TennCare Quarterly Report

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Submitted to the Members of the General Assembly

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Status of TennCare Reforms and Improvements

Progress Report on Measures of Health Care Quality. TennCare published the annual report of HEDIS/CAHPS data on December 13, 2011. The full name for HEDIS is Healthcare Effectiveness Data Information Set, and the full name for CAHPS is Consumer Assessment of Health Plans Surveys. This report—available online at http://www.tn.gov/tenncare/forms/hedis11.pdf —provides data that enables the State to compare the performance of its MCOs against national norms and benchmarks and to compare performance among MCOs.

Improved statewide performance was noted for an array of child health measures, with many also exceeding the HEDIS 2009 Medicaid National Average. Higher success rates were achieved in all of the following categories:

- Childhood Immunization Status
- Lead Screening in Children
- Appropriate Testing for Children with Pharyngitis
- Appropriate Treatment for Children with Upper Respiratory Infection
- Children and Adolescents' Access to Primary Care Practitioners
- Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life
- Adolescent Well-Care Visits

Improvement was also observed in the following categories related to women's health:

- Breast Cancer Screening
- Cervical Cancer Screening
- Chlamydia Screening
- Timeliness of Prenatal Care

HEDIS 2011 was the second year of statewide reporting of behavioral health measures following the integration of medical and behavioral health services among TennCare's health plans. Results superior to those in 2010 were achieved in such categories as Follow-Up Care for Children Prescribed ADHD

Medication, Follow-Up After Hospitalization for Mental Illness, and Initiation and Engagement of Alcohol and Other Drug Dependence Treatment.

Fraud Prevention Webpage. In November 2011, TennCare's Division of Audit and Program Integrity updated the "TennCare Fraud" page of the Bureau's website. The refurbished site—located online at http://www.tn.gov/tenncare/fraud.shtml —provides links to the websites of all State agencies that combat TennCare fraud, including the Office of Inspector General, the Tennessee Bureau of Investigation, and the Office of the Attorney General. Additionally, the webpage offers user-friendly definitions and examples of "member fraud" and "provider fraud," as well as a toll-free number for reporting either. The ultimate aim of the "TennCare Fraud" page is to educate the public on a subject of central importance to the program and to furnish the tools for citizens to help solve the problem.

Proposed Increase in Home and Community Based Services Enrollment. On December 15, 2011, TennCare asked permission from the Centers for Medicare and Medicaid Services (CMS) to increase the number of spaces available for new applicants to the TennCare CHOICES in Long-Term Care program to receive cost-effective home and community based services.[1] Without these additional spaces, new applicants who qualify for the CHOICES program would only be able to receive Nursing Facility care.

TennCare's proposal addresses two State Fiscal Years: 2011-2012 and 2012-2013. If CMS approves the plan, then the range of eligible individuals would be increased in the first year from 8,500-11,000 persons to 8,500-12,500 persons, and in the second year from 9,500-12,500 persons to 11,000-15,000 persons.

TennCare projects that implementation of this measure will result in cost avoidance of more than $2 million in Fiscal Year 2011-2012 and more than $4 million in Fiscal Year 2012-2013. If approved as submitted, the proposal will take effect on April 1, 2012.

***John B.* Trial.** The *John B.* lawsuit addresses the adequacy of services provided by TennCare to children under the age of 21. *John B*. was a consent decree filed in 1998 that has been the subject of ongoing litigation since 2000. Shortly after assuming responsibility for the case last year, Judge Thomas A. Wiseman, Jr. issued a Case Management Order, which identified current substantial compliance with the requirements of the consent decree as the primary issue to be resolved at trial. The Order also provided a schedule for discovery and set a trial date of October 31, 2011.

