OPEN MINDS

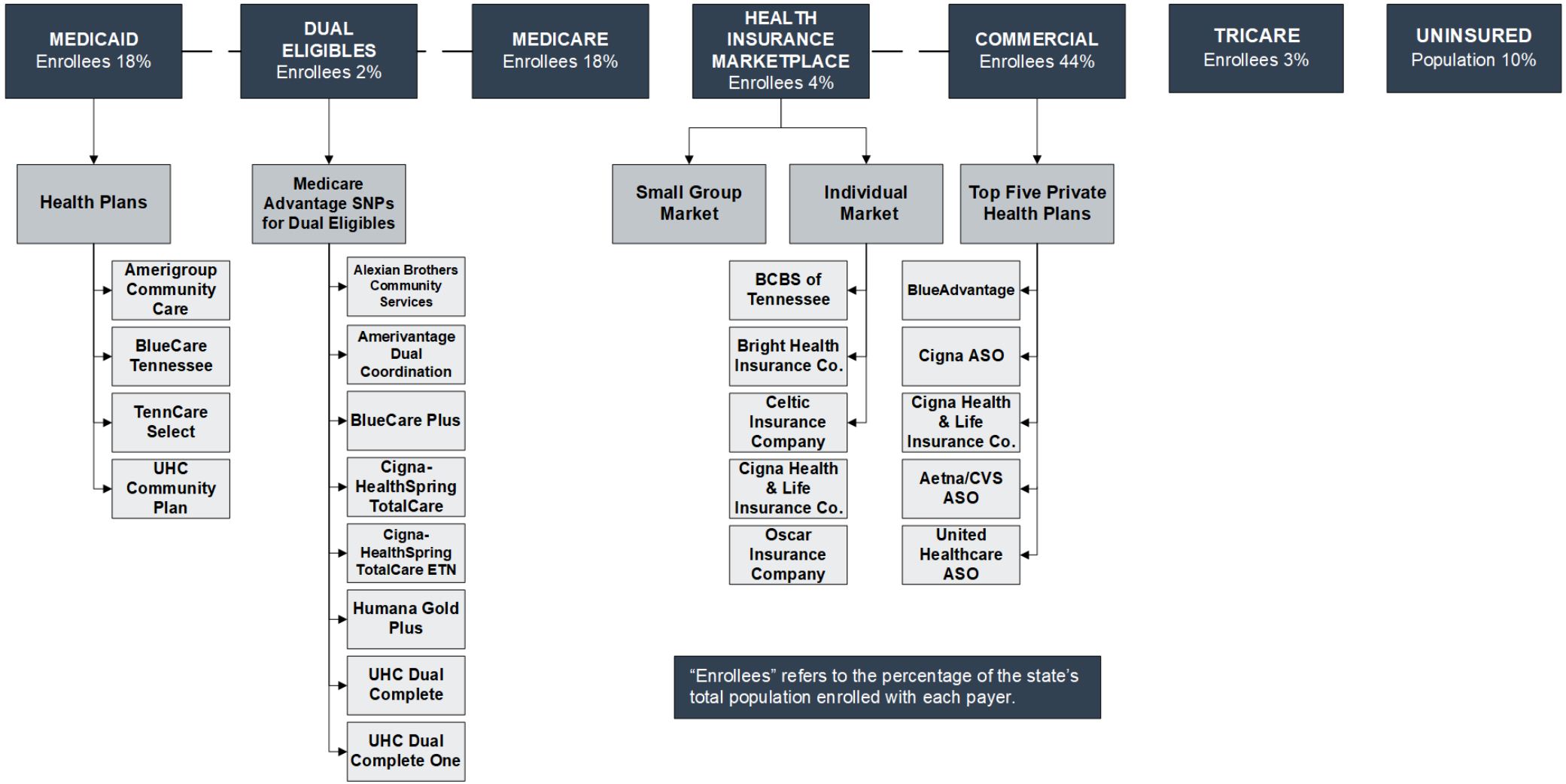
Tennessee Health & Human Services Market Profile

Health & Human Services Market Profile Overview

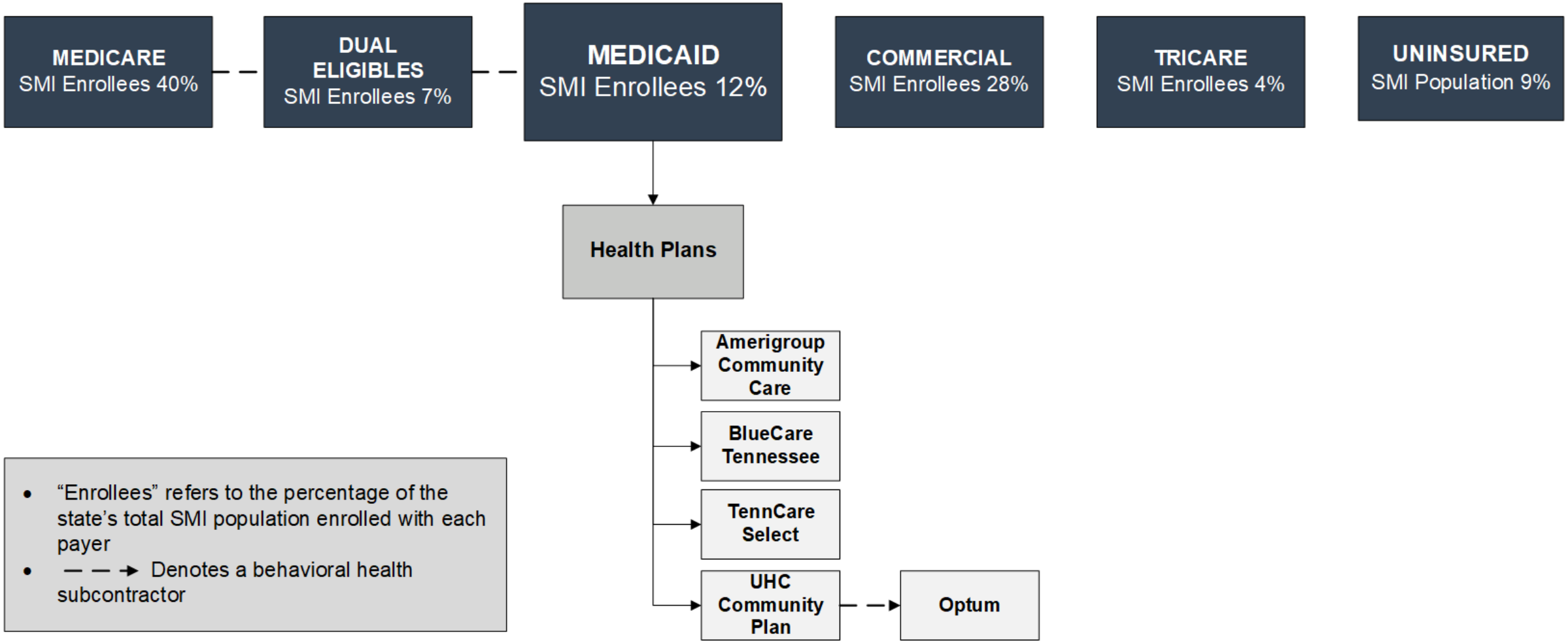
A. Executive Summary

A.1. Tennessee Physical Health Care Coverage by Payer

Total State Population- 6,975,218
Estimated SMI Population- 341,786



A.1. Tennessee Behavioral Health Care Coverage by Payer



A.2. Health & Human Services Care Coordination Initiatives

Care Coordination Entities For Chronic Care Populations (Including SMI)		
Care Coordination Entity	**Active Program**	**Description**
Managed Care Health Plan	✓	The health plans provide care coordination for members receiving long-term services and supports (LTSS).
Primary Care Case Management (PCCM)		None
Accountable Care Organization (ACO) Program	✓	While there are no Medicaid ACO's, there are Medicare ACO's in Tennessee
Affordable Care Act (ACA) Model Health Home	✓	The state implemented health homes for persons with behavioral health conditions in December 2016. The health home model used is non-Patient Protection and Affordable Care Act.
Patient-Centered Medical Home (PCMH)	✓	The state implemented a Medicaid PCMH program in January 2017.
Dual Eligible Demonstration		None
Managed Long-Term Services and Supports (MLTSS)	✓	The TennCare health plans deliver nursing facility services and other LTSS through the CHOICES and Employment and Community First (ECF) CHOICES programs.
Certified Community Behavioral Health Clinics (CCBHC) Grant	✓	Tennessee operates three CCBHC's.

A.3. Health Care Safety-Net Delivery System

State Agencies Responsible For Uninsured Citizens & Delivery System Model

Physical Health Services

The Tennessee Department of Health is responsible for providing physical health services to the uninsured population.

The CoverRx program, operated by the Division of Health Care Finance and Administration and managed by OptumRX, provides pharmacy services to the safety-net population.

Mental Health Services

The Tennessee Department of Mental Health and Substance Abuse Services (TDMHSAS) provides mental health services to the safety-net population by contracting with 20 community mental health agencies.

The CoverRx program, operated by the Division of Health Care Finance and Administration and managed by OptumRX, provides mental health pharmacy services to the safety-net population.

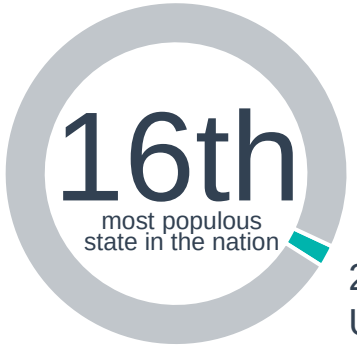
Addiction Treatment Services

TDMHSAS contracts with addiction treatment centers throughout the state to provide addiction disorder treatment services to the safety-net population.

B. Tennessee Health Financing System Overview

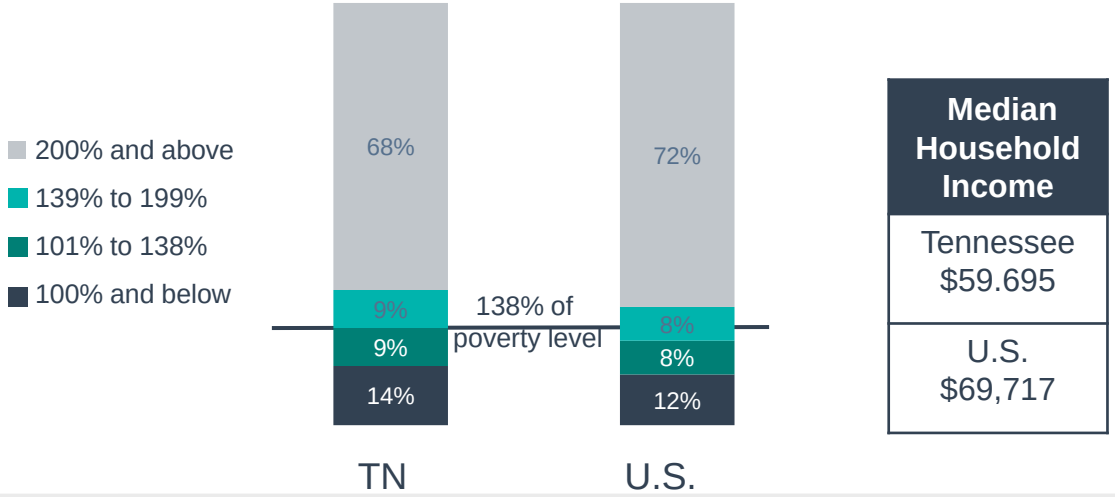
B.1. Population Demographics

Total Tennessee Population- 6,975,218
Estimated SMI Population- 341,786



2% of the
U.S. population

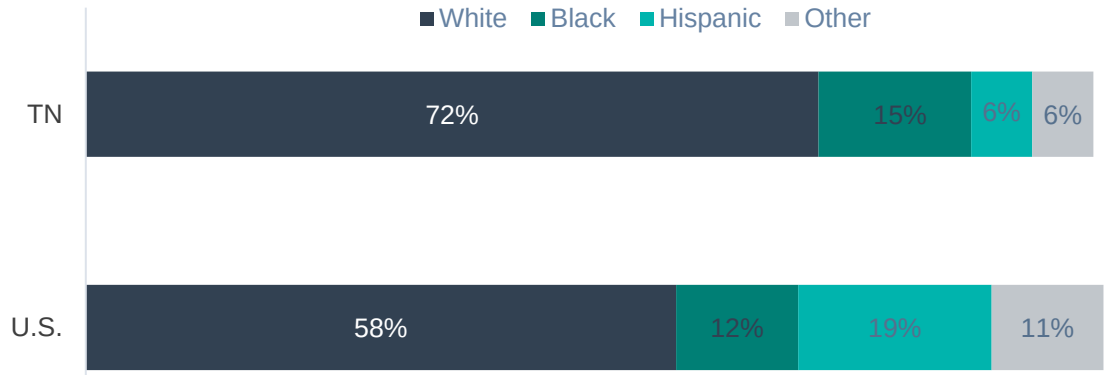
Population Distribution By Income To Poverty Threshold Ratio



