TennCare Quarterly Report

Submitted to the Members of the General Assembly

January 2016

Status of TennCare Reforms and Improvements

Application to Renew the TennCare Demonstration. Unlike traditional fee-for-service Medicaid programs, TennCare is a demonstration project. As such, TennCare receives waivers of certain federal statutes and regulations in order to "demonstrate" that a managed care approach to health care can be used to extend coverage to certain people who would not otherwise be eligible for Medicaid without increasing expenditures or diminishing the quality of care. One limitation imposed on demonstration projects, however, is that they may operate only for finite periods of time (referred to as "approval periods") before having to be renewed.

The current demonstration agreement expires on June 30, 2016. In accordance with the Special Terms and Conditions (STCs)[1] of the agreement, the Bureau of TennCare submitted an application to renew the demonstration to CMS six months prior to the end of the approval period. The renewal request, which was submitted on December 22, 2015, and which may be accessed online at http://www.tn.gov/assets/entities/tenncare/attachments/TennCareExtension.pdf, seeks an extension of the TennCare Demonstration through June 30, 2021. The request asks for only one change to the Demonstration: that the waiver of retroactive eligibility currently scheduled to expire on June 30, 2016, be extended throughout the next approval period.

Prior to submission of the renewal application, the Bureau held a public notice and comment period from November 12, 2015, through December 14, 2015. Notice of the State's intent to seek an extension appeared on dedicated pages of the TennCare website, in several Tennessee newspapers and the *Tennessee Administrative Register*, and via Facebook and Twitter. A working draft of the application was published on the TennCare website. To enable members of the public to offer feedback on the application, the Bureau accepted comments via mail, email, and two public hearings held on November 18 and 23, 2015. These comments were reviewed as part of the process of preparing the final version of the application.

[1] See 42 C.F.R. § 431.412(c) and STC #8 of the demonstration agreement located at http://www.tn.gov/assets/entities/tenncare/attachments/tenncarewaiver.pdf.

Negotiations with CMS on the application are expected to take place during the first half of 2016. Additional information about renewal of the TennCare Demonstration is available at http://www.tn.gov/tenncare/article/extension-of-tenncare-demonstration.

Amendments to the TennCare Demonstration. Four proposed amendments to the TennCare Demonstration were in various stages of development during the quarter.

Demonstration Amendment 26: Expenditures for Hospital Pool Payments. Amendment 26, which was originally submitted to CMS in April 2015, dealt with TennCare's ability to make payments to certain hospitals through "pools" that exist outside the managed care program. The primary purpose of pool payments is to offset the costs that hospitals incur in delivering uncompensated care. Such payments have been predicated on a provision of the TennCare Demonstration—Expenditure Authority #4—that was scheduled to expire on December 31, 2015. Amendment 26 proposed to remove that expiration date and to synchronize the duration of Expenditure Authority #4 with that of the TennCare Demonstration itself.

During the October-December 2015 quarter, the Bureau provided additional documentation to CMS in support of Amendment 26, with particular emphasis on details related to budget neutrality. On December 11, 2015, CMS issued approval of Amendment 26, including updated versions of the STCs, the Waiver List, and the Expenditure Authorities comprising TennCare's demonstration agreement with the federal government. The December 31, 2015, expiration date had been deleted from these materials by CMS. Therefore, the Bureau sent CMS a letter of acceptance on December 15, 2015.

Demonstration Amendment 27: Employment and Community First CHOICES. On June 23, 2015, following an in-depth 18-month stakeholder input process with individuals with intellectual and developmental disabilities and their families and providers, and more than a year of discussion with CMS on a Concept Paper, TennCare submitted Amendment 27. Amendment 27 concerns a new program named *Employment and Community First (ECF) CHOICES*, which would—according to the text of the proposal—implement "an integrated managed long-term services and supports (MLTSS) program that is specifically geared toward promoting and supporting integrated, competitive employment and independent, integrated community living as the first and preferred option for individuals with intellectual and developmental disabilities (I/DD)."[2]

TennCare continued during the October-December 2015 quarter to furnish CMS information that would facilitate review and approval of Amendment 27. Chief among the materials supplied by the Bureau was a set of draft STCs for the TennCare Demonstration, defining the manner in which ECF CHOICES would operate within TennCare's managed care system. As of the conclusion of the quarter, CMS' review of Amendment 27 was ongoing.

