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Rebalancing in Capitated Medicaid Managed Long-Term Services and Supports Programs: Key Issues from a Roundtable Discussion on Measuring Performance

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Executive Summary

Medicaid is an important source of health insurance coverage for seniors and non-elderly people with disabilities who rely on the program for essential long-term services and supports (LTSS) to assist with activities of daily living and maintain their independence in the community. Although the program has an historical bias toward funding institutional care, states have been working to rebalance their LTSS systems by devoting a greater percentage of spending to home and community-based services (HCBS). There is increasing state interest in managed long-term services and supports (MLTSS) delivery systems, and states indicate that incentives in MLTSS programs are expected to increase beneficiary access to HCBS. To explore issues related to how rebalancing progress in capitated Medicaid MLTSS programs is measured, the Kaiser Commission on Medicaid and the Uninsured convened a roundtable meeting on November 13, 2014 with a group of federal and state officials and other experts.

Key issues related to measuring performance in rebalancing identified by the roundtable participants include:

- **Including and using existing measures to assess current MLTSS programs.** Formulating a strategy for how MLTSS will further rebalancing and including detailed measures to assess progress are important parts of state implementation of MLTSS programs. Because beneficiaries presently are receiving services through MLTSS, it is important to assess current MLTSS programs' impact on rebalancing. In addition to yielding insights on the performance of existing MLTSS programs, rebalancing measures may help to inform more standardized approaches to assessing system performance.
- **Further developing measures to assess MLTSS programs' effect on rebalancing.** While some measures exist, rebalancing remains a current gap in assessing MLTSS quality, and states are interested in further developing this area. Additional work on measures is needed to both assess the extent of rebalancing and evaluate the quality of HCBS provided, including the development of uniform or standardized measures to consistently assess the extent of rebalancing and evaluate HCBS quality in a way that allows meaningful comparison by stakeholders. Performance measures also can assess the impact on beneficiaries of delivery systems that integrate LTSS with medical services. A set of core rebalancing measures could facilitate comparisons across states and health plans, although barriers to their development would have to be addressed.

- **Using MLTSS performance measures to examine beneficiary functioning and account for the diversity of the population with LTSS needs and the settings in which services are provided.** Unlike clinical measures, rebalancing measures focus on beneficiary functioning and therefore require a different approach to data collection, measurement, and reporting for health plans. Rebalancing measures also need to account for the diverse needs and preferences among beneficiaries who rely on LTSS. For accurate comparison, it is important that measures are risk adjusted to account for differences in populations served by health plans that may impact rebalancing performance. In addition to tracking where services are provided, performance measures can account for differences in the degree of community integration offered by various settings.
- **Basing MLTSS performance measures on data that is available at the individual service level, accurate, and transparent to stakeholders.** Health plan data at the individual service level, allowing for adjustments to measures impacted by different populations served, is a key part of assessing rebalancing. Data collection systems that are designed to capture information relevant to rebalancing are important to inform MLTSS performance measures. Data is most useful if it is transparent to beneficiaries and other stakeholders.
- **Employing MLTSS performance measures to hold health plans and states accountable for achieving program goals and inform policymakers responsible for overseeing and funding these programs.** State and federal policymakers can use performance measures to monitor and evaluate MLTSS programs and ensure that public dollars are being spent to achieve the program's intended goals. Measures should clearly define the processes and outcomes for which health plans will be held accountable to achieve. Data from MLTSS performance measures can be an important factor in an era of federal and state budget pressures and potential cuts.