Median Household Income
Tennessee $59.695
U.S. $69,717

Population Distribution By Age

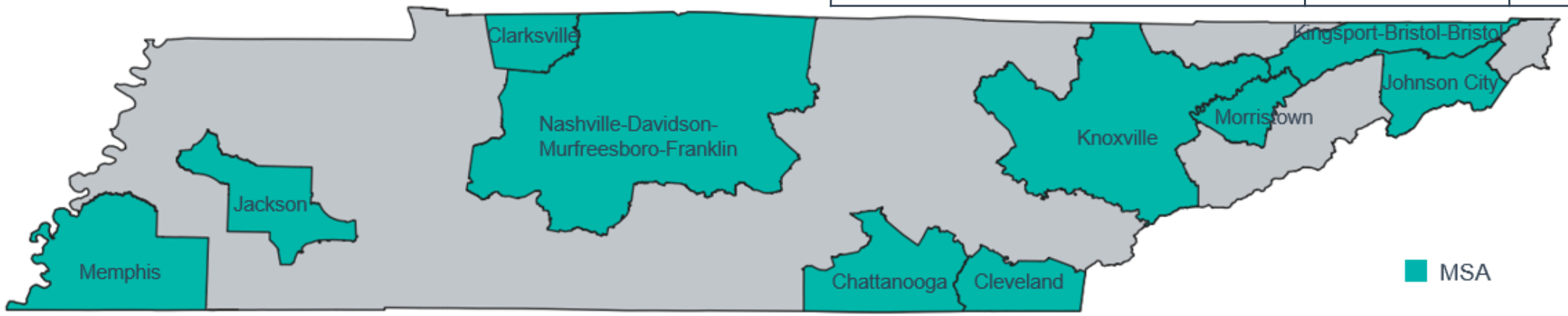
Tennessee & U.S. Racial Composition



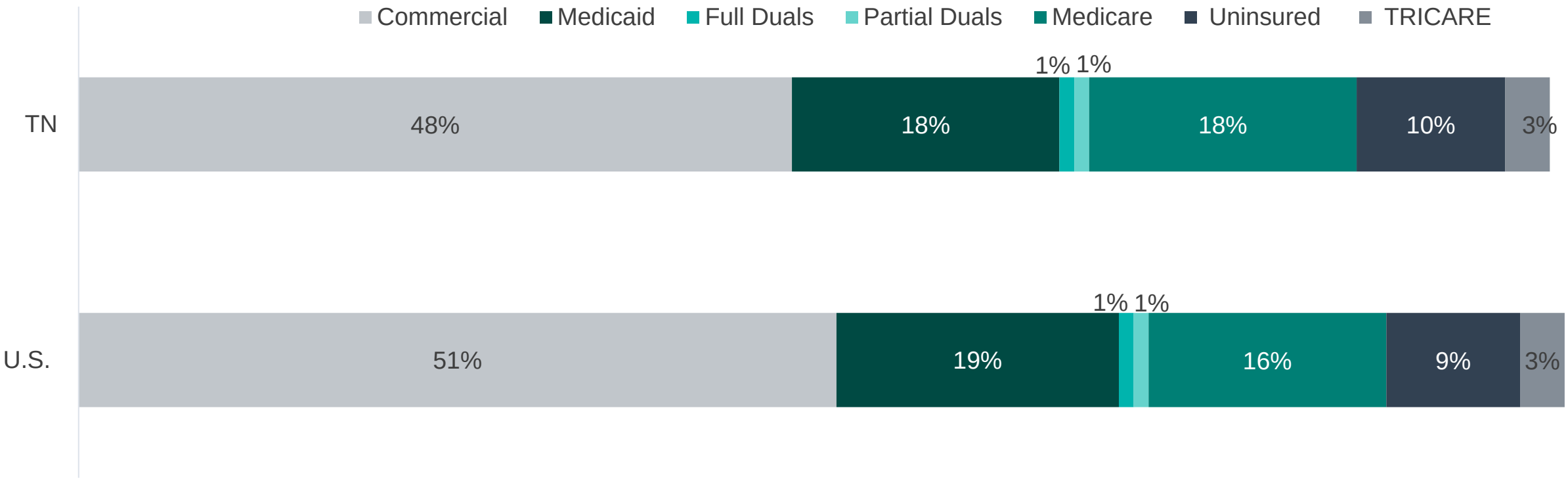
*Totals may not equal 100% due to rounding.

B.2. Population Centers

Metropolitan Statistical Areas (MSAs)		
MSA	**Tennessee MSA Residents**	**Percent Of State Population**
Total MSA Population	**6,197,257**	**88%**
Nashville-Davidson-Murfreesboro-Franklin, TN	2,012,476	29%
Memphis, TN-MS-AR	1,336,103	19%
Knoxville, TN	893,412	13%
Chattanooga, TN-GA	657,641	9%
Clarksville, TN-KY	328,304	5%
Kingsport-Bristol, TN-VA	308,661	4%
Johnson City, TN	208,068	3%
Jackson, TN	180,799	3%
Morristown, TN	143,855	2%
Cleveland, TN	127,938	2%

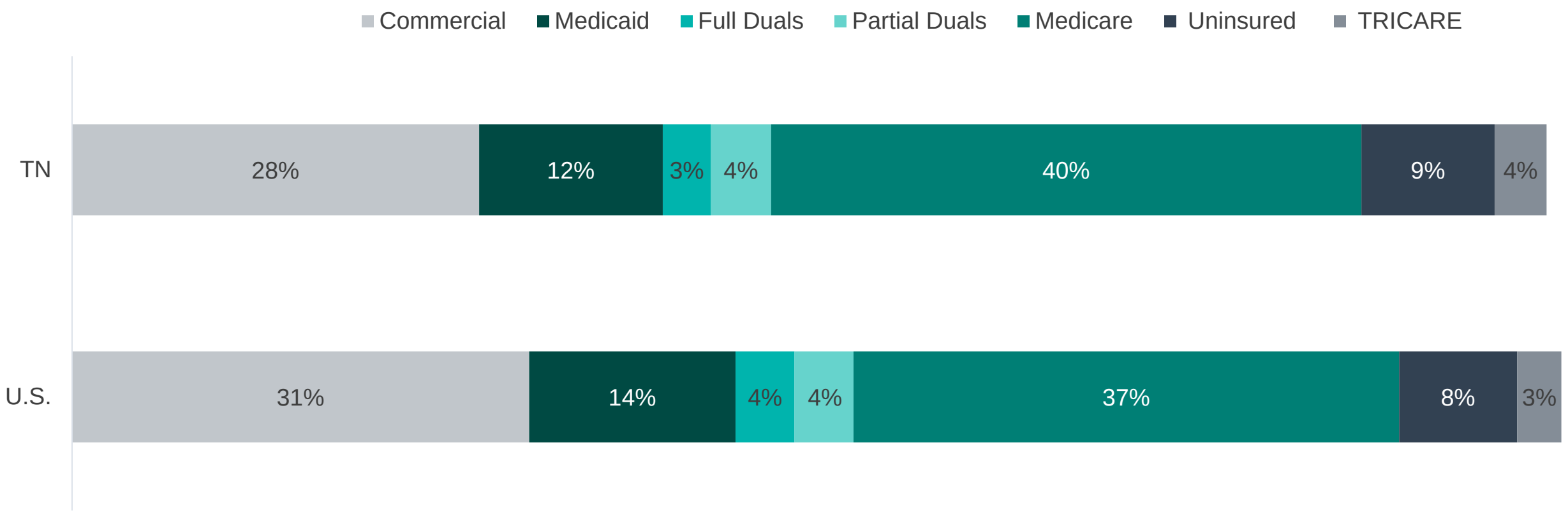


B.3. Population Distribution By Payer: National vs. State



*Totals may not equal 100% due to rounding.

B.3. SMI Population Distribution By Payer: National vs. State



B.4. Largest Tennessee Health Plans By Enrollment

Plan Name	Plan Type	Enrollment*
BlueAdvantage	Commercial	1,721,008
Cigna	Commercial administrative services organization (ASO)	711,653
Medicare fee-for-service (FFS)	Medicare	630,910
BlueCare	Medicaid managed care	609,192
UnitedHealthcare Community Plan	Medicaid managed care	488,999
Amerigroup Community Care	Medicaid managed care	487,872
UnitedHealthcare	Commercial ASO	254,509
TRICARE	Other Public	201,392
BlueAdvantage	Medicare Advantage	139,818
Cigna Health and Life Insurance Company	Commercial	138,305

*Medicaid enrollment as of December 2021; TRICARE as of July 2020; Commercial as of December 2021; Medicare enrollment as of December 2021

B.4. Largest Tennessee Health Plans By Estimated SMI Enrollment

Plan Name	Plan Type	Enrollment*	Estimated SMI Enrollment
Medicare Fee-for-service (FFS)	Medicare	630,910	100,946
BlueAdvantage	Commercial	1,721,008	84,429
Cigna	Commercial ASO	711,653	34,871
BlueCare	Medicaid managed care	609,192	29,850
UnitedHealthcare Community Plan	Medicaid managed care	488,999	23,961
Amerigroup Community Care	Medicaid managed care	487,872	23,906
BlueAdvantage	Medicare Advantage	139,818	22,371
Humana Gold Plus	Medicare Advantage	135,611	21,698
TRICARE	Other public	201,392	16,716
Cigna-HealthSpring	Medicare Advantage	79,593	12,735

*Medicaid enrollment as of December 2021; TRICARE as of July 2020; Commercial as of December 2021; Medicare enrollment as of December 2021

B.5. Health Insurance Marketplace

Health Insurance Marketplace	
Health Insurance Marketplace Enrollment Percentage	4%
Type of Marketplace	Federal
Individual Enrollment Contact	https://www.healthcare.gov/
	1-800-318-2596
Small Business Enrollment Contact	No small group plans are available through the marketplace. Employers must purchase coverage directly from an insurance carrier or through an insurance broker.

2023 Individual Market Health Plans
1. Ascension Personalized Care/ US Health & Life
2. BlueCross BlueShield of Tennessee
3. Celtic/ Ambetter Insurance Company
4. Cigna Health and Life Insurance Company
5. Oscar Insurance Company
6. UnitedHealthcare

2023 Small Group Market Health Plans
None

B.6. Accountable Care Organizations

Medicare Shared Savings ACOs	
1. Accountable Care Coalition of Tennessee, LLC**	17. Integrated Medical Staff of Jackson, PC
2. ACO of Central Alabama 1 LLC (dba Connected Care of West Tennessee)	18. Maury Regional Health Network, LLC
3. ACO of North Delaware, LLC (dba Connected Care of East Tennessee)	19. Mid South ACO, LLC (dba Connected Care of Middle Tennessee)
4. Aledade Accountable Care 35, LLC	20. Mission Health Care Network, LLC
5. Aledade Accountable Care 45, LLC	21. Music City Kidney Care Alliance, LLC*
6. Aledade Mississippi ACO, LLC	22. Network ACO, LLC
7. AnewCare Collaborative, LLC	23. Qualuable Medical Professionals, LLC
8. Ascension Care Management Health Partners Tennessee	24. TP-ACO LLC
9. CHSPSC ACO 14, LLC	25. University Health ACO, LLC
10. CHCPSC ACO 15, LLC	
11. Commonwealth Clinical Partners (West Tennessee Clinical Partners)	
12. Consolidated Medical Practices of Memphis, PLLC	
13. Cumberland ACO, LLC	
14. Cumberland Center for Healthcare Innovation, LLC	
15. Emergent ACO, LLC	
16. HealthChoice, LLC	

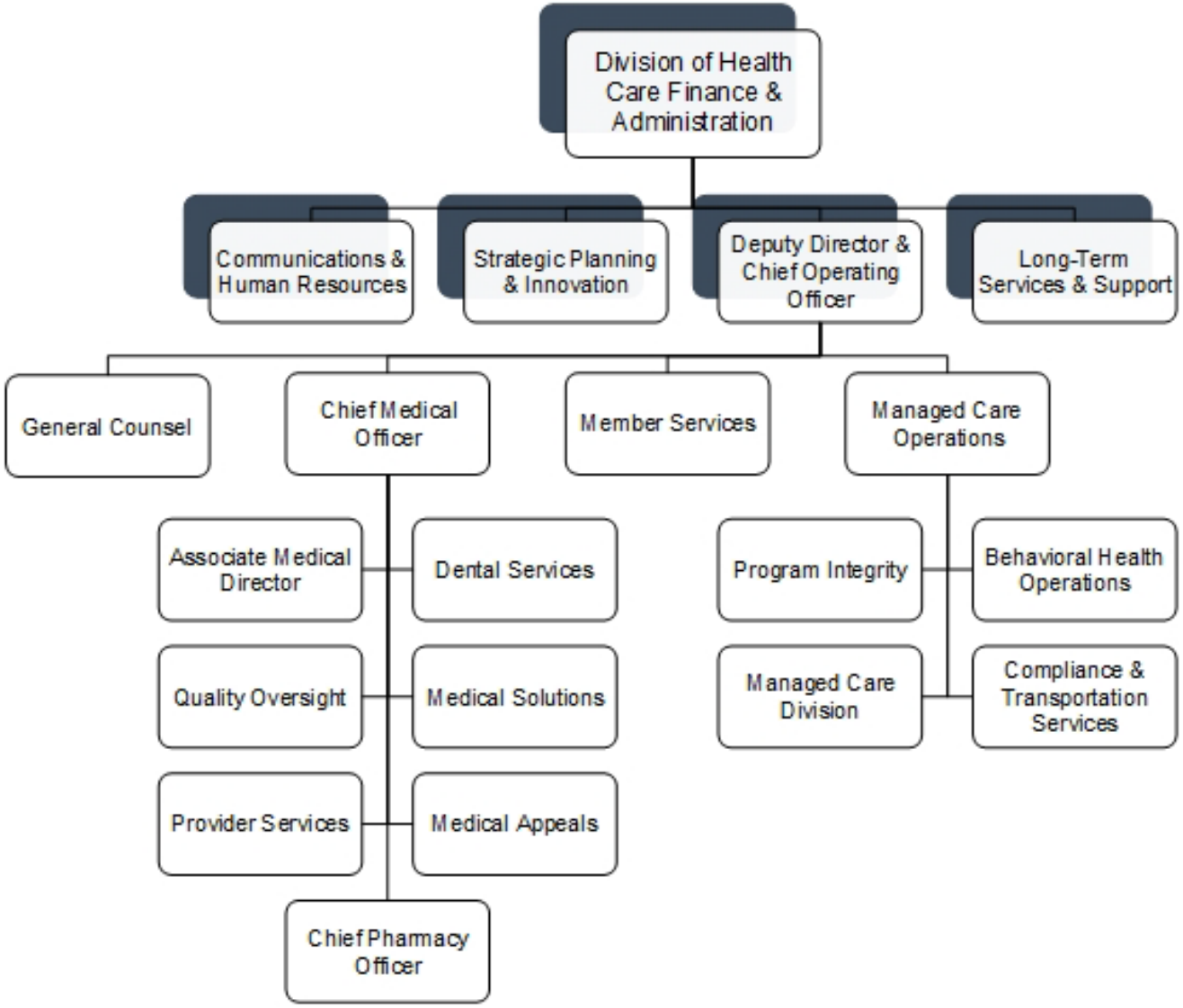
*End Stage Renal Disease Model
** Next Generation Model

