Better than baseline** **2013 objective met**
	4.5 By 2013, the statewide weighted HEDIS rate for antidepressant medication management will be maintained at 63% for acute phase and 48% for continuation phase.[57]	In 2010, the rate was 50.11% for acute phase and 32.03% for continuation phase **2010 is baseline** **2013 objective not yet met**
	4.6 By 2013, the statewide weighted HEDIS rate for follow-up care for children prescribed ADHD medication will be maintained at 36% for initiation and 46% for continuation and maintenance.[58]	In 2010, the rate was 34.29 for acute phase and 44.15 for continuation phase **2010 is baseline** **2013 objective not yet met**

2. Efficiency, stability and viability measures.

Goals	Objectives	Progress to Date
1. Use a managed care approach to provide services to Medicaid State Plan and Demonstration eligibles at a cost		**During the course of the Demonstration, budget neutrality has been successfully maintained and reported in each Quarterly Report submitted to CMS in fulfillment of STC #47.**

[56] Report of Annual EPSDT Medical Record Review, Bureau of TennCare Division of Quality Oversight, July 2011.
[57] HEDIS/CAHPS Report: Comparative Analysis of Audited Results from TennCare MCOs, State of Tennessee, Department of Finance and Administration, Bureau of TennCare (produced yearly-last report August 2011, prepared by Qsource). See http://www.tn.gov/tenncare/forms/hedis11.pdf.
[58] Ibid.

Goals	Objectives	Progress to Date
that does not exceed what would have been spent in a Medicaid fee-for-service program.		
2. Assure that health plans maintain stability and viability while meeting all contract and program requirements.	2.1 By 2013, 100% of the TennCare MCCs will have demonstrated compliance with statutory and/or contractual claims processing timeliness standards in at least 10 out of 12 months in a calendar year. *(2010 baseline=80%)*	In 2011, the rate was 83%. **Better than baseline** **2013 objective not yet met**
	2.2 By 2013, the MCCs will report a compliance rate of 95% for all contractual claims payment accuracy reports. *(2010 baseline=91.5%)*	In 2011, the rate was 87.9% **Not better than baseline*** **2013 objective not yet met**

*3.6% decline in accuracy over the year appears to be a temporary phenomenon attributable to the start-up of the CHOICES program. The start-up of this program, which resulted in some early claims payment challenges, caused a short-term decline in accuracy. This has been resolved and should show improvement in the future.

3. Evaluation for CHOICES program.

When the CHOICES** program was added as part of the TennCare waiver, CMS requested that a CHOICES Special Study for TennCare Health Plans be added to the evaluation design. The question that the study seeks to answer, through a combination of membership, utilization and expenditure data, is this:

> *What is the effect of CHOICES on the use of institutional versus home- and community-based care?*

The first wave of data for our special study is currently being analyzed. In the table below, we list the study indicators.

Choices Special Study

Study Indicators	Denominator	Numerator(a)	Numerator (b)	Numerator (c)
1. Individual-level utilization-based measures (descriptive demographics)	Member months of all eligible CHOICES users at date of measurement/12	Member months of all eligible CHOICES users in Group 1 at date of measurement/12	Member months of all eligible CHOICES users in Group 2 at date of measurement/12	
2. Overall expenditure-based measures (evaluates population expenditures for Group 1 and 2)	Total dollar amount of CHOICES expenditures for Group 1 and 2 services rendered to CHOICES members	Dollar amount of all CHOICES expenditures for Group 1 services rendered to Group 1 members	Dollar amount of all CHOICES expenditures for Group 2 services rendered to Group 2 members	
3. Individual-level utilization and expenditure-based measures combined (actual dollar amounts calculated as a figure of the number of months in the measurement period for a per-user-per month expression)	(a) member months of all eligible CHOICES users at time of measurement/12 (b) member months of eligible CHOICES users in Group 1 at date of measurement/12 (c) member months of eligible CHOICES users in Group 2 at date of measurement/12	Total dollar amount of CHOICES expenditures for Group 1 and 2 services	Dollar amount of all CHOICES expenditures for Group 1 services rendered to Group 1 members	Dollar amount of all CHOICES expenditures for Group 2 services rendered to Group 2 members
4. Transition in level of care from Group 1 to Group 2 (evaluates the number of Group 1 users who transition from Group 1 to Group 2 for a specified time frame)	Number of unique members eligible for CHOICES Group 1 during measurement period	Number of unique CHOICES members who transition from Group 1 to Group 2	Number of CHOICES members who transition from Group 1 to Group 2 and remain in Group 2 for 90 days or longer	
5. Transition in level of care from Group 2 to Group 1 (evaluates the number of Group 2 users who	Number of unique members eligible at any time for CHOICES	Number of CHOICES members who transition from	Number of CHOICES users who transition from Group 2 to	(c) Number of CHOICES users who transition from Group 2 to