Conclusion

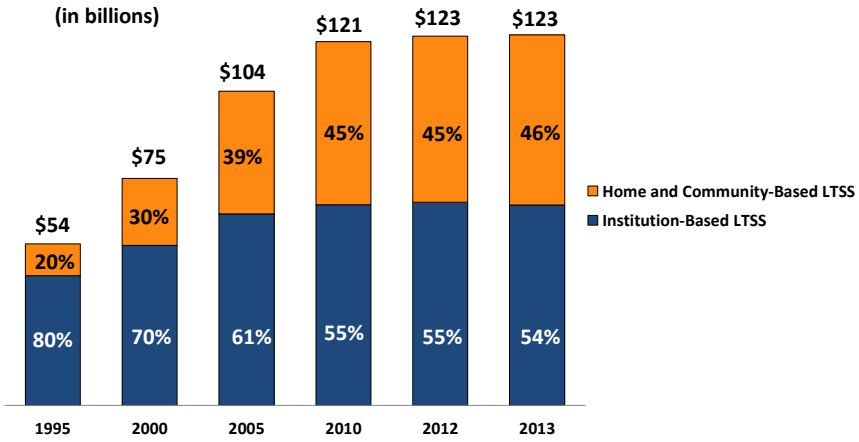
Although work is needed to further develop MLTSS performance measures, there also is a need to assess rebalancing progress now, to determine whether current MLTSS programs are achieving their intended goals. Challenges in assessing rebalancing in MLTSS programs include the diversity of the population receiving LTSS; how to define what is being measured; different reporting requirements associated with different authorities authorizing MLTSS and HCBS; determining the services for which health plans are accountable; health plans' learning curve in moving from a medical model to meeting beneficiary's functional needs and supporting beneficiary choice, independence and community integration; ensuring the availability of data about services provided by health plans; and the speed at which capitated MLTSS programs are implemented. Revised Medicaid managed care regulations expected to be issued by CMS also may inform efforts to assess MLTSS programs. Continued focus in this area by federal and state policymakers and other stakeholders is important to evaluating the success of MLTSS programs in promoting LTSS rebalancing.

Introduction

Medicaid is an important source of health insurance coverage for seniors and non-elderly people with disabilities who rely on the program for essential long-term services and supports (LTSS) to assist with activities of daily living and maintain their independence in the community.[1] Historically, the program has had a bias toward funding institutional care, as nursing facility services are required to be offered by all states that choose to participate in Medicaid, while most home and community-based services (HCBS) are provided at state option.[2] Over the last several decades, states have been working to rebalance their LTSS systems by devoting a greater percentage of spending to HCBS instead of institutional services. These efforts are driven by a number of factors, including beneficiary preferences for HCBS, the typically lower cost of HCBS relative to comparable institutional care, states' community integration obligations under the Americans with Disabilities Act and the Supreme Court's *Olmstead* decision,[3] and the new and expanded initiatives to expand Medicaid HCBS available to states through the Affordable Care Act.[4]

Figure 1

Medicaid LTSS Spending is Increasingly Devoted to HCBS as Opposed to Institutional Care

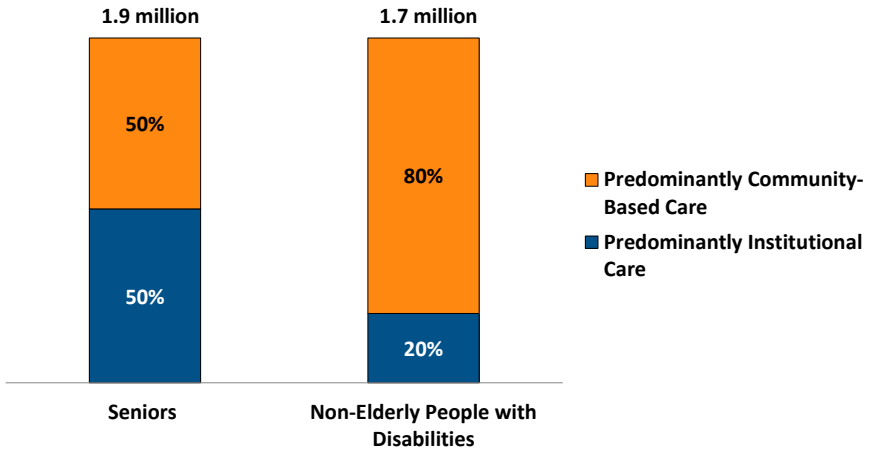


NOTES: Home and community-based care includes state plan home health, state plan personal care services and § 1915(c) HCBS waivers. Institutional care includes intermediate care facilities for individuals with intellectual/developmental disabilities, nursing facilities, and mental health facilities.
SOURCE: KCMU and Urban Institute analysis of CMS-64 data.

