***FRAMEWORK FOR STATE EVALUATION OF CHILDREN'S HEALTH INSURANCE PLANS UNDER TITLE XXI OF THE SOCIAL SECURITY ACT***

**(Developed by States, for States to meet requirements under Section 2108(b) of the Social Security Act)**

State/Territory: Tennessee
(Name of State/Territory)

The following State Evaluation is submitted in compliance with Title XXI of the Social Security Act (Section 2108(b)).

_____
(Signature of Agency Head)

Date: _____

Reporting Period: October 1, 1997 – September 30, 1999

Contact Person/Title: Kasi Tiller, Coordinator of Children Services

Address: Nashville, TN 37247

Phone (615) 741-0213 Fax (615) 741-0882

Email: sbaird@mail.state.tn.us; ktiller@mail.state.tn.us

# Table of Contents

**MCHIP Framework**

**Attachment A…….TennCare enrollment form**

**Attachment B……...……..Reverification letters**

**Attachment C…….MCO/BHO covered services**

**Attachment D…….Addendum to Table 3.1.1**

## SECTION 1. SUMMARY OF KEY ACCOMPLISHMENTS OF YOUR CHIP PROGRAM

This section is designed to highlight the key accomplishments of your CHIP program to date toward increasing the number of children with creditable health coverage (Section 2108(b)(1)(A)). This section also identifies strategic objectives, performance goals, and performance measures for the CHIP program(s), as well as progress and barriers toward meeting those goals. More detailed analysis of program effectiveness in reducing the number of uninsured low-income children is given in sections that follow.

### *1.1 What is the estimated baseline number of uncovered low-income children? Is this estimated baseline the same number submitted to HCFA in the 1998 annual report? If not, what estimate did you submit, and why is it different?*

The Center for Business and Economic Research (CBER) at the University of Tennessee conducts an annual survey of Tennesseans to determine their insurance status, perceptions about quality of medical care, satisfaction with insurance (including TennCare), and use of medical facilities. In 1996, the CBER estimated that there were approximately 68,000 uninsured children in Tennessee.

Currently, there are about 560,000 children under age 18 on TennCare. Of the 560,000 children on TennCare, approximately 390,000 are Medicaid-eligible and the remaining 190,000 are enrolled as Uninsureds (meaning those who lacked access to insurance through a family member's employer) or Uninsurables (meaning those who were turned down for insurance because of a medical condition). The overwhelming majority of children participating in TennCare are from low-income families.

Tennessee's MCHIP plan was approved in September 1999, therefore, an annual report of the MCHIP program was not submitted in 1998. However, the 68,000 uninsured children estimated in 1996, was the same estimate that was used in the original MCHIP plan, which was submitted in December 1997.

#### *1.1.1 What are the data source(s) and methodology used to make this estimate?*

The CBER and the Social Science Research Institute (SSRI), in consultation with the Bureau of TennCare, prepared a survey instrument. A target sample size of 5,000 participants was chosen. The survey was conducted between October 31 and December 4, 1996, using a random-digit dialing based sample and a Computer Assisted Telephone Interviewing System. Four calls were made at staggered times to each residence to minimize non-respondent bias. The design chosen was a "household sample" with the interview conducted with the head of the household.

Approximately 60% of all the households contacted agreed to participate in the survey and as a general rule, the demographics of the random sample closely mirrored those that were obtained for Tennessee during the most recent census.

***1.1.2 What is the State's assessment of the reliability of the baseline estimate? What are the limitations of the data or estimation methodology? (Please provide a numerical range or confidence intervals if available.)***

A correction factor was used to adjust for the degree to which the sample over or under represented statewide figures. As expected, the proportion of the households with incomes under $10,000 was under represented in the sample. Due to the fact that the lowest income residents of Tennessee are the least likely to have telephones, the large sample size enabled the survey to be weighted so that the responses provided unbiased estimates for the entire population.

***1.2 How much progress has been made in increasing the number of children with creditable health coverage (for example, changes in uninsured rates, Title XXI enrollment levels, estimates of children enrolled in Medicaid as a result of Title XXI outreach, anti-crowd-out efforts)? How many more children have creditable coverage following the implementation of Title XXI? (Section 2108(b)(1)(A))***

In Tennessee, the Medicaid program is provided through a Section 1115a waiver called TennCare. In the first year of TennCare (1994), the program was open to uninsured children and adults. The success of the program is shown by the fact that the Uninsured category had to be closed at the end of December 1994, because the program was nearing its cap on the number of people who could be enrolled in TennCare.

On April 1, 1997, TennCare re-opened the Uninsured category to children under the age of 18. This program was called "TennCare for Children" and was marked by intensive efforts by local health departments and community groups all over the State to find children who did not have access to insurance and to enroll them in TennCare.

On December 31, 1997, TennCare filed an MCHIP plan with the Health Care Financing Administration (HCFA). The target population for the State's original MCHIP plan was all uninsured children under the age of 18 who enrolled in the TennCare for Children Program on or after April 1, 1997, and whose family incomes were below 200% poverty. As a part of that application, Tennessee reported that TennCare was covering **almost half a million children under the age of 18.** Over 100,000 of these children were Uninsured and/or Uninsurable.

Effective January 1, 1998, the original "MCHIP group" was expanded to include (1) uninsured children under the age of 19, and (2) uninsured children who had access to health insurance but because of their families financial situation (below 200% poverty) could not afford health insurance for their child(ren).

Tennessee was far ahead of other States in covering uninsured children but was doing so under the TennCare waiver, which was approved prior to CHIP. There were provisions of our approved TennCare waiver, which began in 1994, that were in conflict with CHIP requirements, which were introduced in 1997. As a result, Tennessee submitted a "placeholder" plan which we are calling Phase I of the original MCHIP Plan. Phase I was approved by HCFA on September 3, 1999, and is a subset of the larger group and includes uninsured children born before October 1, 1983, who have not yet attained the age of 19 years and whose family incomes are below 100% of poverty.

As mentioned previously, the CBER estimated that in 1996, there were 68,000 uninsured children in Tennessee. Tennessee has enrolled about 60,000 uninsured children in the TennCare for Children Program since April 1, 1997, which is 88% of the total number of uninsured children projected by the CBER. Considering that the total number of Tennessee children under age 18 in 1996, was 1.322 million (as estimated by the U.S. Bureau of the Census), we can conclude that about 1.254 million had insurance coverage, including TennCare in 1996. It appears that about 750,000 Tennessee children under age 18 had some kind of private or employer-sponsored health insurance other than TennCare, in 1996.

As of July 1, 1999, Tennessee had enrolled 9,732 children who met the criteria of Phase I of the MCHIP plan. Phase I of Tennessee's MCHIP plan was approved September 3, 1999. As of September 30, 1999, 17,046 children had been enrolled that met the criteria of Phase I of the MCHIP plan, an increase of 75%. Two explanations may account for the sizable increase in the number of children who have met the requirements of the MCHIP program.

One, the MCHIP program has received a great deal of publicity in our State. The Advocates were invited to meet with the Commissioner of the Department of Health and provide comments prior to the initial submission of the plan in December 1997. The Governor has held press conferences describing the plan, and a summary of the plan was posted on the TennCare website. Detailed information about the plan has been sent to all requesting it. A public hearing was held on proposed rules for the program and ongoing public involvement, including advocates and provider groups have occurred regularly.

Two, Tennessee has continued its aggressive outreach activities by utilizing health departments and an advocacy agency which conducts outreach activities utilizing a social marketing approach to encourage enrollment of low income children in our State.

### *1.2.1 What are the data source(s) and methodology used to make this estimate?*

The number of children enrolled in TennCare is taken from the TennCare Management Information System (TMIS). Other data, as stated previously in Section 1.2. is taken from the U.S. Census Bureau and from the Center for Business and Economic Research (CBER) at the University of Tennessee.

### *1.2.2 What is the State's assessment of the reliability of the estimate? What are the limitations of the data or estimation methodology? (Please provide a numerical range or confidence intervals if available.)*

Given the credibility and reliability of the data sources (the U.S. Census Bureau and the Center for Business and Economic Research), we are comfortable with the estimated number of children with creditable health coverage and with the number of TennCare eligible children reported from the TMIS system.

## *1.3 What progress has been made to achieve the State's strategic objectives and performance goals for its CHIP program(s)?*

Please complete Table 1.3 to summarize your State's strategic objectives, performance goals, performance measures and progress towards meeting goals, as specified in the Title XXI State Plan. Be as specific and detailed as possible. Use additional pages as necessary. The table should be completed as follows:

Column 1: List the State's strategic objectives for the CHIP program, as specified in the State Plan.

Column 2: List the performance goals for each strategic objective.

Column 3: For each performance goal, indicate how performance is being measured, and progress towards meeting the goal. Specify data sources, methodology, and specific measurement approaches (e.g., numerator, denominator). Please attach additional narrative if necessary.

For each performance goal specified in Table 1.3, please provide additional narrative discussing how actual performance to date compares against performance goals. Please be as specific as possible concerning your findings to date. If performance goals have not been met, indicate the barriers or constraints. The narrative also should discuss future performance measurement activities, including a projection of when additional data are likely to be available.

# CHIP Strategic Objectives and Performance Goals

**Strategic Objective 1:** Reduce the number and proportion of uninsured children in Tennessee.

Performance Goal 1.1: Conduct outreach for the TennCare for Children Program.

Performance Measures:

1) Number of counties with health departments, which have received training materials to help them enroll children in the TennCare for Children/CHIP program.

   **Baseline:** 0 (FFY 96)
   **Target:** 95 (FFY97)

2) Number of organizations other than TennCare, which are conducting TennCare for Children/CHIP outreach activities.

   **Baseline:** 0 (FFY 96)
   **Target:** 3 (FFY 99)

***Progress Summary***

This performance measure has been met. By April 1, 1997, all counties with local health departments (95) had received training materials to assist them in enrolling eligible children into the TennCare for Children Program. Besides the health departments two other organizations are conducting outreach activities.

In the fall of 1998, the Robert Wood Johnson Foundation awarded a grant of $991,648 to the Tennessee Health Care Campaign (THCC), a statewide coalition of grassroots consumer organizations, to support activities especially designed to increase enrollment of children in TennCare. One urban and four rural counties serve as pilot sites for this project. The THCC is utilizing the Social Marketing "Logic Model" for outlining the steps to achieve their goals.

The National Health Care for the Homeless Council administers the TennCare Shelter Enrollment Project. This program is currently the only source of direct training and technical support available in the state to facilitate TennCare enrollment of homeless children. Since 1998, the Project has provided TennCare outreach and enrollment training to more than one hundred emergency shelter staff in twenty-two Tennessee counties, both rural and urban.

Performance Goal 1.2 Enroll uninsured children in the TennCare for Children/MCHIP program.

Performance Measures

1) Number of uninsured children with family incomes less than 100% poverty who are enrolled in the TennCare for Children/CHIP program.