The trial began as scheduled and lasted exactly one month, concluding on November 30. During that period, the State called eight witnesses, including TennCare Director Darin Gordon and Chief Medical Officer Wendy Long. Following the end of the trial, both sides filed Proposed Findings of Fact and Conclusions of Law on December 20, 2011. The Plaintiffs, not surprisingly, contended that the State is still not in compliance with the consent decree. In its filing, the State offered an overview of TennCare and, in particular, its Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program;

[1] As required by T.C.A. § 71-5-104(b), TennCare notified members of the General Assembly of this proposal on December 16, 2011.

demonstrated TennCare's compliance with each relevant paragraph of the *John B.* consent decree; examined in detail the testimony of all witnesses called by the Plaintiffs; and systematically refuted the Plaintiffs' allegations. Within its overview, the State succinctly noted, "TennCare's EPSDT program is replete with state-of-the-art monitoring, safeguards, and overlapping, interrelated mechanisms for facilitating access and delivering care to the children served by the program."[2]

Judge Wiseman is expected to issue a decision in early 2012.

Incentives for Providers to Use Electronic Health Records. The Electronic Health Record (EHR) Incentive Program makes first-year payments to Medicaid providers[3] who have adopted, implemented, or upgraded to certified EHR technology capable of meeting "meaningful use" (i.e., use that is measurable in both quantity and quality) standards. TennCare administers Tennessee's Medicaid EHR program, the vast majority of funding for which is provided by the federal government.[4] During the October-December quarter, TennCare continued to register providers and distribute payments, while simultaneously introducing an interactive, online portal through which interested providers may submit and receive information about the EHR program.

The registration and payment of providers during 2011 exceeded all expectations. Although early estimates had placed the likely number of registrants for all of calendar year 2011 at 1,500, 2,134 providers were registered by the conclusion of December. This total represented 1,102 physicians, 782 nurse practitioners, 89 acute care hospitals, 85 dentists, 47 physician assistants, and 29 certified nurse midwives. In addition, TennCare issued nearly $22 million of EHR payments during 2011 to a total of 699 providers, including 413 physicians, 243 nurse practitioners, 13 certified nurse midwives, 10 physician assistants, 9 acute care hospitals, 9 dentists, and 2 pediatricians.

Although these accomplishments were substantial, TennCare took steps to enhance the efficiency of the EHR program even further. On November 3, 2011, the Bureau introduced an online point of access for providers to gain information about incentive payments, register with CMS, submit and track their attestations (affirmations that encounter and certification requirements have been met), and communicate with TennCare. This "web portal" was developed—and continues to be administered by—Policy Studies, Inc., a consulting firm with expertise in government healthcare administration. The portal, which is located online at https://pipp.tenncare.tn.gov/Default.aspx, automates an array of functions that TennCare employees had previously managed by hand and, as a result, has already improved organization and documentation. Furthermore, the portal is yet another element in TennCare's growing communications network related to the EHR program, other facets of which include a dedicated webpage (located at http://www.tn.gov/tenncare/hitech.html) and newsletters distributed

[2] John B. v. Emkes. U.S. District Court for the Middle District of Tennessee at Nashville. Defendants' Proposed Findings of Fact and Conclusions of Law, page 1. December 20, 2011.

[3] CMS allows two types of providers to participate in the Medicaid EHR Incentive Program: medical professionals (physicians, nurse practitioners, certified nurse midwives, dentists, and certain kinds of physician assistants) and hospitals (acute care hospitals, critical access hospitals, and children's hospitals).

[4] The federal government covers 90% of administrative costs and 100% of the incentive payments.

by the Bureau's EHR ListServ (subscriptions to which are available at http://www.tn.gov/tenncare/medicaidhitemail.html).

