



TennCare Oversight Committee Presentation

Darin Gordon, Deputy Commissioner

Dr. Wendy Long, Chief Medical Officer

Patti Killingsworth, Chief of Long-Term Care

August 24, 2010



1

- **Federal Updates**

3

- Program Updates

4

- Provider Networks

5

- EHR Incentive Program

6

- CHOICES Implementation



Amendments #10 and #11

- TennCare received approval from CMS on Amendment #10 June 30, 2010.
- The amendment allows Tennessee to create an uncompensated care pool for hospitals which is funded by a 3.52 percent fee on private hospitals' annual coverage assessment base.
 - Amendment #10:
 - Prevents the implementation of enrollee benefit limits and reductions in provider reimbursement rates that would have otherwise been required this year. These reductions were sent to CMS for approval as Amendment #9.
 - Provides funding to open enrollment in the standard spend down category for up to 7,000 adults who have sufficient un-reimbursed medical bills to offset their household income. Enrollment is expected to open later this fall.
 - Permits the creation of a smaller pool payment to help offset uncompensated care at the MED.
- Amendment #11 was sent to CMS for approval on July 21, 2010 and would allow Metro General to receive funds from the secondary pool for uncompensated care.



Notable Provisions of the Affordable Care Act Impacting Medicaid

- **Provisions that have already taken effect:**

- Medicaid agencies can not make eligibility standards, methodologies or procedures more restrictive than they were when the bill was signed into law.
- Effective Jan. 1, 2010, the way pharmacy rebates are shared with the federal government changed, increasing the federal government's share of the rebates.
- The temporary federally administered high-risk pool for people with pre-existing conditions began accepting applications July 1, 2010.

- **Provisions that will take effect before 2014:**

- Starting Sept. 23, 2010, all health care insurers – including Medicaid – are prohibited from charging co-pays for preventative care services and immunizations.
- Starting Oct. 1, 2010, all Medicaid agencies must cover smoking cessation services for pregnant women.
- Starting Jan. 1, 2013, Medicaid agencies must pay 100% Medicare for primary care physician services.
- The creation and development of a seamless interface with the newly-created Health Insurance Exchange, CHIP and TennCare programs to be implemented on Jan. 1, 2014.

- **Provisions that will take effect Jan. 1, 2014:**

- Significant changes to the eligibility and enrollment systems.
- Anyone with a household income below 138% poverty (133% plus a 5% income disregard) will qualify for Medicaid coverage.
- Medicaid agencies are required to cover benzodiazepines, barbiturates, and tobacco cessation products for all enrollees.
- Medicaid agencies must cover foster children up to age 26 who have aged out of the system.



Federal Funding Update

ARRA and FMAP Recap

- The Recovery Act (ARRA) increased states' FMAP (Federal Medical Assistance Payment) percentage to financially assist states through the recession.
- Tennessee's FMAP rate went from 65 percent to 75 percent.
- ARRA defined the period in which the enhanced match rate would be in effect as Oct. 1, 2008 to Dec. 31, 2010.

Enhanced FMAP Extension

CPE FMAP Agreement

- Congress passed and the President signed into law, a six-month enhanced match rate extension (to June 30, 2011). States will receive a phased down match rate during the six-month extension.
- In Tennessee, the rate will phase down from 75 percent to 72 percent over six months, resulting in approximately \$131 million less than the original \$341 million appropriated in the contingency budget.

- TennCare recently reached an agreement with CMS in regard to the CPE federal match rate during the ARRA enhanced match rate period.
- TennCare began discussions with CMS about the issue more than a year ago.
- CMS has agreed to pay TennCare the enhanced match rate for all CPE payments made during ARRA enhanced match rate period.
- It is estimated this will bring in approximately \$75 million federal dollars in retro-active collections.