Study Indicators	Denominator	Numerator(a)	Numerator (b)	Numerator (c)
transition from Group 2 to Group 1 for a specified time frame)	Group 2 during measurement period	Group 2 to Group 1	Group 1 and remain in Group 1 for less than 90 days	Group 1 and remain in Group 1 between 90 and 179 days (d) Number of CHOICES users who transition from Group 2 to Group 1 and remain in Group 1 for 180 days or longer

We would like to note that we already have some preliminary outcome-related data that shows the CHOICES program has been quite effective in rebalancing enrollment in favor of home- and community-based care, as shown in the table below.

CHOICES 1 and 2 Membership**

	February 2010 (pre-CHOICES)	April 2012
CHOICES 1 (NF)	23,076 (82.6%)	20,763 (66.5%)
CHOICES 2 (HCBS)	4,861 (17.4%)	10,438 (33.5%)

** Implementation of the CHOICES program occurred in the Middle Grand region on March 1, 2010, and in the East and West regions on August 1, 2010.
Initial implementation included two CHOICES groups and a recent waiver amendment request will allow the State to implement a third group, effective July 1, 2012:

Group 1 is for individuals receiving services in a nursing facility. These individuals are enrolled in TennCare Medicaid.

Group 2 is for individuals who meet the nursing facility level-of-care and are receiving home and community-based services as an alternative to Medicaid, if they are eligible for SSI, or TennCare Standard, if they are not SSI-eligible.

A waiver amendment was submitted to CMS on March 1, 2012 to make certain modifications to CHOICES Group 3, for those "at risk" of nursing facility care as well. This group was part of the original approved program design but had not been implemented due to federal maintenance of effort (MOE) provisions. These changes will allow the State to comply with MOE provisions and open CHOICES Group 2 for enrollment.

Part VII: Documentation of the State's Compliance with the Public Notice Process

The Bureau of TennCare has used multiple mechanisms to inform interested parties about the waiver extension application and to solicit public input. These public notice and public input procedures were developed to ensure compliance with the requirements specified at 42 CFR § 431.408.

1. Public Notice and Input Procedures.

The State's 30-day public notice and comment period began on May 7, 2012. A comprehensive description of the extension to be submitted to CMS was made available for public review and comment on an extension-specific Web page on the TennCare Web site. An easily identifiable link on TennCare's home page was used to refer users to the extension Web page. This extension-specific Web page, which was maintained and updated throughout the public comment and review process, included all of the following:

- The physical locations and Internet address where copies of the extension request were available for public review;
- A mailing address, email address, and telephone number available for making public comments on the extension (along with instructions for requesting copies of public comments received);
- The locations, dates, and times of two public hearings to seek public comment on the extension; and
- Information about the State's public notice process, public input process, and a link to the relevant demonstration page on CMS's Web site.

Furthermore, the State developed an abbreviated public notice including a summary description of the demonstration, the locations, dates, and times of the two public hearings, and a link to the full public notice on the extension Web page. This abbreviated public notice was published in *The Tennessee Administrative Register* and in the newspapers of widest circulation in the eight Tennessee cities with 50,000 or more citizens.