While the majority of Medicaid LTSS dollars still go toward institutional services, the national share of Medicaid LTSS spending on HCBS has more than doubled from 20 percent in 1995 to 46 percent in 2013 (Figure 1). (Notably, these data do not include LTSS provided through Medicaid MLTSS § 1115 waivers.) The extent of rebalancing varies by state and by beneficiary population. For example, non-elderly people with disabilities currently are more likely to receive LTSS in a community-based setting, while seniors are more likely to receive LTSS in an institutional setting (Figure 2).

Figure 2

Among Beneficiaries Who Use LTSS, a Larger Share of Non-Elderly People with Disabilities Live in the Community Than Seniors

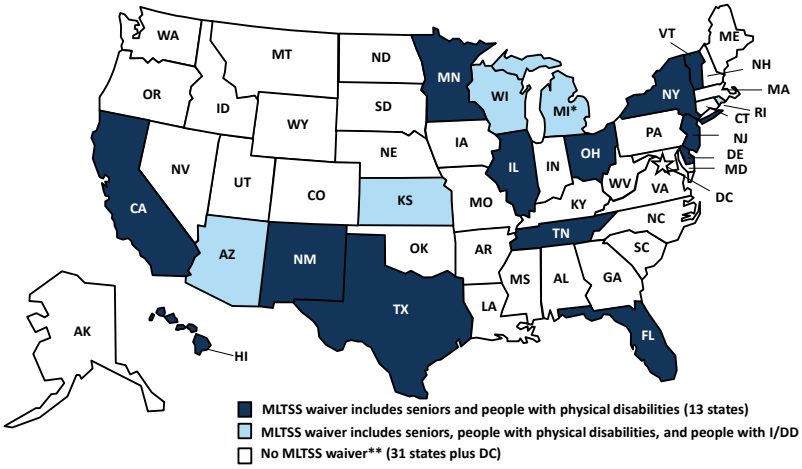


NOTE: Individuals who used both institutional and community-based services in the same year are classified as using institutional services in this figure.
SOURCE: KCMU and Urban Institute estimates based on MSIS and CMS-64 FY 2011 data.

There is increasing state interest in LTSS delivery system reforms, including integrating LTSS with medical services and providing LTSS through managed care models, including capitated managed care organizations (MCOs). As of October 2014, 19 states had waivers under § 1115 or § 1915(b)/(c) for managed long-term services and supports (MLTSS) programs, most of which require beneficiaries to enroll in an MCO to receive services (Figure 3).[5] Most of these waivers require MCOs to deliver a comprehensive set of benefits, including acute/primary care, behavioral health, nursing facility, and HCBS, and some operate with concurrent demonstration authority to integrate services and align financing for beneficiaries who are dually eligible for Medicare and Medicaid.[6] Notably, there is variation among states in the amount of financial risk for nursing facility services embedded in the capitated rate paid to health plans. In addition to these waivers, other states are operating capitated MLTSS programs through § 1932 state plan authority or § 1915(a) waiver authority.

Figure 3

State Interest in Capitated MLTSS Waivers Is Increasing



NOTES: *MI has 1 waiver for seniors and people with physical disabilities and another waiver for people with I/DD. **Analysis includes states with § 1115 or § 1915(b)/(c) capitated MLTSS waivers. Other states may have capitated MLTSS programs through § 1932 state plan or § 1915(a) waiver authority.
SOURCE: KCMU analysis of approved waiver terms and conditions, available at www.medicaid.gov.

A significant number of states (13 in FY 2014 and 16 in FY 2015) report that incentives built into their MLTSS programs are expected to increase beneficiary access to HCBS.[7] While some measures to assess state progress in LTSS rebalancing exist, this area remains a gap in evaluating HCBS quality and determining whether MLTSS programs are achieving their intended goals. To explore issues related to how rebalancing in capitated Medicaid MLTSS programs is measured, the Kaiser Commission on Medicaid and the Uninsured convened a roundtable meeting on November 13, 2014 with a group of federal and state officials and other experts, including researchers, representatives from health plans, and beneficiary advocates. This issue brief summarizes the key issues related to measuring performance in rebalancing identified and discussed by the invited participants. A companion fact sheet provides a brief overview of LTSS rebalancing measures.[8]

Key Issues

1. Existing performance measures can provide valuable information about rebalancing in current MLTSS programs, while additional measures are in development.