Enhanced FMAP Extension	
Funded Contingency Appropriations	
Community College Special Capital Outlay Appropriation	\$ 84,000,000
High Priority Technology Centers Capital Outlay	36,000,000
West Tennessee Mega-Site	9,600,000
Grants to Critical Access Hospitals	10,000,000
Small-Business Job Opportunities	10,000,000
Driver License Issuance System	30,000,000
Highway Patrol Communication System	30,200,000
Total - Funded Contingency Appropriations	\$ 209,800,000



1

- Federal Updates

3

- **Program Updates**

4

- Provider Networks

5

- EHR Incentive Program

6

- CHOICES Implementation

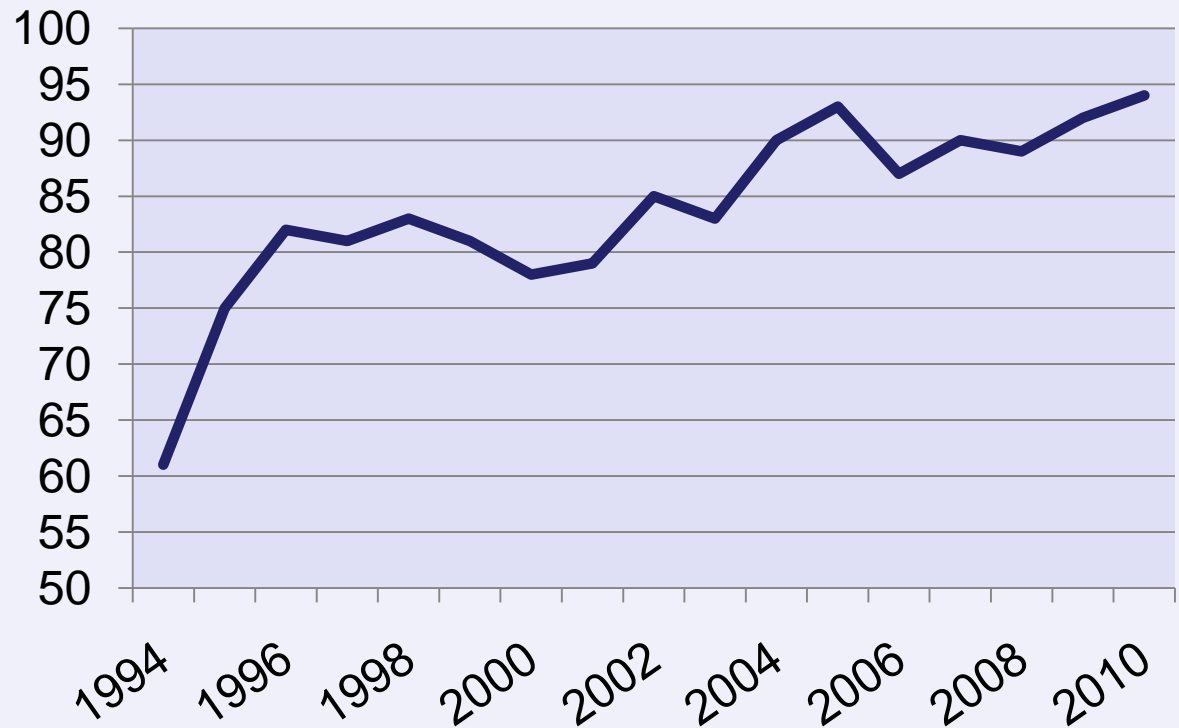


TennCare Continues to Receive High Marks in Enrollee Satisfaction

UT Annual Enrollee Satisfaction Poll Results show:

- 94 percent of TennCare enrollees are satisfied with the program – a 2 point increase over last year and a 33-point increase from the first year.
- Survey participants have continued to see physicians more often and visit emergency rooms less for routine care.