B.6. Accountable Care Organizations

Commercial	
ACO	**Commercial Insurer**
Ascension Care Management Health Partners Tennessee	BlueCross BlueShield of Tennessee, UnitedHealthcare
Ballad Health (formerly Wellmont Medical Associates CCC)	Cigna
Cumberland Center for Healthcare Innovation, LLC	Cigna
HealthChoice, LLC	Cigna, UnitedHealthcare
Holston Medical Group Collaborative Accountable Care	Cigna
Jackson Clinic Collaborative Accountable Care	BlueCross BlueShield of Tennessee, Cigna
Vanderbilt Health Affiliated Network	Cigna, UnitedHealthcare

C. Medicaid Administration, Governance & Operations

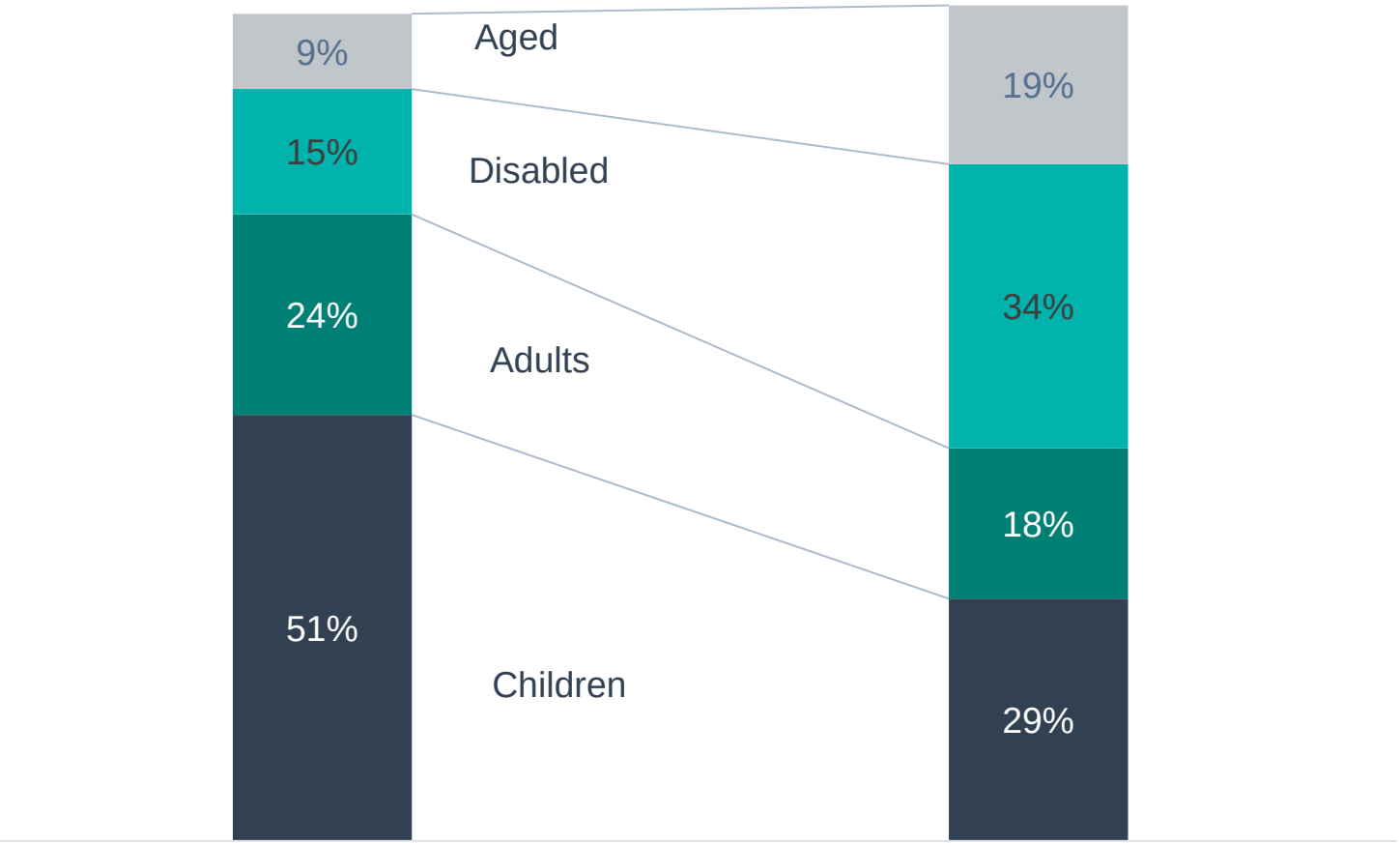
C.1. Medicaid Governance: Organization Chart



C.1. Medicaid Governance: Key Leadership

Name	Position	Department	Email
Stephen Smith	Deputy Commissioner, Director of TennCare	Health Care Finance and Administration Division	stephen.smith@tn,gov
Aaron Butler	Director of Policy, TennCare	Health Care Finance and Administration Division	aaron.butler@tn.gov
Adele Lewis	Chief Medical Examiner	Health Care Finance and Administration Division	adele.lewis@tn.gov
Johnny Lai	Director of Managed Care Operations, TennCare	Health Care Finance and Administration Division	johnny.lai@tn.gov
Kimberly Hagan	Director of Member Services, TennCare	Health Care Finance and Administration Division	kimberly.hagan@tn.gov
Jessica Hill	Director of Strategic Planning, TennCare	Health Care Finance and Administration Division	jessica.hill@tn.gov
Katie Moss	Chief of Long-Term Services and Supports, TennCare	Health Care Finance and Administration Division	katie.moss@tn.gov
Amy Lawrence	Director, Communications and Employee Relations	Health Care Finance and Administration Division	amy.lawrence@tn.gov

C.2. Medicaid Program Spending By Eligibility Group



Medicaid Spending Per Enrollee, FY 2020		
	U.S.	TN
All populations	$8,718	$6,945
Children	$3,495	$3,767
Adults	$5,461	$5,429
Expansion adults	$7,227	N/A
Blind and disabled	$23,123	$14,706
Aged	$18,552	$15,243

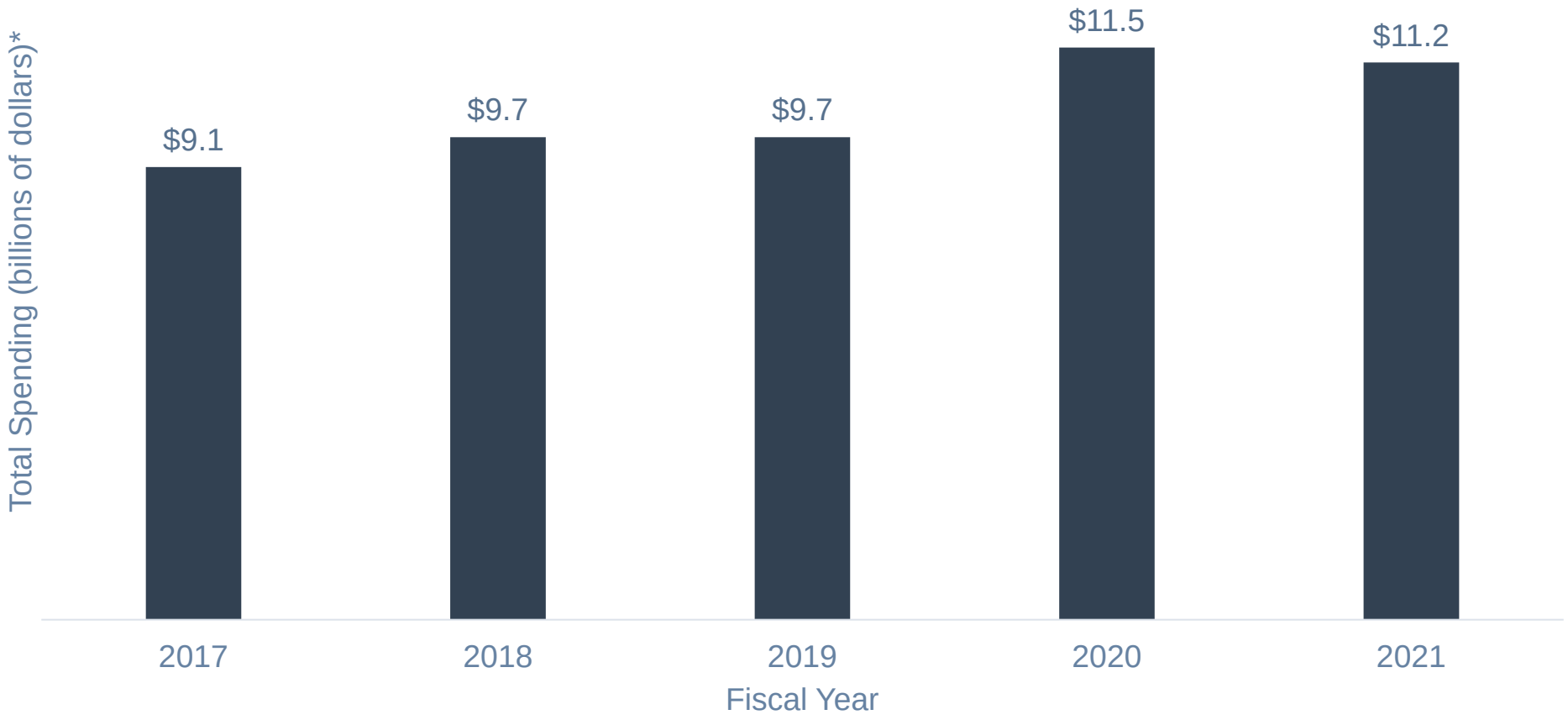
Based on FY 2020 data

C.2. Medicaid Program Spending: Budget

Budget Item	SFY 2021 Spending	Percent Of Budget
Managed care and premium assistance	$8,017,000,000	72%
Home and community-based LTSS	$667,000,000	6%
Hospital	$553,000,000	5%
Drugs	$545,000,000	5%
Medicare premiums and coinsurance	$507,000,000	5%
Other acute	$350,000,000	3%
Institutional LTSS	$252,000,000	2%
Dental	$152,000,000	1%
Clinic and health center	$83,000,000	1%
Physician	$33,000,000	<1%
Budget Total: $11,159,000,000		

Federal & County Financial Participation	
FY 2023 Federal Medical Assistance Percentage (FMAP)	72.3%
CY 2023 Newly Eligible FMAP (expansion population)	56.2%
Counties contribute to state Medicaid share	No

C.2. Medicaid Program Spending: Change Over Time



*All years actual spending

C.3. Medicaid Expansion Status

Medicaid Expansion	
Participating In Expansion	No
Date Of Expansion	Not currently applicable, but a bill has been introduced to expand Medicaid. The bill is currently on hold due to a lack of support.
Medicaid Eligibility Income Limit For Able-Bodied Adults	98% of the federal poverty level (FPL) for parents and caretaker relatives. Childless adults without disabilities are not covered.
Legislation Used To Expand Medicaid	N/A
Number Of Individuals Enrolled In The Expansion Group (March 2022)	N/A
Number Of Enrollees Newly Eligible Due To Expansion	N/A
Benefits Plan For Expansion Population	N/A

