



NEWS RELEASE

GOVERNOR'S COMMUNICATIONS OFFICE

FOR IMMEDIATE RELEASE
JUNE 9, 2005

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STATE RECEIVES FEDERAL APPROVAL FOR PHASE TWO OF TENNCARE CHANGES

CLEARs MAJOR HURDLE TO LIMIT DISENROLLMENT

Nashville -The State of Tennessee today received approval from the federal government for the second phase of requested changes to the TennCare program. The approval clears a major hurdle blocking implementation of an agreement between the state of Tennessee and some TennCare enrollee attorneys and stakeholders that would limit TennCare disenrollment.

"Today's approval is another significant step forward in our efforts to regain control of TennCare spending while trying to preserve healthcare coverage for as many Tennesseans as possible," said Governor Phil Bredesen. "We still have significant challenges ahead of us, but we are making progress and we will continue to do so."

In a letter to Finance and Administration Commissioner Dave Goetz, Dr. Mark McClellan, administrator of the Centers for Medicare and Medicaid Services (CMS) approved the state's request to implement a number of changes including:

- New pharmacy benefit limits for some adults,
- Elimination of coverage of certain optional Medicaid services and products for adults, and
- Nominal co-pays for some TennCare enrollees.

The State of Tennessee requested modifications to the state's TennCare waiver in order to control the explosive and unchecked growth of the TennCare program. The modifications have been approved in phases due to the timing of federal court hearings on TennCare, among other factors.

On March 24, 2005, CMS approved the first phase of the state's TennCare changes which included the elimination of coverage for certain optional adult Medicaid eligibility categories and the procedures to be used to disenroll individuals from the program.

The third phase of changes sought by the state requests additional benefit and program modifications in order to further control TennCare spending. These changes are still pending before CMS.

On April 26, 2005, Governor Bredesen announced a tentative agreement with some TennCare enrollee attorneys and stakeholders that would preserve health coverage for the sickest and neediest who generally don't qualify for Medicaid – contingent upon legal relief from the Grier Consent Decree. The Medically Needy eligibility category currently serves 97,000 adult TennCare enrollees.

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Administrator
Washington, DC 20201

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Mr. M. D. Goetz, Jr.
Commissioner of Finance and Administration
Tennessee Department of Finance and Administration
1st Floor
State Capitol
Nashville, TN 37243

Dear Mr. Goetz:

The purpose of this letter is to respond to your requests for several amendments to the TennCare section 1115 Demonstration Project that were submitted on September 24, 2004 and February 18, 2005. Your requests for additional amendments related to pharmacy and non-pharmacy benefit limits as referenced in this letter and the accompanying Special Terms and Conditions (STCs) have been approved through June 30, 2007. These approvals supplement our March 24, 2005, letter approving certain amendments related to eligibility and enrollment to the TennCare Demonstration project (No. 11-W-00151/4). Approval of the project modifications is granted under the authority of section 1115 of the Social Security Act (the Act). Except as otherwise noted, any other change that you requested that is not reflected in this letter or the accompanying STCs is still under review and should not be considered approved.

Our approval of these demonstration amendments, the associated waivers, and Federal matching provided thereunder, is contingent upon compliance with the enclosed revised list of STCs and its attachments for the TennCare Demonstration project. This approval is also subject to our receipt of your written acceptance of the attached revised STCs within 30 calendar days from the date of this letter.

We are approving the State's request to amend the demonstration in order to make the following benefit changes:

- Eliminate pharmacy coverage for adults (age 21 and older) in expansion groups (TennCare Standard¹ enrollees), and adult, non-pregnant Medically Needy enrollees, except for the Medically Needy in nursing facilities (NFs), intermediate care facilities for the mentally retarded (ICFs/MR) and those who receive services under a Home and Community Based Services (HCBS) waiver;

¹ The TennCare Standard Program, also referred to as the demonstration population, consists of individuals who are not eligible for benefits under Title XIX of the Social Security Act or under Tennessee's Medicaid State Plan, but who receive services under the authority of the Federally approved TennCare Demonstration Project.