   **Baseline:** 0 (FFY 96)
   **Target:** 10,000 (FFY 99)

2) Number of counties with health departments that are enrolling children in the TennCare for Children/CHIP program

   **Baseline:** 0 (FFY 96)
   **Target:** 95 (FFY 97)

***Progress Summary***

As of September 30, 1999, there were 17,046 children enrolled in Tennessee's MCHIP program, an increase of 75%. We have far exceeded our target and all 95 counties are enrolling children in the TennCare for Children/MCHIP program.

**Strategic Objective 2:** Increase the percentage of children in the TennCare program who have had appropriate EPSDT screenings.

Performance Goal 2.1: Develop improved EPSDT clinical screening guidelines in the areas of vision, hearing, child development, and behavioral health.

Performance Measures:

1) Establishment of EPSDT Screening Guidelines Committee composed of physicians and nurses representing various professional organizations in Tennessee.

   **Timeframe:** Fall 1998

2) Completion of draft guidelines

   **Timeframe:** Summer 1999

3) Pilot testing of guidelines in a pediatric practice in Tennessee.

   **Timeframe:** Late summer 1999

4) Refinement and distribution of guidelines

**Timeframe:** Fall 1999

***Progress Summary:***

In June 1998, the Bureau of TennCare appointed an EPSDT Screening Guidelines Committee. The Committee is composed of physicians and nurses representing various professional organizations, and the managed care organization's (MCOs) and behavioral health organization's (BHOs) medical directors. The committee completed the hearing and vision guidelines in the fall of 1998. The behavioral and developmental guidelines were completed early summer 1999. A contract with Le Bonheur Children's Medical Center was executed and finalized in order to field test the hearing, vision, behavioral and developmental guidelines. The pilot study began mid-July and was completed August 1999. The study was conducted in two local pediatric practices in Shelby County, Tennessee, to examine, in clinical practices, the subjective and objective recommendations of the screening instruments proposed by the EPSDT Screening Guidelines Committee. The guidelines have been widely distributed to MCO/BHO medical directors, EPSDT coordinators at each MCO/BHO, the Pediatric Society of Tennessee and to the Tennessee Nursing Association (TNA). The guidelines have also been included in past EPSDT semi-annual progress reports, and in TennCare Standard Operating Procedures (TSOPs), both of which are distributed to the MCOs/BHOs, their providers and other state agencies such as the Department of Health (DOH), Department of Human Services (DHS), Department of Children Services (DCS), and Department of Mental Health and Mental Retardation (DMHMR).

Performance Goal 2.2: Conduct annual measurements of the percentage of TennCare children who have had appropriate screens which include all 7 required components, and use the results of these measurements to communicate with the MCOs about improvements needed.

Performance Measures:

1) Screening ratio

**Baseline:** .39 (FFY 96)
**Target:** 1.00 (FFY 01)

2) Percentage of the 7 required components contained in EPSDT screens

**Baseline:** 56.2% (FFY 96)
**Target:** 80% (FFY 01)

3) Adjusted periodic screening percentage (APSP) (annual periodic screening percentage multiplied by the percentage of screens with required 7 components present)

**Baseline:** 21.9% (FFY 96)
**Target:** 80% (FFY 01)

***Progress Summary:***

This performance measure is ongoing. The screening ratio for FFY 97 increased to 45% and the APSP also increased to 24.8%. The percentage of the 7 required components contained in EPSDT screens for FFY 97 was 55.1%. Each MCO/BHO is notified of their individual screening results and when there are deficiencies they are required to submit corrective actions plans to the Bureau of TennCare. TennCare's Quality Improvement Unit reviews, accepts and monitors the plans of corrections.

Performance Goal 2.3: Conduct annual measurements of compliance with dental screening requirements and use the results of these measurements to communicate with the MCOs about improvements needed.

Performance Measure:

1) Percentage of TennCare children receiving dental screens

**Baseline:** 28.2% (FFY 96)
**Target:** 80% (FFY 03)

***Progress Summary:***

This performance measure is ongoing. The dental screening percentage for FFY 97 was 31.1%. Each MCO/BHO is notified of their individual screening results and when there are deficiencies they are required to submit corrective actions plans to the Bureau of TennCare. TennCare's Quality Improvement Unit reviews, accepts and monitors the plans of corrections.

**Strategic Objective 3:** Identify and reduce factors that exist in a managed care system which could serve as barriers to delivery of quality health care services to TennCare children.

Performance Goal 3.1: Examine all templates of the Managed Care Organizations: and Behavioral Health Organizations: contracts with providers to determine if there are any elements which present potential barriers to EPSDT and require that these elements be corrected.

Performance Measure:

1) Review of all provider contract templates and identification of potential problems, with requirements for correction of potential problems

**Timeframe:** Summer and fall 1998

2) Review of new provider contract templates for identification of potential problems

**Timeframe:** Ongoing

***Progress Summary:***

During the summer and fall of 1998, the Tennessee Department of Commerce and Insurance completed a review of MCO and BHO contracts. Where potential problems were identified the MCOs/BHOs were required to submit corrective action plans. TennCare's Office of Contract Development and Compliance Unit in conjunction with TDCI continues to monitor new provider contracts for identification of potential problems.

Performance Goal 3.2: Require that the MCOs provide primary care providers with up-to-date list of specialists to whom children may be referred.

Performance Measure:

1) Contract requirement in place

**Timeframe:** Fall of 1998

2) Schedule of quarterly due dates for producing this information

**Timeframe:** June 1999

3) Amendment of contract to include financial consequences for non-compliance with this provision

**Timeframe:** July 2000

***Progress Summary:***

By Amendment, on February 1, 1998, TennCare required MCOs to provide primary care providers with up-to-date lists of specialists to whom children may be referred. In July 1998, the contract was further amended to require that the MCOs implement the schedule of quarterly listings by September 1998, and supplements be provided on a quarterly basis thereafter.

The amendment regarding specific liquidated damages on this requirement is still pending, but is currently being enforced with the reporting requirements in Section 4-8 of the Contractor Risk Agreement.

Performance Goal 3.3: Review all EPSDT activities at each MCO and BHO, identify deficiencies, and

check to see that deficiencies are corrected.

Performance Measure:

1) Letters sent to MCOs/BHOs about deficiencies found in their EPSDT activities

**Timeframe:** Winter 1998

2) Corrective action plans returned by MCOs and approved by TennCare

**Timeframe:** Spring 1999

3) EQRO review of MCOs= and BHOs= corrective action activities

**Timeframe:** Fall 1999

***Progress Summary:***

This performance measure has been met. The Bureau of TennCare requested for the External Quality Review Organization (EQRO) to conduct a review of EPSDT activities at each MCO/BHO as a part of their 1998 fall focus review survey. The EQRO report titled, MCO/BHO EPSDT Activities Report was submitted to TennCare in February 1999. The EQRO developed recommendations specific to each MCO regarding modifications that they might make in their programs; these recommendations were sent to the MCOs and corrective action plans were requested from the MCOs/BHOs. TennCare's Quality Improvement Unit continues to monitor the progress and implementation of the corrective action plans and the EQRO completed a follow-up review of the MCOs' and BHOs' corrective activities in the fall of 1999. The EQRO will continue to monitor the MCO's and BHO's operational activities in an effort to identify and remove elements which may be potential barriers to EPSDT.

Performance Goal 3.4: Identify an AEPSDT Liaison@ at each MCO/BHO who can serve as a focal point for information about EPSDT within the MCO/BHO and who can report to TennCare on activities and concerns.

Performance Measure:

1) Identification of EPSDT Liaisons by the MCOs/BHOs

**Timeframe: Fall 1998**

***Progress Summary:***

In the fall of 1998, each MCO and BHO was asked to appoint an EPSDT representative to serve as a contact person for their organization.

| ***Table 1.3*** | | |
|---|---|---|
| (1)<br>Strategic Objectives<br>(as specified in Title XXI State Plan) | (2)<br>Performance Goals for each Strategic Objective | (3)<br>Performance Measures and Progress<br>(Specify data sources, methodology, numerators, denominators, etc.) |
| **OBJECTIVES RELATED TO REDUCING THE NUMBER OF UNINSURED CHILDREN** | | |
| Reduce the number and proportion of uninsured children in Tennessee | 1) Conduct outreach for the TennCare for Children Program. | 1) Number of counties with health departments which have received training materials to help them enroll children in the TennCare for children/MCHIP program.<br><br>2) Number of organizations other than TennCare which are conducting TennCare for Children/CHIP outreach activities.<br><br>Data Sources: Key contact persons at the Bureau of TennCare and the Bureau of Health Services Administration (HSA).<br><br>Progress Summary:<br><br>By April 1, 1997, all counties with local health departments (95) had received training materials to assist them in enrolling eligible children in the TennCare for Children Program. Besides the health departments two other organizations are conducting outreach activities. |
| | 2) Enroll uninsured children in the TennCare for Children/MCHIP program. | 1) Number of uninsured children with family incomes less than 100% poverty who are enrolled in TennCare for Children/MCHIP program.<br>2) Number of counties with health departments that are enrolling children in the TennCare for Children/CHIP program<br><br>Data Sources: TennCare Management Information System (TMIS) and key contact persons at the Bureau of HSA.<br><br>Progress Summary:<br><br>As of September 30, 1999, 17,046 children were enrolled in Tennessee's MCHIP program. All 95 counties are enrolling children in the TennCare for Children/MCHIP program. |

| OBJECTIVES RELATED TO USE OF PREVENTIVE CARE (IMMUNIZATIONS, WELL-CHILD CARE) | | |
|---|---|---|
| | | |
| Increase the percentage of children in the TennCare program who have had appropriate EPSDT screenings. | 1) Develop improved EPSDT clinical screening guidelines in the areas of vision, hearing, child development, and behavioral health. | 1) Establishment of EPSDT Screening Guidelines Committee composed of physicians and nurses representing various professional organizations in Tennessee.<br>2) Completion of draft guidelines.<br>3) Pilot testing of guidelines is a pediatric practice in Tennessee.<br>4) Refinement and distribution of guidelines.<br><br>Data Sources: Key contact persons at the Bureau of TennCare.<br><br>Progress Summary:<br><br>The EPSDT Screening Guidelines Committee was established in June of 1998. The screening guidelines have been completed, tested and widely distributed to MCOs/BHOs and providers. |
| | 2) Conduct annual measurements of the percentage of TennCare children who have had appropriate screens which include all 7 required components, and use the results of these measurements to communicate with the MCOs about improvements needed. | 1) Screening ratio<br>2) Percentage of the 7 required components contained in EPSDT screens<br>3) Adjusted periodic screening percentage (APSP) (annual periodic screening percentage multiplied by the percentage of screens with required 7 components present)<br><br>Data Source: HCFA 416 report and annual medical record review of a statistically significant sample of screening visits.<br><br>Progress Summary:<br><br>The baseline screening ratio in FFY 96 increased from 39% to 45% for FFY 1997. The percentage of the 7 required components contained in EPSDT screens slightly decreased from 56.2% in FFY96 to 55.1% in FFY 97. The APSP for FFY 97 increased from 21.9% in FFY 96 to 24.8% in FFY 97. |
| | 3) Conduct annual measurements of compliance with dental screening requirements and use the results of thee measurements to communicate with the MCOs about improvements needed. | 1) Percentage of TennCare children receiving dental screens.<br><br>Data Source: HCFA 416 report and TCMIS for dental encounter codes.<br><br>Progress Summary: Dental screenings increased from 28.2% in FFY 96 to 31.1% in FFY 97. |