Percent of Enrollees who are Satisfied with their TennCare Coverage





Additional Program Updates

- The *Daniels* backlog re-verification process is complete.
 - 72 percent of those in the class retained health coverage through either TennCare or Medicare.
 - Now all TennCare enrollees losing SSI go through the same re-verification process as all other Medicaid eligible enrollees to ensure only those eligible for the program receive benefits.
- Delta Dental was selected via a competitive bid process to serve as TennCare's DBM.
 - This is a 3-year contract with options to renew two more years.
 - TennCare's DBM is responsible for administering dental benefits to more than 730,000 children.
 - Delta begins duties as DBM October 1, 2010.
- Q-Source will continue to serve as TennCare's external quality review organization (EQRO).
 - This is a 3-year contract with two one-year options to renew.
 - Q-Source was one of two organizations that responded to TennCare's request for proposal.
 - EQROs evaluate the quality, timeliness and access to care provided to enrollees through TennCare's MCOs.



1

- Federal Updates

3

- Program Updates

4

- **Provider Networks**

5

- EHR Incentive Program

6

- CHOICES Implementation



Provider Network Adequacy

Provider Network Distance Standards

	MCO – Primary Care	MCO – Hospital	MCO – Specialists	MCO – Behavioral Health	DBM	PBM*
Urban	20 miles or 30 minutes	30 minutes	60 miles for 75% of non-dual enrollees	Varies by service type	30 minutes	90% live within two miles of a retail pharmacy
Rural	30 miles or 30 minutes	Community standard	90 miles for all non-dual enrollees	Varies by service type	Community standard	70% live within 15 miles of a retail pharmacy

*90% must live within five miles of a retail pharmacy in suburban areas.

Provider Network Appointment Time Standards

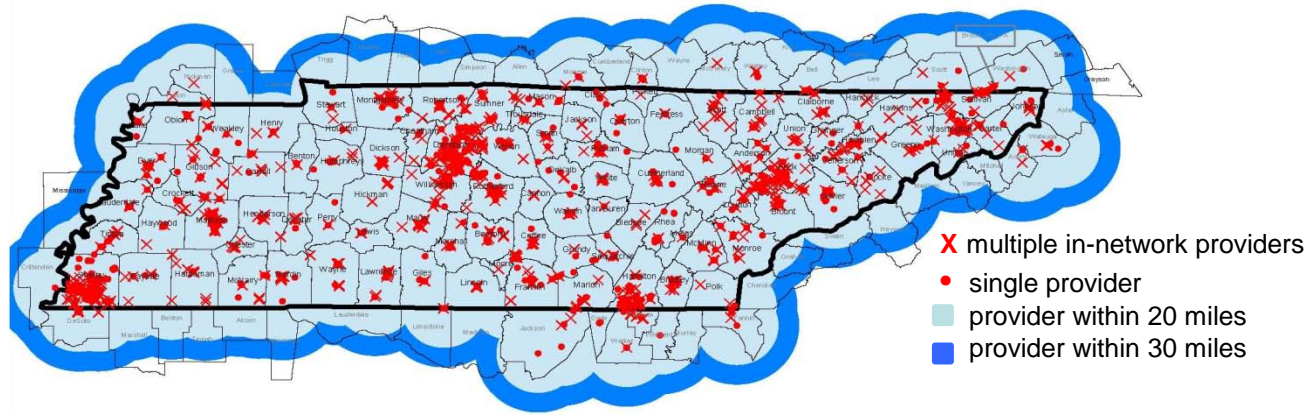
	Primary Care	Dental	Optometry	Lab and X-ray	Specialist
Routine Care	3 weeks	3 weeks	3 weeks	3 weeks	30 days
Urgent Care	48 hours	48 hours	48 hours	48 hours	48 hours



Provider Network Monitoring

- MCOs, DBM, and PBM submit monthly provider files.
- Bureau uses GeoAccess software to assess compliance with distance standards.

Sample GeoAccess Provider Map



- Bureau assess compliance with provider to enrollee ratios for primary and specialty care.
- A quarterly telephone survey of a subset of MCC providers is conducted to assess accuracy of monthly provider files and confirm compliance with appointment time standards.



