TennCare Quarterly Report

Submitted to the Members of the General Assembly

January 15, 2014

Status of TennCare Reforms and Improvements

Preparation for the Implementation of Eligibility Changes Mandated by the Affordable Care Act (ACA) on January 1, 2014. The October-December 2013 quarter was a time of intense preparation for these changes, which included coordination with the newly established Health Care Marketplace, called the Federally Facilitated Marketplace (FFM). HCFA has been involved for over a year in building a new eligibility system that will be able to review applications for health care assistance and identify which persons are eligible for an "insurance affordability program," meaning Medicaid, CoverKids, or subsidized insurance under the Marketplace. The new system is to be called "TEDS" (Tennessee Eligibility Determination System).

Toward the middle of the quarter, HCFA determined that it would not be prudent to allow TEDS to begin processing electronic applications on January 1, 2014. Due to tight federal implementation timeframes, late changes being made by the federal government, and ongoing work on account transfers between the FFM and states, adequate testing has not taken place to minimize implementation challenges similar to those seen at the federal level in October. Rather than repeating the federal experience of going live with a system that had not been sufficiently tested, HCFA decided not to implement TEDS prematurely. Anticipating that such action would be appropriate, HCFA developed a contingency plan for processing applications in the meantime. HCFA also began taking steps during the quarter to engage the Centers for Medicare and Medicaid Services (CMS) in working together to identify and resolve problems in the weekly flat files that CMS was sending the state in lieu of account transfers.

Proposal Concerning CHOICES Program and Supplemental Pools ("Demonstration Amendment 20"). On December 17, 2013, the Bureau of TennCare submitted Demonstration Amendment 20 to CMS. Amendment 20 proposed three modifications to the TennCare program:

- Continuing, through June 30, 2015, to offer new enrollment in the At Risk Demonstration Eligibility Category of the CHOICES program. Without approval by CMS of the changes proposed in Amendment 20, this category was due to have closed to new enrollment on December 31, 2013. To be eligible in this category, individuals must be adults who are financially eligible for Long-Term Services and Supports (LTSS), who meet the Level of Care criteria for LTSS that

existed in Tennessee on June 30, 2012, but not the criteria that went into effect on July 1, 2012, and who are at risk for institutionalization in the absence of Home and Community Based Services that are available to them through the CHOICES Program;

- Expanding the State's Essential Access Hospital Pool to address the fact that Tennessee is now the only state in the country without a Disproportionate Share Hospital (DSH) allotment specified in federal statute. Under Amendment 20, funds previously associated with DSH payments in Tennessee would be added to the Essential Access Hospital Pool; and
- Adding Erlanger Hospital in Chattanooga to the list of hospitals eligible for special payments under the State's Public Hospital Supplemental Payment Pool.

CMS notified TennCare on December 30, 2013, that the component of Amendment 20 concerning the At Risk Demonstration Eligibility Category had been approved and that negotiations regarding the other two components would take place "in the coming weeks."

Possible Changes to TennCare Benefits ("Demonstration Amendment 21"). On December 30, 2013, the Bureau notified the public of another proposal to be submitted to CMS. Demonstration Amendment 21 repeats several changes proposed in each of the last four years that were made unnecessary each time by the General Assembly's passage or renewal of a one-year Enhanced Coverage Fee. Changes to the TennCare benefit package for adults that would be necessary if the one-year Enhanced Coverage Fee were not renewed this year are as follows:

- Elimination of physical therapy, speech therapy, and occupational therapy for all adults
- Benefit limits on certain hospital services, lab and X-ray services, and health practitioners' office visits for non-pregnant adults and non-institutionalized adults

Additional information about Amendment 21 is available online at http://www.tn.gov/tenncare/pol-notice4.shtml.

Managed Care Contracts. The Bureau issued a Request for Proposals (RFP) on October 2, 2013, for three organizations to furnish managed care services to the TennCare population. The RFP required the winning bidders to provide physical health services, behavioral health services, and LTSS throughout the state, with actual service delivery scheduled to begin in Middle Tennessee on January 1, 2015, and in East and West Tennessee later that calendar year. (Each of TennCare's current managed care contracts is limited to one of Tennessee's three grand regions, although a single entity may hold more than one contract. BlueCare, for instance, has managed care contracts in East Tennessee and West Tennessee.)