[2] Page 1 of Amendment 27, which is available online at http://www.tn.gov/assets/entities/tenncare/attachments/Amendment27ECFCHOICES.pdf.

Demonstration Amendment 28: Closure of Standard Spend Down Category. TennCare submitted Amendment 28 to CMS on October 8, 2015. Amendment 28 would close a TennCare eligibility category called "Standard Spend Down" (or "SSD"), which provides coverage to approximately 800 individuals who are not otherwise eligible for Medicaid but 1) are aged, blind, disabled, or the caretaker relative of a Medicaid-eligible child and 2) have enough unreimbursed medical bills to allow them to "spend down" to the Medically Needy Income Standard, a very low threshold. New enrollment in the category has been closed since 2013, and TennCare anticipates that many of the remaining enrollees may be eligible for health coverage through either Medicare or the Health Insurance Marketplace established by the Affordable Care Act.

Upon CMS's approval, TennCare would review SSD enrollees for eligibility in all open categories of TennCare coverage. Any individual found to qualify in another category would be transferred with no interruption in coverage. Individuals who do not qualify in another category would be disenrolled from TennCare and referred to Medicare and/or the Health Insurance Marketplace. These operational details, as well as others concerning the demographics of the SSD population and the fiscal impact of the proposal, were offered by the Bureau to CMS as part of the negotiations on Amendment 28 that took place throughout the October-December 2015 quarter.

Demonstration Amendment 29: Program Modifications. Amendment 29 was a contingency plan to address the budgetary challenges that would have arisen if CMS had not extended TennCare's authority to make hospital pool payments by approving Amendment 26. (See "Expenditures for Hospital Pool Payments" above.) Specifically, Amendment 29 outlined several benefit limits to be imposed on non-exempt adults, including—

- A combined annual limit of eight days per person for inpatient hospital and impatient psychiatric hospital services;
- An annual limit on non-emergency outpatient hospital visits of eight occasions per person;
- A combined annual limit on health care practitioners' office visits of eight occasions per person;
- An annual limit on lab and X-ray services of eight occasions per person; and
- Elimination of coverage for occupational therapy, speech therapy, and physical therapy.

The Bureau held a public notice and comment period on Amendment 29 from November 16 through December 18, 2015. Near the conclusion of that period, CMS extended the authority for TennCare's hospital pool payments, thereby eliminating the need for Amendment 29. As a result, the proposal was not submitted to CMS.

Budget Presentation. On December 1, 2015, four members of TennCare's executive staff—Director Darin Gordon, Deputy Director and Chief of Staff Dr. Wendy Long, Chief Financial Officer Casey Dungan, and Chief of Long-Term Services and Supports Patti Killingsworth—presented the Fiscal Year 2017 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://www.tn.gov/assets/entities/hcfa/attachments/HCFAbudgetFY17.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 manage inflationary growth. Evidence of these achievements as highlighted by the presentation includes the following:

- Provision of health insurance to approximately half of Tennessee children and more than 20 percent of the entire state population;
- Enrollee satisfaction levels above 90 percent for seven years in a row, including an all-time high of 95 percent in 2015;
- Improvement in 85 percent of 33 HEDIS (Healthcare Effectiveness Data and Information Set) measures tracked since 2007;
- Ranking of three TennCare health plans in the top half of plans nationwide; and
- Medical inflation levels well below those of commercial insurance programs and of Medicaid programs nationally.