Formulating a strategy for how MLTSS will further rebalancing and including detailed measures to assess progress are important parts of state implementation of MLTSS programs.

Roundtable participants agreed that, while states are identifying LTSS rebalancing as a key objective in their MLTSS programs, managed care is not necessarily a panacea to achieve this goal. Participants noted that the intention of improving rebalancing alone is insufficient to ensure progress when states move from a fee-for-service (FFS) delivery system to MLTSS; instead, participants emphasized that states need a detailed strategy for how delivery system reforms will result in progress in LTSS rebalancing. Some health plans in newly implemented MLTSS programs are finding that beneficiaries who were not previously identified in the FFS system as needing an institutional level of care nevertheless have unmet LTSS needs. Without careful planning in program design, implementation, and assessment efforts, these beneficiaries may be underserved in the FFS system and remain underserved once they transition to MLTSS. In addition to yielding insights on the performance of existing MLTSS programs, rebalancing measures may help to inform more standardized approaches to assessing system performance. The speed at which MLTSS programs are implemented also was noted as a challenge in designing and implementing rebalancing measures, which can be an afterthought or deferred instead of being part of the development of the overall MLTSS program, if adequate time is not devoted to these efforts.

Because beneficiaries presently are receiving services through MLTSS, it is important to assess current MLTSS programs' impact on rebalancing.

Because beneficiaries are being enrolled and receiving services in MLTSS programs now, roundtable participants emphasized the need to use existing measures to evaluate rebalancing progress without waiting for additional measures to be developed. Absent nationally validated measures, which will take time to be tested and implemented, states and health plans can use some of the available measures to assess rebalancing in current MLTSS programs so that beneficiaries and policymakers know what progress is being made. Participants suggested that states and health plans first focus on core rebalancing measures, such as the number of beneficiaries and amount of spending in nursing facilities vs. home and community-based settings, and then move to assessing beneficiary quality of life, which is a more complex inquiry. Examples of existing measures in capitated MLTSS programs cited by participants include:

- the number of beneficiaries receiving long-term care services in nursing facilities and in home and community-based settings both annually and at a point-in-time;
- spending on services in nursing facilities and in home and community-based settings;
- the average per-person cost of care in nursing facilities and in home and community-based settings;
- the number of beneficiaries discharged from a nursing facility who do not return; and
- the success of nursing facility diversion efforts.[9]

For accurate comparison when assessing spending, it is important that measures are risk adjusted to account for differences in populations served by health plans that may impact rebalancing performance. Participants also noted that MLTSS programs must build in financial incentives for health plans and provider payment reforms to achieve the desired outcomes identified in measures. For example, global budgets that include both institutional and HCBS can provide fiscal incentives to promote HCBS. Other potential sources of information about the effects of MLTSS on rebalancing include independent ombudsman programs, assessments of health plan network adequacy, and service denial or termination appeals.

2. Further development of performance measures to assess the effect of MLTSS programs on rebalancing is needed.

Rebalancing measures are a current gap in assessing MLTSS quality, and states are interested in further developing this area.

Roundtable participants agreed that, in most states, sufficient measures do not currently exist to determine whether progress on rebalancing is occurring. MLTSS programs typically have many clinical measures and only a handful of measures relevant to LTSS, and some managed care programs do not include any LTSS measures. However, states are interested in further developing LTSS measures, especially those related to assessing beneficiaries' quality of life. For example, 18 states will participate in the expansion of the National Core Indicators (NCI), first developed for people with I/DD, by using the new NCI-Aging and Disability measures to survey seniors and people with physical disabilities in 2015. There is a waiting list for additional states to participate in the NCI-Aging and Disability survey in 2016. Additional work on measures is needed to both assess the extent of rebalancing and evaluate the quality of HCBS provided, including the development of uniform or standardized measures to consistently assess the extent of rebalancing and evaluate HCBS quality in a way that allows meaningful comparison by stakeholders.

MLTSS measure development is needed to both assess the extent of rebalancing and evaluate the quality of HCBS provided.