New Electronic Transactions Standards. On November 26, 2011, TennCare became one of the first Medicaid programs to upgrade the standards governing some of its most important electronic transactions, including claims, payment, and eligibility verification. This undertaking, which took two years and hundreds of thousands of personnel hours to complete, placed TennCare in compliance with federal requirements several months early.[5]

Because the old standards (sometimes referred to as "Version 4010") had been in place for eight years, an array of confusing, redundant, or unnecessary elements had been identified. The new standards (called "Version 5010") introduced such improvements as:

- Expanded technical fields to accommodate the newest version of International Classification of Diseases (or "ICD") codes
- A significant number of new transaction edits
- A variety of transaction qualifiers

These revisions, as well as a host of others, ensure that data submitted electronically to TennCare is more specific and streamlined and that parties responsible for such transmissions have a better understanding of what to include. Furthermore, faster processing speeds[6] and ongoing cost-savings[7] more than justify the resources TennCare has invested.

Essential Access Hospital (EAH) Payments. The TennCare Bureau continued to make Essential Access Hospital payments during this period. Essential Access Hospital payments are payments from a pool of $100 million ($34,220,000 in State dollars) appropriated by the General Assembly and funded by the hospital assessment fee.

The methodology for distributing these funds specifically considers each hospital's relative contribution to providing services to TennCare members, while also acknowledging differences in payer mix and hospitals' relative ability to make up TennCare losses. Data from the Hospital Joint Annual Report is used to determine hospitals' eligibility for these payments. Eligibility is determined each quarter based on each hospital's participation in TennCare. In order to receive a payment for the quarter, a hospital must be a contracted provider with TennCare Select and at least one other Managed Care Organization (MCO), and it must have contracted with TennCare Select for the entire quarter that the payment represents. Excluded from the Essential Access Hospital payments are Critical Access Hospitals, which

[5] Although January 1, 2012, had originally been established as the deadline for states to upgrade their transactions standards, CMS announced on November 17, 2011, that no enforcement action would be taken until March 31, 2012. See http://www.cms.gov/ICD10/Downloads/CMSStatement5010EnforcementDiscretion111711.pdf (accessed on January 6, 2012).

[6] In some instances, transactions that used to be processed in six one-hundredths of a second can now be processed in six ten-thousandths of a second.

[7] Under the new transactions standards, TennCare has been able to eliminate equipment that had previously been leased at an annual cost of $385,000.

receive cost-based reimbursement from the TennCare program and, therefore, do not have unreimbursed TennCare costs, and the five State mental health institutes.

The Essential Access Hospital payments for the second quarter of State Fiscal Year 2012 are shown in the table below.

Essential Access Hospital Payments for the Quarter

Hospital Name	County	EAH First Quarter FY 2012
Regional Medical Center at Memphis	Shelby County	$3,918,611
Erlanger Medical Center	Hamilton County	$2,815,559
Vanderbilt University Hospital	Davidson County	$2,471,141
University of Tennessee Memorial Hospital	Knox County	$1,369,701
Johnson City Medical Center (with Woodridge)	Washington County	$1,173,395
LeBonheur Children's Medical Center	Shelby County	$768,520
Metro Nashville General Hospital	Davidson County	$751,593
Jackson - Madison County General Hospital	Madison County	$630,757
Methodist Healthcare - South	Shelby County	$567,179
Parkridge Medical Center (with Parkridge Valley)	Hamilton County	$497,192
East Tennessee Children's Hospital	Knox County	$481,480
Parkwest Medical Center (with Peninsula)	Knox County	$442,401
Methodist University Healthcare	Shelby County	$408,488
Saint Jude Children's Research Hospital	Shelby County	$345,034
Centennial Medical Center	Davidson County	$304,488
Saint Francis Hospital	Shelby County	$298,022
Delta Medical Center	Shelby County	$273,699
University Medical Center	Wilson County	$249,878
Skyline Medical Center (with Madison Campus)	Davidson County	$249,155
Wellmont Holston Valley Medical Center	Sullivan County	$244,410
Maury Regional Hospital	Maury County	$242,257
Mercy Medical Center	Knox County	$238,950
Pathways of Tennessee	Madison County	$222,372
Fort Sanders Regional Medical Center	Knox County	$213,117
Ridgeview Psychiatric Hospital and Center	Anderson County	$199,927
Middle Tennessee Medical Center	Rutherford County	$177,312
Methodist Healthcare - North	Shelby County	$174,868
Gateway Medical Center	Montgomery County	$173,520
Cookeville Regional Medical Center	Putnam County	$171,153
Baptist Hospital	Davidson County	$171,065
Wellmont Bristol Regional Medical Center	Sullivan County	$169,781
Skyridge Medical Center	Bradley County	$161,171

