Managed Care in Tennessee

This profile reflects state managed care program information as of August 2014, and only includes information on active federal operating authorities, and as such, the program start date may not reflect the earliest date that a program enrolled beneficiaries and provided services. Some states report populations and services available to program participants under the federal authority (e.g. Section 1115 waiver), so these features cannot be easily distinguished for each program.

Overview of Current Managed Care Programs

In 2011, all Medicaid beneficiaries in Tennessee were enrolled managed care. Tennessee began its Medicaid managed care program, **TennCare,** in 1994. Its managed care program is statewide and mandatory for all coverage groups. The program has evolved over time to include or exclude ("carve out") various services from the managed care organization (MCO) contracts. In 1996, the state began offering behavioral health services to managed care enrollees through a prepaid limited benefit plan but began reintegrating behavioral health under the medical MCO contracts in 2007. Beginning in 2002, dental services for children enrolled in managed care were covered by a single, prepaid dental benefits manager and as of 2003, pharmacy benefits for all managed care enrollees were covered by a single, prepaid pharmacy benefits manager. Starting in 2010, the MCOs began to cover long-term services and supports for older adults and individuals with physical disabilities via the TennCare CHOICES program (services had previously been paid for on a fee-for-service basis by the state). With the inclusion of CHOICES, TennCare MCOs now cover medical, behavioral health, and long-term care services.

The state also operates TennCare Select, a Prepaid Inpatient Health Plan (PIHP), for children who are in foster care, receive Supplemental Security Income (SSI), or receive care in particular institutional settings. TennCare Select is also the statewide backup health plan designated to receive members if other plans have problems with capacity; the plan covers the same services available through an MCO (that is, medical, behavioral health, and long-term care services) but is reimbursed for some care on a fee-for-service basis. Since 2002, Tennessee also has operated a **Program of All-inclusive Care for the Elderly (PACE)** program, which provides all Medicaid and Medicare services to individuals over age 55 who require a nursing home level of care and live in Hamilton County.

In July 2013, CMS reapproved the demonstration authority used to operate TennCare. Under the renewed demonstration, beneficiaries will face small increases in cost sharing for prescription drugs.

Participating Plans, Plan Selection, and Rate Setting

Tennessee contracts with two **national, for-profit plans** (AmeriGroup Community Care and UnitedHealthcare Community Plan, which was formerly AmeriChoice) and **one local, for-profit plan** (Volunteer State Health Plan, also called BlueCare) for TennCare and TennCare CHOICES. One TennCare Plan (Volunteer State Health Plan) also participates in TennCare Select. In addition, Tennessee contracts with Magellan Health Services to manage pharmacy benefits and DentaQuest to manage dental benefits. Tennessee selects MCOs and prepaid limited benefit plans through competitive procurement. The state sets payments rates for MCOs based on competitive bids within rate ranges and pays prepaid limited benefit plans an administrative fee plus the cost of services provided on a fee-for-service basis.

Quality and Performance Incentives

TennCare requires MCOs to report HEDIS and CAHPS measures to the state, and also requires all contracting plans to receive NCQA accreditation. TennCare also offers incentives for quality care by paying plans $.03 per member month of enrollment for high performance and year-to-year improvement (the definition of which varies by contract year and measure set) on select HEDIS measures related to physical and behavioral. TennCare also withholds a portion of the annual capitation amount each month (10% for the first 6 months, and between 2.5 and 5% thereafter) and returns it to the contractor each month that it meets the state's performance expectations.

Table: Managed Care Program Features, as of August 2014

Program Name	**TennCare II***				**Program for the All-Inclusive Care for the Elderly (PACE)**
Program Type	MCO	PIHP	Pharmacy PAHP	Dental PAHP	PACE
Program Start Date	July 2002*				November 2002
Statutory Authorities	1115(a)				PACE
Geographic Reach of Program	Statewide				Select Region
Populations Enrolled *(Exceptions may apply for certain individuals in each group)*					
Aged	X		X		X
Disabled Children & Adults	X	X (at NF level of care)	X	X (age <21 only)	X (age 55+)
Children	X	X	X	X	
Low-Income Adults	X		X		
Medicare-Medicaid Eligibles ("duals")	X (full benefit duals only)	X (full benefit duals only)	X (full benefit duals age <21 only)	X (full benefit duals age <21 only)	X (age 55+)
Foster Care Children	X	X	X		
American Indians/Alaska Natives					
Mandatory or Voluntary enrollment?	Mandatory	Mandatory	Mandatory	Mandatory	Voluntary
Medicaid Services Covered in Capitation *(Specialized services other than those listed may be covered. Services not marked with an X are excluded or "carved out" of the benefit package.)*					
Inpatient hospital	X	X			X
Primary Care and Outpatient services	X	X			X
Pharmacy			X		X
Institutional LTC	X	X			X
Personal Care/ HCBS	X	X			X
Inpatient Behavioral Health Services	X	X			X
Outpatient Behavioral Health Services	X	X			X
Dental				X	X
Transportation	X	X			X

Program Name	TennCare II*				Program for the All-Inclusive Care for the Elderly (PACE)
Participating Plans or Organizations	1. AmeriChoice 2. AmeriGroup Community Care 3. Volunteer State Health Plan (Bluecare)	1. Volunteer State Health Plan (TennCare Select)	1. SXC Health Solutions Corporation	1. DentaQuest	1. Alexian Brothers Community Services
Uses HEDIS Measures or Similar	X				NA
Uses CAHPS Measures or Similar	X				NA
State requires MCOs to submit HEDIS or CAHPS data to NCQA	X	NA	NA	NA	NA
State Requires MCO Accreditation	X	NA	NA	NA	NA
External Quality Review Organization	Q-Source				
State Publicly Releases Quality Reports	Yes				

Sources: Centers for Medicare and Medicaid Services (CMS),National Summary of State Medicaid Managed Care Programs as of July 1, 2011.

Kaiser Commission on Medicaid and the Uninsured. Profile of Medicaid Managed Care Programs in 2010. September 2011.

National Committee on Quality Assurance. NCQA Medicaid Managed Care Toolkit 2012 Health Plan Accreditation Standards. State Use of Accreditation as of February 2012.

Notes: Managed Care Organization (MCO); Prepaid Inpatient Health Plans (PIHP); Prepaid Ambulatory Health Plan (PAHP); Mental Health/Substance Use Disorder (MH/SUD); Healthcare Effectiveness Data and Information Set (HEDIS); Consumer Assessment of Healthcare Providers and Systems (CAHPS).

Primary care and Outpatient services include physician services, hospice, laboratory, imaging, FQHC, and other specialty services delivered in outpatient offices and clinics. Institutional Long Term Care (LTC) includes Skilled Nursing Facilities (SNF) and/or Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IDD).

External Quality Review Organization activities are only required for MCOs, PIHPs, PAHPs, and other applicable entities with comprehensive risk contracts.

* The initial TennCare 1115 waiver began in 1994 and ended in 2002. The 1115 waiver under which TennCare now operates is called "TennCare II." The TennCare II waiver began in 2002 and has been extended several times. In 2013, another extension was approved through 2016.