In addition to measuring rebalancing progress, roundtable participants emphasized the importance of also assessing the quality of HCBS, including outcome measures, and beneficiary quality of life. Participants identified a range of measures, including where money is spent, where beneficiaries are being served, and quality of life, and observed that measures should encompass this entire continuum. For example, health plans may be able to report on the number of institutional to community transitions but also need to assess whether a beneficiary's functional needs have been addressed. Participants pointed out that focusing solely on the number of beneficiaries served in a particular setting, while important, does not provide sufficient information to fully evaluate HCBS quality. Participants also noted that looking at spending alone is insufficient as most home health and nursing facility services are short-term, and it is important to look at where beneficiaries are receiving long-term HCBS. Other measures are needed to identify factors that make institutional to community transitions difficult, the extent to which beneficiaries are able to self-direct their services, and the number of people waiting to access HCBS, even if a state already is spending a high percentage of its LTSS funding in the community. Participants also recommended that common definitions, such as what constitutes a reduction in services, are needed to ensure that measures are applied uniformly. Participants emphasized that measures

should not only focus on what is working but also should be designed to reveal barriers to accessing care and should identify actionable items so that system improvements can result.

Performance measures can assess the impact on beneficiaries of delivery systems that integrate LTSS with medical services.

Many states are using MLTSS programs to integrate LTSS with physical health services, and participants discussed the potential value of these efforts in terms of improving care coordination and reducing health disparities though increased utilization of preventive health care services by people with disabilities. MLTSS performance measures could be designed to assess program progress and the impact on beneficiaries in these areas. One participant suggested identifying the key activities that are viewed as resulting in an integrated MLTSS model, such as care coordination, and then measuring the impact of those elements.

A set of core rebalancing measures could facilitate comparisons across states and health plans, although barriers to their development would have to be addressed.

Participants noted that CMS funds Medicaid HCBS under various authorities with different reporting requirements and pointed to the need for a core set of measures for capitated MLTSS programs across states to facilitate federal and state evaluations of programs and beneficiaries' ability to compare health plans when making enrollment choices. However, participants also observed that there is a lack of national consensus on the need for a core set of measures and what those measures should include. Participants also identified the difficulty in setting a national benchmark standard for core measures, and one participant cautioned that having a core set of measures could risk using the lowest common denominator as the standard to attain, given the current extent of variation in rebalancing across states and beneficiary populations to date. The lack of standardization in IT systems across states to collect data and the lack of consensus on service definitions and coding are additional issues to be addressed.

3. MLTSS performance measures examine beneficiary functioning and need to account for the diversity of the population with LTSS needs and the settings in which services are provided.

Unlike clinical measures, rebalancing measures focus on beneficiary functioning and therefore require a different orientation for health plans.

Roundtable participants agreed that health plans face a learning curve when moving from applying clinical measures related to medical conditions to those that assess beneficiaries' functioning in the community. MTLSS was described as "very unfamiliar territory" for many health plans, involving new stakeholders, services, and provider types and requiring a different approach to data collection, measurement, and reporting. MCOs may be accustomed to defining their enrollees by utilization of medical services or medical diagnosis and may need to develop their ability to include the role of functioning, environment and supports to promote beneficiary choice, independence and community integration in assessing performance. Participants emphasized the importance of orienting health plans to how to best support beneficiaries with functional tasks in home and community-based settings as opposed to the clinical medical model with which plans may be more familiar when serving relatively healthy populations without LTSS needs. For example, participants pointed out that health plans are accustomed to relying on medical necessary definitions when authorizing services, which often do not translate well to the HCBS context which instead centers on a care plan to address

a beneficiary's functional needs. Participants also suggested that serving beneficiaries who need LTSS also may require changes in how MCOs interact with enrollees, such as offering in-person meetings and in-home assessments, in addition to telephone calls.

Rebalancing measures need to account for the diverse needs and preferences among beneficiaries who rely on LTSS.

Many beneficiaries who need LTSS have complex needs, and the types and extent of needs may vary within and across different subpopulations. This is underscored by the person-centered planning requirements in CMS's recent HCBS regulations, which focus on whether services are reflective of an individual beneficiary's needs. For example, seniors with dementia often need services that differ in intensity and duration from people with other types of disabilities. The 2014 NCI- Aging and Disability pilot study revealed that seniors and non-elderly people with disabilities had different responses about how they prefer to spend their day. Consequently, roundtable participants agreed that MLTSS measures must account distinctly for the range of needs and preferences within the overall population of beneficiaries with LTSS needs.