Hospital Name	County	EAH First Quarter FY 2012
Baptist Memorial Hospital for Women	Shelby County	$144,904
Parkridge East Hospital	Hamilton County	$144,815
Morristown - Hamblen Healthcare System	Hamblen County	$139,812
NorthCrest Medical Center	Robertson County	$139,054
Summit Medical Center	Davidson County	$126,383
Regional Hospital of Jackson	Madison County	$115,342
LeConte Medical Center	Sevier County	$113,715
Sweetwater Hospital Association	Monroe County	$113,290
Sumner Regional Medical Center	Sumner County	$112,687
StoneCrest Medical Center	Rutherford County	$110,156
Baptist Hospital of Cocke County	Cocke County	$110,053
Dyersburg Regional Medical Center	Dyer County	$109,390
Methodist Medical Center of Oak Ridge	Anderson County	$106,850
Southern Hills Medical Center	Davidson County	$106,607
Baptist Memorial Hospital - Tipton	Tipton County	$106,255
Horizon Medical Center	Dickson County	$103,811
Blount Memorial Hospital	Blount County	$103,801
United Regional Medical Center	Coffee County	$98,623
Saint Mary's Medical Center of Campbell County	Campbell County	$98,351
Takoma Regional Hospital	Greene County	$84,088
Harton Regional Medical Center	Coffee County	$84,015
Jellico Community Hospital	Campbell County	$83,928
Hendersonville Medical Center	Sumner County	$83,885
Sycamore Shoals Hospital	Carter County	$81,178
Community Behavioral Health	Shelby County	$77,701
Athens Regional Medical Center	McMinn County	$72,868
Lakeway Regional Hospital	Hamblen County	$71,774
Hardin Medical Center	Hardin County	$71,737
Heritage Medical Center	Bedford County	$70,122
Henry County Medical Center	Henry County	$69,531
Indian Path Medical Center	Sullivan County	$68,522
Crockett Hospital	Lawrence County	$64,484
Saint Mary's Jefferson Memorial Hospital	Jefferson County	$61,910
River Park Hospital	Warren County	$61,016
Humboldt General Hospital	Gibson County	$60,755
Southern Tennessee Medical Center	Franklin County	$59,347
Grandview Medical Center	Marion County	$58,710
Bolivar General Hospital	Hardeman County	$58,263
Claiborne County Hospital	Claiborne County	$58,010
Lincoln Medical Center	Lincoln County	$56,893
Wellmont Hawkins County Memorial Hospital	Hawkins County	$53,605
Baptist Memorial Hospital - Union City	Obion County	$52,893
Jamestown Regional Medical Center	Fentress County	$50,293

Hospital Name	County	EAH First Quarter FY 2012
Roane Medical Center	Roane County	$48,738
Hillside Hospital	Giles County	$47,564
Skyridge Medical Center - West	Bradley County	$46,619
Riverview Regional Medical Center - North	Smith County	$41,536
Livingston Regional Hospital	Overton County	$41,506
Volunteer Community Hospital	Weakley County	$38,195
Methodist Healthcare - Fayette	Fayette County	$35,737
McKenzie Regional Hospital	Carroll County	$34,407
Wayne Medical Center	Wayne County	$32,724
McNairy Regional Hospital	McNairy County	$29,037
Henderson County Community Hospital	Henderson County	$28,381
Haywood Park Community Hospital	Haywood County	$26,979
Baptist Memorial Hospital - Huntingdon	Carroll County	$26,526
Erlanger East Hospital	Hamilton County	$24,153
Gibson General Hospital	Gibson County	$23,949
Johnson City Specialty Hospital	Washington County	$21,465
White County Community Hospital	White County	$20,329
Decatur County General Hospital	Decatur County	$20,029
Emerald Hodgson Hospital	Franklin County	$16,503
TOTAL		$25,000,000