1

- Federal Updates

3

- Program Updates

4

- Provider Networks

5

- **EHR Incentive Program**

6

- CHOICES Implementation



EHR Adoption Provider Incentive Program

- Created by the HITECH Act (Health Information Technology for Economic and Clinical Health).
- Financial incentives available through Medicare and Medicaid/TennCare to encourage the adoption and “meaningful use” of electronic health records (EHRs).
- Payments to providers are 100% federal funds.
 - Administration of program is funded at 90:10 match rate.
- Hospitals and “eligible professionals” may receive payments through Medicare and/or Medicaid/TennCare.
- **Medicare** incentive program will run from 2011-2016.
 - 2014 is the last year for a professional to enter the program.
 - 2015 is the last year for a hospital to enter the program.
- **TennCare** incentive program will run from 2011-2021.
 - 2016 is the last year to enter the program.
- Medicare fee schedule adjustments begin in 2015 for providers who are not “meaningful users”.



EHR Adoption Provider Incentive Program

- Hospitals

- May receive payments from both Medicare **and** TennCare (except Children's Hospitals are only eligible for TennCare payment).
- Under both Medicare and Medicaid/TennCare, payments are derived from a base payment of \$2 million which is adjusted for total discharges and the applicable Medicare or Medicaid/TennCare share of case mix.
- To be eligible for TennCare incentive, hospitals (except for Children's hospitals) must have at least 10% TennCare patient volume.

- Eligible Professionals (EPs)

- Must choose to receive payments from either Medicare **or** TennCare.
- Can receive \$44,000 over 5 years from Medicare or \$63,750 over 6 years from TennCare.

TennCare EP Payment Schedule

Year	1	2	3	4	5	6	Beyond	Total
Payment	\$21,250	\$8,850	\$8,850	\$8,850	\$8,850	\$8,850	\$0	\$63,750



EHR Adoption Provider Incentive Program

To qualify for TennCare EP payments providers must:

- Have 30% TennCare patient volume (20% for pediatricians; 30% needy individuals for FQHCs/RHCs); AND
- Not be hospital-based; AND
- Have provider type = physician, dentist, nurse practitioner, certified nurse midwife or PA in “PA led” FQHC/RHC; AND
- Adopt, implement or upgrade “certified” EHR technology (year one); OR
- Meet “meaningful use” criteria (years 2-6):
 - Stage 1 – Rules have been promulgated
 - Capture data electronically in a structured format
 - Implement decision support tools
 - Engage patients in their care
 - Public Health and Quality Reporting
 - Stages 2 and 3 – Rules to be promulgated at a later date
 - Enhanced focus on health information exchange (HIE)
 - Demonstrated improvements in quality of care and patient access



1

- Federal Updates

3

- Program Updates

4

- Provider Networks

5

- EHR Incentive Program

6

- **CHOICES Implementation**



CHOICES Recap

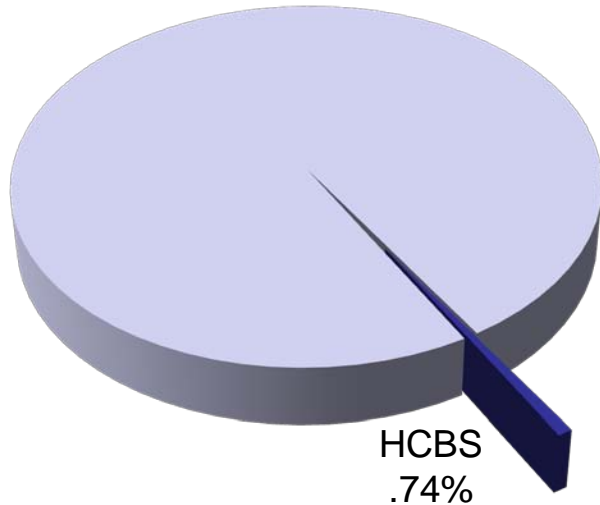


- TennCare Choices in Long-Term Care (LTC)
 - Implements key provisions of the Long-Term Care Community Choices Act of 2008.
 - Integrates TennCare nursing facility (NF) services and Home and Community Based Services (HCBS) for the elderly and adults with physical disabilities into the existing managed care system.
- Program Objectives:
 - 1) Decrease fragmentation and improve coordination of care.
 - 2) Increase options and choices for those who need LTC.
 - 3) Expand access to HCBS so that more Tennesseans who need LTC can receive care in their homes and communities.
 - 4) Rebalance LTC funding allowing the state to serve more people using existing LTC funds.



