



# BRIEFING

GOVERNOR'S COMMUNICATIONS OFFICE

## Medical Necessity

Tennessee's former medical necessity definition essentially requires that TennCare pays for anything ordered by a physician, regardless of cost, effectiveness, or practical clinical value. The former definition leaves the TennCare program little control over the cost and appropriateness of services provided to enrollees.

The new medical necessity definition ensures enrollees receive appropriate, needed medical care and allows the State to become a deliberate purchaser of services, not just an open checkbook.

To be deemed medically necessary, a product or service must be within the scope of defined benefits for which an enrollee is eligible, must be recommended by a physician or health care professional and must meet all of the following four criteria:

1. It must be required to diagnose or treat an enrollee's medical condition, **AND**
2. It must be safe and effective, **AND**
3. It must be the least costly alternative course of diagnosis or treatment that is adequate for the medical condition of the enrollee, **AND**
4. It must not be experimental or investigational.

The state currently is drafting rules and regulations to expand and clarify the medical necessity definition, to assure that TennCare continues to cover appropriate preventive and screening procedures such as:

- Prostate cancer screening
- Pap smears
- Mammograms
- EPSDT-related services

The new medical necessity definition will be applied to:

- Guarantee that cost considerations will not override a patient's medical needs because all TennCare services must be "safe and effective" and "adequate for the medical condition of the enrollee"
- Require appropriate screening and preventative care, such as vaccinations, prostate cancer screening, pap smears, and mammograms
- Cover services mandated under EPSDT requirements
- Allow for off-label use of prescriptions when it is "widespread" and "generally accepted"

The new definition means the state will no longer be required to cover items such as cosmetic dentistry, ear or body piercing, equine therapy, garter belts, pedicures, tattoo removal - all of which have been ordered and paid for in the past.



# BRIEFING

GOVERNOR'S COMMUNICATIONS OFFICE

## Definition of Disability

**The new definition of disability goes above the federal social security disability definition.** Individuals who are determined to be disabled will be excluded from benefit limits. The definition that will be used to determine who is disabled is the same definition used by the Social Security Administration to determine disability for SSI and SSDI, and by the State to determine disability for Medicaid. This definition states that an individual is disabled if the person's physical or mental impairment is expected to last 12 months or result in death. As a result, these individuals are unable to work. This includes:

- Persons who receive SSI
- Persons who are Medicaid eligible that receive SSDI
- Persons eligible for Medically Needy Spenddown as Aged, Blind, or Disabled

In addition to the Social Security definition, the state has included the following categories in its definition of disabled:

- Persons who are receiving Medicaid Institutional Services
- Persons who are receiving Home and Community Based Waiver Services



# BRIEFING

GOVERNOR'S COMMUNICATIONS OFFICE

## Copay Safety Net and TennCare Foundation

The initial reform proposal called for the creation of a network of Safety Net hospitals that would be located throughout the state to provide services to those in need, but who could not meet their co-pay obligations.

The initial reform proposal also called for the creation of the TennCare Foundation, a designated pool of funds - subject to budget availability - that could be used to:

- Provide funding for services that are covered by TennCare but were beyond an enrollee's benefit limits or
- Fund services that are not included in the TennCare benefit package but needed by an Enrollee

In attempting to operate these two entities, it became clear to the state that the safety net and Foundation would create high administrative costs and significant operational challenges, particularly if federal dollars were not available. The State determined it would be more beneficial to adjust the core design of the program to meet many of the same needs that these two entities were designed to provide through investing safety net dollars in services for which federal match is available for these and other needy populations. Some of these changes include:

- No limits will be applied to inpatient, outpatient, physician, or emergency visits related to behavioral health services
- Copays will not be charged to 79% of the enrollees, including all core Medicaid enrollees
- A shortlist will be created which outlines services that will not count toward benefit limits
- An expanded definition of disability will exempt additional enrollees from limits, copays, and premiums

Additionally, the state is continuing to search for ways to effectively operate these safety nets, and maintains the possibility of implementing one or both of them in the future.