Number of Recipients on TennCare and Costs to the State

At the end of the period October 1, 2011, through December 31, 2011, there were 1,140,238 Medicaid eligibles and 23,898 Demonstration eligibles enrolled in TennCare, for a total of 1,164,136 persons.

Estimates of TennCare spending for the first quarter are summarized in the table below.

	2nd Quarter*
Spending on MCO services**	$1,374,445,800
Spending on dental services	$44,745,700
Spending on pharmacy services	$209,162,600
Medicare "clawback"***	$41,179,600

**These figures are cash basis as of December 31 and are unaudited.*

***This figure includes Integrated Managed Care MCO expenditures.*

****The Medicare Part D clawback is money states pay to the federal government to help offset costs the federal government incurs by covering the prescription benefit for enrollees who have both Medicare and Medicaid.*

Claims payment analysis. TennCare's prompt pay requirements may be summarized as shown below.

Entity	Standard	Authority
MCOs (non-CHOICES services)	90% of clean claims for payment for services delivered to TennCare enrollees are paid within 30 calendar days of the receipt of such claims. 99.5% of all provider claims are processed, and, if appropriate, paid within 60 calendar days of receipt.	T.C.A . § 56-32-126(b)
MCOs (CHOICES services)	90% of clean electronically submitted Nursing Facility and applicable Home and Community Based Services claims[8] are processed and paid within 14 calendar days of receipt. 99.5% of clean electronically submitted Nursing Facility and applicable Home and Community Based Services claims[9] are processed and paid within 21 calendar days of receipt.	TennCare contract
DBM	90% of clean claims for payment for services delivered to TennCare enrollees are processed, and, if appropriate, paid within 30 calendar days of the receipt of such claims. 99.5% of all provider claims are processed, and, if appropriate, paid within 60 calendar days of receipt.	TennCare contract and in accordance with T.C.A . § 56-32-126(b)
PBM	100% of all clean claims submitted by pharmacy providers are paid within 10 calendar days of receipt.	TennCare contract

The MCOs, the DBM, and the PBM are required to submit monthly claims data files of all TennCare claims processed to the Tennessee Department of Commerce and Insurance (TDCI) for verification of statutory and contractual prompt pay compliance. The plans are required to separate their claims data by TennCare Contract (i.e., East, Middle, or West Grand Region) and by subcontractor (i.e., claims processed by a vision benefits manager). Furthermore, the MCOs are required to identify separately non-emergency transportation (NEMT) claims in the data files. Finally, the MCOs are required to submit separate claims data files representing a subset of electronically submitted Nursing Facility and applicable Home and Community Based Services claims for the CHOICES enrollees. TDCI then performs an analysis and reports the results of the prompt pay analyses by NEMT and CHOICES claim types, by subcontractor, by TennCare contract, and by total claims processed for the month.

If an MCO does not comply with the prompt pay requirements based on the total claims processed in a month, TDCI has the statutory authority to levy an administrative penalty of $10,000 for each month of non-compliance after the first instance of non-compliance was reported to the plan. The TennCare

[8] Excludes Personal Emergency Response Systems (PERS), assistive technology, minor home modifications, and pest control claims. Claims for delivery of these services are handled like general MCO claims.
[9] Ibid.

Bureau can also assess liquidated damages pursuant to the terms of the TennCare Contract. If the DBM and PBM do not meet their contractual prompt pay requirements, only the TennCare Bureau can assess applicable liquidated damages against these entities.

Net worth requirement. By statute, the minimum net worth requirement for each TennCare MCO is calculated based on premium revenue for the most recent calendar year.