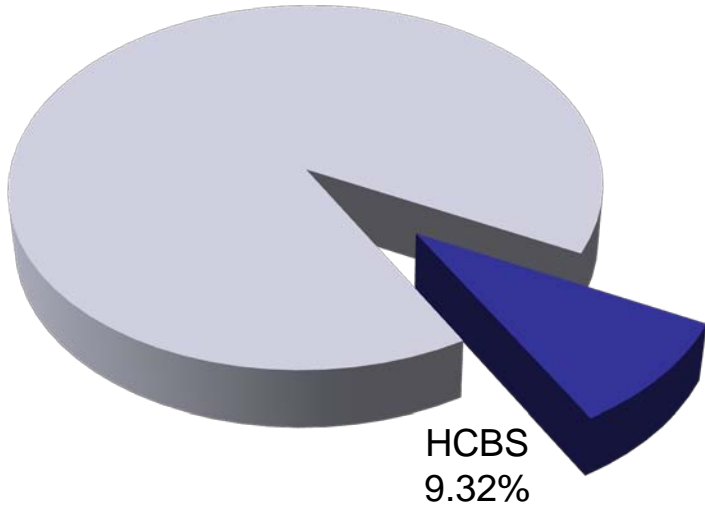
Progress in Balancing TennCare LTC Funding