In addition to tracking where services are provided, performance measures also can account for differences in the degree of community integration offered by various settings.

Roundtable participants highlighted the need for measures to capture the variation in home and community-based settings and the degree of integration available to beneficiaries in different settings in the community. For example, beneficiaries can experience different degrees of independence and community access when they receive services in their own apartment as opposed to a group home. Participants agreed that measures should assess not only whether beneficiaries are served in the community but also whether they are in the setting that affords them the fullest extent of community integration and independence, such as measures related to social activity and engagement.

4. Meaningful MLTSS performance measures are based on data that is available, accurate, and transparent to stakeholders.

Health plan data at the individual service level is a key part of assessing rebalancing.

Roundtable participants expressed caution about avoiding the "black box" of managed care and emphasized the need for states to require health plans to collect and provide encounter and utilization data to inform assessments of whether MLTSS programs are meeting their goal of rebalancing. States engaged in MLTSS emphasized the importance of contract provisions that require health plans to provide encounter data by type of service and by level of care. Participants identified a need for states to ensure that health plans are collecting and reporting data relevant to rebalancing, such as the types and amount of services funded and any service reductions during transitions to managed care. Participants emphasized the need to examine data at the individual service level, such as the number of personal care hours authorized, when assessing whether MLTSS programs are meeting their goals of rebalancing and ensuring that services are provided in an amount that is sufficient to meet beneficiary needs.

Data collection systems that are designed to capture information relevant to rebalancing are important to inform MLTSS performance measures.

Roundtable participants pointed out that data collected by states and health plans must be relevant to measures and outcomes related to rebalancing. If health plans are asked to take on new tasks through MLTSS programs, such as care coordination or nursing facility diversion or transition initiatives, then new codes must be used to reflect the services that plans are providing to support beneficiaries in the community. Participants also noted that electronic health records need to incorporate information about LTSS, especially in delivery systems that seek to integrate LTSS with physical and behavioral health services, and that measures must be tested at the health plan level to ensure that plans have the appropriate systems in place and the capacity to capture accurate information. Data systems must be able to capture information that includes beneficiary functioning, socialization, quality of life, and caregiver-related issues, in addition to medical information.

Data is most useful if it is transparent to beneficiaries and other stakeholders.

Roundtable participants underscored that information about health plan performance should be transparent to beneficiaries, in addition to rating plans on issues that are important to beneficiaries, such as rebalancing. Performance measures were described as "report cards" for beneficiaries to use to evaluate health plans and inform their enrollment choices, based on the plan's performance. Participants also noted that some states do not include any rebalancing measures in their MLTSS programs, with the result that beneficiaries lack this important information when making plan choices. The availability and transparency of data about MLTSS programs at the state level also is important so that stakeholders have access to relevant reliable information to assess whether the program is achieving its intended goals.

5. Clear expectations about what states and health plans are accountable for achieving and enforceable standards are important factors in assessing whether MLTSS promotes rebalancing.

MLTSS performance measures can be a means of holding health plans and states accountable for achieving program goals.

Roundtable participants uniformly agreed that states must monitor and evaluate their MLTSS programs to ensure that public dollars are being spent to achieve the program's intended goals. Participants noted that states should clearly define the processes and outcomes for which health plans will be held accountable to achieve and use performance measures aimed at assessing those goals. An important related part of these efforts is ensuring that health plans collect and make available encounter and utilization data relevant to MLTSS performance measures.

MLTSS performance measures can inform policymakers responsible for overseeing and funding these programs.

While roundtable participants did not want to focus on rebalancing solely as a source of cost savings, some pointed out that demonstrating that rebalanced LTSS systems provide more efficient services over time can be an important factor in an era of federal and state budget pressures and potential cuts. States are focused on increasing beneficiary access to HCBS as a means of improving beneficiaries' quality of life and not solely as a cost-saving measure. At the same time, states are using savings from decreased institutional services to fund

additional HCBS and serve more beneficiaries in the community. In the absence of measures based on data, states and health plans are left with anecdotes to demonstrate the outcomes produced by care delivery system reforms, which may be less compelling than information about the value and outcomes of MLTSS programs based on data from performance measures.