# BRIEFING

GOVERNOR'S COMMUNICATIONS OFFICE

## Coverage and Benefits

The benefits structure proposed in the waiver application includes a three tiered system that simplifies eligibility categories and the benefit limits, copays and premium obligations for each category.

This three-tiered structure allows the state to provide reasonable benefits to those most needy and makes it possible to extend coverage to as many people as possible. This includes coverage for those who do not qualify for Medicaid and those in optional Medicaid eligibility categories.

### TennCare Medicaid

**No benefit limits, No co-pays, No premiums applied.**

### TennCare Standard

Benefit limits and co-payments apply to some of the TennCare population based on income level, but do not apply to children in this category.

Description	Limits	Copays	Premiums
<b>TennCare Medicaid</b> <ul style="list-style-type: none"> <li>• Families and children on public assistance</li> <li>• Pregnant women and children below certain income levels</li> <li>• Disabled people receiving SSI</li> <li>• Low-income people receiving care in institutional setting</li> </ul>	No Limits	No Copays	No Premiums
<b>TennCare Standard A</b> <ul style="list-style-type: none"> <li>• Children*, pregnant women, and disabled not mentioned above</li> </ul>	No Limits	Tiered by income *	Only if above poverty *
<b>TennCare Standard B</b> <ul style="list-style-type: none"> <li>• All remaining enrollees</li> </ul>	As outlined in waiver	Tiered by income	Only if above poverty

*\* Children in TennCare are exempt from benefit limits, co-pays and premiums.*

### Total Enrollment by Eligibility Category

TennCare Medicaid: 900,000  
 TennCare Standard: 435,000



# BRIEFING

GOVERNOR'S COMMUNICATIONS OFFICE

## Co-payments and Premiums

The proposed waiver application reflects the belief that some enrollees should share appropriately in the cost of their health care coverage through co-payments and/or premiums. Approximately 7.5 percent of TennCare enrollees currently pay premiums and co-payments. Under the proposed waiver, 21 percent of the TennCare population will be required to make copays, meaning 79 percent will be exempt from copays.

## Co-pays

TennCare Medicaid enrollees will continue to be exempt from premium and copay responsibilities. The optional Medicaid enrollees will be moved to the TennCare Standard population and will no longer be exempt from premiums or copays. Rather than having copays just for those with incomes at or above poverty, the draft waiver proposes copays for all adult TennCare Standard enrollees according to a sliding scale based on income.

Service	Below 50% of poverty level	50 - 99 % of poverty level	100 - 299% of poverty level	300% or poverty level or higher
Inpatient hospital (per admission)	\$30	\$50	\$100	\$250
Outpatient services (per visit)				
--Non specialist	\$1	\$10	\$20	\$30
--Specialist/OP hospital service	\$3	\$15	\$25	\$40
--ER visit that does not lead to admission	\$10	\$20	\$40	\$60
Pharmacy				
--A-drugs*	\$1	\$3	\$5	\$10
--B-drugs*	\$2	\$7	\$10	\$20
--C-drugs*	\$3	\$10	\$15	\$40
Other (per visit)				
--Speech therapy/PT/OT outside of a home health visit	\$1	\$10	\$15	\$20

In non-emergency situations, providers will be allowed to deny service to individuals who cannot or will not meet their co-pay requirements. This includes co-payments for pharmacy for the TennCare Standard population (TennCare Medicaid will not have pharmacy co-payments).



# BRIEFING

GOVERNOR'S COMMUNICATIONS OFFICE

## Premiums

Despite health care inflation in recent years, TennCare premiums have remained at the same level since 2000. The waiver proposal seeks to reset the premiums to be more consistent with the rate of medical inflation.