LTC Actual Expenditures FY 1999



FY 1999
< 1%
HCBS

LTC Actual Expenditures FY 2009



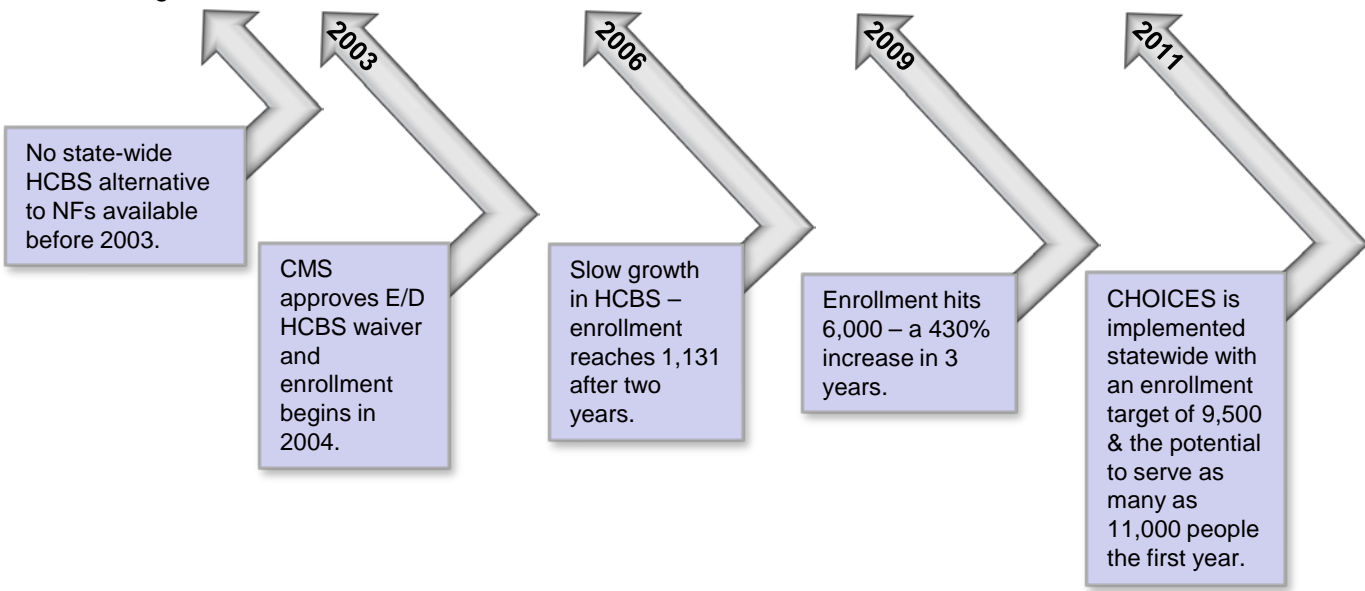
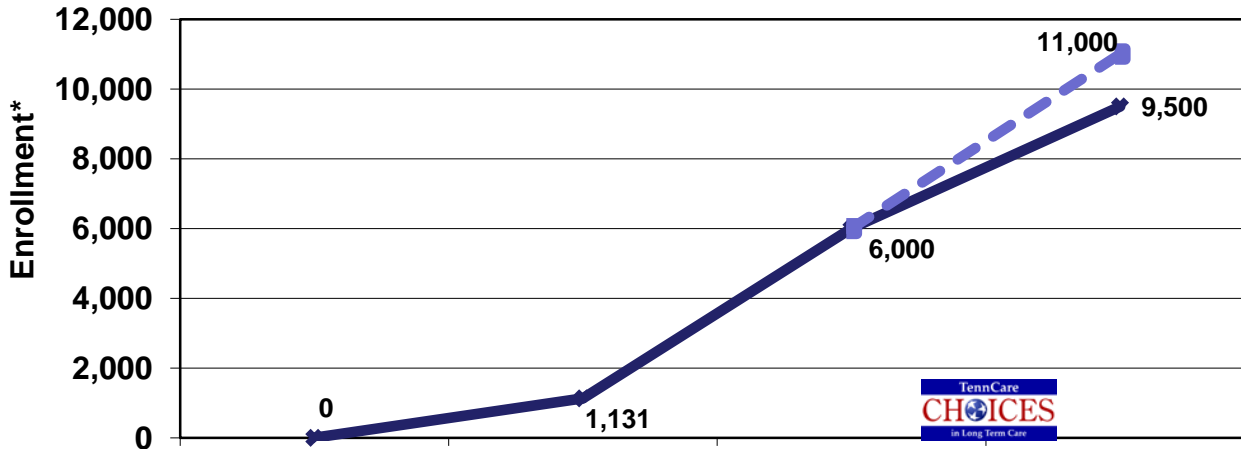
FY 2009
~ 10%
HCBS

- Progress:
 - Improved from offering almost no HCBS to the E/D population to HCBS comprising nearly 10 percent of LTC funding.
 - We were once dead last in the country in HCBS expenditures for the elderly and adults with disabilities, but are now trending rapidly in the right direction.
- Goal:
 - A more balanced long-term care system depending on the needs and preferences of the people receiving LTC services.



Progress in Balancing TennCare LTC Enrollment

HCBS Enrollment



- **Where are we?**
 - On March 1, the initial enrollment target for CHOICES was set at 7,500 for HCBS.
 - The HCBS enrollment target increased to 9,500 on July 1, 2010

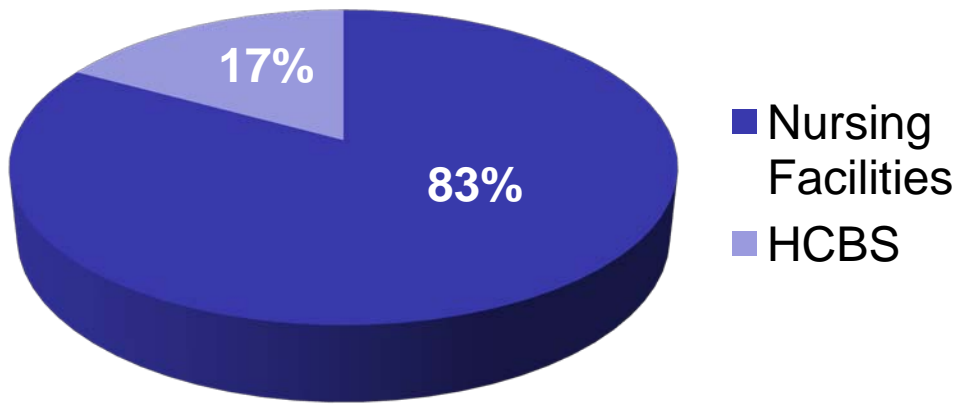
- **Where are we going?**
 - We have the potential to serve as many as 11,000 members now that program slots can be re-filled as soon as they become available, nearly doubling the number of people receiving HCBS in the first year of the CHOICES program.