On December 16, 2013, the Bureau announced that the winning proposals had been submitted by Amerigroup, BlueCare, and UnitedHealthcare, the three companies that currently form TennCare's managed care network. New contracts with these entities will last from January 1, 2014, through December 31, 2016, and contain options for five one-year extensions. Additional information about this process appears on the TennCare website at https://news.tn.gov/node/11831.

Budget Presentation. On November 18, 2013, three members of TennCare's executive staff—Director Darin Gordon, Deputy Director and Chief of Staff Dr. Wendy Long, and Chief Financial Officer Casey Dungan—presented the Fiscal Year 2015 proposed budget for the Division of Health Care Finance and Administration (HCFA) to Governor Bill Haslam, Finance and Administration Commissioner Larry Martin, Budget Director David Thurman, and Chief Operating Officer Greg Adams.

The presentation document itself, which is available on HCFA's website at http://tn.gov/HCFA/forms/HCFAbudgetFY15.pdf, concisely summarizes the manner in which TennCare has been able to deliver quality care and achieve high levels of member satisfaction while continuing to control inflationary growth. Projections from accounting firm PricewaterhouseCoopers and the CMS Office of the Actuary included within the presentation indicate that, due to fiscal controls implemented by TennCare, inflation of medical costs under TennCare is expected to be held to 3.5 percent over a three year period, as compared to a 7.5 percent inflation rate for commercial insurance programs and a 6.6 percent inflation rate for Medicaid programs as a whole. Factors contributing to this accomplishment, as stated in the presentation, include the use of enrollment and claims data to pinpoint and eliminate inefficiencies, as well as the successful integration of most TennCare services within managed care.

As Governor Haslam had requested of all State agencies, HCFA included within its budget a proposed plan for reducing expenditures by 5 percent. Potential cost-controlling measures ranged from enhanced anti-fraud efforts and managed care strategies to limited reductions in provider reimbursement rates, enrollee benefits, and grant funding.

Touching on program changes necessitated by the Affordable Care Act and concluding with an overview of the system of payment reform that TennCare is pursuing, the presentation laid out the challenges and opportunities facing HCFA and Tennessee in the years to come.

Incentives for Providers to Use Electronic Health Records. The Electronic Health Record (EHR) Incentive Program is a partnership between federal and state governments that grew out of the Health Information Technology for Economic and Clinical Health (HITECH) Act. The purpose of the program, as its name suggests, is to provide financial incentives to Medicaid providers[1] to replace outdated, often paper-based approaches to medical record-keeping with electronic systems that meet rigorous certification criteria and that can improve health care delivery and quality. The federal government provides 100 percent of the funding for the incentive payments and 90 percent of the administrative costs.

Currently, Medicaid providers may qualify for two types of payments:

[1] 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).

- First-year payments to providers who 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; and
- Second-year payments to providers who earned first-year payments in Calendar Year 2012 and who achieved meaningful use of EHR technology for any period of 90 consecutive days in Fiscal Year 2013 (for eligible hospitals) or Calendar Year 2013 (for eligible professionals).

First-year and second-year EHR payments made by TennCare during the October-December 2013 quarter as compared with payments made throughout the life of the program appear in the table below:

Payment Type	Number of Providers Paid	Quarterly Amount Paid (Oct-Dec 2013)	Cumulative Amount Paid to Date
First-year payments	100 providers (35 nurse practitioners, 33 physicians, 18 dentists, 6 certified nurse midwives, 5 hospitals, and 3 physician assistants)	$3,364,873	$132,790,952
Second-year payments	81 providers (45 physicians, 18 nurse practitioners, 14 hospitals, and 4 certified nurse midwives)	$4,181,236	$27,193,188

Outreach activities conducted by Bureau staff during the quarter included:

- Participation in six statewide workshops conducted by the Tennessee Medical Association during October;
- Hosting a provider help desk at the annual meeting of the Tennessee Academy of Family Physicians from October 29 through November 1;
- Conducting a "Meaningful Use Technical Assistance" webinar on November 1;
- Presentation to 30 members of tnREC (Tennessee's regional extension center for health information technology) on November 18;
- Participation in the UnitedHealthcare Provider Expo in December;
- Attendance at the eHealth Summit on December 6;
- Monthly newsletters distributed by the Bureau's EHR ListServ; and
- A quarterly reminder issued through the Provider Incentive Payment Program ("PIPP") system to Tennessee providers who had registered at the federal level but who have not registered or attested at the state level.

A significant priority for the Bureau during the first quarter of Calendar Year 2014 is the planning of several provider workshops throughout the state. The meetings, which will be coordinated with tnREC, are designed to update providers on—and thereby maintain the momentum of—the EHR program.

Public Forum on the TennCare Demonstration. In compliance with federal regulation and the terms of its Demonstration agreement with CMS, TennCare hosted a public forum in the downtown branch of the Nashville Public Library on December 18, 2013. The purpose of the forum was to provide members of the public an opportunity to comment on the progress of the TennCare Demonstration project, which has delivered Medicaid services to eligible Tennesseans under a managed care model since 1994.

The December 18 open meeting was not the only avenue through which feedback could be offered. Notice of the forum—which appeared in such diverse settings as the TennCare website, eight different Tennessee newspapers, and county offices of the Department of Human Services—included an email address, a physical address, and a dedicated phone line at which comments would be accepted.

Although public response was limited, additional opportunities to assess the TennCare Demonstration will be available, as TennCare is required to convene a forum on this subject each year for the foreseeable future.

Essential Access Hospital (EAH) Payments. The TennCare Bureau continued to make Essential Access Hospital payments during the October-December 2013 quarter. 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 Enhanced Coverage 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 receive cost-based reimbursement from the TennCare program and, therefore, are not included, and the four State mental health institutes.

The Essential Access Hospital payments made during the second quarter of State Fiscal Year 2014 for dates of service during the first quarter are shown in the table below.

Essential Access Hospital Payments for the Quarter

Hospital Name	County	EAH Second Quarter FY 2014
Vanderbilt University Hospital	Davidson County	$3,275,631
Regional Medical Center at Memphis	Shelby County	$3,072,008
Erlanger Medical Center	Hamilton County	$2,618,413
University of Tennessee Memorial Hospital	Knox County	$1,498,746
Johnson City Medical Center (with Woodridge)	Washington County	$1,259,775
Metro Nashville General Hospital	Davidson County	$775,427
LeBonheur Children's Medical Center	Shelby County	$715,777
Parkridge Medical Center (with Parkridge Valley)	Hamilton County	$653,989
East Tennessee Children's Hospital	Knox County	$534,223
Jackson – Madison County General Hospital	Madison County	$528,354
Methodist Healthcare – South	Shelby County	$443,711
Methodist Healthcare – Memphis Hospitals	Shelby County	$413,340
Saint Jude Children's Research Hospital	Shelby County	$408,108
University Medical Center (with McFarland)	Wilson County	$389,627
Saint Thomas Midtown Hospital	Davidson County	$381,325
Centennial Medical Center	Davidson County	$288,040
Physicians Regional Medical Center	Knox County	$284,354
Methodist Healthcare – North	Shelby County	$274,578
Skyline Medical Center (with Madison Campus)	Davidson County	$266,243
Saint Francis Hospital	Shelby County	$246,950
Saint Thomas Rutherford Hospital	Rutherford County	$244,441
Parkwest Medical Center (with Peninsula)	Knox County	$240,097
Wellmont Holston Valley Medical Center	Sullivan County	$235,084
Maury Regional Hospital	Maury County	$228,572
Fort Sanders Regional Medical Center	Knox County	$210,243
Pathways of Tennessee	Madison County	$206,684
Skyridge Medical Center	Bradley County	$190,095
Ridgeview Psychiatric Hospital and Center	Anderson County	$186,980
Gateway Medical Center	Montgomery County	$173,333
Cookeville Regional Medical Center	Putnam County	$172,102
Delta Medical Center	Shelby County	$167,817
Parkridge East Hospital	Hamilton County	$162,909
Methodist Hospital – Germantown	Shelby County	$161,496
Blount Memorial Hospital	Blount County	$151,337
Wellmont Bristol Regional Medical Center	Sullivan County	$149,288
Baptist Memorial Hospital for Women	Shelby County	$143,694
Haywood Park Community Hospital	Haywood County	$139,898
NorthCrest Medical Center	Robertson County	$132,607