| OBJECTIVES RELATED TO INCREASING ACCESS TO CARE (USUAL SOURCE OF CARE, UNMET NEED) | | |
|---|---|---|
| | | |
| Identify and reduce factors that exist in a managed care system which could serve as barriers to delivery of quality health care services to TennCare-eligible children. | 1) Examine all template of the MCOs' and BHOs' contracts with providers to determine if there are any elements which present potential barriers to EPSDT and require that these elements be corrected. | 1) Review all provider contract templates for identification of potential problems with requirements for correction of potential problems.<br>2) Review of new provider contract templates for identification of potential problems.<br><br>Data Sources: TennCare Contract Development and Compliance Unit<br><br>Progress Summary:<br><br>The Tennessee Department of Commerce and Insurance (TDCI) has completed reviews of MCO and BHO provider contracts. The Office of Contract Development and Compliance Unit in conjunction with TDCI monitors new provider contracts. |
| | 2) Require that the MCOs provide primary care providers with up-to-date lists of specialists to whom children may be referred. | 1) Contract requirement<br>2) Schedule of quarterly due dates for producing this information<br>3) Amendment of contract to include financial consequences for non-compliance with this provision.<br><br>Data Source: TennCare Contract Development and Compliance Unit.<br><br>Progress Summary: The Risk Agreements with the managed care organizations have been amended to include the provision that primary care providers are to receive an up-to-date lists of specialists on a quarterly basis. |
| | 3) Review all EPSDT activities at each MCO and BHO, identify deficiencies, and check to see that deficiencies are corrected. | 1) Letters sent to MCOs/BHOs about deficiencies found in their EPSDT activities<br>2) Corrective action plans returned by MCOs and approved by TennCare<br>3) EQRO review of MCOs and BHOs' corrective action activities<br><br>Data Source: EQRO EPSDT Activities Report and EQRO Annual Surveys<br><br>Progress Summary: The EQRO completed a review of activities in the fall of 1998 and the MCOs and BHOs submitted corrective action plans as required. The EQRO continues to monitor EPSDT activities during their annual surveys. |

| OBJECTIVES RELATED TO INCREASING ACCESS TO CARE (USUAL SOURCE OF CARE, UNMET NEED) | | |
|---|---|---|
| | | |
| | 1) Identify an "EPSDT Liaison" at each MCO/BHO who can serve as a focal point for information about EPSDT within the MCO/BHO and who can report to TennCare on activities and concerns. | 1) Identification of EPSDT Liaisons by the MCOs/BHOs.<br><br>Data Sources: Key contact persons at the Bureau of TennCare.<br><br>Progress Summary: Each MCO and BHO has appointed an EPSDT Liaison for their organization. |

## SECTION 2. BACKGROUND

This section is designed to provide background information on CHIP program(s) funded through Title XXI.

2.1 ***How are Title XXI funds being used in your State?***

Tennessee's CHIP plan is a Medicaid expansion , which means that all TennCare covered benefits are available for children in the expansion population. There are no other programs funded by Title XXI funds.

2.1.1 ***List all programs in your State that are funded through Title XXI. (Check all that apply.)***

__T__ Providing expanded eligibility under the State's Medicaid plan (Medicaid CHIP expansion)

Name of program: _____TennCare for Children_____

Date enrollment began (i.e., when children first became eligible to receive services): _____October 1, 1997_____

___ Obtaining coverage that meets the requirements for a State Child Health Insurance Plan (State-designed CHIP program)

Name of program: _____

Date enrollment began (i.e., when children first became eligible to receive services): _____

___ Other - Family Coverage

Name of program: _____

Date enrollment began (i.e., when children first became eligible to receive services): _____

___ Other - Employer-sponsored Insurance Coverage

Name of program: _____

Date enrollment began (i.e., when children first became eligible to receive services): _____

___ Other - Wraparound Benefit Package

Name of program: _____

Date enrollment began (i.e., when children first became eligible to receive services): _____

___ Other (specify) _____

Name of program: _____

Date enrollment began (i.e., when children first became eligible to receive services): _____

2.1.2 ***If State offers family coverage:*** *Please provide a brief narrative about requirements for participation in this program and how this program is coordinated with other CHIP programs.*

NA

2.1.3 ***If State has a buy-in program for employer-sponsored insurance:*** *Please provide a brief narrative about requirements for participation in this program and how this program is coordinated with other CHIP programs.*

NA

2.2 ***What environmental factors in your State affect your CHIP program? (Section 2108(b)(1)(E))***

2.2.1 ***How did pre-existing programs (including Medicaid) affect the design of your CHIP program(s)?***

In Tennessee, the Medicaid program is provided through a Section 1115a waiver called TennCare. In the first year of TennCare (1994), the program was open to uninsured children and adults. This category was closed at the end of 1994 because the number of people in the program was nearing the enrollment cap. As stated previously in section 1.2, There were provisions of our approved TennCare waiver, which began in 1994, that were in conflict with CHIP requirements, which were introduced in 1997. As a result, Tennessee submitted a "placeholder" plan which we are calling Phase I of the original MCHIP Plan. Phase I was approved by HCFA on September 3, 1999, and is a subset of the larger group and includes uninsured children born before October 1, 1983, who are under age 19 and whose family incomes are below 100% poverty. Tennessee had previously submitted an MCHIP plan that included all uninsured children under the age of 18 who enrolled in the TennCare for Children Program on or after April 1, 1997, and whose family incomes were below 200% poverty.

2.2.2 ***Were any of the preexisting programs "State-only" and if so what has happened to that program?***

__T__ No pre-existing programs were "State-only"

Tennessee does not have any "State-only" programs. The Title XXI program is an expansion of the existing TennCare Program.

___ One or more pre-existing programs were "State only" ! Describe current status of program(s): Is it still enrolling children? What is its target group? Was it folded into CHIP?

2.2.3 ***Describe changes and trends in the State since implementation of your Title XXI program that "affect the provision of accessible, affordable, quality health insurance and healthcare for children." (Section 2108(b)(1)(E))***

Families presenting for services at local health departments (including those interested in TennCare) are routinely asked whether all of their children are insured. It does not appear that there has been any noticeable movement of children out of private insurance plans and into TennCare, thus "crowd out" does not appear to be an issue in Tennessee. Since our CHIP program is limited to children in families at or below 100% poverty, most of those families would not likely be in the private insurance market and are therefore not subject to "crowd out". Tennessee will of course continue to monitor the enrollment of uninsured children in TennCare to make certain that "crowd out" does not become a factor.

Examples are listed below. Check all that apply and provide descriptive narrative if applicable. Please indicate source of information (e.g., news account, evaluation study) and, where available, provide quantitative measures about the effects on your CHIP program.

___ Changes to the Medicaid program

___ Presumptive eligibility for children
___ Coverage of Supplemental Security Income (SSI) children
___ Provision of continuous coverage (specify number of months ___ )
___ Elimination of assets tests
___ Elimination of face-to-face eligibility interviews
___ Easing of documentation requirements

___ Impact of welfare reform on Medicaid enrollment and changes to AFDC/TANF (specify)_____

___ Changes in the private insurance market that could affect affordability of or accessibility to private health insurance

___ Health insurance premium rate increases
___ Legal or regulatory changes related to insurance
___ Changes in insurance carrier participation (e.g., new carriers entering market or existing carriers exiting market)
___ Changes in employee cost-sharing for insurance
___ Availability of subsidies for adult coverage
___ Other (specify) _____

___ Changes in the delivery system

___ Changes in extent of managed care penetration (e.g., changes in HMO, IPA, PPO activity)
___ Changes in hospital marketplace (e.g., closure, conversion, merger)
___ Other (specify) _____

___ Development of new health care programs or services for targeted low-income children (specify) _____

___ Changes in the demographic or socioeconomic context

___ Changes in population characteristics, such as racial/ethnic mix or immigrant status (specify)_____
___ Changes in economic circumstances, such as unemployment rate (specify) _____
___ Other (specify)_____
___ Other (specify) _____

## SECTION 3. PROGRAM DESIGN

This section is designed to provide a description of the elements of your State Plan, including eligibility, benefits, delivery system, cost-sharing, outreach, coordination with other programs, and anti-crowd-out provisions.

### 3.1 *Who is eligible?*

#### 3.1.1 ***Describe the standards used to determine eligibility of targeted low-income children for child health assistance under the plan. For each standard, describe the criteria used to apply the standard. If not applicable, enter "NA."***

***Table 3.1.1***

| | **Medicaid CHIP Expansion Program** | **State-designed CHIP Program** | **Other CHIP Program*** _____ |
|---|---|---|---|
| Geographic area served by the plan (Section 2108(b)(1)(B)(iv)) | Statewide | NA | NA |
| Age | Born before October 1,1983; not yet attained 19 years | | |
| Income (define countable income) | Below 100% poverty | | |
| Resources (including any standards relating to spend downs and disposition of resources) | NA | | |
| Residency requirements | Must be Tennessee Resident | | |
| Disability status | NA | | |
| Access to or coverage under other health coverage (Section 2108(b)(1)(B)(i)) | Must be uninsured at the time of application | | |
| Other standards (identify and describe) | NA | | |

**See Addendum to Table 3.1.1 in Attachment D.**

**Make a separate column for each "other" program identified in Section 2.1.1. To add a column to a table, right click on the mouse, select "insert" and choose "column".*

### *3.1.2* ***How often is eligibility redetermined?***

| ***Table 3.1.2*** | | | |
|---|---|---|---|
| Redetermination | Medicaid CHIP Expansion Program | State-designed CHIP Program | Other CHIP Program* _____ |
| Monthly | | | |
| Every six months | | | |
| Every twelve months | **T** | | |
| Other (specify) | | | |

*Make a separate column for each "other" program identified in Section 2.1.1. To add a column to a table, right click on the mouse, select "insert" and choose "column".

### ***3.1.3 Is eligibility guaranteed for a specified period of time regardless of income changes? (Section 2108(b)(1)(B)(v))***

__T__ Yes ° Which program(s)? TennCare for Children

For how long? For a period of 12 months

___ No

### ***3.1.4 Does the CHIP program provide retroactive eligibility?***

___ Yes ° Which program(s)?

How many months look-back?

__T__ No

### ***3.1.5 Does the CHIP program have presumptive eligibility?***

___ Yes ° Which program(s)?

Which populations?

Who determines?