- Impose a monthly limit of five prescriptions, of which no more than two can be brand name drugs, for adults who are eligible to receive Medicaid under the State plan (TennCare Medicaid enrollees). This limit will not apply to TennCare Medicaid children (under age 21), TennCare Standard children, or TennCare Medicaid adults who reside in an NF or ICF/MR, or who receive services under a HCBS waiver. Brand name drugs that are not on the State's Preferred Drug List (PDL) will be subject to a prior authorization requirement. Also, the State has the authority to exempt certain drugs from the monthly limit;
- Eliminate coverage of over-the-counter (OTC) drugs for adults in both TennCare Medicaid and TennCare Standard, except prenatal vitamins for pregnant women. TennCare Medicaid and TennCare Standard children will have coverage for prescribed OTC drugs;
- Eliminate coverage of methadone clinic services for adults in both TennCare Medicaid and TennCare Standard;
- Eliminate coverage of dental services for adults in both TennCare Medicaid and TennCare Standard;
- Add the benefit of private duty nursing for TennCare Standard children, while implementing previously approved authority to eliminate private duty nursing for adults in TennCare Medicaid and TennCare Standard;
- Impose nominal co-payments of \$3.00 per brand name drug prescription or refill for adults in TennCare Medicaid and for TennCare Standard children in families with income at or above 100 percent of the Federal Poverty Level (FPL). There will be no cost-sharing for prescribed generic drugs. Exemptions from the co-payments will be allowed for individuals who are institutionalized, receiving services under a HCBS waiver, of child-bearing age and receiving family planning services, pregnant and receiving pregnancy-related services, receiving emergency services or receiving hospice services;
- Removal of the out-of-pocket (OOP) maximum presently applied to the TennCare Standard population, including children;
- Implement previously approved authority to limit substance abuse services for adults in TennCare Medicaid and TennCare Standard to a lifetime maximum of \$30,000, regardless of whether or not the adult has been designated as seriously and persistently mentally ill (SPMI); and
- Implement previously approved authority to not cover convalescent care and sitter services for all enrollees in TennCare Medicaid and TennCare Standard.

I. List of Sections Waived

Under the authority of section 1115(a)(1) of the Act, in addition to the waivers granted in the May 30, 2002, and March 24, 2005, approval letters, the following waivers are granted in order to enable Tennessee to carry out the TennCare demonstration, as amended, through the period ending June 30, 2007. These waivers are to statutory requirements governing the Medicaid State plan and permit Tennessee to operate its program in a manner that does not comply with these statutory requirements and that does not conform with the relevant provisions of its approved State plan for medical assistance.

Amount, Duration, and Scope

Section 1902(a)(10)(B)

To enable the State to modify the Medicaid benefit package to offer different pharmacy and non-pharmacy coverage and benefits to different segments of the Medicaid eligible population (including Categorically Needy and Medically Needy beneficiaries); and, if otherwise required by section 1902(a)(10)(B), with respect to certain pharmacy and non-pharmacy benefits, to provide benefits to some members of the TennCare Standard population that are not equal in amount, duration, and scope to benefits available to certain Medicaid eligible groups.

Comparability

Section 1902(a)(10)(C)

Section 1902(a)(17)

To enable the State to establish exceptions and exclusions of otherwise applicable pharmacy benefit limits and coverage restrictions for some members of Medicaid eligible groups while applying such limits to other members of those groups.

Pharmacy Benefit Restrictions

Section 1902(a)(54)

To enable the State to eliminate coverage of outpatient drugs from the benefit package provided to adult non-pregnant Medically Needy (other than those receiving services in an NF, in ICF/MR, or under a HCBS waiver), while providing such coverage to other Medicaid eligible individuals.

II. Costs Not Otherwise Matchable

Under the authority of section 1115(a)(2) of the Act, expenditures made by the State to provide services identified in the STCs to children under age 21 who are enrolled in the TennCare Standard program shall, for the period of the amended project, be regarded for purposes of receiving Federal financial participation, as expenditures under the State's title XIX plan. This authority is consistent with and/or in addition to the expenditure authority granted in the May 30, 2002, and March 24, 2005, approval letters and previously approved amendments to the TennCare Demonstration project. All requirements of the Medicaid statute will be applicable to

such expenditures, except those previously waived or specifically waived or otherwise addressed in this letter or in the accompanying STCs. In addition, all requirements in the enclosed STCs will apply to this expenditure authority.