A portion of the presentation was devoted to HCFA's *ECF CHOICES* proposal (described above in the summary of Demonstration Amendment 27). The need for *ECF CHOICES* arises from a variety of challenges impacting the service delivery system for individuals with intellectual and developmental disabilities, including the disproportionately high cost in Tennessee of providing Home and Community Based-Services (HCBS) to individuals with intellectual disabilities; a substantial waiting list for such services; the current lack of HCBS options for individuals who have developmental disabilities but not intellectual disabilities; and a significant gap between the number of people with intellectual disabilities who want to work and those who are actually working. *ECF CHOICES* has been designed to address these issues in a number of ways. For instance, services in *ECF CHOICES* will be tiered based on the needs of persons served, allowing those services to be provided more cost-effectively; the resulting cost savings will allow more individuals currently on waiting lists to be served and will begin to address the needs of individuals with developmental disabilities other than intellectual disabilities. In addition, the unique array of employment services and supports in *ECF CHOICES* will help to create a pathway to employment, even for individuals with significant disabilities, resulting in improved employment, better health and quality of life outcomes, and reduced reliance on public benefits.

As Governor Haslam had requested of all State agencies, HCFA included within its budget presentation a proposal for reducing expenditures by 3.5 percent. Potential cost-controlling measures identified by HCFA ranged from use of Guaranteed Net Unit Pricing (GNUP) in pharmacy contracts and ongoing reform of payment and delivery systems to value-based purchasing for enhanced respiratory care and elimination of the perinatal grant program.

Touching on the application to renew the TennCare Demonstration for five years, as well as the challenges posed by various cost drivers (such as Medicare costs borne by the State), the presentation outlined the environment in which HCFA will operate for years to come and reiterated the agency's commitment to high-quality, cost-effective services that offer the best value for Tennessee taxpayers.

Payment Reform. In February 2013, Governor Haslam launched Tennessee's Health Care Innovation Initiative to change the way that health care is paid for in Tennessee. The desired direction is to move from paying for volume to paying for value by rewarding health care providers for certain outcomes such as high quality and efficient treatment of medical conditions, and to help in maintaining people's health over time.

The Tennessee Health Care Innovation Initiative is located in the Division of Health Care Finance and Administration (HCFA), which is the agency in which TennCare is located as well. Although its goals transcend Medicaid, there is much emphasis on Medicaid and TennCare as playing a pivotal role in meeting the Initiative's goals. All of TennCare's providers are included in the Initiative.

Two of the most important strategies being used to reform health care payment approaches are primary care transformation and episodes of care:

- Primary care transformation focuses on the role of the primary care provider in promoting the delivery of preventive services and managing chronic illnesses over time. The Initiative is developing an aligned model for multi-payer Patient Centered Medical Homes (PCMHs), Health Homes for TennCare members with Serious and Persistent Mental Illness, and a shared care coordination tool that includes hospital and Emergency Department admission, discharge, and transfer alerts for attributed providers.
- Episodes of care focuses on the health care delivered in association with acute health care events, such as a surgical procedure or an inpatient hospitalization. Episodes encompass care delivered by multiple providers in relation to a specific health care event. Each episode has a "quarterback" who leads and coordinates the team of care providers and helps drive improvement through various activities including, but not limited to, care coordination, early intervention, and patient education.

Both of these strategies have benefitted from the input of Technical Advisory Groups (TAGs) composed of subject matter experts. TAG recommendations span a variety of topics, including the patient journey and care pathways, the definition of the principal accountable provider (i.e., the quarterback), any aspects of care delivery unique to Tennessee, the components of the episode of care, and appropriate quality measures.

During the October-December 2015 quarter, TAGs completed their reviews and provided advice on the fourth set ("Wave 4") of episodes of care, consisting of Attention Deficit Hyperactivity Disorder and Oppositional Defiant Disorder; Coronary Artery Bypass Graft and Valve Repair and Replacement; Acute Exacerbation of Congestive Heart Failure; and Bariatric Surgery. Although the State and participating

insurance companies are still working to implement these episodes, the intent of the Initiative is to incorporate all of the advice of the TAGs as detailed in the Appendix to this report. Furthermore, finalized TAG recommendations concerning PCMHs and Health Homes are expected in early Spring 2016, while the next round of recommendations related to episodes of care is expected in early Summer 2016.