__T__ No, Why? (i)(b) Note: Local health departments have the capability to complete an emergency application, meaning coverage can begin as quickly as the application can be competed and basic eligibility information obtained and verified

### *3.1.6 Do your Medicaid program and CHIP program have a joint application?*

___ Yes ° Is the joint application used to determine eligibility for other State programs? If yes, specify.

__T__ No

### *3.1.7 Evaluate the strengths and weaknesses of your eligibility determination process in increasing creditable health coverage among targeted low-income children*

Children seeking to enroll in the TennCare for Children program do so by completing a one page TennCare enrollment form (See Attachment A). The forms are widely available throughout the State—at State offices including all local health departments and through statewide hotlines.

The completed forms are mailed to the Bureau of TennCare where they are keyed in and the social security numbers are verified with the Social Security Administration. Within 7-10 days a notice is sent to the child's family instructing them to go to their local health department to complete the enrollment process. Applicants must have a social security number or have applied for one and proof of income and insurance status is required to complete the enrollment process. If there is inaccurate information on the application, corrections and updates can be made at the local health department immediately and not delay enrollment. During the visit, health department staff provides information regarding benefits as well as the enrollee's rights/responsibilities as a TennCare member.

The MCO and BHO in which the child is to be enrolled are notified of their eligibility and those organizations send the child a card and a Member Handbook. Additional mailings from TennCare and the MCOs/BHOs occur periodically throughout the year.

Generally, the application process can be completed within two to three weeks. However, in an emergency situation the health department can enroll a child immediately, provided technical requirements of the program are met and proof of income and insurance availability is documented and verified.

Shortening the enrollment process and developing a joint Medicaid-CHIP application are areas that may be explored in the future.

3.1.8 ***Evaluate the strengths and weaknesses of your eligibility redetermination process in increasing creditable health coverage among targeted low-income children. How does the redetermination process differ from the initial eligibility determination process?***

The reverification process closely mirrors the eligibility determination process, a positive characteristic of the reverification process. Enrollees are not required to provide any more information than was requested for eligibility determination. During the reverification interview, TennCare members are required to update basic information, i.e. address and telephone numbers, current income, and whether or not they have access to health insurance.

TennCare selects an enrollee (a family case) for reverification during a given month. At the first of the month, TennCare mails a letter (See examples of letters mailed to enrollees regarding reverification in Attachment B) to the enrollee that instructs them to make an appointment at the health department for reverification within 30 days. In actuality, a 90-day clock is started for the enrollee at TennCare. TennCare notifies the health department in the enrollee's home county that his/her name is on the reverification list for that month.

The envelope for the letter is marked "Return Service Requested," which means that if the enrollee has moved and the post office has a forwarding address, they will return the letter to us with a statement of what the new address is so that we can update our files.

If **Letter #1** is returned to TennCare by the post office with a forwarding address, TennCare immediately re-sends **Letter #1** to the enrollee at the new address. The 90-day clock is not re-started.

If **Letter # 1** is returned to TennCare by the post office as undeliverable, TennCare contacts the enrollee's MCO to determine if they have a new address for the enrollee.

- If TennCare is able to obtain a new address for the enrollee, we send another **Letter #1** to the enrollee and re-start the 90-day clock.
- If TennCare is unable to find a new address for the enrollee, TennCare sends **Letter #2** to the enrollee at the same address. (This letter is headed **Warning: Your TennCare is Ending**.) This letter sets a termination date, which is 30 days in the future. If the enrollee has not called the health department by the date in the letter, he is disenrolled effective that date.

  If the enrollee does not contact the health department within 90 days of receiving **Letter #1**, TennCare sends a copy of **Letter #3** to the enrollee. (This letter is headed **FINAL NOTICE**.) **Letter #3** includes a termination date, which is 30

days in the future after the date of the letter.

If the enrollee does not contact the health department by the date stated in **Letter #3**, his enrollment in TennCare is terminated. However, if he contacts the health department any time within 60 days *after* his TennCare is terminated and he is reverified, his TennCare is reinstated without a break.

The strength in the reverification process lies in the fact that it closely mirrors the eligibility determination process, thus minimizing the complexity of the system. There are no new forms to complete, documentation requirements are the same as for eligibility determination, and local health departments assist each enrollee in the reverification process. In addition, safeguards are built into the process for those enrollees who do not respond to initial letters, seek health care and subsequently finds out only then that their TennCare has been terminated. The health department can reverify members during a 60 day grace period, but after that time one must go through the appeal process if he wishes to get back on TennCare.

If the enrollee completes the reverification process in a timely manner, one of the following actions will occur:

- Enrollee is determined to meet criteria, with family income less than 100% poverty. **Letter #4** is mailed to the enrollee notifying him that his TennCare will continue and he will not have a premium. (**This letter is headed Good News about Your TennCare**.)
- Enrollee is determined to meet criteria with family income greater than 100% poverty. **Letter #5** is mailed to the enrollee notifying him that his TennCare will continue. (Children who fall into this category are no longer considered to be in the MCHIP program.) The enrollee also gets an appeal form if he wants to appeal his premium amount. (**This letter is also headed Good News about Your TennCare**.)
- Enrollee is determined not to meet criteria. **Letter #6** is mailed to the enrollee, along with a form for appealing the decision. (This letter is headed **Your TennCare is Ending**.)

TennCare has made great efforts in trying to ensure that members are reminded to notify TennCare when there address changes. Just recently, we implemented a public awareness campaign that was aimed at reminding TennCare members to notify the Bureau of TennCare in the event their address changed. We are working in conjunction with the Advocates to ensure that we make an effort to contact all enrollees. In April, one hundred and fifty thousand postage-paid, post cards were printed for distribution to members throughout the State for quick and easy address changes. The post cards are available at all 95 health departments and the Advocates are assisting us in distributing the post cards to enrollees. A press conference was also held on April 7, 2000, to inform the public of the campaign

and it was well received and attended by the media.

## 3.2 *What benefits do children receive and how is the delivery system structured? (Section 2108(b)(1)(B)(vi))*

### 3.2.1 *Benefits*

***Please complete Table 3.2.1 for each of your CHIP programs, showing which benefits are covered, the extent of cost sharing (if any), and benefit limits (if any).***

There is no cost-sharing for the target group in Phase I of Tennessee's MCHIP Plan.

NOTE: To duplicate a table: put cursor on desired table go to Edit menu and chose "select" "table." Once the table is highlighted, copy it by selecting "copy" in the Edit menu and then "paste" it under the first table.

| ***Table 3.2.1 CHIP Program Type*** Medicaid Expansion | | | |
|---|---|---|---|
| Benefit | Is Service Covered? (**T** = yes) | Cost-Sharing (Specify) | Benefit Limits (Specify) |
| Inpatient hospital services | **T** | None | As medically necessary |
| Emergency hospital services | **T** | None | As medically necessary |
| Outpatient hospital services | **T** | None | As medically necessary |
| Physician services | **T** | None | As medically necessary |
| Clinic services | **T** | None | As medically necessary |
| Prescription drugs | **T** | None | As medically necessary |
| Over-the-counter medications | **T** | NA | MCOs cover a limited amount of OTC medication |
| Outpatient laboratory and radiology services | **T** | None | As medically necessary |
| Prenatal care | **T** | None | As medically necessary |
| Family planning services | **T** | None | As medically necessary |
| Inpatient mental health services | **T** | None | As medically necessary |
| Outpatient mental health services | **T** | None | As medically necessary |
| Inpatient substance abuse treatment services | **T** | None | As medically necessary |
| Residential substance abuse treatment services | **T** | None | As medically necessary |
| Outpatient substance abuse treatment services | **T** | None | As medically necessary |
| Durable medical equipment | **T** | None | As medically necessary |

| ***Table 3.2.1 CHIP Program Type*** Medicaid Expansion | | | |
|---|---|---|---|
| Benefit | Is Service Covered? (**T** = yes) | Cost-Sharing (Specify) | Benefit Limits (Specify) |
| Disposable medical supplies | **T** | None | As medically necessary |
| Preventive dental services | **T** | None | As medically necessary |
| Restorative dental services | **T** | None | As medically necessary |
| Hearing screening | **T** | None | As medically necessary |
| Hearing aids | **T** | None | As medically necessary |
| Vision screening | **T** | None | As medically necessary |
| Corrective lenses (including eyeglasses) | **T** | None | As medically necessary |
| Developmental assessment | **T** | None | As medically necessary |
| Immunizations | **T** | None | As medically necessary |
| Well-baby visits | **T** | None | Screening, interperiodic screening, diagnoses and follow-up treatment services as medically necessary for enrollees under age 21 in accordance with Federal regulations as described in 42 C.F.R. Part 441, Subpart B and 42 U.S.C. 1396d(r). |
| Well-child visits | **T** | None | Screening, interperiodic screening, diagnoses and follow-up treatment services as medically necessary for enrollees under age 21 in accordance with Federal regulations as described in 42 C.F.R. Part 441, Subpart B and 42 U.S.C. 1396d(r). |
| Physical therapy | **T** | None | As medically necessary |
| Speech therapy | **T** | None | As medically necessary |
| Occupational therapy | **T** | None | As medically necessary |
| Physical rehabilitation services | **T** | None | As medically necessary, when determined to be cost effective by the MCO |

| ***Table 3.2.1 CHIP Program Type*** Medicaid Expansion | | | |
|---|---|---|---|
| Benefit | Is Service Covered? (**T** = yes) | Cost-Sharing (Specify) | Benefit Limits (Specify) |
| Podiatric services | **T** | None | As medically necessary, when determined to be cost effective by the MCO |
| Chiropractic services | **T** | None | When determined cost effective by the MCO |
| Medical transportation | **T** | None | As medically necessary |
| Home health services | **T** | None | As medically necessary |
| Nursing facility | **T** | None | TennCare covers nursing facility services for all ages, but there are covered outside of the MCO/BHO |
| ICF/MR | **T** | None | Services are covered outside of the MCO/BHO |
| Hospice care | **T** | None | As medically necessary |
| Private duty nursing | **T** | None | As medically necessary |
| Personal care services | **T** | None | As medically necessary |
| Habilitative services | **T** | None | As medically necessary |
| Case management/Care coordination | **T** | None | As medically necessary |
| Non-emergency transportation | **T** | None | As medically necessary |
| Interpreter services | **T** | None | As medically necessary |
| Other (Specify) Prosthetic devices | **T** | None | As medically necessary |
| Other (Specify) Home and Community Based Waiver services | **T** | None | TennCare has three Home and Community Based Waiver Service programs and a PACE program; these are operated outside the MCOs and BHOs. |
| Other (Specify) Respiratory care service | **T** | None | As medically necessary |

| ***Table 3.2.1 CHIP Program Type*** Medicaid Expansion | | | |
|---|---|---|---|
| Benefit | Is Service Covered? (**T** = yes) | Cost-Sharing (Specify) | Benefit Limits (Specify) |
| Other (Specify) Christian Science Sanatoria Services | **T** | None | |
| Other (Specify) Convalescent Care | **T** | None | Covered under certain conditions, up to 100 days per year |
| Other (Specify) Sitter Services | **T** | None | As medically necessary |

NOTE: To duplicate a table: put cursor on desired table go to Edit menu and chose "select" "table." Once the table is highlighted, copy it by selecting "copy" in the Edit menu and then "paste" it under the first table.