III. Specific Rules Applicable to the TennCare Standard Demonstration Population

Because the TennCare Standard population is not covered under Tennessee's approved State plan for medical assistance or subject to the rules of the Medicaid statute and regulations, the requirements of the statute and regulations only apply to them by virtue of the approval documents including the STCs contained in those documents. In order to permit the demonstration project to function as amended, in addition to and/or consistent with previously approved waiver and expenditure authority, the following Medicaid requirements will not apply to the TennCare Standard demonstration population:

Amount, Duration, and Scope

Section 1902(a)(10)(B)

To enable the State to offer demonstration enrollees benefits that are not equal in amount, duration, and scope to benefits available to other TennCare enrollees and Medicaid recipients, and to provide a different amount, duration, and scope of benefits or coverage to some segments of the demonstration population than the State provides to other segments of that population.

Pharmacy Benefit Restrictions

Section 1902(a)(54)

To enable the State to eliminate coverage of outpatient drugs from the benefits package provided to adult members of the demonstration population, including both OTC and prescription medications.

IV. List of Previously Granted Waivers and Expenditure Authorities

In addition to the aforementioned waivers and expenditure authorities, CMS has approved the following waivers and expenditure authorities, as set forth in the May 30, 2002, and March 24, 2005, approval letters, applicable to the current TennCare demonstration. Although the State has been granted approval of these waivers and expenditure authorities, the State may have elected to postpone implementation of the program changes described.

Title XIX Waivers

Under the authority of section 1115(a)(1) of the Act, the following waivers of provisions of the Act are in effect to enable Tennessee to carry out the TennCare 1115 demonstration:

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| 7. | Payment for Drugs | Section 1902(a)(54) |
| | <p>To enable the State to permit managed care contractors to establish drug formularies based on cost, therapeutic equivalent, and clinical efficacy.</p> | |
| 8. | Indirect Payment | Section 1902(a)(32) |
| | <p>To enable the State to pay indirectly for covered benefits through a group health plan that meets requirements set by the State and approved by CMS.</p> | |
| 9. | Comparability of Eligibility | Section 1902(a)(17) |
| 10. | Simplicity of Administration | Section 1902(a)(19) |
| 11. | Description of Eligibility for Categories of Medically Needy | Section 1902(a)(10)(C) |
| 12. | Eligibility for all Individuals Described in State Plan | Section 1902(a)(8) |
| | <p>To enable the State to close enrollment for the Aged, Blind, Disabled, and Caretaker Relative Medically Needy categories only, as defined in the State plan, who are age 21 or older and not pregnant, until the completion of eligibility redetermination and termination of individuals currently enrolled in these Medically Needy categories prior to and upon the end of their current eligibility periods.</p> | |

Costs Not Otherwise Matchable

Under the authority of section 1115(a)(2) of the Act, expenditures by the State for the items identified below (which are not otherwise included as expenditures under section 1903), are regarded as expenditures under the State's title XIX Plan.

1. Expenditures for the following demonstration populations who would not be eligible under the approved State plan. These populations may be automatically disenrolled after a year in the absence of a reapplication and redetermination of eligibility:
 - Individuals who are uninsured and meet the State-defined criteria as “medically eligible;”
 - Individuals who are uninsured with family income at or below 200 percent of the FPL;
 - Children under age 19, with family income at or below 200 percent of the FPL, who were enrolled in the previous demonstration as of December 31, 2001, under the category of “uninsured who had access to insurance;”