Conclusion

Although work is needed to further develop MLTSS performance measures, there also is a need to assess rebalancing progress now, to determine whether current MLTSS programs are achieving their intended goals. Challenges in assessing rebalancing in MLTSS programs include the diversity of the population receiving LTSS; how to define what is being measured; different reporting requirements associated with different authorities authorizing MLTSS and HCBS; determining the services for which health plans are accountable; health plans' learning curve in moving from a medical model to meeting beneficiary's functional needs and supporting beneficiary choice, independence and community integration; ensuring the availability of data about services provided by health plans; and the speed at which capitated MLTSS programs are implemented. Revised Medicaid managed care regulations expected to be issued by CMS also may inform efforts to assess MLTSS programs. Continued focus in this area by federal and state policymakers and other stakeholders is important to evaluating the success of MLTSS programs in promoting LTSS rebalancing.

The Kaiser Commission on Medicaid and the Uninsured acknowledges Judy Feder of Georgetown University and Molly O'Malley Watts of Watts Health Policy Consulting for moderating the roundtable discussion and thanks the participants for sharing their time and expertise.

Endnotes

[1] *See* Kaiser Commission on Medicaid and the Uninsured, *Medicaid Beneficiaries Who Need Home and Community-Based Services: Supporting Independent Living and Community Integration* (March 2014), available at http://kff.org/medicaid/report/medicaid-beneficiaries-who-need-home-and-community-based-services-supporting-independent-living-and-community-integration/.

[2] *See generally* Kaiser Commission on Medicaid and the Uninsured, *Medicaid Long-Term Services and Supports: An Overview of Funding Authorities* (Sept. 2013), available at http://kff.org/medicaid/fact-sheet/medicaid-long-term-services-and-supports-an-overview-of-funding-authorities/.

[3] *See generally* Kaiser Commission on Medicaid and the Uninsured, Olmstead's *Role in Community Integration for People with Disabilities Under Medicaid: 15 Years After the Supreme Court's* Olmstead *Decision* (June 2014), available at http://kff.org/medicaid/issue-brief/omsteads-role-in-community-integration-for-people-with-disabilities-under-medicaid-15-years-after-the-supreme-courts-olmstead-decision/.

[4] *See generally* Kaiser Commission on Medicaid and the Uninsured, *How is the Affordable Care Act Leading to Changes in Medicaid Long-Term Services and Supports Today? State Adoption of Six LTSS Options* (April 2013), available at http://kff.org/medicaid/issue-brief/how-is-the-affordable-care-act-leading-to-changes-in-medicaid-long-term-services-and-supports-today-state-adoption-of-six-ltss-options/.

[5] For more information, *see* Kaiser Commission on Medicaid and the Uninsured, *Key Themes in Capitated Medicaid Managed Long-Term Services and Supports Waivers* (Nov. 2014), available at http://kff.org/medicaid/issue-brief/key-themes-in-capitated-medicaid-managed-long-term-services-and-supports-waivers/.

[6] *See generally* Kaiser Commission on Medicaid and the Uninsured, *Financial and Administrative Alignment Demonstrations for Dual Eligible Beneficiaries Compared: States with Memoranda of Understanding Approved by CMS* (July 2014), available at http://kff.org/medicaid/issue-brief/financial-alignment-demonstrations-for-dual-eligible-beneficiaries-compared/.

[7] Kaiser Commission on Medicaid and the Uninsured, *Medicaid in an Era of Health & Delivery System Reform: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2014 and 2015* at 29 (Oct. 2014), available at http://kff.org/medicaid/report/medicaid-in-an-era-of-health-delivery-system-reform-results-from-a-50-state-medicaid-budget-survey-for-state-fiscal-years-2014-and-2015/.

[8] Kaiser Commission on Medicaid and the Uninsured, *Measuring Long-Term Services and Supports Rebalancing* (Jan. 2015), available at http://kff.org/medicaid/fact-sheet/measuring-long-term-services-and-supports-rebalancing/.

[9] *See, e.g.,* CMS, TennCare II Special Terms and Conditions at STC 43(d)(i) (July 1, 2013 – June 30, 2016), available at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/tn/tn-tenncare-ii-ca.pdf.