### 3.2.2 *Scope and Range of Health Benefits (Section 2108(b)(1)(B)(ii))*

***Please comment on the scope and range of health coverage provided, including the types of benefits provided and cost-sharing requirements. Please highlight the level of preventive services offered and services available to children with special health care needs. Also, describe any enabling services offered to CHIP enrollees. (Enabling services include non-emergency transportation, interpretation, individual needs assessment, home visits, community outreach, translation of written materials, and other services designed to facilitate access to care.)***

TennCare services are offered through managed care organizations (MCOs) and behavioral health organizations (BHOs) under contract with the State. TennCare services, as determined medically necessary by the MCO, cover inpatient and outpatient hospital care, physician services, prescription drugs, lab and x-ray services, medical supplies, home health care, hospice care and ambulance transportation (See a list of MCO/BHO covered services in Attachment C). Excluded from TennCare managed care services are long-term care services and Medicare cross-over payments which are continuing as they were under the former Medicaid system. Tennessee's CHIP plan is a Medicaid expansion, which means that all TennCare covered benefits are available for children in the expansion population and the quality control measures currently used under the TennCare program will be used for the children in the MCHIP program.

### 3.2.3 *Delivery System*

***Identify in Table 3.2.3 the methods of delivery of the child health assistance using Title XXI funds to targeted low-income children. Check all that apply.***

| ***Table 3.2.3*** | | | |
|---|---|---|---|
| Type of delivery system | Medicaid CHIP Expansion Program | State-designed CHIP Program | Other CHIP Program* _____ |
| A. Comprehensive risk managed care organizations (MCOs) | **T** | NA | NA |
| Statewide? | **T** Yes ___ No | ___ Yes ___ No | ___ Yes ___ No |
| Mandatory enrollment? | ___ Yes ___ No | ___ Yes ___ No | ___ Yes ___ No |
| Number of MCOs | | | |
| B. Primary care case management (PCCM) program | NA | | |
| C. Non-comprehensive risk contractors for selected services such as mental health, dental, or vision (specify services that are carved out to managed care, if applicable) | NA | | |
| D. Indemnity/fee-for-service (specify services that are carved out to FFS, if applicable) | NA | | |
| E. Other (specify) | | | |
| F. Other (specify) | | | |
| G. Other (specify) | | | |

*Make a separate column for each "other" program identified in Section 2.1.1. To add a column to a table, right click on the mouse, select "insert" and choose "column".

3.3 ***How much does CHIP cost families?***

***3.3.1 Is cost sharing imposed on any of the families covered under the plan? (Cost sharing includes premiums, enrollment fees, deductibles, coinsurance/ copayments, or other out-of-pocket expenses paid by the family.)***

__T__ No, skip to section 3.4

___ Yes, check all that apply in Table 3.3.1

| ***Table 3.3.1*** | | | |
|---|---|---|---|
| Type of cost-sharing | Medicaid CHIP Expansion Program | State-designed CHIP Program | Other CHIP Program* _____ |
| Premiums | NA | | |
| Enrollment fee | NA | | |
| Deductibles | NA | | |
| Coinsurance/copayments** | NA | | |
| Other (specify) _____ | | | |

*Make a separate column for each "other" program identified in section 2.1.1. To add a column to a table, right click on the mouse, select "insert" and choose "column".
**See Table 3.2.1 for detailed information.

3.3.2 ***If premiums are charged:*** *What is the level of premiums and how do they vary by program, income, family size, or other criteria? (Describe criteria and attach schedule.) How often are premiums collected? What do you do if families fail to pay the premium? Is there a waiting period (lock-out) before a family can re-enroll? Do you have any innovative approaches to premium collection?*

NA

3.3.3 ***If premiums are charged:*** *Who may pay for the premium? Check all that apply. (Section 2108(b)(1)(B)(iii))*

NA

___ Employer
___ Family
___ Absent parent
___ Private donations/sponsorship
___ Other (specify) _____

3.3.4 ***If enrollment fee is charged:*** *What is the amount of the enrollment fee and how does it vary by program, income, family size, or other criteria?*

NA

3.3.5 ***If deductibles are charged:*** *What is the amount of deductibles (specify, including variations by program, health plan, type of service, and other criteria)?*

NA

3.3.6 ***How are families notified of their cost-sharing requirements under CHIP, including the 5 percent cap?***

NA

3.3.7 ***How is your CHIP program monitoring that annual aggregate cost-sharing does not exceed 5 percent of family income? Check all that apply below and include a narrative providing further details on the approach.***

NA

___ Shoebox method (families save records documenting cumulative level of cost sharing)
___ Health plan administration (health plans track cumulative level of cost sharing)
___ Audit and reconciliation (State performs audit of utilization and cost sharing)
___ Other (specify)_____

3.3.8 ***What percent of families hit the 5 percent cap since your CHIP program was implemented? (If more than one CHIP program with cost sharing, specify for each program.)***

NA

3.3.9 ***Has your State undertaken any assessment of the effects of premiums on participation or the effects of cost sharing on utilization, and if so, what have you found?***

NA

## 3.4 *How do you reach and inform potential enrollees?*

### 3.4.1 *What client education and outreach approaches does your CHIP program use?*

*Please complete Table 3.4.1. Identify all of the client education and outreach approaches used by your CHIP program(s). Specify which approaches are used (**T**=yes) and then rate the effectiveness of each approach on a scale of 1 to 5, where 1=least effective and 5=most effective.*

***Table 3.4.1***

| Approach | Medicaid CHIP Expansion | | State-Designed CHIP Program | | Other CHIP Program* _____ | |
|---|---|---|---|---|---|---|
| | **T** = Yes | Rating (1-5) | **T** = Yes | Rating (1-5) | **T** = Yes | Rating (1-5) |
| Billboards | | | | | | |
| Brochures/flyers | **T** | 4 | | | | |
| Direct mail by State/enrollment broker/administrative contractor | | | | | | |
| Education sessions | **T** | 3 | | | | |
| Home visits by State/enrollment broker/administrative contractor | Certain local health depts. | 5 | | | | |
| Hotline | **T** | 4 | | | | |
| Incentives for education/outreach staff | | | | | | |
| Incentives for enrollees | | | | | | |
| Incentives for insurance agents | | | | | | |
| Non-traditional hours for application intake | Health departments in metropolitan areas | 3 | | | | |
| Prime-time TV advertisements | | | | | | |
| Public access cable TV | | | | | | |
| Public transportation ads | | | | | | |

| ***Table 3.4.1*** | | | | | | |
|---|---|---|---|---|---|---|
| Approach | Medicaid CHIP Expansion | | State-Designed CHIP Program | | Other CHIP Program* _____ | |
| | **T** = Yes | Rating (1-5) | **T** = Yes | Rating (1-5) | **T** = Yes | Rating (1-5) |
| Radio/newspaper/TV advertisement and PSAs | **T** | 3 | | | | |
| Signs/posters | **T** | 4 | | | | |
| State/broker initiated phone calls | | | | | | |
| Other (specify) Advocacy Agency (RWJ grantee) | **T** | 5 | | | | |
| Other (specify) Title V agency | **T** | 5 | | | | |
| Other (specify) TennCare shelter project (homeless/domestic violence outreach | **T** | 5 | | | | |

*Make a separate column for each "other" program identified in section 2.1.1. To add a column to a table, right click on the mouse, select "insert" and choose "column".

3.4.2 ***Where does your CHIP program conduct client education and outreach?***

***Please complete Table 3.4.2. Identify all the settings used by your CHIP program(s) for client education and outreach. Specify which settings are used (T = yes) and then rate the effectiveness of each setting on a scale of 1 to 5, where 1=least effective and 5=most effective.***

***Table 3.4.2***

| Setting | Medicaid CHIP Expansion | | State-Designed CHIP Program | | Other CHIP Program* _____ | |
|---|---|---|---|---|---|---|
| | **T** = Yes | Rating (1-5) | **T** = Yes | Rating (1-5) | **T** = Yes | Rating (1-5) |
| Battered women shelters | **T** | 5 | | | | |
| Community sponsored events | **T** | 4 | | | | |
| Beneficiary's home | | | | | | |
| Day care centers | **T** | 4 | | | | |
| Faith communities | **T** | 4 | | | | |
| Fast food restaurants | **T** | 4 | | | | |
| Grocery stores | **T** | 4 | | | | |
| Homeless shelters | **T** | 5 | | | | |
| Job training centers | | | | | | |
| Laundromats | | | | | | |
| Libraries | **T** | 3 | | | | |
| Local/community health centers | **T** | 5 | | | | |
| Point of service/provider locations | **T** | 5 | | | | |
| Public meetings/health fairs | **T** | 5 | | | | |
| Public housing | **T** | 4 | | | | |

| | | | | | | |
|---|---|---|---|---|---|---|
| Refugee resettlement programs | **T** | 5 | | | | |

| ***Table 3.4.2*** | | | | | | |
|---|---|---|---|---|---|---|
| Setting | Medicaid CHIP Expansion | | State-Designed CHIP Program | | Other CHIP Program* _____ | |
| | **T** = Yes | Rating (1-5) | **T** = Yes | Rating (1-5) | **T** = Yes | Rating (1-5) |
| Schools/adult education sites | **T** | 4 | | | | |
| Senior centers | | | | | | |
| Social service agency | **T** | 4 | | | | |
| Workplace | **T** | 3 | | | | |
| Other (specify) | | | | | | |
| Other (specify) | | | | | | |

*Make a separate column for each "other" program identified in section 2.1.1. To add a column to a table, right click on the mouse, select "insert" and choose "column".

3.4.3 ***Describe methods and indicators used to assess outreach effectiveness, such as the number of children enrolled relative to the particular target population. Please be as specific and detailed as possible. Attach reports or other documentation where available.***

While Tennessee has conducted numerous outreach activities very few of them have been monitored for effectiveness. We are beginning to take steps to determine what activities work best so that we can provide outreach more effectively and efficiently. There are two organizations that collaborate with TennCare which have begun to track preliminary results of their activities.

The Robert Wood Johnson Foundation (RWJ) awarded a grant of $991,648 to the Tennessee Health Care Campaign (THCC) to support activities especially designed to increase enrollment of children in TennCare. Four rural and one urban county serve as research sites for this project. THCC is utilizing the Social Marketing "Logic Model" for outlining the steps to achieve their goals. This model is aimed at trying to reach individuals whom we have failed to reach through more traditional outreach and marketing strategies.

The National Health Care for the Homeless Council administers the TennCare Shelter Enrollment Project. This program is currently the only source of direct training and technical support available in the state to facilitate TennCare enrollment of homeless children. Since 1998, the Project has provided TennCare outreach enrollment training to more than one hundred emergency shelter staff in twenty-two Tennessee counties, both rural and urban.

The THCC and the TennCare Shelter Enrollment Project are both devising mechanisms to track the effectiveness of their outreach efforts.