As requested by letter from the Tennessee Senate Health and Welfare Committee on December 12, 2015, future Quarterly Reports from TennCare to the General Assembly will summarize TAG recommendations as they become available and will detail the manner in which HCFA plans to address those recommendations.

Incentives for Providers to Use Electronic Health Records. The Electronic Health Records (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 is to provide financial incentives to Medicaid providers[3] 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 the following types of payments:

- First-year payments to providers (eligible hospitals or practitioners) who either—
    - Adopt, implement, or upgrade to certified EHR technology capable of meeting "meaningful use" in accordance with CMS standards, or
    - Achieve meaningful use of certified EHR technology for any period of 90 consecutive days;
- Second-year payments to providers who have received first-year payments and who achieved meaningful use for a subsequent period of 90 consecutive days;
- Third-year and fourth-year payments to providers who continue to demonstrate meaningful use.

EHR payments made by TennCare during the October-December 2015 quarter as compared with payments made throughout the life of the program appear in the table below:

[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).

Payment Type	Number of Providers Paid During the Quarter	Quarterly Amount Paid (Oct-Dec 2015)	Cumulative Amount Paid to Date
First-year payments	332[4]	$1,360,495	$157,128,183
Second-year payments	40	$628,863	$50,186,258
Third-year payments	6	$51,000	$16,962,038
Fourth-year payments	3	$25,500	$1,394,005

Technical assistance activities, outreach efforts, and other EHR-related projects conducted by Bureau staff during the quarter included:

- Hosting seven webinars for eligible professionals on the subject of CMS's final rule—published on October 16, 2015—on EHR programs;
- Attending more than a dozen meetings throughout the state, including six sessions hosted by the Tennessee Medical Association (TMA), six town hall meetings hosted jointly by Amerigroup and UnitedHealthcare, and the 67th Annual Scientific Assembly of the Tennessee Academy of Family Physicians;
- Participation throughout the quarter in several Southeast Regional Collaboration for HIT/HIE (SERCH) calls;
- Monthly newsletters distributed by the Bureau's EHR ListServ; and
- A quarterly reminder to Tennessee providers who had registered at the federal level but who have not registered or attested at the state level.

TennCare continues to schedule EHR workshops with a variety of provider organizations to maintain the momentum of the program. Events planned for the spring of 2016, for instance, include participation in the statewide TMA meeting.

Public Forum on the TennCare Demonstration. In compliance with the federal regulation at 42 CFR § 431.420(c) and Special Term and Condition 10 of the TennCare Demonstration, the Bureau hosted a public forum in Nashville on December 17, 2015. 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 17 open meeting was not the only avenue through which feedback could be offered. Notice of the forum, which appeared on the TennCare website, included an email address and a physical address at which comments would be accepted. Although the Bureau received comments from only two sources, 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.

[4] Of the 332 providers receiving first-year payments in the October-December 2015 quarter, 21 earned their incentives by successfully attesting to meaningful use of EHR technology in their first year of participation in the program.

The two sets of comments received by TennCare address a variety of subjects, ranging from the specific (enrollee notices concerning estate recovery, assistive technology options for CHOICES members) to the expansive (Governor Haslam's Insure Tennessee proposal, the appropriate role of government in the provision of health insurance). As required by regulation, the Bureau will furnish CMS a summary of the public forum and the comments received there.

Essential Access Hospital (EAH) Payments. The TennCare Bureau continued to make EAH payments during the October-December 2015 quarter. EAH payments are made from a pool of $100 million ($34,965,000 in State dollars) appropriated by the General Assembly and funded by the hospital assessment fee.