* Does not include the PACE program which serves 325 people almost exclusively in HCBS, and other limited waiver programs no longer in operation.



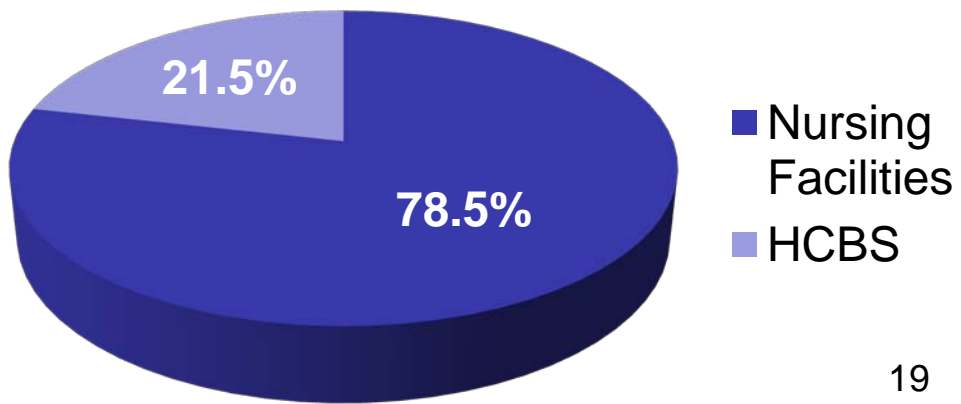
Progress in Re-Balancing Middle TN LTC Enrollment

CHOICES Enrollment at Implementation in Middle 3/1/2010



**3,306 total new members since go-live:
26% HCBS
74% NF**

CHOICES Enrollment in Middle 8/19/2010



61 transitions from NFs to the home and community



Electronic Visit Verification System

- Required component of the CHOICES Program.
- Services are scheduled and authorized in accordance with member's needs.
- Schedules (and authorizations) may be adjusted based on the member's needs.
- Provider staff/Consumer Directed workers log in/log out by phone at each visit.
- Twofold purpose:

1. Financial Accountability

- Only services actually delivered can be reimbursed.
- Facilitates timely payment.

2. Quality Assurance

- Track the provisions of HCBS.
- Increased ability to detect and resolve gaps/delays in service delivery.



Implementing Consumer Direction in TennCare CHOICES

- “Prior Authorization” model
 - MCO authorizes a fixed amount of services based on need
 - Any member assessed to need one or more of the services available through Consumer Direction can elect to participate
- TennCare contracts with single statewide Fiscal Employer Agent
- Member may use a representative to assist with Consumer Direction
- Member/representative, using a fiscal/employer agent, is the employer of record for qualified workers and must sign a Service Agreement with each
- Consumer Directed (and all CHOICES) services support, but do not supplant existing natural supports

Consumer Direction Continuum

<p>Member selects and supervises unskilled workers employed by a provider agency</p>	<p>Member hires, fires and supervises unskilled workers; utilize Fiscal Intermediary (no cash payments to member)</p>	<p>Member negotiates unskilled workers' reimbursement rate; lower rate = ability to purchase additional services</p>	<p>Member manages individual acuity-based budget</p> <ul style="list-style-type: none"> • Selects HCBS covered services • Flexibility to adjust services within capitated budget • Minimal “flex funding” (e.g., \$500/yr) for non-covered needs if budget exceeds expenditures by specified percentage
--	---	--	--

Some Consumer Control → More Consumer Control → The Most Consumer Control