3.4.4 ***What communication approaches are being used to reach families of varying ethnic backgrounds?***

Our local health departments have taken the lead in tailoring outreach activities to meet the needs of their specific counties. Depending on the diversity of the county, some health departments work with Multicultural Service agencies to conduct presentations at neighborhood associations. Some counties work with the Black Ministerial Associations and African American Churches. TennCare has a contract with the Crisis Intervention Center to operate the TennCare Hispanic Information Line and to perform outreach activities in the Hispanic communities throughout the State. Just recently we have begun to strategize with the Native American Indian Association on how best to educate Native Americans about TennCare. Each of these groups participate on a Statewide Advisory committee facilitated by the THCC to brainstorm and develop outreach strategies.

Effective social marketing strategies developed through the RWJ pilot sites will be shared with health departments and other agencies throughout the State. The pilot site coordinators have recently begun their research on the effectiveness of various outreach activities. From April to June 1999, the THCC spent its time building a statewide advisory committee and a communication network. The network is composed of over 8,000 new contacts in agencies and organizations serving children and families.

The THCC distributes faxes, e-mails and/or TennCare for Children newsletters and flyers to the various organizations in the communications network. Organizations that serve refugees and migrant workers, minority coalitions, homeless coalitions and disability coalitions are represented on the statewide advisory committee and are also part of the grassroots communications network.

Shelby county, Tennessee's largest county, works with Catholic Charities of Tennessee to conduct informational meetings for immigrants and refugees and provides information on how to enroll in TennCare while volunteers of Catholic Charities provides translators to interpret the information. Other counties are also developing relationships in their area with Catholic Charities and similar organizations.

The Department of Health's Minority Affairs' Office provides information about TennCare to its member organizations for distribution to their consumers.

3.4.5 ***Have any of the outreach activities been more successful in reaching certain populations? Which methods best reached which populations? How have you measured their effectiveness? Please present quantitative findings where available.***

Again, we have little quantitative results of the effectiveness of our outreach activities at this time, but anticipate having preliminary results quantified from the THCC and the TennCare Shelter Enrollment Project within the next few months.

3.5 ***What other health programs are available to CHIP eligibles and how do you coordinate with them? (Section 2108(b)(1)(D))***

The TennCare Program relies heavily on the Title V agency to coordinate outreach and eligibility determination for the title XXI program. The Healthy Start program and the Child Health and Development (CHAD) program are intensive case management and outreach home visiting programs. The nurses/case workers that visit homes regularly check with their clients to ensure that they have health insurance. In cases where the child is not covered, the caseworkers assist the parent in completing the application process for TennCare. The caseworker will also assist the parent in scheduling EPSDT appointments. Caseworkers also are currently required to monitor the rates of EPSDT appointments for their caseloads.

The Children's Special Services (CSS) program is another intensive case management program for special needs children. The caseworker ensures that every child applies for TennCare and they assist the family in accessing care for the child. Caseworkers provide education on how to access care and explain the TennCare benefits package to families and children.

3.5

***Describe procedures to coordinate among CHIP programs, other health care programs, and non-health care programs. Table 3.5 identifies possible areas of coordination between CHIP and other programs (such as Medicaid, MCH, WIC, School Lunch). Check all areas in which coordination takes place and specify the nature of coordination in narrative text, either on the table or in an attachment.***

***Table 3.5***

| Type of coordination | Medicaid* | Maternal and child health | Other (specify) WIC | Other (specify) School Lunch | Other (specify) Local health dept. | Tennessee Health Care Campaign | TennCare Shelter Enrollment Program |
|---|---|---|---|---|---|---|---|
| Administration | | | | | | | |
| Outreach | | T | T | T | T | T | T |
| Eligibility determination | | | | | T | | |
| Service delivery | | | | | | | |
| Procurement | | | | | | | |
| Contracting | | | | | | | |
| Data collection | | | | | | T | T |
| Quality assurance | | | | | | | |
| Other (specify) | | | | | | | |

*Note: This column is not applicable for States with a Medicaid CHIP expansion program only.

3.6 ***How do you avoid crowd-out of private insurance?***

3.6.1 ***Describe anti-crowd-out policies implemented by your CHIP program. If there are differences across programs, please describe for each program separately. Check all that apply and describe.***

Since our MCHIP program is limited to children in families at or below 100% of poverty, most of those families would not likely be in the private insurance market and are therefore not subject to crowd out.

Eligibility determination process:

___ Waiting period without health insurance (specify)
T Information on current or previous health insurance gathered on application (specify)
Applicant must be uninsured at the time of application.
T Information verified with employer (specify) ***Employer must verify insurance availability.***
___ Records match (specify) ***Social security numbers are verified with the Social Security Administration.***
T
___ Other (specify) ***Proof of family income is a requirement***.
T Other (specify)

___ Benefit package design:

___ Benefit limits (specify)
___ Cost-sharing (specify)
___ Other (specify)
___ Other (specify)

___ Other policies intended to avoid crowd out (e.g., insurance reform):

___ Other (specify)
___ Other (specify) _____

3.6.2 ***How do you monitor crowd-out? What have you found? Please attach any available reports or other documentation.***

See question 3.6.1

## SECTION 4. PROGRAM ASSESSMENT

This section is designed to assess the effectiveness of your CHIP program(s), including enrollment, disenrollment, expenditures, access to care, and quality of care.

### 4.1 *Who enrolled in your CHIP program?*

#### 4.1.1 *What are the characteristics of children enrolled in your CHIP program? (Section 2108(b)(1)(B)(i))*

Please complete Table 4.1.1 for each of your CHIP programs, based on data from your HCFA quarterly enrollment reports. Summarize the number of children enrolled and their characteristics. Also, discuss average length of enrollment (number of months) and how this varies by characteristics of children and families, as well as across programs.

States are also encouraged to provide additional tables on enrollment by other characteristics, including gender, race, ethnicity, parental employment status, parental marital status, urban/rural location, and immigrant status. Use the same format as Table 4.1.1, if possible.

NOTE: To duplicate a table: put cursor on desired table go to Edit menu and chose "select" "table." Once the table is highlighted, copy it by selecting "copy" in the Edit menu and then "paste" it under the first table.

***Table 4.1.1 CHIP Program Type*** Medicaid Expansion

| Characteristics | Number of children ever enrolled | | Average number of months of enrollment | | Number of disenrollees | |
|---|---|---|---|---|---|---|
| | FFY 1998 | FFY 1999 | FFY 1998 | FFY 1999 | FFY 1998 | FFY 1999 |
| **All Children** | 12,819 | 17,468 | 2.78 | 2.83 | 102 | 179 |
| | | | | | | |
| **Age** | | | | | | |
| Under 1 | | | | | | |
| 1-5 | | | | | | |
| 6-12 | | | | | | |
| 13-18 | 12,819 | 17,468 | 2.78 | 2.83 | 102 | 179 |

| ***Table 4.1.1 CHIP Program Type*** Medicaid Expansion | | | | | | |
|---|---|---|---|---|---|---|
| Characteristics | Number of children ever enrolled | | Average number of months of enrollment | | Number of disenrollees | |
| | FFY 1998 | FFY 1999 | FFY 1998 | FFY 1999 | FFY 1998 | FFY 1999 |
| **Countable Income Level*** | | | | | | |
| At or below 150% FPL | 12,819 | 17,468 | 2.78 | 2.83 | 102 | 179 |
| Above 150% FPL | | | | | | |
| | | | | | | |
| **Age and Income** | | | | | | |
| Under 1 | | | | | | |
| At or below 150% FPL | | | | | | |
| Above 150% FPL | | | | | | |
| | | | | | | |
| 1-5 | | | | | | |
| At or below 150% FPL | | | | | | |
| Above 150% FPL | | | | | | |
| 6-12 | | | | | | |
| At or below 150% FPL | | | | | | |
| Above 150% FPL | | | | | | |
| | | | | | | |
| 13-18 | | | | | | |
| At or below 150% FPL | 12,819 | 17,468 | 2.78 | 2.83 | 102 | 179 |
| Above 150% FPL | | | | | | |
| | | | | | | |
| **Type of plan** | | | | | | |
| Fee-for-service | | | | | | |
| Managed care | 12,819 | 17,468 | 2.78 | 2.83 | 102 | 179 |
| PCCM | | | | | | |

*Countable Income Level is as defined by the states for those that impose premiums at defined levels other than 150% FPL. See the HCFA Quarterly Report instructions for further details.

SOURCE: HCFA Quarterly Enrollment Reports, Forms HCFA-21E, HCFA-64.21E, HCFA-64EC, HCFA Statistical Information

***4.1.2 How many CHIP enrollees had access to or coverage by health insurance prior to enrollment in CHIP? Please indicate the source of these data (e.g., application form, survey). (Section 2108(b)(1)(B)(i))***

Since our MCHIP program was recently approved (September 1999), at this time we do not have access to this information.

***4.1.3 What is the effectiveness of other public and private programs in the State in increasing the availability of affordable quality individual and family health insurance for children? (Section 2108(b)(1)(C))***

Based on data from the U.S Bureau of the Census and the Center for Business and Economic Research (CBER), it appears that about 750,000 Tennessee children under age 18 had some kind of private or employer-sponsored health insurance other than TennCare, in 1996. Considering that the total number of Tennessee children under age 18 in 1996, was 1.322 million, we can conclude that about 1.254 million had insurance coverage, including TennCare. A significant number of these children are covered by ERISA plans, which do not report to the State.

4.2 ***Who disenrolled from your CHIP program and why?***

4.2.1 ***How many children disenrolled from your CHIP program(s)? Please discuss disenrollment rates presented in Table 4.1.1. Was disenrollment higher or lower than expected? How do CHIP disenrollment rates compare to traditional Medicaid disenrollment rates?***

In FFY 1998, 102 children disenrolled from the program and in FFY 1999, 179 children disenrolled. At this time, we are not able to compare MCHIP disenrollment rates to Medicaid disenrollment rates. We anticipate reporting on this information in future reports.

4.2.2 ***How many children did not re-enroll at renewal? How many of the children who did not re-enroll got other coverage when they left CHIP?***

We are unable to report on this information.

4.2.3 ***What were the reasons for discontinuation of coverage under CHIP? (Please specify data source, methodologies, and reporting period.)***

| ***Table 4.2.3*** | | | | | | |
|---|---|---|---|---|---|---|
| Reason for discontinuation of coverage | Medicaid CHIP Expansion Program<br>FFY 1999 | | State-designed CHIP Program | | Other CHIP Program*<br>_____ | |
| | Number of disenrollees | Percent of total | Number of disenrollees | Percent of total | Number of disenrollees | Percent of total |
| Total | 179 | | | | | |
| Access to commercial insurance | | | | | | |
| Eligible for Medicaid | | | | | | |
| Income too high | | | | | | |
| Aged out of program | | | | | | |
| Moved/died | | | | | | |
| Nonpayment of premium | | | | | | |
| Incomplete documentation | | | | | | |
| Did not reply/unable to contact | | | | | | |
| Other (specify) | | | | | | |
| Other (specify) | | | | | | |
| Don't know | **T** | | | | | |

*Make a separate column for each "other" program identified in section 2.1.1. To add a column to a table, right click on the mouse, select "insert" and choose "column".