The methodology for distributing these funds, as outlined in Special Term and Condition 55.e. of the TennCare Demonstration Agreement with CMS, 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 2016 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 2016
Regional Medical Center at Memphis	Shelby County	$3,494,251
Vanderbilt University Hospital	Davidson County	$3,333,176
Erlanger Medical Center	Hamilton County	$2,561,577
University of Tennessee Memorial Hospital	Knox County	$1,457,096
Johnson City Medical Center (with Woodridge)	Washington County	$1,093,472
Parkridge Medical Center (with Parkridge Valley)	Hamilton County	$720,911
LeBonheur Children's Medical Center	Shelby County	$715,194
Jackson – Madison County General Hospital	Madison County	$595,473
Metro Nashville General Hospital	Davidson County	$560,428
Methodist Healthcare – Memphis Hospitals	Shelby County	$549,344
East Tennessee Children's Hospital	Knox County	$534,806
Saint Jude Children's Research Hospital	Shelby County	$433,200

Hospital Name	County	EAH Second Quarter FY 2016
Methodist Healthcare – South	Shelby County	$421,805
Parkwest Medical Center (with Peninsula)	Knox County	$327,189
Methodist Healthcare – North	Shelby County	$320,590
TriStar Centennial Medical Center	Davidson County	$309,788
TriStar Skyline Medical Center (with Madison Campus)	Davidson County	$300,660
Wellmont – Holston Valley Medical Center	Sullivan County	$289,318
University Medical Center (with McFarland)	Wilson County	$256,304
Parkridge East Hospital	Hamilton County	$253,280
Saint Francis Hospital	Shelby County	$251,638
Saint Thomas Rutherford Hospital	Rutherford County	$251,113
Lincoln Medical Center	Lincoln County	$250,317
Saint Thomas Midtown Hospital	Davidson County	$235,144
Maury Regional Hospital	Maury County	$220,978
Baptist Memorial Hospital for Women	Shelby County	$214,991
Wellmont – Bristol Regional Medical Center	Sullivan County	$207,423
Cookeville Regional Medical Center	Putnam County	$199,783
Fort Sanders Regional Medical Center	Knox County	$192,789
Pathways of Tennessee	Madison County	$191,254
Ridgeview Psychiatric Hospital and Center	Anderson County	$184,156
Tennova Healthcare – Physicians Regional Medical Center	Knox County	$165,423
Blount Memorial Hospital	Blount County	$143,785
Delta Medical Center	Shelby County	$141,521
TriStar Summit Medical Center	Davidson County	$136,416
TriStar StoneCrest Medical Center	Rutherford County	$128,672
Rolling Hills Hospital	Williamson County	$124,590
Skyridge Medical Center	Bradley County	$123,453
Southern Hills Medical Center	Davidson County	$120,882
NorthCrest Medical Center	Robertson County	$120,066
Gateway Medical Center	Montgomery County	$118,920
TriStar Horizon Medical Center	Dickson County	$117,334
Sumner Regional Medical Center	Sumner County	$113,140
Morristown – Hamblen Healthcare System	Hamblen County	$109,717
Dyersburg Regional Medical Center	Dyer County	$103,236
Baptist Memorial Hospital – Tipton	Tipton County	$92,929
Methodist Medical Center of Oak Ridge	Anderson County	$87,881
TriStar Hendersonville Medical Center	Sumner County	$87,707
Jellico Community Hospital	Campbell County	$86,791
LeConte Medical Center	Sevier County	$85,786
Baptist Rehabilitation – Germantown	Shelby County	$82,672
Harton Regional Medical Center	Coffee County	$81,692
Takoma Regional Hospital	Greene County	$81,016