- Individuals who have Medicare coverage but not Medicaid coverage, were enrolled in the previous demonstration as of December 31, 2001, and continue to meet the criteria for “Uninsurable” that were in place at that time (whose coverage under this demonstration will be limited to pharmacy benefits); and
 - Enrollees in the TennCare Assist program who would otherwise be eligible in one of the categories above (whose benefits under this demonstration will be limited to employee health insurance subsidy payments).
2. Expenditures under contracts that do not meet the requirements in section 1903(m) of the Act specified below. Specifically, Tennessee managed care plans will be required to meet all requirements of section 1903(m) except the following:
- Section 1903(m)(2)(A)(vi), 42 CFR 434.27, to the extent that the rules in section 1932(a)(4) incorporated therein are inconsistent with the enrollment and disenrollment rules under the demonstration such as restricting an enrollee’s right to disenroll within 90 days of enrollment in a new managed care organization (MCO). Enrollees may change MCOs once within the first year of enrollment, and annually thereafter, except that during initial transition enrollment, enrollees may be limited to one change during the first enrollment period which may be less than 12 months but no less than 6 months.
3. Expenditures for services to a TennCare enrollee residing in an institution for mental disease for the first 30 days of an inpatient episode, subject to an aggregate annual limit of 60 days and other limitations specified in the STCs. *This expenditure authority has been withdrawn, except to the extent it has been agreed upon and is outlined in the Attachment D.5.e. to the STCs, because CMS has determined that it would not promote the objectives of title XIX.*
4. Expenditures for the following demonstration populations which would not be eligible under the approved State plan:
- Individuals under age 19 who are uninsured and meet the State-defined criteria as “medically eligible;”
 - Individuals under age 19 who are uninsured with family incomes at or below 200 percent of the FPL;
 - Individuals under age 19, with family incomes at or below 200 percent of the FPL, who were enrolled in the previous demonstration as of December 31, 2001, under the category of “uninsured who had access to insurance;”
 - Individuals under age 19 and who have Medicare coverage but not Medicaid coverage, were enrolled in the previous demonstration as of December 31, 2001, and continue to meet the criteria for “Uninsurable” that were in place December 31, 2001;

- Pending their eligibility redetermination and disenrollment, individuals who are:
 - Eligible as Medically Needy Aged, Blind, Disabled, and Caretaker Relatives;
 - Age 19 and older who are uninsured and meet the State-defined criteria as “medically eligible;”
 - Age 19 and older who are uninsured with family incomes at or below 200 percent of the FPL; and
 - Age 19 and older who have Medicare coverage but not Medicaid coverage, were enrolled in the previous demonstration as of December 31, 2001, and continue to meet the criteria for “Uninsurable” that were in place at that time.

Exceptions to Medicaid Requirements for the Demonstration Population

The following provision will not be applicable to the demonstration population:

1. Continuous Enrollment Section 1902(a)(8)

To permit the State to redetermine eligibility and disenroll members of the demonstration population pursuant to the process described in Attachment E of the enclosed STCs.

The CMS is also requiring that the State develop procedures to assist in the transition of Medicare beneficiaries in the TennCare demonstration into the Medicare Part D Prescription Drug program, including tracking demonstration participants who are eligible for benefits under the program and excluding from the demonstration any payment for Medicare Part D prescription drugs. Federal Medicaid funds are not available as of January 1, 2006, for any drugs covered by the Medicare Prescription Drug program for individuals eligible for Part D or for any cost-sharing for such drugs.

Your project officer is Carolyn Milanowski. She is available to answer questions concerning this demonstration project. Ms. Milanowski’s contact information is as follows:

Centers for Medicare & Medicaid Services
Center for Medicaid and State Operations
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Baltimore, MD 21244-1850
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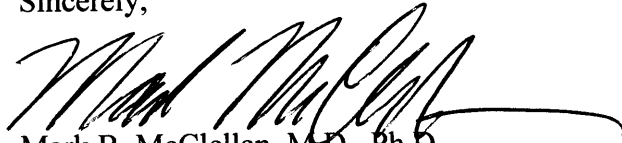
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Official communications regarding program matters should be submitted simultaneously to the project officer and to Mr. Renard Murray, Associate Regional Administrator in our Atlanta Regional Office. Mr. Murray's address is:

Centers for Medicare & Medicaid Services
Atlanta Federal Center, 4th Floor
61 Forsyth Street, 4T20
Atlanta, GA 30303-8909

If you have additional questions, please contact Ms. Jean Sheil, Director, Family and Children's Health Programs Group, Center for Medicaid and State Operations, at 410-786-5647.

Sincerely,



Mark B. McClellan, M.D., Ph.D.

Enclosures