4.2.4 ***What steps is your State taking to ensure that children who disenroll, but are still eligible, re-enroll?***

Local health departments conduct outreach to encourage families of children who may continue to be eligible for TennCare to complete the reverification process. The Tennessee Health Care Campaign (THCC) and the TennCare Shelter Enrollment Project have a component of their outreach efforts that are targeted to those families whose children who may have lost their TennCare coverage because the reverification process was not completed. Children who lose coverage, yet continue to meet the eligibility requirements of the MCHIP program, will be allowed to re-enroll.

4.3 ***How much did you spend on your CHIP program?***

4.3.1 ***What were the total expenditures for your CHIP program in federal fiscal year (FFY) 1998 and 1999?***

FFY 1998 11,625,298.30

FFY 1999 22,556,919.00

Please complete Table 4.3.1 for each of your CHIP programs and summarize expenditures by category (total computable expenditures and federal share). What proportion was spent on purchasing private health insurance premiums versus purchasing direct services?

***Table 4.3.1 CHIP Program Type*** Expansion

| Type of expenditure | Total computable share | | Total federal share | |
|---|---|---|---|---|
| | FFY 1998 | FFY 1999 | FFY 1998 | FFY 1999 |
| **Total expenditures** | 11,625,298.30 | 22,556,919.00 | 8,643,409.29 | 16,728,211.13 |
| | | | | |
| **Premiums for private health insurance (net of cost-sharing offsets)*** | 11,625,298.30 | 22,556,919.00 | 8,643,409.29 | 16,728,211.13 |
| | | | | |
| **Fee-for-service expenditures (subtotal)** | | | | |
| Inpatient hospital services | | | | |
| Inpatient mental health facility services | | | | |
| Nursing care services | | | | |
| Physician and surgical services | | | | |

***Table 4.3.1 CHIP Program Type*** Expansion

| Type of expenditure | Total computable share | | Total federal share | |
|---|---|---|---|---|
| | FFY 1998 | FFY 1999 | FFY 1998 | FFY 1999 |
| Outpatient hospital services | | | | |
| Outpatient mental health facility services | | | | |
| Prescribed drugs | | | | |
| Dental services | | | | |
| Vision services | | | | |
| Other practitioners' services | | | | |
| Clinic services | | | | |
| Therapy and rehabilitation services | | | | |
| Laboratory and radiological services | | | | |
| Durable and disposable medical equipment | | | | |
| Family planning | | | | |
| Abortions | | | | |
| Screening services | | | | |
| Home health | | | | |
| Home and community-based services | | | | |
| Hospice | | | | |
| Medical transportation | | | | |
| Case management | | | | |
| Other services | | | | |

4.3.2 ***What were the total expenditures that applied to the 10 percent limit? Please complete Table 4.3.2 and summarize expenditures by category***.

What types of activities were funded under the 10 percent cap?____Outreach____

What role did the 10 percent cap have in program design? ____None____

| ***Table 4.3.2*** | | | | | | |
|---|---|---|---|---|---|---|
| **Type of expenditure** | Medicaid Chip Expansion Program | | State-designed CHIP Program | | Other CHIP Program* _____ | |
| | FY 1998 | FY 1999 | FY 1998 | FY 1999 | FY 1998 | FY 1999 |
| **Total computable share** | 38,597 | 535,792 | | | | |
| Outreach | | | | | | |
| Administration | | | | | | |
| Other_____ | | | | | | |
| **Federal share** | | | | | | |
| Outreach | | | | | | |
| Administration | | | | | | |
| Other _____ | | | | | | |

*Make a separate column for each "other" program identified in section 2.1.1. To add a column to a table, right click on the mouse, select "insert" and choose "column".

4.3.3 ***What were the non-Federal sources of funds spent on your CHIP program (Section 2108(b)(1)(B)(vii))***

__T_ State appropriations
___ County/local funds
___ Employer contributions
___ Foundation grants
___ Private donations (such as United Way, sponsorship)
___ Other (specify) _____

4.4 ***How are you assuring CHIP enrollees have access to care?***

4.4.1 ***What processes are being used to monitor and evaluate access to care received by CHIP enrollees? Please specify each delivery system used (from question 3.2.3) if approaches vary by the delivery system within each program. For example, if an approach is used in managed care, specify 'MCO.' If an approach is used in fee-for-service, specify 'FFS.' If an approach is used in a Primary Care Case Management program, specify 'PCCM.'***

***Table 4.4.1***

| Approaches to monitoring access | Medicaid CHIP Expansion Program | State-designed CHIP Program | Other CHIP Program* _____ |
|---|---|---|---|
| Appointment audits | MCO | | |
| PCP/enrollee ratios | MCO | | |
| Time/distance standards | MCO | | |
| Urgent/routine care access standards | MCO | | |
| Network capacity reviews (rural providers, safety net providers, specialty mix) | MCO | | |
| Complaint/grievance/ disenrollment reviews | MCO | | |
| Case file reviews | MCO | | |
| Beneficiary surveys | | | |
| Utilization analysis (emergency room use, preventive care use) | MCO | | |
| Other (specify) _____ | | | |
| Other (specify) _____ | | | |
| Other (specify) _____ | | | |

*Make a separate column for each "other" program identified in section 2.1.1. To add a column to a table, right click on the mouse, select "insert" and choose "column".

***4.4.2 What kind of managed care utilization data are you collecting for each of your CHIP programs? If your State has no contracts with health plans, skip to section 4.4.3.***

| ***Table 4.4.2*** | | | |
|---|---|---|---|
| Type of utilization data | Medicaid CHIP Expansion Program | State-designed CHIP Program | Other CHIP Program* _____ |
| Requiring submission of raw encounter data by health plans | ___ Yes ___ No T | ___ Yes ___ No | ___ Yes ___ No |
| Requiring submission of aggregate HEDIS data by health plans | ___ Yes ___ No | ___ Yes ___ No | ___ Yes ___ No |
| Other (specify)_____ | ___ Yes ___ No | ___ Yes ___ No | ___ Yes ___ No |

*Make a separate column for each "other" program identified in section 2.1.1. To add a column to a table, right click on the mouse, select "insert" and choose "column".

***4.4.3 What information (if any) is currently available on access to care by CHIP enrollees in your State? Please summarize the results.***

Tennessee's CHIP plan is a medicaid expansion. All access to care standards currently used under the TennCare program will be used for MCHIP children.

***4.4.4 What plans does your CHIP program have for future monitoring/evaluation of access to care by CHIP enrollees? When will data be available?***

The same monitoring/evaluation of access to care for the TennCare program will be used for children in the expansion population.

4.5 ***How are you measuring the quality of care received by CHIP enrollees?***

See answer to question 4.4.3

***4.5.1 What processes are you using to monitor and evaluate quality of care received by CHIP enrollees, particularly with respect to well-baby care, well-child care, and immunizations? Please specify the approaches used to monitor quality within each delivery system (from question 3.2.3). For example, if an approach is used in managed care, specify 'MCO.' If an approach is used in fee-for-service, specify 'FFS.' If an approach is used in primary care case management, specify 'PCCM.'***

***Table 4.5.1***

| Approaches to monitoring quality | Medicaid CHIP Expansion Program | State-designed CHIP Program | Other CHIP Program |
|---|---|---|---|
| Focused studies (specify) | MCO | | |
| Client satisfaction surveys | MCO | | |
| Complaint/grievance/ Disenrollment reviews | MCO | | |
| Sentinel event reviews | | | |
| Plan site visits | MCO | | |
| Case file reviews | MCO | | |
| Independent peer review | | | |
| HEDIS performance measurement | | | |
| Other performance measurement (specify) | | | |
| Other (specify) Annual medical record reviews | MCO | | |
| Other (specify) _____ | | | |
| Other (specify) _____ | | | |

*Make a separate column for each "other" program identified in section 2.1.1. To add a column to a table, right click on the mouse, select "insert" and choose "column".

4.5.2 ***What information (if any) is currently available on quality of care received by CHIP enrollees in your State? Please summarize the results.***

Services for children under the Medicaid expansion will be evaluated in the same manner as for other TennCare members. This will be accomplished through our Quality Oversight Program.

In order to assure that all TennCare enrollees have access to the full range of covered health care services and that those services are of a high quality, quality assurance activities are undertaken at three

different levels in the TennCare

program. First, each MCO and BHO is required to have an internal quality assurance program. Second, the Bureau of TennCare contracts with an External Quality Review Organization (EQRO) to ensure that the MCOs' and BHOs' internal quality assurance program is operating effectively. Finally, the TennCare Bureau, either directly or through contracts with other agencies such as universities, assesses plan-specific and overall program performance.

Active oversight of MCO/BHO internal quality assurance activities is provided by the EQRO. A team from the EQRO makes an onsite visit to each MCO/BHO during the first six months of the year. MCO/BHO performance is reviewed in the areas of utilization management, preventive services, coordination of services, management information systems, network adequacy, provider credentialing, member services, and quality improvement. The results of the upcoming survey should be available by mid-summer.

4.5.3 ***What plans does your CHIP program have for future monitoring/evaluation of quality of care received by CHIP enrollees? When will data be available?***

Given our commitment to quality of care issues, TennCare will continue to fund studies and conduct data validation activities. The EQRO conducts an annual medical record review to compare information in the record to information reported by the MCO in the form of encounter data. TennCare monitors submission of encounter data on an ongoing basis and takes action in the form of retention of a withhold of 10% of the monthly capitation payment whenever it is determined that a contractor is not in compliance.

***4.6 Please attach any reports or other documents addressing access, quality, utilization, costs, satisfaction, or other aspects of your CHIP program's performance. Please list attachments here.***

NA

## SECTION 5. REFLECTIONS

This section is designed to identify lessons learned by the State during the early implementation of its CHIP program as well as to discuss ways in which the State plans to improve its CHIP program in the future. The State evaluation should conclude with recommendations of how the Title XXI program could be improved.

5.1 ***What worked and what didn't work when designing and implementing your CHIP program? What lessons have you learned? What are your "best practices"? Where possible, describe what evaluation efforts have been completed, are underway, or planned to analyze what worked and what didn't work. Be as specific and detailed as possible. (Answer all that apply. Enter 'NA' for not applicable.)***

5.1.1 ***Eligibility Determination/Redetermination and Enrollment***

5.1.2 ***Outreach***

5.1.3 ***Benefit Structure***

5.1.4 ***Cost-Sharing (such as premiums, copayments, compliance with 5% cap)***

5.1.5 ***Delivery System***

5.1.6 ***Coordination with Other Programs (especially private insurance and crowd-out)***

5.1.7 ***Evaluation and Monitoring (including data reporting)***

*5.1.8* ***Other (specify)***

5.1.1 – 5.1.8

Tennessee's original MCHIP plan included uninsured children under the age of 18 who enrolled in the TennCare for Children Program on or after April 1, 1997, and whose family incomes were below 200% of poverty. There were two provisions (cost-sharing and premium revenue match) in the previously approved Section 1115a waiver that were not in sync with CHIP requirements. In an effort to address the cost-sharing requirements under our current waiver, we *reduced* the cost-sharing arrangements for uninsured children with family incomes between 100% and 200% poverty, but we

have not eliminated cost-sharing responsibilities altogether. To change the existing cost-sharing requirements beyond what we have already done would change the terms of the waiver and create unnecessary confusion in the TennCare program. Additionally, cost-sharing is one of the

measures that we feel helps combat "crowd out." To change the current arrangement for the premium revenues associated with CHIP children would change the terms of the waiver and therefore create unnecessary administrative burden for Tennessee.