C.4. Medicaid Program Benefits

Federally Mandated Services

1. Inpatient hospital services other than services in an institution for mental disease (IMD)
2. Outpatient hospital services
3. Rural Health Clinic services
4. Federally Qualified Health Center (FQHC) services
5. Laboratory and x-ray services
6. Nursing facilities for individuals 21 and over
7. Early and Periodic Screening and Diagnosis and Treatment (EPSDT)
8. Family planning services and supplies
9. Free standing birth centers
10. Pregnancy-related and postpartum services
11. Nurse midwife services
12. Tobacco cessation programs for pregnant women
13. Physician services
14. Medical and surgical services of a dentist
15. Home health services
16. Nurse practitioner services
17. Non-emergency transportation to medical care

Tennessee's Optional Services

1. Podiatry services
2. Optometry services
3. Chiropractor services
4. Other practitioner services
5. Clinic services
6. Dental services
7. Physical and occupational therapy
8. Services for individuals with speech, hearing, and language disorders
9. Prescribed drugs
10. Eyeglasses, prosthetics, and dentures
11. Diagnostic, screening, rehabilitative, and preventive services
12. Services for individuals aged 65 and older in IMDs
13. Intermediate care facility services
14. Inpatient psychiatric care for individuals under age 22
15. Nursing facility services for individuals under age 21
16. Case management
17. Care and services provided in religious nonmedical health care institutions
18. Personal care services
19. Hospice care

D. Medicaid Financing & Service Delivery System

D.1. Medicaid Financing & Service Delivery System

Medicaid System Characteristics		
Characteristics	**Medicaid Fee-For-Service (FFS)**	**Medicaid Managed Care**
Enrollment (December 2022)	0: Tennessee does not operate a FFS delivery system	1,736,417
SMI Enrollment	N/A	85,084
Management	N/A	• TennCare Select populations: Prepaid inpatient health plan administered by BlueCare Tennessee • Other populations: Three health plans
Payment Model	N/A	• TennCare Select: Partially at-risk per member per month (PMPM) administrative fee • Health plans: Capitated rate
Geographic Service Area	N/A	Statewide

Total Medicaid: 1,638,660 | Total Medicaid With SMI: 85,084

D.1. Medicaid System Overview

Medicaid Financial Delivery System Enrollment	
Total Medicaid population distribution	• The state does not operate a fee-for-service (FFS) system; therefore, the entirety of the Medicaid population is enrolled in managed care. • 0% in FFS, 100% in managed care
SMI population inclusion in managed care	
Dual eligible population inclusion in managed care	
LTSS population inclusion in managed care	

Medicaid Financing & Risk Arrangements: Behavioral Health		
Service Type	**FFS Population**	**Managed Care Population**
Traditional behavioral health	N/A	• Managed care: Included in the health plan's capitation rate • TennCare Select: Covered FFS by the state; BlueCare Tennessee receives administrative fee
Specialty behavioral health	N/A	
Pharmaceuticals	N/A	All: Excluded from the health plan's capitation rate, covered by the state's pharmacy benefits manager
Long-term services and supports (LTSS)	N/A	• LTSS for most populations are included in the health plan's capitation rate • LTSS for the I/DD population will be integrated into managed care upon CMS approval.

D.1. Medicaid Care Coordination Initiatives

Medicaid Care Coordination Entities For Chronic Care Populations (Including SMI)		
Care Coordination Entity	**Active Program**	**Description**
Managed Care Health Plan	✓	The health plans provide care coordination for members receiving long-term services and supports (LTSS).
Primary Care Case Management (PCCM)		None
Accountable Care Organization (ACO) Program		None
Affordable Care Act (ACA) Model Health Home	✓	The state implemented health homes for persons with behavioral health conditions in December 2016. The health home model used is not considered a part of the Patient Protection and Affordable Care Act.
Patient-Centered Medical Home (PCMH)	✓	The state implemented a Medicaid PCMH program in January 2017.
Dual Eligible Demonstration		None
Managed Long-Term Services and Supports (MLTSS)	✓	The TennCare health plans deliver nursing facility services and other LTSS through the CHOICES and Employment and Community First (ECF) CHOICES programs.
Certified Community Behavioral Health Clinics (CCBHC) Grant	✓	Tennessee now operates three CCBHC's..

D.2. Medicaid Service Delivery System Enrollment By Eligibility Group

Tennessee does not operate a FFS program. Therefore, the majority of beneficiaries are enrolled in managed care.

Population	Mandatory FFS Enrollment	Option To Enroll In FFS Or Managed Care	Mandatory Managed Care Enrollment
Parents and caretakers			X
Children			X
Blind and disabled individuals			X
Aged individuals			X
Dual eligibles	X (partial benefit)		X (full benefit)
Medicaid expansion			X
Individuals residing in nursing homes			X
Individuals residing in ICF/IDD			X
Individuals in foster care			X
Other populations			

D.3. Medicaid FFS Program: Overview

- Tennessee serves all full benefit and most partial benefit Medicaid eligibility groups through the managed care program and no longer operates a traditional FFS program.

D.4. Medicaid Managed Care Program: Overview

- Managed care enrollment as of December 2022 was 1,736,417.
- Tennessee's Medicaid managed care program is called TennCare III, but typically referred to as TennCare. The program is authorized through a 1115 demonstration waiver.
  - On January 8, 2021, the state received approval from CMS to operate the latest version of the TennCare waiver (see section D.6 for more information).
- Medicaid services, including long-term services and supports (LTSS), are provided to enrollees using two different delivery vehicles:
  - **Health plans:** The state's three statewide health plans provide coverage on a full-risk capitated basis for most of the Medicaid population. Enrollees may select a health plan or be assigned to one.
    - Amerigroup Community Care
    - BlueCare Tennessee
    - UnitedHealthcare Community Plan
  - **TennCare Select:** Provides services to special populations through a partially at-risk Prepaid Inpatient Health Plan (PIHP) that receives an administrative fee from the state. Beneficiaries have the option to enroll in one of the health plans instead of the PIHP. Enrollment as of November 2021 was 52,442.
- The state does not require the health plans to have value-based reimbursement arrangements with provider organizations, but the health plans must participate in PCMHs, health homes, and episodes of care.

D.4. Medicaid Managed Care Program: Overview

- Although the health plans deliver services to all populations, the state uses different benefit packages to serve enrollees based on their Medicaid eligibility. Each enrollee is eligible for one of the following four benefit packages:
  - **TennCare Medicaid:** State plan and section 1115 demonstration benefits for persons who do not need LTSS.
  - **TennCare Standard:** Limited state plan and section 1115 demonstration benefits for enrollees who are eligible only through the demonstration, and who do not need LTSS.
  - **CHOICES:** Provides LTSS to aged and physically disabled individuals in need of a nursing facility level of care, in addition to TennCare Standard or TennCare Medicaid services, as appropriate.
  - **Employment and Community First (ECF) CHOICES:** Provides LTSS to individuals (adults and children) with I/DD and severe co-occurring behavioral health or psychiatric conditions, in addition to TennCare Standard or TennCare Medicaid services, as appropriate.
    - These populations are eligible to receive specialized home- and community-based (HCBS) services – intensive behavioral family-centered treatment, stabilization, and supports and intensive behavioral community transition and stabilization services.
- Not all health plans deliver all benefit packages:
  - Amerigroup Community Care and BlueCare Tennessee deliver all four TennCare packages.
  - Currently, TennCare Select does not offer the ECF CHOICES benefits package, but does offer TennCare Medicaid, TennCare Standard, and CHOICES.

D.4. Medicaid Managed Care Program: Prepaid Inpatient Health Plan Characteristics

TennCare Select provides services through a partially at-risk PIHP that receives an administrative fee from the state.

TennCare Select Prepaid Inpatient Health Plan	
Populations Enrolled	• Children in state custody, adding in 6 months post-custory • Children in a nursing facility or ICF/DD • Individuals receiving HCBS services through an I/DD waiver may opt-in • Residents of areas with insufficient health plan service capacity • Back-up plan for unexpected health plan withdrawal from TennCare • Katie Beckett (Part A) eligibility group – unless SelectCommunity program is covered elsewhere • Inmates of public institutions who are enrolled in TennCare
Financial Arrangement	• Services are paid on an FFS basis. • As plan administrator, BlueCare Tennessee receives a PMPM administrative fee. • A total of 10% of the administrative fee is at-risk; 5% is at-risk for EPSDT compliance, and 5% is at-risk for meeting a medical services budget target.
Behavioral Health Subcontractor	None
Enrollment Share	3%
Benefits Packages	All except ECF CHOICES

D.4. Medicaid Managed Care Program: Managed Care Regions

Managed Care Regions

- East Tennessee
- Middle Tennessee
- West Tennessee

D.4. Medicaid Managed Care Program: Health Plan Characteristics

Amerigroup Community Care	Blue Care Tennessee	UnitedHealthcare Community Plan
1. Profit status: For-profit 2. Parent company: Anthem, Inc. 3. Behavioral health subcontractor: None 4. Pharmacy benefits manager: None* 5. Benefits packages: All 6. Region: All 7. Enrollment share: 31%	1. Profit status: Non-profit 2. Parent company: BlueCross BlueShield of Tennessee 3. Behavioral health subcontractor: None 4. Pharmacy benefits manager: None* 5. Benefits packages: All 6. Region: All 7. Enrollment share: 38%	1. Profit status: For-profit 2. Parent company: UnitedHealth 3. Behavioral health subcontractor: Optum 4. Pharmacy benefits manager: None* 5. Benefits packages: All 6. Region: All 7. Enrollment share: 31%

*Pharmacy benefits are covered by the state through OptumRX.

D.4. Medicaid Managed Care Program: Behavioral Health Overview

- Behavioral health services are included in the health plan's capitation rates.
- Enrollees in the TennCare Select PIHP receive their behavioral health benefits on an FFS basis. BlueCross Tennessee receives a PMPM administrative fee as the plan administrator.
- Behavioral health pharmacy, along with general pharmacy, is excluded from the health plan's capitation rate and covered by the state.

Managed Care Mental Health Benefits
1. Psychiatric inpatient hospital
2. Psychiatric residential treatment
3. Outpatient services
4. Intensive community-based treatment
5. Psychiatric rehabilitation services
6. Crisis services
7. Intensive behavioral family-centered treatment, stabilization, and supports
8. Intensive behavioral community transition and stabilization services

Managed Care Addiction Treatment Benefits
1. Inpatient services
2. Residential services
3. Outpatient services
4. Intensive community-based treatment
5. Crisis services

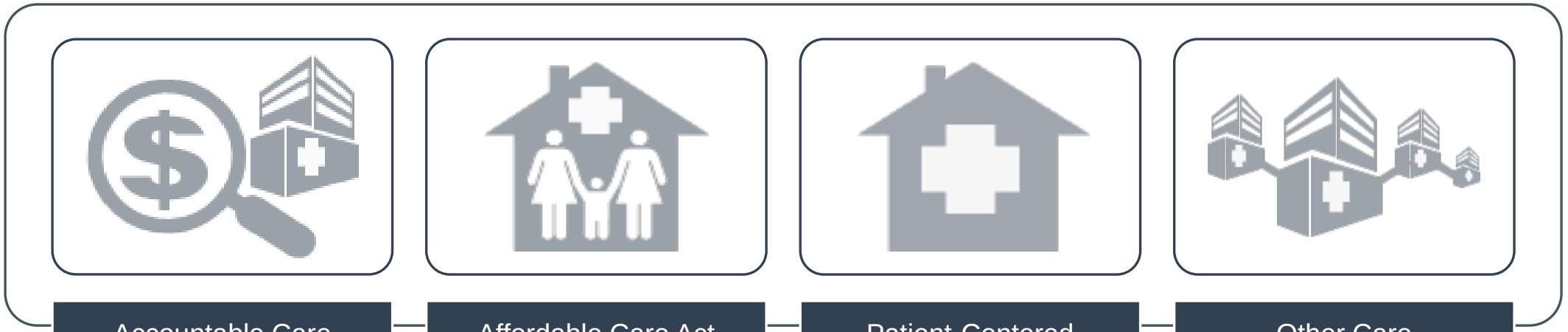
D.4. Medicaid Managed Care Program: SMI Population

- The state does not operate an FFS program; therefore, the entirety of the SMI population is in managed care.

D.4. Medicaid Managed Care Program: Pharmacy Benefit

Tennessee Managed Care Program Pharmacy Benefit	
Responsible For Financing General Pharmacy Benefit	State, Optum Rx acts as pharmacy benefit manager
Responsible For Financing Mental Health Pharmacy Benefit	State, Optum Rx acts as pharmacy benefit manager
Health Plan Uses A Preferred Drug List (PDL) For General Pharmacy	Yes, the TennCare Preferred Drug List.
Health Plan Uses A PDL For Mental Health Drugs	Yes, antidepressants, antipsychotics, anticonvulsants, anxiolytics, and mood stabilizers are included on the pharmacy PDL.
Health Plan Uses A PDL For Addiction Treatment Drugs	Yes, opioid agonists are included on the pharmacy's PDL.
Health Plan Use Of Utilization Restrictions For Mental Health & Addiction Treatment Drugs	The state is responsible for utilization controls, including but not limited to, prior authorization and quantity limits.
Health Plan Allowed To Implement Pharmacy Lock-In Program	A member may be locked in or restricted to one prescriber, one pharmacy provider, or both. Additionally, specific enrollees may be subject to prior authorization requirements for all controlled substances.

D.5. Medicaid Program: Care Coordination Initiatives



Accountable Care Organization (ACO) Program

None

Affordable Care Act Health Home

- The state implemented health homes for persons with behavioral health conditions in December 2016.
- The model used is non-PPACA, which means the state does not have to meet federal health home requirements.