Hospital Name	County	EAH Second Quarter FY 2014
Southern Hills Medical Center	Davidson County	$116,743
LeConte Medical Center	Sevier County	$114,442
Horizon Medical Center	Dickson County	$113,659
Sumner Regional Medical Center	Sumner County	$111,091
Tennova Healthcare – Newport Medical Center	Cocke County	$107,325
Rolling Hills Hospital	Williamson County	$106,336
Takoma Regional Hospital	Greene County	$101,875
Methodist Medical Center of Oak Ridge	Anderson County	$100,374
Heritage Medical Center	Bedford County	$100,115
Baptist Memorial Hospital – Tipton	Tipton County	$96,590
StoneCrest Medical Center	Rutherford County	$96,173
Summit Medical Center	Davidson County	$95,154
Tennova Healthcare – LaFollette Medical Center	Campbell County	$95,007
Dyersburg Regional Medical Center	Dyer County	$91,340
Morristown – Hamblen Healthcare System	Hamblen County	$90,703
Henry County Medical Center	Henry County	$88,269
Sweetwater Hospital Association	Monroe County	$75,388
Sycamore Shoals Hospital	Carter County	$74,430
Harton Regional Medical Center	Coffee County	$72,489
Grandview Medical Center	Marion County	$70,389
Indian Path Medical Center	Sullivan County	$69,889
Humboldt General Hospital	Gibson County	$69,722
Regional Hospital of Jackson	Madison County	$67,394
Baptist Memorial Hospital – Union City	Obion County	$64,853
Lakeway Regional Hospital	Hamblen County	$63,581
Jellico Community Hospital	Campbell County	$63,061
Wellmont Hawkins County Memorial Hospital	Hawkins County	$62,662
Hardin Medical Center	Hardin County	$57,850
Crockett Hospital	Lawrence County	$57,727
Athens Regional Medical Center	McMinn County	$56,895
River Park Hospital	Warren County	$56,164
Southern Tennessee Medical Center	Franklin County	$54,845
Livingston Regional Hospital	Overton County	$54,382
Tennova Healthcare – Jefferson Memorial Hospital	Jefferson County	$52,578
Henderson County Community Hospital	Henderson County	$43,890
McNairy Regional Hospital	McNairy County	$42,263
Roane Medical Center	Roane County	$42,150
Skyridge Medical Center – Westside	Bradley County	$41,596
Bolivar General Hospital	Hardeman County	$36,846
McKenzie Regional Hospital	Carroll County	$36,658
Claiborne County Hospital	Claiborne County	$36,244

Hospital Name	County	EAH Second Quarter FY 2014
Hillside Hospital	Giles County	$35,736
Volunteer Community Hospital	Weakley County	$33,058
Gibson General Hospital	Gibson County	$32,282
United Regional Medical Center	Coffee County	$32,045
Jamestown Regional Medical Center	Fentress County	$30,327
Wayne Medical Center	Wayne County	$28,309
Methodist Healthcare – Fayette	Fayette County	$28,166
Erlanger Health System – East Campus	Hamilton County	$27,381
DeKalb Community Hospital	DeKalb County	$25,765
Baptist Memorial Hospital – Huntingdon	Carroll County	$20,365
White County Community Hospital	White County	$16,800
Emerald – Hodgson Hospital	Franklin County	$15,328
TOTAL		**$25,000,000**

Number of Recipients on TennCare and Costs to the State

At the end of the period October 1, 2013, through December 31, 2013, there were 1,185,741 Medicaid eligibles and 19,900 Demonstration eligibles enrolled in TennCare, for a total of 1,205,641 persons.