TDCI's calculations for the net worth requirement reflect payments made for the calendar year ended December 31, 2010. The TennCare Contract further requires the TennCare MCOs to establish an enhanced net worth based on projected additional annual premiums for the CHOICES program. TDCI based the net worth requirement calculation on the greatest of total projected premiums, reported premiums, or cash premiums for calendar year 2010. During this quarter, the MCOs submitted their National Association of Insurance Commissioners (NAIC) Third Quarter 2011 Financial Statement. As of September 30, 2011, TennCare MCOs reported net worth as indicated in the table below.

	Net Worth Requirement	Reported Net Worth	Excess/ (Deficiency)
AmeriGroup Tennessee	$17,616,712	$135,738,788	$118,122,076
UnitedHealthcare Plan of the River Valley (UnitedHealthcare Community Plan)	$53,559,633	$425,147,211	$371,587,578
Volunteer State Health Plan (BlueCare & TennCare Select)	$34,651,682	$159,450,400	$124,798,718

All TennCare MCOs met their minimum net worth requirements as of September 30, 2011.

Success of Fraud Detection and Prevention

The mission of the OIG is: *To identify, investigate, and prosecute persons who commit fraud or abuse against the TennCare program and to recoup money owed to the State of Tennessee.* The OIG staff receives case information from a variety of sources including: local law enforcement, the TennCare Bureau, Health Related Boards (HRB), the Department of Human Services (DHS), other state agencies, health care providers, Managed Care Contractors (MCCs), and the general public via the OIG web site, fax, written correspondence, and phone calls to the OIG hotline. The statistics for the second quarter of the 2011 - 2012 fiscal year are as follows:

Summary of Enrollee Cases

	Quarter	Grand Total to Date (since creation of OIG in July 2004)
Cases Received	1,483	137,155
Abuse Cases Received*	1,434	64,005

***** *Abuse cases may be referred to the appropriate Managed Care Organization (MCO), the TennCare Bureau, or DHS for further review/action.*

Court Fines & Costs Imposed

	Grand Total to Date (since creation of OIG in July 2004)
Fines	$504,942.00
Court Costs & Taxes	$194,582.90
Court Ordered Restitution	$1,837,911.97
Drug Funds/Forfeitures	$418,704.40

The OIG aggressively pursues enrollees who have apparently committed fraud or abuse against the TennCare program. The primary criminal case types are: prescription drug cases (drug diversion, drug seekers, doctor shopping, and forging prescriptions), reporting a false income, access to other insurance when one is enrolled in an "uninsured" category, and ineligible individuals using a TennCare card.

Arrest Categories

Category	Grand Total to Date (since creation of OIG in July 2004)
Drug Diversion/Forgery RX	485
Drug Diversion/Sale RX	599
Doctor Shopping	201
Access to Insurance	55
Operation Falcon III	32
Operation Falcon IV	16
False Income	75
Ineligible Person Using Card	20
Living Out Of State	19
Asset Diversion	7
ID Theft	49
Aiding & Abetting	5
Failure to Appear in Court	2
GRAND TOTAL	**1,565**

OIG Case Recoupment & Recommendations

	Grand Total to Date (since February 2005)[10]
Court Ordered Recoupment	$3,828,321.42
Recommended TennCare Terminations [11]	49,455
Potential Savings[12]	$173,984,908.78

[10] In February 15, 2005, a Fiscal Manager and an attorney joined the OIG staff to facilitate and document recoupment and recommended terminations.

[11] Recommendations that enrollees' TennCare coverage should be terminated are sent to the TennCare Bureau for review and determination of appropriate action. These recommendations are based on information received and reviewed by the OIG. The Bureau determines whether these referrals meet the criteria for termination.

[12] Savings are determined by multiplying the number of enrollees whose coverage would be terminated by the average annual cost per enrollee for MCO, pharmacy, and dental services (currently, $3,656.39).