Patient-Centered Medical Home

The state's three health plans launched a patient-centered medical home (PCMH) program in January 2017.

Other Care Coordination Initiatives

- Episodes of Care (EOC) payment rewards and penalties program started in 2015.
- The state operates three CCBHC's.

D.5. Medicaid Program Care Coordination Initiatives: Tennessee Health Link Health Home Characteristics

Health Link Health Homes Concept	
Target Population	Health Link eligible members include: • High-needs members based on a diagnosis of attempted suicide or self-injury, bipolar disorder, homicidal ideation, or schizophrenia • High-needs members based on other mental health diagnosis with inpatient, emergency room, crisis stabilization unit, or residential treatment facility admission • Members with functional needs as attested by a clinical professional
Enrollment Model	• Eligibility determined by claims data or provider organization's referral; members must sign a consent form to be enrolled • Members are assigned health homes by the health plan, but may request to change health homes
Geographic Service Area	280 locations statewide operated by 19 Health Link organizations
Care Delivery Model	• Community mental health centers (CMHCs) and other qualified provider organizations with at least 250 attributable Health Link members across all health plans serve as Health Links. • Care team including a registered nurse clinical care coordinator and case managers • Onsite psychiatrist or a primary care physician plus a psychologist or licensed masters-level mental health professional • Use of web-based state care coordination tool
Payment Model (Established 2016)	• TennCare contracted health plans have the full responsibility for negotiating rates and contracting for Tennessee Health Link services. • Outcome payments are rewarded to Health Links annually for providing high quality care and performance and are determined using the formula: Average Cost of Care PMPM ($801)*Efficiency Improvement Percentage + Efficiency Stars * Maximum Share of Savings (25%)* Quality Stars* Member Months.
Practice Performance & Improvement	• Outcome payments are based on a 10-point quality score and on the Health Link's performance relative to the previous year. Health homes performance measures must exceed the threshold measures to receive compensation. Measures are listed on the next slide.

D.5. Medicaid Program Care Coordination Initiatives: Tennessee Health Link Health Home Characteristics

Health Link 2023 Quality Measures		
Core Metric	**Description**	**Threshold**
Seven- and 30-day psychiatric hospital/ Residential Treatment Facility (RTF) readmission rate–seven days	Rate of psychiatric hospital or RTF readmissions within seven days	≤5%
Seven- and 30-day psychiatric hospital/RTF readmission rate–30 days	Rate of psychiatric hospital or RTF readmissions within 30 days	≤13%
Adherence to antipsychotic medications for individuals with schizophrenia	Percentage of members, ages 19 to 64, with schizophrenia or schizoaffective disorder who remained on antipsychotic medication for 80% of their treatment period	≥62%
Antidepressant medication management: Continuation phase	Percentage of members over the age of 18 who were treated with antidepressant medication and had a diagnosis of major depression who remained on an antidepressant.	>40%
Comprehensive Diabetes Care: Eye Exam	Percentage of members, aged 18-75, with type 1 or type 2 diabetes who received an eye exam.	>51%
Controlling high blood pressure	Percentage of members, aged 18/85, who had a diagnosis of hypertension and had a BP under 140/90.	≥49%
Diabetes screening for individuals with bipolar disorder or schizophrenia	Percentage of members that were prescribed an antipsychotic medication and had a diabetes screening during the year	≥82%
Follow-up after hospitalization for mental illness within seven days	Percentage of discharges for mental illness where the member received follow-up within seven days of discharge	≥37%
Metabolic monitoring for children and adolescents on antipsychotics	Percentage of children and adolescents that have two or more antipsychotic prescriptions and had metabolic testing	≥35%

D.5. Medicaid Program Care Coordination Initiatives: Patient-Centered Medical Homes

- Tennessee's three Medicaid health plans launched a state-aligned PCMH initiative in January 2017.
- As of January 2023, the initiative includes 83 provider organizations, and over 700,000 members (37% of the TennCare population).
  - Participating practices must have at least 500 members with one health plan to qualify.
  - PCMHs must maintain a level 2 or 3 recognition by NCQA or must meet Tennessee's specific requirements and begin working on NCQA recognition by June 30, 2021.
  - The state planned to add practices to the program every year and expects 250 practices covering 65% of the state's Medicaid population to participate in the program by 2022.
  - As of March 2022, approximately 40% percent of TennCare members are attributed to one of over 80 organizations, and 450 sites statewide.
- Most Medicaid populations are eligible for attribution to a PCMH.
  - Dual eligibles may be attributed only if they are enrolled in a D-SNP aligned with their Medicaid health plan.
  - Members with third party liability coverage are excluded.
  - Members residing in nursing facilities or residential treatment facilities for more than 90 days are excluded.
  - Members that have less than nine months of attribution to that PCMH are excluded.
- As of January 1, 2021, all CoverKids members assigned to a Primary Care Provider organization must be attributed to the PCMH program.
- Participating practices may be eligible for practice transformation payments, activity payments, and outcome payments. The chart on the following slide outlines the payment structure for the PCMH program.

D.5. Medicaid Program Care Coordination Initiatives: Patient-Centered Medical Homes

Patient-Centered Medical Home Payment Structure (est. 2020)		
Payment Type	**Payment**	**Explanation**
Practice transformation	$1.00 per member per month (PMPM)	Practices receive during first year of participation only.
Activity payment	• PCMHs will be assigned to a risk band based on membership acuity • Health plans will set payment levels, but average across practices will be $4.00 PMPM. No PMPM will be less than $1.00.	Beginning in year three, a portion will be at-risk based on quality and efficiency metrics.
Outcome payment	• Practices with 5,000 or more members: Eligible for shared savings based on total cost of care and quality metrics* • Practices with fewer than 5,000 members: Eligible for bonus based on efficiency and quality metrics*	Annual bonus payment to high-performing PCMHs.

*Quality measures are a combination of HEDIS and state-specific measures.

D.5. Medicaid Program Care Coordination Initiatives: Tennessee PCMH Quality Metrics

PCMH Quality Measures		
Core Metric	**Description**	**Threshold**
Antidepressant medication management (adults only): Effective continuation phase.	Percentage of members over the age of 18 who were treated with antidepressant medication, had a diagnosis of major depression, and who remained on an antidepressant medication for at least 180 days.	≥40%
Comprehensive Diabetes Care: BP control (<140/90 mmHg)	Percentage of members 18-75 years of age with diabetes (types 1 and 2) whose most recent blood pressure reading is less than 140/90 mm hg.	≥56%
Comprehensive Diabetes Care: Eye exam performed	Percentage of members, ages 18 to 75, with diabetes (types 1 and 2) who had an eye exam performed.	≥51%
Comprehensive Diabetes Care: hbA1c poor control (>9.0%)	Percentage of members, ages 18-75, with diabetes (types 1 and 2) with most recent HbA1c level during measurement year greater than 9.0%	≤47%
EPSDT: Adolescent well-care visits age 12-17	Percentage of members, aged 12-17, who had at least one comprehensive well-care visit with a PCP or OB/GYN during the measurement year.	≥57%
EPSDT: Adolescent well-care visits age 18-21	Percentage of members, aged 18-21, who had at least one comprehensive well-care visit with a PCP or OB/GYN during the measurement year.	≥39%

D.6. Medicaid Program: Demonstration & Care Management Waivers

Waiver Title	Waiver Description	Waiver Type	Enrollment Cap	Effective Date	Expiration Date
TennCare III	Authorizes Tennessee's managed care programs, additional benefits, and new Medicaid eligibility groups.	1115	None	01/08/2021*	12/31/2030

1. The state's 1115 demonstration waiver, TennCare II, has recently proposed new amendments that would allow the state to include short-term addiction treatment services in institutions for mental disease (IMDs) in the health plan's capitation rate, allow the state to extend their medication therapy management pilot program for another twelve months, allow the state to utilize a new approach to block grants, allow the state to increase graduate medical student funding, and allow the state to establish a new program aimed at individuals under the age of 18 with disabilities and complex medical needs who do not currently qualify for TennCare.
2. On August 10, 2021, Tennessee also posted a proposed future amendment for public comment. This amendment details the following changes:
   - A combined annual limit of 8 days per person for inpatient hospital and psychiatric hospital services
   - Annual limit of non-emergency outpatient hospital days of 8 per person
   - Annual limit on health care practitioners' office visits of 8 days per person.
   - Annual limit on lab and x-ray services of 8 instances per person.
   - Elimination of coverage for occupational therapy, speech therapy, and physical therapy.
3. On October 12, 2022, Tennessee posted a new proposed amendment. This amendment will allow Tennessee to continue providing an enhanced array of HCBS supports for individuals with disabilities on an ongoing bases beyond the end of the state's currently approved, PHE-based authority.

*Still listed as pending per Medicaid.gov

D.6. Medicaid Program: Section 1915 (c) HCBS Waivers

Waiver Title	Target Population	2023 Enrollment Cap	Operating Unit	Concurrent Management Authority
TN Statewide HCBS Waiver (0128.R05.00)	Individuals with a developmental disability ages 0 to 5, and individuals with an intellectual disability of any age	4,243	Department of Intellectual and Developmental Disabilities (DIDD)	No
TN Comprehensive Aggregate Cap (or CAC) (0357.R03.00)	Individuals with an intellectual disability of any age	1,462	Department of Intellectual and Developmental Disabilities (DIDD)	No

D.7. Medicaid Program New Initiatives: Medicaid Block Grant

- On May 24, 2019, Tennessee's Governor Bill Lee signed House Bill 1280 of 2019 to request federal approval to transition the state's Medicaid program to a block grant. This waiver amendment was then submitted to CMS on November 17, 2019.
  - On January 8, 2021, Tennessee received federal approval to operate the Medicaid Block Grant. The state is currently awaiting authorization from the Tennessee General Assembly.
- The legislature added an amendment to require that the block grant convert the federal share of all medical assistance funding for Tennessee into an allotment that—according to the legislature—is tailored to meet the needs of the state. The state intends to use the block grant proposal to promote healthcare reform such as:
  - Consumer empowerment and choice, so that members have more information to make healthcare decisions
  - Community-based solutions to recognize the factors beyond healthcare play in promoting and maintaining health
  - Prevention and wellness to better ensure that members receive care that is individualized, outcomes orientated, and focused on prevention, wellness, recovery, and maintaining independence
  - Competition and value to allow for greater competition between providers and ensure cost effective purchasing strategies that promote value for taxpayers
  - Pay for performance to deploy TennCare's purchasing power to encourage and reward service quality and cost effectiveness by linking reimbursement to quality performance measures
- The state proposes the following financing model:
  - A block grant amount calculated based on CMS's projected cost of providing care to TennCare's member population. This will be considered the floor for which federal financing will not fall below. It is expected this amount will increase each year on a predetermined index based on CBO data
  - Per Capita Adjustments to the block grant amount to reflect growth in TennCare enrollment that may occur in the future
  - A shared savings mechanism recognizing that all savings to the federal government reflected in TennCare's actual costs compared to what was projected without waiver costs are attributable to the state and the state should share equitably with the federal government in those savings
- Tennessee intends to use the block grant to assume autonomy over their federal spending, and hopes to invest further in health programs, lower drug costs, promote rural healthcare transformation, realign incentives, improve administrative efficiency, and streamline the approval process.

D.7. Medicaid Program New Initiatives: Timeline

2021

- January: Enrollment in the Katie Beckett waiver begins; the state's TennCare II demonstration went into effect.
- April/May: The state intends to release a new procurement for the managed care contracts in Q2 2021.

2022

- December: Expiration date for the state's managed care health plans

2023

- January: Congress set April 1, 2023 as the Medicaid renewal start date.

E. Dual Eligible Financing & Service Delivery System

E.1. Dual Eligible Medicaid Financing & Service Delivery System

Dual Eligible* Medicaid System Characteristics		
Characteristics	**Medicaid Managed Care**	**PACE**
Enrollment (December 2021)	155,021	282
Estimated SMI Enrollment	43,974	90
Management	• TennCare Select populations: PIHP administered by BlueCare Tennessee • Other populations: Three health plans • Additionally, the state offers 6 D-SNPS	One program
Payment Model	• TennCare Select: Partially at-risk PMPM administrative fee • Health plans: Capitated rate	Blended capitated rate
Geographic Service Area	Statewide	Chattanooga area

Total Dual Eligible Enrollment: 155,303 | Total Dual Eligible Enrollment With SMI: 49,696

*Unless otherwise noted, the term *dual eligibles* in this section refers to Medicare enrollees with full Medicaid benefits.

E.2. Largest Dual Eligible Plans By Estimated SMI Enrollment

Health Plans	Parent Company	Plan Type	December 2021 Enrollment	Estimated SMI Enrollment
UnitedHealthcare Dual Complete	UnitedHealthcare	Medicare Advantage D-SNP	65,069	22,822
BlueCare Plus	BlueCare Tennessee	Medicare Advantage D-SNP	21,907	7,010
Amerivantage Dual Coordination	Anthem, Inc	Medicare Advantage D-SNP	14,559	4,659
Humana Gold Plus	Humana, Inc	Medicare Advantage D-SNP	14,496	4,639
Cigna-HealthSpring TotalCare	HealthSpring of Tennessee, Inc	Medicare Advantage D-SNP	8,119	2,598
WellCare Access	WellCare Health Plans, Inc	Medicare Advantage D-SNP	5,185	1,659
Alexian Brothers	Alexian Brothers Senior Ministries	PACE	282	90

E.3. Dual Eligible Medicaid Financing & Delivery System: Overview

- Dual eligible enrollment as of December 2021 was 155,021.
- Medicare covers most acute services (which may include psychiatric care), while Medicaid, the payer of last resort, covers LTSS and non-physician behavioral health services.
- Tennessee has moved all Medicaid eligible groups to managed care; therefore, dual eligibles are automatically enrolled in managed care.