The State used several additional mechanisms to inform interested parties of the waiver extension process.

- The State's Medical Care Advisory Committee discussed the waiver extension in a meeting that took place on April 11, 2012.
- On April 24, 2012, the State convened a statewide conference call with stakeholders that included information about the waiver extension. This conference call included representatives of the Tennessee Medical Association, the Tennessee Hospital Association, TennCare's current MCOs, and others.

- On May 8, 2012, the State shared information about the waiver extension and a link to the full public notice on the extension Web page via Facebook and Twitter to individuals who have elected to receive updates about the TennCare program through these media.
- On May 9, 2012, the State disseminated information about the waiver extension to representatives of more than 25 agencies and advocacy organizations, including the Tennessee Disability Coalition, the Rural Health Association of Tennessee, the Tennessee Mental Health Consumers Organization, and others through an e-mail list maintained by the State. Some of these organizations were also represented at a meeting convened by the State on May 8, 2012, during which information about the extension was shared.
- On May 10, 2012, the Bureau notified members of the Tennessee General Assembly of the waiver extension by e-mail and encouraged members to review the full public notice and draft extension request on the Bureau of TennCare's Web site.

The Bureau of TennCare held two public hearings to seek public comment on the waiver extension. The first hearing took place on May 15, 2012, at 10:00 a.m. CT at the Bordeaux Branch Library, 4000 Clarksville Pike in Nashville. The second public hearing took place on May 22, 2012, at 2:30 p.m. CT at the Ellington Agricultural Center, 440 Hogan Road in Nashville. The times, dates, and locations of both public hearings were included in the State's public notice and abbreviated public notice. Telephonic access to the May 22, 2012, hearing was available for individuals unable to attend the hearing in person. The State's public notices encouraged persons with disabilities needing special accommodations in order to participate in the hearings to contact the Bureau to ensure that appropriate accommodations could be arranged.

Tennessee has no Federally-recognized Indian tribes, Indian health programs, or urban Indian health organizations with which to consult or from which to seek advice.

Table 8 summarizes the State's public notice and public input processes for this waiver extension request.

Table 8. Summary of Public Notice and Input Processes

Public Notice and Input Component	Date	Requirement
MCAC discussed waiver extension	April 11, 2012	42 CFR § 431.408(a)(2)(iii)
Information about waiver extension provided to stakeholders via conference call	April 24, 2012	42 CFR § 431.408(a)(2)(iii)
Abbreviated public notice sent to newspapers for publication	May 4, 2012	42 CFR § 431.408(a)(2)(ii)
Public notice and comment period began Extension-specific Web site launched, including a comprehensive description of the waiver extension, the State's public notice and public input processes, and other required information	May 7, 2012	42 CFR § 431.408(a)(1) 42 CFR § 431.408(a)(2)(i)

Public Notice and Input Component	Date	Requirement
Abbreviated public notice appeared in the State's *Administrative Register*	May 7, 2012	42 CFR § 431.408(a)(2)(ii)
TennCare Facebook friends and Twitter followers notified of waiver extension	May 8, 2012	42 CFR § 431.408(a)(2)(iii)
Information about waiver extension provided to stakeholders at meeting of state advocacy organizations	May 8, 2012	42 CFR § 431.408(a)(2)(iii)
Information about waiver extension disseminated to stakeholders via e-mail list to state agencies and advocacy organizations	May 9, 2012	42 CFR § 431.408(a)(2)(iii)
Members of the Tennessee General Assembly notified of waiver extension	May 10, 2012	42 CFR § 431.408(a)(2)(iii)
First public hearing held	May 15, 2012	42 CFR § 431.408(a)(3)
Second public hearing held	May 22, 2012	42 CFR § 431.408(a)(3)
Public notice and comment period ends	June 7, 2012	42 CFR 431.408(a)(1)

Materials documenting the State's compliance with public notice and input requirements are available upon request.