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

Spending Category	2nd Quarter*
MCO services**	$1,814,602,700
Dental services	$38,593,100
Pharmacy services	$228,772,500
Medicare "clawback"***	$43,145,000

**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 are required to 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.*

Viability of MCCs in the TennCare Program

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[2] 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[3] are processed and paid within 21 calendar days of receipt.	TennCare contract

[2] 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.

[3] Ibid.

Entity	Standard	Authority
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 (e.g., 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 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 Bureau can also assess liquidated damages pursuant to the terms of the Contractor Risk Agreement. 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, as well as any TennCare payments made to the MCO that are not reported as premium revenue.

During this quarter, the MCOs submitted their National Association of Insurance Commissioners (NAIC) Third Quarter 2013 Financial Statements. As of September 30, 2013, TennCare MCOs reported net worth as indicated in the table below.[4]

MCO	Net Worth Requirement	Reported Net Worth	Excess/ (Deficiency)
Amerigroup Tennessee	$17,323,202	$95,287,126	$79,963,924

[4] The "Net Worth Requirement" and "Reported Net Worth" figures in the table are based on the MCOs' company-wide operations, not merely their TennCare operations. Amerigroup, for instance, operates a Medicare Advantage Plan in Middle Tennessee, while UnitedHealthcare has several lines of business in Illinois, Iowa, Virginia, and Tennessee. Volunteer State Health Plan, by contrast, conducts only TennCare business.

MCO	Net Worth Requirement	Reported Net Worth	Excess/ (Deficiency)
UnitedHealthcare Plan of the River Valley (UnitedHealthcare Community Plan)	$64,481,178	$467,656,463	$403,175,285
Volunteer State Health Plan (BlueCare & TennCare Select)	$35,639,453	$242,079,721	$206,440,268

All TennCare MCOs met their minimum net worth requirements as of September 30, 2013.

Success of Fraud Detection and Prevention

The mission of the Tennessee Office of Inspector General (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 website, fax, written correspondence, and phone calls to the OIG hotline. The statistics for the second quarter of Fiscal Year 2014 are as follows:

Summary of Enrollee Cases

	Quarter	Grand Total to Date (since creation of OIG in July 2004)
Cases Received	2,532	155,852
Abuse Cases Received*	804	75,628

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

Court Fines & Costs Imposed

	Quarter	Grand Total to Date (since creation of OIG in July 2004)
Fines	$43,175	$792,580
Court Costs & Taxes	$4,910	$244,573
Court Ordered Restitution (Criminal Cases)	$31,626	$2,275,627
Drug Funds/Forfeitures	$6,453	$444,313

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), child not in the home, 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	Quarter	Grand Total to Date (since creation of OIG in July 2004)
Drug Diversion/Forgery RX	13	557
Drug Diversion/Sale RX	18	775
Doctor Shopping	8	305
Access to Insurance	0	55
Operation FALCON III	0	32
Operation FALCON 2007	0	16
False Income	2	83
Ineligible Person Using Card	0	20
Living Out Of State	1	33
Asset Diversion	0	7
ID Theft	0	68
Aiding & Abetting	0	7
Failure to Appear in Court	0	4
Child Not in the Home	2	25
DEA Task Force	0	38
CHOICES	1	1
GRAND TOTAL	**45**	**2,026**

OIG Case Recoupment & Recommendations

	Quarter	Grand Total to Date (since February 2005)[5]
Non-Criminal Case Recoupment[6]	$7,506	$2,450,400
Recommended TennCare Terminations [7]	100	50,112
Potential Savings[8]	$365,639	$176,387,157

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

[6] This total reflects dollars identified for recoupment by the OIG in such non-criminal contexts as civil cases, administrative hearings, and voluntary reimbursements to TennCare.

[7] 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.

[8] Savings are determined by multiplying the number of enrollees whose coverage would be terminated, assuming all of the State's criteria for termination are met, by the average annual cost per enrollee for MCO, pharmacy, and dental services (currently, $3,656.39).