E.4. Dual Eligible Medicaid Financing & Delivery System: New Initiatives

- The Tennessee Medicaid program (TennCare) Long Term Services and Supports (LTSS) wants to develop a new state roadmap to improve programs for individuals dually eligible for Medicare and Medicaid. The roadmap is intended to address oversight and planning for Tennessee's Dual Special Needs Plans (D-SNPs).
- To develop the D-SNP roadmap, TennCare released a request for information (RFI 31865-00707) that runs from May 18, 2022 through June 1, 2022, seeking information and insight from organizations to perform analytic, policy, and program administration services, including possible outsourcing functions. The state seeks to identify solutions in the market that use program approaches to support person-centered care, independent living, and better outcomes. TennCare also seeks solutions that at the same time strengthen the state's position as a strong fiscal steward of Medicaid funding, and maximizing Medicare service coverage.

F. Long-Term Services & Supports Financing & Service Delivery System

F.1. LTSS Financing & Service Delivery System

LTSS* Medicaid System Characteristics	
Characteristics	**Medicaid Managed Care**
Enrollment (December 2020)	70,533
Estimated SMI Enrollment	6,277
Management	• Physical health: Five health plans • Behavioral health: Department of Human Services and ASO
Payment Model	• Physical health: Capitated rate • Behavioral health: FFS and administrative rate
Geographic Service Area	Statewide

Total LTSS Beneficiary Enrollment: 70,533 | Total LTSS Beneficiary Enrollment With SMI: 6,277

*Long-Term Services & Supports

F.1. Medicaid LTSS Service Delivery System Enrollment By Eligibility Group

Tennessee does not operate a FFS program. Therefore, a majority of beneficiaries are enrolled in managed care.

Population	Mandatory FFS Enrollment	Option To Enroll In FFS Or Managed Care	Mandatory Managed Care Enrollment
Disabled adults			X
Disabled children			X
Blind individuals			X
Aged individuals			X
Dual eligibles	X (partial benefit)		X (full benefit)
Individuals with I/DD			X
Individuals residing in nursing homes			X
Individuals residing in ICF/IDD			X
Other HCBS Recipients			X
Other populations			

F.2. LTSS Medicaid Financing & Delivery System: Overview

- LTSS beneficiary enrollment as of December 2020 was 70,533.
- Tennessee delivers LTSS services, in addition to comprehensive physical and behavioral health services, through the CHOICES and Employment and Community First (ECF) Choices programs.
- In June 2016, the program was given an extension for two months to cover individuals while a new waiver could be drafted and approved. This new waiver draft was approved in December 2016 and was original scheduled to end in June 2021, but the state has had no update on whether the program is being phased out or extended as of April 2022.
- Included in this demonstration was an amendment for the CHOICES program, a managed long-term care program. CHOICES is a Medicaid managed care program that provides LTSS to aged and physically disabled individuals in need of a nursing facility level of care. The 1115 waiver that established both CHOICES and ECF Choices was first submitted in July 2012.
  - The CHOICES program serves three groups; Group 1 is nursing facility residents, Group 2 is elderly adults and adults with physical disabilities who are in nursing facilities, and Group 3 is for elderly adults and adults with physical disabilities who do not meet the requirements for nursing facilities.
- Tennessee does operate a value-based purchasing reimbursement program for provider organizations offering services to LTSS beneficiaries (see the next slide).

F.2. LTSS Medicaid Financing & Delivery System: QuILTSS

- To improve the quality of LTSS, Tennessee introduced the Quality Improvement in Long Term Services and Supports or QuILTSS in FY 2016.
- QuILTSS is a TennCare value-based purchasing initiative for provider organizations to focus on performance measure that are important to beneficiaries receiving LTSS.
  - The QuILTSS rewards providers for promoting person-centered care and improving beneficiaries' experiences of care
  - Specific outcome-based reimbursement is provided for nursing facility care services, enhanced respiratory care, home- and community-based services, behavioral health crisis prevention intervention and stabilization services (SOS), and the development of LTSS workforce services.
- Although QuILTSS is expected to collect data yearly, the novel coronavirus (COVID-19) pandemic has severely impacted the delivery of services for the LTSS population, especially those in nursing facilities.
  - Therefore, the state may modify the collection of performance outcome measures in 2021.
- The state has not reported specific performance measure outcome percentages and reimbursement rates as of 2022.

F.3. Medicaid LTSS Program: Health Plan Characteristics

Amerigroup Community Care	Blue Care Tennessee	UnitedHealthcare Community Plan
1. Profit status: For-profit 2. Parent company: Anthem, Inc. 3. Behavioral health subcontractor: None 4. Pharmacy benefits manager: None* 5. Benefits packages: All 6. Region: All	1. Profit status: Non-profit 2. Parent company: BlueCross BlueShield of Tennessee 3. Behavioral health subcontractor: None 4. Pharmacy benefits manager: None* 5. Benefits packages: All 6. Region: All	1. Profit status: For-profit 2. Parent company: UnitedHealth 3. Behavioral health subcontractor: Optum 4. Pharmacy benefits manager: None* 5. Benefits packages: All 6. Region: All

*Pharmacy benefits are covered by the state through OptumRX.

F.4. Medicaid LTSS Program: Health Benefits

- Physical health services for the LTSS population are integrated through the managed care health plans.
- Behavioral health and addiction treatment services are delivered through the state's Department of Health Services and ASO

LTSS Mental Health Benefits
1. Psychiatric inpatient hospital
2. Psychiatric residential treatment
3. Outpatient services
4. Intensive community-based treatment
5. Psychiatric rehabilitation services
6. Crisis services
7. Intensive behavioral family-centered treatment, stabilization, and supports
8. Intensive behavioral community transition and stabilization services

LTSS Addiction Treatment Benefits
1. Inpatient services
2. Residential services
3. Outpatient services
4. Intensive community-based treatment
5. Crisis services

LTSS Physical Care Benefits
1. Chiropractic services
2. Community health clinic services
3. Dental services
4. Durable medical equipment
5. Home health services
6. Hospice care
7. Inpatient and outpatient hospital services
8. Lab and X-ray services
9. Medical supplies
10. Non-emergency transport
11. Nursing facility care
12. Occupational therapy
13. Pharmacy services

F.5. LTSS Medicaid Financing & Delivery System New Initiatives: Katie Beckett Waiver

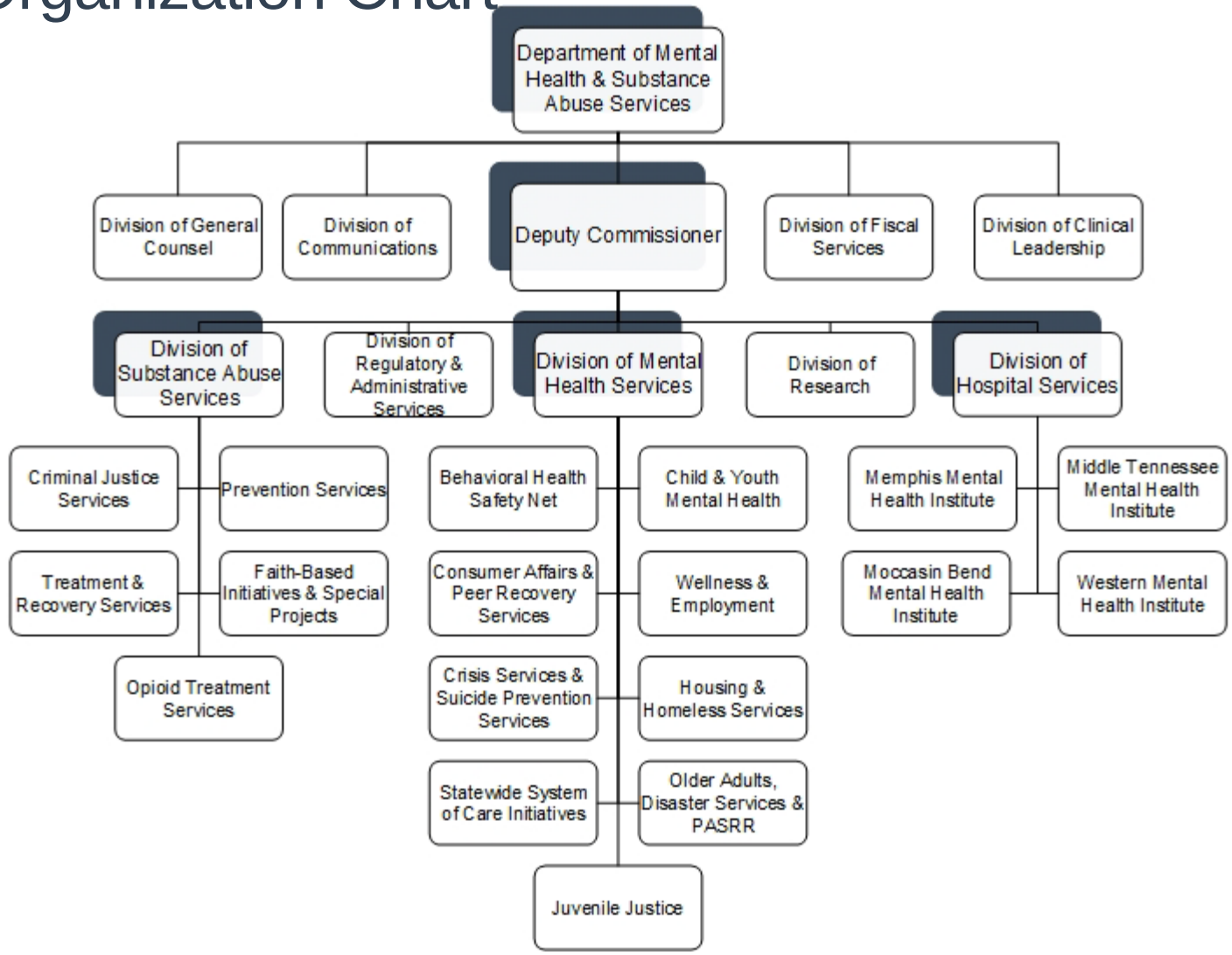
- Tennessee introduced the Katie Beckett Program in 2019, a program for children with complex medical needs or a disability under the age of 18. This program was developed for children who are not eligible for Medicaid because of their parents' income or assets.
  - The Katie Beckett program provides services and helps to pay medical care/services that private insurance does not cover.
- Tennessee's Katie Beckett program has three parts: Part A, Part B, and Part C.
  - **Katie Beckett Part A:** Part A will deliver services to 300 children with complex disabilities and medical needs. Children receive full Medicaid benefits, including therapy services (occupational, physical, and speech therapies), home health services, durable medical equipment, and private duty nursing. Additionally, children receive up to $15,000 per year for non-medical home- and community-based services such as respite care, home and/or vehicle modifications, and supportive home care.
  - **Katie Beckett Part B:** Part B will deliver services to approximately 2,700 children with complex medical needs and disabilities. Children in Part B will not be enrolled in Medicaid instead, beneficiaries receive up to $10,000 for services. Families enrolled in Part B can spend their funding on the following services: a health care savings account, premium assistance, self-directed respite and supportive home care service, services from a community-based provider, or benefits not covered by health insurance.
  - **Katie Beckett Part C:** Part C of the Katie Beckett program allows children with complex medical needs and disabilities who are already enrolled in Medicaid; but will lose coverage due to increases in their parents' income or assets, to maintain Medicaid coverage.
- The Katie Beckett program was supposed to begin in Summer 2020. However, due to the novel coronavirus (COVID-19) outbreak, the program was delayed. Eligible beneficiaries were able to begin enrolling in the program starting November 23, 2020.
  - As of January 21, 2022, 1,159 children are enrolled in the Katie Beckett Program. 129 children are enrolled in Part A, and 1, 030 are enrolled in Part B.

F.5. LTSS Medicaid Financing & Delivery System New Initiatives: I/DD Integration

- In an attempt to align services for individuals with intellectual and developmental disabilities, The Department of Intellectual and Developmental Disabilities and TennCare are planning to integrate all programs for individuals with I/DD participating in Section 1915 (c) HCBS waivers, the Employment and Community First CHOICES program, and Intermediate Care Facility Services for Individuals with Intellectual Disabilities (ICF/IID) under one operational leadership.
- The goal of this integration is to establish a comprehensive, person-centered delivery system for individuals with I/DD to support them to increase their independence, participate in their community, and achieve their integrated employment goals.
  - The state has allocated an estimated $34 million to fill in the budget gaps without negatively impacting services.
- The state has included the plans for integration of I/DD services into the TennCare waiver renewal process.
  - If approved by CMS, the state anticipates beginning the delivery of services on July 1, 2021.
  - As of March 2022, the program has not begun.