Tennessee's "best practices" are outreach, informing, and enrolling uninsured children into the TennCare program. We've been enrolling uninsured children and adults since 1994. As a result of our successful efforts we had to close enrollment to the uninsured population (except for certain groups) January 1995, because we were nearing our enrollment cap.

January 27, 2000, Governor Don Sundquist appointed a Commission on the Future of TennCare. The commission is charged with considering possible changes that can be made to the TennCare program. The Commission will be evaluating the program as a whole rather than the MCHIP program alone. In March of this year the Governor hosted a "Summit on the Future of TennCare." The primary goal of the Summit was to bring together managed care experts, doctors, and hospital executives from all over the U.S. to solicit possible solutions, ideas, or directions that TennCare may take in order to improve the program.

The goals of the Commission are:

- To assess TennCare from the perspectives of cost, efficiency and effectiveness of service delivery and overall benefit to the people of Tennessee;
- To examine the state's options with respect to continuation of the TennCare Waiver of adoption of an alternate plan;
- To obtain broad-based public comment of the state's future directions in publicly funded health care; and,
- To make recommendations to the Governor regarding the continuation of TennCare or adoption of an alternate plan.

5.2 ***What plans does your State have for "improving the availability of health insurance and health care for children"? (Section 2108(b)(1)(F))***

See Section 5.1 through 5.1.8

5.3 ***What recommendations does your State have for improving the Title XXI program? (Section 2108(b)(1)(G))***

We do not believe that it was the intent of CHIP to undo the Section 1115a waiver process, rather we think it

makes sense for these programs to work together to achieve their mutual goals of offering health insurance to as many uninsured low-income children as possible.

Tennessee also suggests that States that already have HCFA approval for certain provisions in an existing plan, such as cost-sharing, should not be superseded by CHIP requirements when the State's existing plan is not consistent with CHIP requirements. It seems appropriate to implement a grandfather clause that would allow states that have been progressive in enrolling uninsured children, prior to CHIP, to be acknowledged for their efforts, time and energy in adopting such programs.

Tennessee implemented a program for uninsured children and adults prior to CHIP and would argue that States that have already implemented programs for uninsured children should be allowed to fold their existing programs under CHIP without having to change the design of their existing program because they are not in complete alignment with CHIP requirements. State's efforts to be proactive and to design programs for uninsured children prior to CHIP should be recognized, rather than penalized.

# Addendum to Table 3.1.1

The following questions and tables are designed to assist states in reporting countable income levels for their Medicaid and SCHIP programs and included in the NASHP SCHIP Evaluation Framework (Table 3.1.1). This technical assistance document is intended to help states present this extremely complex information in a structured format.

The questions below ask for countable income levels for your Title XXI programs (Medicaid SCHIP expansion and State-designed SCHIP program), as well as for the Title XIX child poverty-related groups. Please report your eligibility criteria as of **September 30, 1999.** Also, if the rules are the same for each program, we ask that you enter duplicate information in each column to facilitate analysis across states and across programs.

If you have not completed the Medicaid (Title XIX) portion for the following information and have passed it along to Medicaid, please check here **9** and indicate who you passed it along to. Name_____, phone/email_____

3.1.1.1 For each program, do you use a gross income test or a net income test or both?

| | | | |
|---|---|---|---|
| Title XIX Child Poverty-related Groups | ____Gross | ____Net | ____Both |
| Title XXI Medicaid SCHIP Expansion | _X___Gros | ____Net | ____Both |
| Title XXI State-Designed SCHIP Program | ____Gross | ____Net | ____Both |
| Other SCHIP program_____ | ____Gross | ____Net | ____Both |

T

3.1.1.2 What was the income standard or threshold, as a percentage of the Federal poverty level, for countable income for each group? If the threshold varies by the child=s age (or date of birth), then report each threshold for each age group separately.

Title XIX Child Poverty-related Groups ____% of FPL for children under age _____

____% of FPL for children aged _____

____% of FPL for children aged _____

Title XXI Medicaid SCHIP Expansion _100_% of FPL for children aged _____ ___ 16 - 18 years (children born before

____% of FPL for children aged _____

____% of FPL for children aged _____

Title XXI State-Designed SCHIP Program ____% of FPL for children aged _____

____% of FPL for children aged _____

____% of FPL for children aged _____

Other SCHIP program_____ ____% of FPL for children aged _____

____% of FPL for children aged _____

____% of FPL for children aged _____

3.1.1.3 Complete Table 1.1.1.3 to show whose income you count when determining eligibility for each program and which household members are counted when determining eligibility? (In households with multiple family units, refer to unit with applicant child)

***Enter AY@ for yes, AN@ for no, or AD@ if it depends on the individual circumstances of the case.***

**Table 3.1.1.3**

| Family Composition | Title XIX Child Poverty-related Groups | Title XXI Medicaid SCHIP Expansion | Title XXI State-designed SCHIP Program | Other SCHIP Program* |
|---|---|---|---|---|
| Child, siblings, and legally responsible adults living in the household | | **D** | | |
| All relatives living in the household | | D | | |
| All individuals living in the household | | **D** | | |
| Other (specify) | | | | |

* Don't use it for determining eligibility/premium calculations

3.1.1.4 How do you define countable income? For each type of income please indicate whether it is counted, not counted or not recorded.

***Enter AC@ for counted, ANC@ for not counted and ANR@ for not recorded.***

**Table 3.1.1.4**

| Type of Income | Title XIX Child Poverty-related Groups | Title XXI Medicaid SCHIP Expansion | Title XXI State-designed SCHIP Program | Other SCHIP Program* |
|---|---|---|---|---|
| Earnings of dependent children | | NC | | |
| Earnings of students | | NC – if member is under age 21 | | |
| Earnings from job placement programs | | C | | |
| Earnings from community service programs under Title I of the National and Community Service Act of 1990 (e.g., Serve America) | | C | | |
| Earnings from volunteer programs under the Domestic Volunteer Service Act of 1973 (e.g., AmeriCorps, Vista) | | NC | | |
| Education Related Income<br>Income from college work-study programs | | NC – if member is under age 21 | | |
| Assistance from programs administered by the Department of Education | | NC | | |
| Education loans and awards | | NC | | |
| Other Income<br>Earned income tax credit (EITC) | | NC | | |
| Alimony payments received | | C | | |
| Child support payments received | | NC | | |
| Roomer/boarder income | | C | | |
| Income from individual development accounts | | C | | |
| Gifts | | NC | | |
| In-kind income | | NC | | |
| Program Benefits<br>Welfare cash benefits (TANF) | | C | | |
| Supplemental Security Income (SSI) cash benefits | | NC | | |
| Social Security cash benefits | | C | | |
| Housing subsidies | | NC | | |

| Type of Income | Title XIX Child Poverty-related Groups | Title XXI Medicaid SCHIP Expansion | Title XXI State-designed SCHIP Program | Other SCHIP Program* |
|---|---|---|---|---|
| Foster care cash benefits | | NC | | |
| Adoption assistance cash benefits | | C | | |
| Veterans benefits | | C | | |
| Emergency or disaster relief benefits | | NC | | |
| Low income energy assistance payments | | NC | | |
| Native American tribal benefits | | NC | | |
| Other Types of Income (specify)<br>Unemployment | | C | | |

*Make a separate column for each Aother@ program identified in Section 2.1.1. To add a column to a table, right click on the mouse, select Ainsert@ and choose Acolumn@.

3.1.1.5 What types and *amounts* of disregards and deductions does each program use to arrive at total countable income?

***Please indicate the amount of disregard or deduction used when determining eligibility for each program. If not applicable, enter ANA.@***

Do rules differ for applicants and recipients (or between initial enrollment and redetermination) ____
Yes ____ No T

If yes, please report rules for applicants (initial enrollment).

**Table 3.1.1.5**

| Type of Disregard/Deduction | Title XIX Child Poverty-related Groups | Title XXI Medicaid SCHIP Expansion | Title XXI State-designed SCHIP Program | Other SCHIP Program* |
|---|---|---|---|---|
| Earnings | $ | $ NA | $ | $ |
| Self-employment expenses | $ | $ NA | $ | $ |
| Alimony payments<br>Received | $ | $ NA | $ | $ |
| Paid | $ | $ NA | $ | $ |
| Child support payments<br>Received | $ | $ NA | $ | $ |
| Paid | $ | $ NA | $ | $ |
| Child care expenses | $ | $ NA | $ | $ |
| Medical care expenses | $ | $ NA | $ | $ |
| Gifts | $ | $ NA | $ | $ |
| Other types of disregards/deductions (specify) | $ | $ | $ | $ |

*Make a separate column for each Aother@ program identified in Section 2.1.1. To add a column to a table, right click on the mouse, select Ainsert@ and choose Acolumn@.

3.1.1.6 For each program, do you use an asset or resource test?

Title XIX Poverty-related Groups ____No ____Yes (complete column A in 3.1.1.7)

Title XXI SCHIP Expansion program ____No ____Yes (complete column B in 3.1.1.7)

T

Title XXI State-Designed SCHIP program____No ____Yes (complete column C in 3.1.1.7)

Other SCHIP program_____ ____No ____Yes (complete column D in 3.1.1.7)

3.1.1.7 How do you treat assets/resources?

***Please indicate the countable or allowable level for the asset/resource test for each program and describe the disregard for vehicles. If not applicable, enter ANA.@***

**Table 3.1.1.7**

| | Title XIX Child Poverty-related Groups (A) | Title XXI Medicaid SCHIP Expansion (B) | Title XXI State-designed SCHIP Program (C) | Other SCHIP Progr (D) |
|---|---|---|---|---|
| Treatment of Assets/Resources | | NA | | |
| Countable or allowable level of asset/resource test | $ | $ NA | $ | $ |
| Treatment of vehicles: Are one or more vehicles disregarded? *Yes or No* | | NA | | |
| What is the value of the disregard for vehicles? | $ | $ NA | $ | $ |
| When the value exceeds the limit, is the child ineligible(AI@) or is the excess applied (AA@) to the threshold allowable amount for other assets? *(Enter I or A)* | | NA | | |

*Make a separate column for each Aother@ program identified in Section 2.1.1. To add a column to a table, right click on the mouse, select Ainsert@ and choose Acolumn@.

3.1.1.8 Have any of the eligibility rules changed since September 30, 1999? ___ Yes _T__ No