To apply the medical inflation rate for the period from 2000-2004 would mean an increase of 24 percent<sup>1</sup> in premiums. However, we are proposing a more modest increase of about 20 percent (see Table below.) Premiums will be adjusted annually in future years according to the rate of medical inflation.

Premiums will apply to adults in TennCare Standard with incomes at or above poverty level (TennCare Medicaid enrollees will not pay premiums).

Income Levels	Medicaid	TennCare Standard Individual	TennCare Standard Family*
Below 100% poverty	None	None	None
100%-149% poverty	None	\$24	\$48
150%-199% poverty	None	\$42	\$84
200%-249% poverty	None	\$120	\$300

---

<sup>1</sup> Since the 2004 calendar year is not yet complete, the 2004 figures are based on the compounded annual growth rate (CAGR) from 2000-2003.



# BRIEFING

GOVERNOR'S COMMUNICATIONS OFFICE

## Pharmacy

Pharmacy is the largest single cost category in the TennCare program and is growing faster than any other segment in the TennCare budget. In the next four years, pharmacy costs are expected to increase by nearly 60 percent if changes are not made. Pharmacy costs must be contained through pharmacy benefit limits and the use of lower cost, equally effective drugs.

The state seeks to reduce pharmacy costs while maintaining or improving quality by:

- Implementing a 6 prescriptions per month per enrollee limit (does not apply to pregnant women, children or the disabled)
- Establishing a multi-tier pharmacy program. The first tier includes preferred drugs that require no prior authorization. These will typically be generic drugs, but may include brand names as well. The second tier includes generic and brand name drugs that will require prior authorization. All other drugs that fall outside these two tiers will covered only in rare and unique situations.

Except for children under age 21, two classes of drugs which have effective over-the-counter alternatives will no longer be covered:

- Sedating and non-sedating antihistamines
- Gastric acid reducers

TennCare will also implement a new prospective and retrospective drug utilization programs to reduce the overuse and potential misuse of drugs such as narcotics and anti-psychotics.



# BRIEFING

GOVERNOR'S COMMUNICATIONS OFFICE

## Improving Ongoing Bureau Operations

We are looking at all aspects of TennCare to improve performance, this includes improving management, giving better service to enrollees and providers, and maintaining a stable and sustainable program.

## Advisory Commission

The Governor will appoint 12-15 individuals from health care, business leaders, providers, and consumers to the TennCare Advisory Commission.

The Advisory Commission's charge will be to track the program's performance over time and recommend adjustments as needed to reflect changes in the health care system and the financial situation of the state. The commission will review the eligibility criteria, enrollment trends, benefits package and other components and make annual recommendations based on the following principles:

- Additional funding should first go to expanding enrollment
- If reductions are needed, services should be reduced before enrollment is cut
- Protect vulnerable populations until all other options are exhausted

## MCOs and risk

Tennessee would prefer to transition TennCare MCOs to full or partial risk arrangements. In the short-term, however, the state will continue to assume risk and will work towards returning to risk sharing arrangements over time.

The state is considering structural reforms within the MCO system to improve the stability and efficiency of the MCOs, and ensure that high quality care is provided to all TennCare enrollees. Such potential reforms include:

- Standardized reporting
- Requiring all participating MCOs to adhere to standardized performance measures such as mandatory accreditation by the National Commission for Quality Assurance (NCQA).
- Increasing its enforcement of all financial and quality regulations for our MCOs.



# BRIEFING

GOVERNOR'S COMMUNICATIONS OFFICE

## Improving Ongoing Bureau Operations (cont.)

### Fraud and TPL

- Greater enforcement to eliminate fraud and abuse through the Office of TennCare Inspector General (created July 1)
- More aggressive pursuit of third-party liability (TPL) when other insurance coverage should pay instead of TennCare

### In addition to these TennCare will

- Enhance information technology with linkages across health care entities and state agencies in Tennessee
- Place greater focus on managing vendor partners to improve efficiency and align incentives
- Improve care management to improve quality of care for targeted disease conditions