G. State Behavioral Health Administration & Finance System

G.1. Department Of Mental Health & Substance Abuse Services Governance: Organization Chart



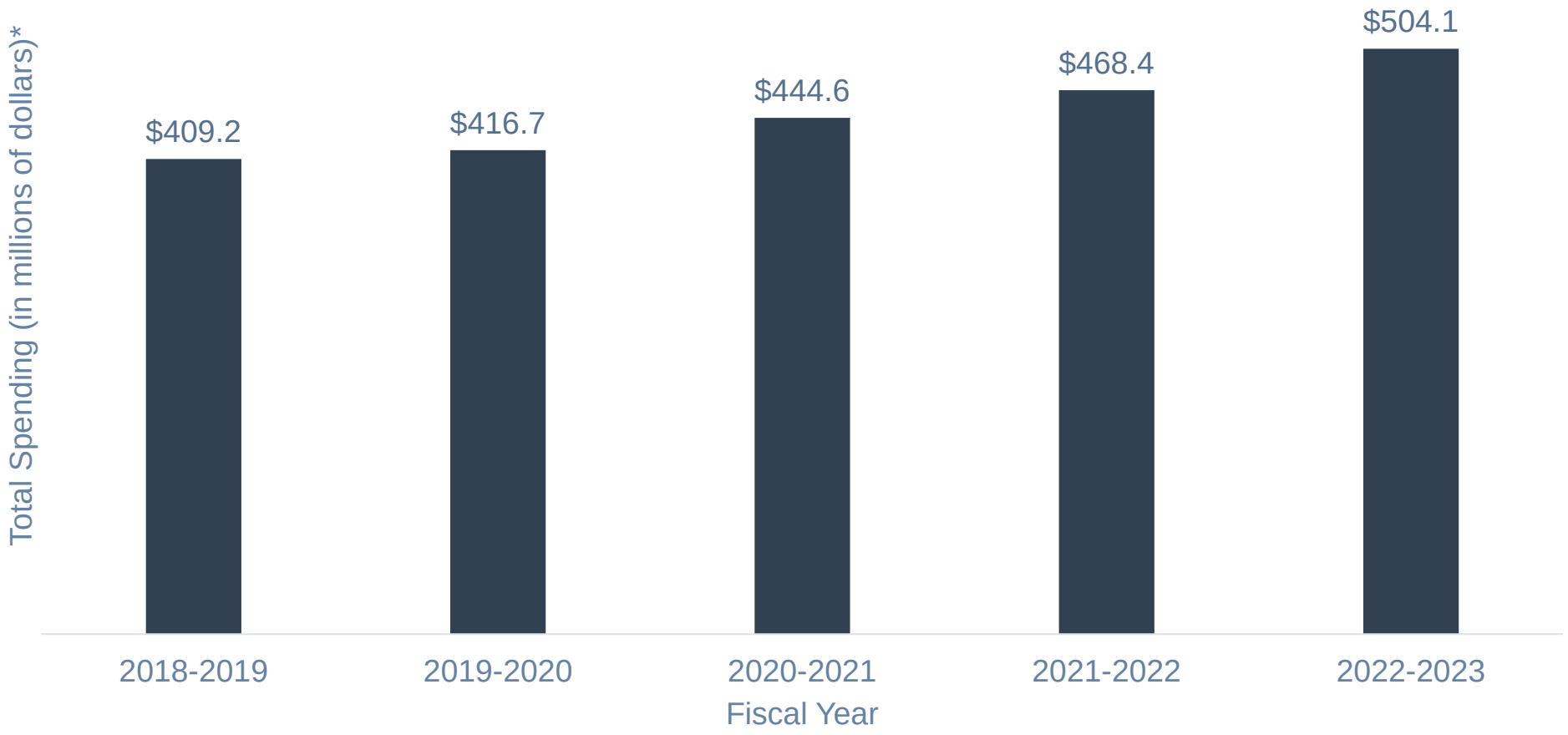
G.1. Division Of Mental Health & Addiction Services: Key Leadership

Name	Position	Department	Email
Marie Williams, LCSW	Commissioner	Department of Mental Health and Substance Abuse Services (DMHAS)	marie.williams@tn.gov
Ty Thorton, Esq.	Chief of Staff/Chief of Hospital Services	DMHAS	ty.thornton@tn.gov
Matt Yancey	Dep. Commissioner of Behavioral Health Community Programs	DMHAS	matt.yancey@tn.gov
Rob Cotterman	Assistant Commissioner	DMHAS, Division of Mental Health Services	rob.l.cotterman@tn.gov
Taryn Harrison Sloss	Assistant Commissioner	DMHAS, Division of Substance Abuse Services	taryn.sloss@tn.gov
Jessica Ivey, LMSW	Director of Strategic Initiatives	DMHAS	jessica.ivey@tn.gov

G.2. Department Of Mental Health & Addiction Services: Spending

Budget Item	SFY 2022-2023 Budget Request	Percent Of Budget
Community Mental Health Services	$178,235,900	35%
Community Substance Abuse Services	$133,903,400	27%
Middle Tennessee Mental Health Institute	$57,112,100	11%
Moccasin Bend Mental Health	$43,396,600	9%
Western Mental Health Institute	$40,540,800	8%
Administrative Services	$29,400,800	6%
Memphis Mental Health Institute	$21,099,500	4%
Maintenance Services	$450,000	<1%
Budget Total: $504,139,100		

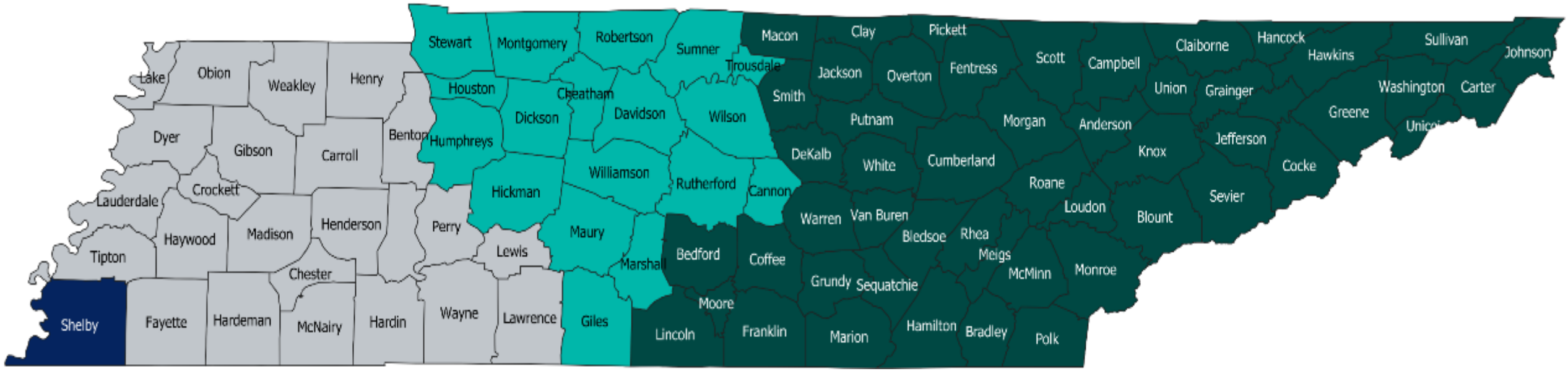
G.2. Department Of Mental Health & Addiction: Spending Over Time



G.3. State Psychiatric Institutions

State Psychiatric Institutions			
Institution	**Location**	**Beds**	**FY 2022 Average Daily Census**
Memphis Mental Health Institute	Memphis	55	34
Middle Tennessee Mental Health Institute	Nashville	207	176
Moccasin Bend Mental Health Institute	Chattanooga	165	120
Western Mental Health Institute	Bolivar	150	130
Total		**577**	**460**

G.3. State Psychiatric Institutions



State Psychiatric Institution Catchment Areas

- Memphis Mental Health Institute
- Middle Tennessee Mental Health Institute
- Moccasin Bend Mental Health Institute
- Western Mental Health Institute

G.4. Behavioral Health Safety-Net Delivery System

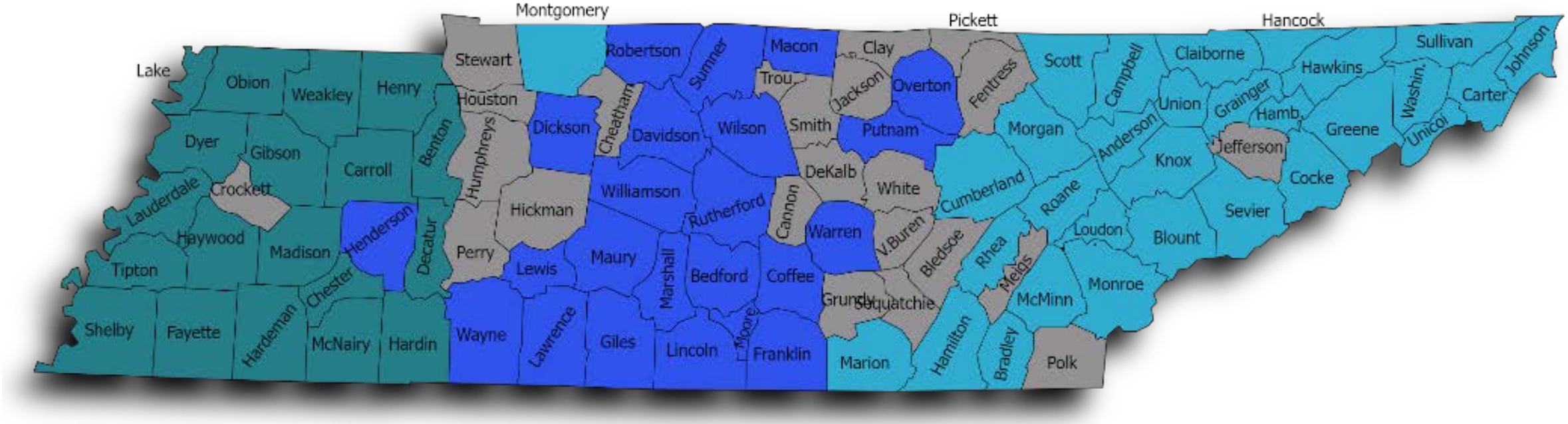
- The Tennessee Department of Mental Health and Substance Abuse Services (TDMHSAS) is the single state agency responsible for providing mental health and addiction treatment services to the uninsured population.
- To qualify for the Behavioral Health Safety Net (BHSN) program, individuals must meet the following eligibility criteria:
  - Behavioral health assessment
  - Psychological evaluation
  - Face-to-face and telemedicine therapy
  - Case management
  - Peer support services
  - Psychiatric medication management
  - Medication management laboratory services
  - Pharmacy coordination
- Have a qualifying serious mental illness (SMI) diagnosis, 19 years of age or older, current Tennessee resident, income level at or below 138% FPL, and have no other behavioral health coverage.
- As administrator of the BHSN program, TDMHSAS contracts with 15 Community Mental Health Agencies (CMHAs) to provide the following services:
- TDMHSAS contracts with alcohol and drug treatment service provider organizations throughout the state to provide addiction treatment services to the safety-net population.
- TMDHSAS has partnered with CoverRX for individuals with no prescription coverage to have access to affordable generic prescriptions.

G.4. Behavioral Health Safety-Net Delivery System: Community Mental Health Agencies

Community Mental Health Agencies		
West Tennessee	**Middle Tennessee**	**East Tennessee**
1. Alliance Healthcare Services 2. Carey Counseling Center 3. Cherokee Health Systems 4. CMI Healthcare Services 5. Pathways of Tennessee 6. Professional Care Services of West Tennessee 7. Quinco Community MHC 8. TN Voices	1. Centerstone of Tennessee 2. Mental Health Cooperative 3. TN Voices 4. Volunteer Behavioral Health	1. Centerstone of Tennessee 2. Cherokee Health Systems 3. Frontier Health 4. Helen Ross McNabb Center 5. Mental Health Cooperative 6. Peninsula 7. Ridgeview 8. TN Voices 9. Volunteer Behavioral Health

Note: Counties that do not have a community mental health agency may receive services from neighboring community mental health agencies.

G.4. Behavioral Health Safety-Net Delivery System: Community Mental Health Agency Regions



Community Mental Health Agencies Catchment Areas

- East Tennessee
- Middle Tennessee
- West Tennessee
- No CMHAs available

G.4. Behavioral Health Safety-Net Delivery System

- The Division of Mental Health and Addiction Services (DMHAS) contracts with 120 non-profit community mental health service provider organizations to provide mental health treatment services to the uninsured population. Available services include:
  - Outpatient care
  - Partial care
  - Integrated case management
  - Assertive community treatment programs
  - Supported employment services
  - System advocates
- DMHAS contracts with Rutgers University Behavioral Health Care (UBHC) to administer state and federal grant funded addiction services.
  - Treatment is provided by a network of provider organizations.
  - Individuals access treatment through a UBHC telephone screening, or by a provider organization associated with UBHC.