2. Issues Raised by the Public During the Public Notice and Input Period

The Bureau's public notice and comment period began on May 7, 2012, and lasted through June 7, 2012. During this time, the draft extension request was available for public review and comment on an extension-specific Web page. The Bureau made arrangements and was prepared to receive public comments submitted through mail, e-mail, telephone, and at the two public hearings.

The Bureau received no comments from the public on the waiver extension through mail, e-mail, or telephone. No members of the public attended the first public hearing. One individual attended the second public hearing; however, he did not offer any comments on the waiver extension.

As noted elsewhere in this document, this request seeks to extend the existing TennCare program. We believe that the lack of comments from the public—despite the multiple opportunities to provide public input—reflects the public's familiarity with the TennCare program and the principles upon which the program is organized. The Bureau will work with CMS to consider public input received during the federal public notice process.

3. Post-Award Public Input Process

The Bureau of TennCare will comply with all post-award public input requirements. Within six months of the renewal of the TennCare demonstration (anticipated to begin on July 1, 2013), the Bureau will hold a public forum to solicit comments on the progress of the demonstration. After this first public forum, the Bureau will convene a similar forum at least annually throughout the extension period. The Bureau will publish the date, time, and location of each

public forum on its public Web site at least 30 days prior to the forum date. Summaries of the comments provided at the public forums will be included in the appropriate quarterly reports to CMS.

Part VIII: Affordable Care Act Transition Plan

1. Requirement for a Transition Plan.

Paragraph 45(e)(i) of the Special Terms and Conditions requires that the extension proposal include:

> [A] Transition Plan consistent with the provisions of the Affordable Care Act and CMS regulations for any individuals enrolled in Demonstration Eligible Groups (as defined in paragraph 17, Table 1a) who will be eligible for coverage under the State plan as of January 1, 2014, including under the new Medicaid eligibility group identified in Section 1902(a)(10)(A)(i)(VIII) of the Act, (called the Medicaid "VIII" group, for short) or who elect to move to an Exchange plan. Persons who are demonstration eligibles at the time of transition will continue to receive demonstration benefits as long as they are enrolled in a Medicaid category and they continue to meet the criteria for their particular demonstration program. The Transition Plan will include procedures for ensuring that these individuals transition to their new eligibility status without interruption in coverage to the maximum extent possible.

2. Demonstration Eligible Groups.

As discussed previously in this Extension Request, there are five "active" demonstration groups at the present time.

- Two of these groups are limited to children under age 19, who would not be included in the "VIII" group. Children under 6 can be eligible for Medicaid today with incomes below 133 percent of poverty, and children between the ages of 6 and 19 can be eligible with incomes below 100 percent of poverty. Therefore, the group affected by the Transition Plan would be demonstration children between the ages of 6 and 19 who have family incomes between 100 percent and 133 percent of poverty.

- Two of the active demonstration groups are LTSS-related groups. These are the 217-Like HCBS Group and the At-Risk Demonstration Group. The Medicaid final rule clarified that individuals seeking coverage based on the need for LTSS may be enrolled in an eligibility group where such services are provided, regardless of their eligibility for a MAGI-Medicaid group. For individuals already enrolled in a LTSS-related demonstration group, presumably there would be no need for them to ever be in a MAGI group.

- There is only one demonstration group left, and that is the SSD group. Some of these individuals likely have incomes that would qualify them for the "VIII" group. However, some of them have Medicare, which would disqualify them from the "VIII" group.

So, to summarize, the focus of the Transition Plan would be on the following individuals:

- Demonstration children between the ages of 6 and 19 who have family incomes between 100 percent and 133 percent of poverty
- Individuals in the SSD group who do not have Medicare and who have incomes below 133 percent of poverty

3. Transition Planning Process.

Given the Supreme Court decision that was announced yesterday, we need to evaluate our options with respect to inclusion of the expansion population in 2014.

We are continuing to monitor CMS guidance regarding eligibility after January 1, 2014. Should we decide to go forward with enrollment of this group, we will work with CMS to develop the specifics of a Transition Plan.