H. Appendices

H.1. *OPEN MINDS* Estimates For Share Of SMI Consumers Per Payer/Plan

Enrollment Category	Serious Mental Illness (SMI) Prevalence Estimate	Source
Commercial	4.1% of the commercially insured population over age 18	Substance Abuse and Mental Health Services Administration. (2022, January). Results from the 2020 National Survey on Drug Use and Health: Mental Health Detailed Tables. Retrieved October 2022 from https://www.samhsa.gov/data/sites/default/files/reports/rpt35323/NSDUHDetailedTabs2020v25/NSDUHDetailedTabs2020v25/2020NSDUHDetTabs01112022.zip
Medicaid	38.2% of adults age 18 to 64, not dually eligible for Medicare, who qualify for Medicaid based on a disability	Medicaid and CHIP Payment and Access Commission. (2022, June). Report to Congress on Medicaid and Chip. Retrieved October 2022 from https://www.macpac.gov/publication/june-2022-report-to-congress-on-medicaid-and-chip/
	8.1% of persons in the Medicaid expansion population	Substance Abuse and Mental Health Services Administration. (2022, January). Results from the 2020 National Survey on Drug Use and Health: Mental Health Detailed Tables. Retrieved October 2022 from https://www.samhsa.gov/data/sites/default/files/reports/rpt35323/NSDUHDetailedTabs2020v25/NSDUHDetailedTabs2020v25/2020NSDUHDetTabs01112022.zip
Medicare	16% of persons in the Medicare population, not dually eligible for Medicaid	Centers for Medicare and Medicaid Services. (2021). Medicare-Medicaid Coordination Office Report to Congress. Retrieved October 2022 from https://www.cms.gov/files/document/reporttocongressmmco.pdf

H.1. *OPEN MINDS* Estimates For Share Of SMI Consumers Per Payer/Plan

Enrollment Category	Serious Mental Illness (SMI) Prevalence Estimate	Source
Medicare-Medicaid Dual Eligibility	25% of persons in the Medicare population dually eligible for partial Medicaid benefits	Congressional Budget Office. (2013, June). Dual-Eligible Beneficiaries of Medicare and Medicaid: Characteristics, Health Care Spends, and Evolving Policies. Retrieved October 2022 from https://www.cbo.gov/sites/default/files/113th-congress-2013-2014/reports/44308_DualEligibles2.pdf
	32% of persons in the Medicare population dually eligible for full Medicaid benefits	U.S. Department of Health and Human Services. (2019, May 9). Analysis of Pathways to Dual Eligible Status: Final Report. Retrieved October 2022 from https://aspe.hhs.gov/basic-report/analysis-pathways-dual-eligible-status-final-report
Other Public	8.3% of persons served by the Veterans Administration health care system or the TRICARE military health system	Military Health Systems. (2020, August 7). Examination of Mental Health Accession Screening: Predictive Value of Current Measures and Report Processes. Retrieved October 2022 from https://www.health.mil/Reference-Center/Presentations/2019/11/04/Examination-of-Mental-Health-Accession-Screening-Update
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H.2. Glossary Of Terms

Word	Abbreviation	Definition
Alternative Benefit Plan	ABP	State designed benefit package for the Medicaid expansion population (childless adults with income below 138% of the FPL). The benefit package must include the ten essential benefits as laid out in the PPACA. The Medicaid expansion population deemed medically frail (including those with SMI) are exempt from receiving benefits through the ABP.
Accountable Care Organizations	ACO	ACOs are groups of provider organizations—such as physicians and hospital systems—that form an agreement to coordinate care for a set group of individuals. If the ACO delivers high quality care—measured through performance metrics—and lowers the cost of providing care against a baseline, then the organization receives a portion of the savings generated. ACOs can exist alongside all payment structures (fee-for-service and managed care delivery systems) and payers (Medicare, Medicaid, commercial).
Administrative Services Organization	ASO	An arrangement in which an organization hires a third party to deliver administrative services to the organization, such as claims processing and billing. The ASO is not at-risk.
Capitation		A set amount of money paid per enrollee per month to a health care entity to cover the cost of health care services. Capitation can cover the cost of all health care services or subset of services, such as care coordination or home- and community-based services.
Carve-out		A carve-out is a Medicaid managed care financing model where some portion of Medicaid benefits—dental services, pharmacy services, behavioral health services, etc.—are separately managed and/or financed. Carve-out services can be financed on an at-risk basis by another organization or retained by the state Medicaid agency on a fee-for-service basis.
Certified Community Behavioral Health Clinic	CCBHC	Behavioral health clinics specially certified in a demonstration established by section 223 of the Protecting Access to Medicare Act of 2014. The clinics are designed to provide community-based mental health and addiction treatment services, to advance the integration of behavioral health with physical health care, and to provide care coordination across the full spectrum of health services.

H.2. Glossary Of Terms

Word	Abbreviation	Definition
Community Mental Health Center	CMHC	An organization that can demonstrate that it is actively providing all services in section 1913(c)(I) of the Public Health Services Act, including a.) Outpatient services, including specialized outpatient services for children, the elderly, individuals who are chronically mentally ill, and residents of the CMHC's mental health service area who have been discharged from inpatient treatment at a mental health facility; b.) 24 hour-a-day emergency care services; c.) Day treatment, or other partial hospitalization services, or psychosocial rehabilitation services; and d.) Screening for patients being considered for admission to state mental health facilities to determine the appropriateness of such admission. Additionally, the organization must meet the specifications for the state where it provides services.
Dual Eligible		An individual who is eligible for Medicare (Part A and B) and Medicaid. Medicare serves as the individual's primary insurance, and Medicaid acts as a supplement. Dual eligibles are sometimes referred to as Medicare-Medicaid enrollees (MMEs).
Federal Poverty Level	FPL	The U.S. Department of Health and Human Services sets a standard level of income that is used to determine eligibility for services and benefits, including Medicaid. In 2023, the FPL is $13,590 for an individual and $27,750 for a family of four.
Fee-For-Service	FFS	A system where the payer, in this case Medicaid, contracts directly with provider organizations and pays for providing care on a unit by unit basis. Health plans may also reimburse provider organizations on a FFS basis meaning they pay for each unit of care or test.
Health Home		A "whole person" care coordination model that specifically targets populations with chronic conditions including those with SMI. Health homes provide six essential functions: 1.) Comprehensive care management; 2.) Care coordination and health promotion; 3.) Comprehensive transitional care from inpatient to other settings, including appropriate follow-up; 4.) Individual and family support; 5.) Referral to community and social support services; 6.) Use of health information technology to link services. Health homes were originally developed as a Medicaid program, but have been adopted by other payers. For a state to have an official health home program they must have an approved state plan amendment.

H.2. Glossary Of Terms

Word	Abbreviation	Definition
Health Insurance Marketplace	HIM	Created by the PPACA, the health insurance marketplace is an online platform where individuals and small businesses can purchase health insurance. The federal government subsidizes coverage purchased on the marketplace through premium tax credits for individuals with income up to 400% of the FPL.
Home- & Community-Based Services	HCBS	Long-term services and supports provided in the home or community in order to avoid institutionalization. Traditionally provided through 1915(c) waivers, HCBS services are usually limited to specific populations and a specific number of people. HCBS services include skilled nursing care, personnel care services, assistance with activities of daily living, and custodial care.
Institutions For Mental Disease	IMD	A hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including addiction. Federal financial participation is available for Medicaid IMD services for individuals under the age of 21 and age 65 and over. In recent years, CMS has relaxed the rules prohibiting payments in IMDs for individuals age 21-64. Medicaid health plans may provide up to 15 days of IMD services per month in lieu of state plan services if medically appropriate, cost effective, and consented to by the individual. Additionally, states may be granted a 1115 waiver authority to allow individuals to receive addiction and mental health treatment in IMDs.
Long-Term Services & Supports	LTSS	Services provided in the home, community, or institutional setting to those who experience difficulty living independently and completing activities of daily living as a result of cognitive disabilities, physical impairments, disabling chronic conditions, and/or age.
Managed Care		A health care delivery and financing system designed to manage cost, utilization, and quality. In Medicaid, states generally implement managed care through contracts with health plans, which provide a limited set of benefits to enrollees through a capitated or per person per month (PMPM) rate. The health plans generally assumes full-risk for the cost of treatment, and therefore contracts with a network of provider organizations to provide care at the most efficient rate possible while still maintaining member health.

H.2. Glossary Of Terms

Word	Abbreviation	Definition
Medicaid		Medicaid is a joint federal-state program that provides health coverage to economically disadvantaged populations, such as low-income adults, children, and aged, blind, and disabled (ABD) individuals. States establish their own eligibility standards, benefit packages, provider payment policies, and administrative structures under broad federal guidelines. Financing is a shared responsibility of the federal government and the states.
Medicaid Waiver		Granted by CMS, waivers allow states to make temporary changes to their Medicaid program in order to test out new ways to deliver health coverage.
Medicaid Waiver Section 1115	1115 waiver	Known as research and demonstration waivers, states can apply for program flexibility to test new or existing approaches to financing and delivering Medicaid and CHIP.
Medicaid Waiver Section 1915(b)	1915(b) waiver	States can apply for waivers to provide services through managed care delivery systems, or otherwise limit an individual's choice of health plan or provider organization.
Medicaid Waiver Section 1915(c)	1915(c) waiver	States can apply for waivers to provide long-term care services in home- and community-based settings, rather than institutional settings.
Medical Home		A medical home is not a physical place, but a model for care coordination. Medical homes provide primary care services, care coordination, enhanced access to care, and care that is culturally and linguistically appropriate. Medical homes exist across multiple payers.
Medicare		Federal health insurance for individuals over the age of 65, individuals with certain disabilities, and individuals with end stage renal disease. Medicare covers most acute care services (which may include psychiatric care), but does not cover LTSS or non-physician behavioral health services.
Medicare Advantage	MA	Medicare Part C - also known as Medicare Advantage - is a program which allows individuals who are eligible for Medicare Parts A and B to elect a private health plan to provide their Medicare coverage. The federal government pays the plan's premiums up to a set level, and individuals are responsible for the difference.

H.2. Glossary Of Terms

Word	Abbreviation	Definition
Medicare Advantage Special Needs Plan	SNP	A special type of Medicare Advantage plan that is designed to provide targeted coordinated care to individuals who are a) institutionalized; b) dual eligible; and/or c) meet the severe chronic disabled conditions set forth by CMS. Plans emphasize improved care primarily through continuity of care and care coordination.
Medicare Part A		Hospital Insurance: Covers hospital, skilled nursing care, hospice, and home health care for most eligible individuals at no cost. Financed through payroll tax and deductibles, copayments are only charged if a stay becomes long-term.
Medicare Part B		Supplementary Medical Insurance: Covers most outpatient services, and consumers pay a premium based on income level.
Medicare Part C		Medicare Part C - also known as Medicare Advantage - is a program which allows individuals who are eligible for Medicare Parts A and B to elect a private health plan to provide their Medicare coverage. The federal government pays the plan's premiums up to a set level, and individuals are responsible for the difference.
Medicare Part D		Outpatient Prescription Drug Benefit: Private plans contract with Medicare to provide coverage for prescription drugs. Most consumers pay premiums based on their income.
Metropolitan Statistical Area	MSA	An urbanized area with a population of at least 50,000 plus adjacent territory that has a high degree of social and economic integration as measured by commuting ties.
Patient-Centered Medical Home	PCMH	See Medical Home.
Patient Protection & Affordable Care Act	PPACA or ACA	U.S. health care reform signed into law in 2010. The legislation regulates certain aspects of private and public health insurance programs and authorizes an individual mandate to secure essential health coverage, premium tax credits for the purchase of private health insurance, and increased insurance coverage of preexisting conditions. In 2012 the Supreme Court ruled that state participation is optional for provisions of the law expanding Medicaid coverage to adults ages 18 to 64 with incomes under 138% of the FPL. In 2017, Congress repealed the tax penalties associated with the individual mandate essentially ending the mandate.

H.2. Glossary Of Terms

Word	Abbreviation	Definition
Primary Care Case Management	PCCM	A health care delivery system model with limited utilization and cost control. Under the PCCM model, Medicaid enrollees choose a primary care physician who acts as a gatekeeper for more intensive services. The primary care physician generally receives a per person per month (PMPM) fee for care coordination, and is reimbursed fee-for-service for all medical services provided.
Program Of All Inclusive Care For The Elderly	PACE	PACE serves populations over the age of 55 who are eligible for skilled nursing home care by utilizing a comprehensive delivery system of social, medical, and long-term care services to keep enrollees in the community for as long as possible. PACE is an optional state Medicaid program, and may only be available in certain states, or regions within states.
Serious Mental Illness	SMI	A mental, behavioral, or emotional disorder that lasts for a sufficient duration of time and causes impairment of major life activities. Serious mental illnesses include major depression, schizophrenia, bipolar disorder, obsessive compulsive disorder (OCD), panic disorder, post traumatic stress disorder (PTSD), and borderline personality disorder.
Supported Employment		Provides services and supports to help individuals with disabilities become employed in an integrated or competitive work environment, and retain that employment.
Supported Housing		Housing provided for as long as needed at little or no cost to individuals with mental illness, or other vulnerable populations who are homeless or at-risk for homelessness. Mental health and social services are offered to participants, but are not a condition for participation in the program. The goal is to allow individuals to live as self-sufficient, independent lives as possible.
Value-Based Reimbursement	VBR	Reimbursement model in which payers financially reward or penalize health care provider organizations for performance on quality and cost of care. VBR payment mechanisms include P4P; capitation; shared savings models; shared risk models; and payments based on clinically-defined episodes, called episodes of care or bundled payments.

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