Hospital Name	County	EAH Second Quarter FY 2016
Tennova Healthcare – LaFollette Medical Center	Campbell County	$77,458
Grandview Medical Center	Marion County	$75,749
Skyridge Medical Center – Westside	Bradley County	$72,548
Southern Tennessee Medical Center	Franklin County	$65,407
United Regional Medical Center and Medical Center of Manchester	Coffee County	$63,035
Sycamore Shoals Hospital	Carter County	$62,612
Indian Path Medical Center	Sullivan County	$61,985
Lakeway Regional Hospital	Hamblen County	$60,751
Roane Medical Center	Roane County	$58,827
Laughlin Memorial Hospital	Greene County	$58,448
Starr Regional Medical Center – Athens	McMinn County	$57,548
Regional Hospital of Jackson	Madison County	$57,518
Hardin Medical Center	Hardin County	$56,626
Crockett Hospital	Lawrence County	$54,345
Henry County Medical Center	Henry County	$54,209
Stones River Hospital	Cannon County	$52,456
Wellmont Hawkins County Memorial Hospital	Hawkins County	$51,342
River Park Hospital	Warren County	$48,420
Jamestown Regional Medical Center	Fentress County	$45,902
Hillside Hospital	Giles County	$44,292
Livingston Regional Hospital	Overton County	$43,281
Heritage Medical Center	Bedford County	$42,770
Baptist Memorial Hospital – Union City	Obion County	$42,323
McNairy Regional Hospital	McNairy County	$39,416
Claiborne County Hospital	Claiborne County	$38,724
McKenzie Regional Hospital	Carroll County	$34,762
Erlanger Health System – East Campus	Hamilton County	$31,045
Henderson County Community Hospital	Henderson County	$28,355
Volunteer Community Hospital	Weakley County	$26,978
Wayne Medical Center	Wayne County	$25,394
DeKalb Community Hospital	DeKalb County	$21,744
Cumberland River Hospital	Clay County	$19,962
Decatur County General Hospital	Decatur County	$18,005
Baptist Memorial Hospital – Huntingdon	Carroll County	$17,135
Emerald Hodgson Hospital	Franklin County	$9,551
TOTAL		**$25,000,000**

Number of Recipients on TennCare and Costs to the State

During the month of December 2015, there were 1,463,500 Medicaid eligibles and 29,335 Demonstration eligibles enrolled in TennCare, for a total of 1,492,835 persons.[5]

Estimates of TennCare spending for the second quarter of State Fiscal Year 2016 are summarized in the table below.

Spending Category	2nd Quarter*
MCO services**	$1,650,855,900
Dental services	$39,909,600
Pharmacy services	$289,738,800
Medicare "clawback"***	$45,003,000

**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.*

[5] The number of Demonstration eligibles reported here is somewhat higher than the number presented in recent Quarterly Reports. This change is due to a modification in our methodology for calculating membership in this group.

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 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.	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[6] 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[7] 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 claims processor (e.g., MCO, vision benefits manager, etc.). 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 claims processor, 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

[6] 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.
[7] 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 and company action level requirements. According to Tennessee's "Health Maintenance Organization Act of 1986" statute (T.C.A. § 56-32-101 *et seq.*), 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 the October-December 2015 quarter, the MCOs submitted their National Association of Insurance Commissioners (NAIC) Third Quarter 2015 Financial Statements. As of September 30, 2015, TennCare MCOs reported net worth as indicated in the table below.[8]

MCO	Net Worth Requirement	Reported Net Worth	Excess/ (Deficiency)
Amerigroup Tennessee	$18,895,648	$160,078,554	$141,182,906
UnitedHealthcare Plan of the River Valley (UnitedHealthcare Community Plan)	$67,602,074	$465,398,529	$397,796,455
Volunteer State Health Plan (BlueCare & TennCare Select)	$37,185,058	$307,523,663	$270,338,605

During the October-December 2015 quarter, the MCOs were also required to comply with Tennessee's "Risk-Based Capital for Health Organizations" statute (T.C.A. § 56-46-201 *et seq.*). Risk-based capital (RBC) involves a method of calculating the minimum amount of capital necessary for a health entity to support its overall business operations depending on its size and risk profile. A health entity with a higher amount of risk is required to hold a higher amount of capital. The RBC statute gives TDCI the authority and mandate to use preventive and corrective measures that vary depending on the amount of capital deficiency indicated by the RBC calculations. A "Company Action Level" deficiency (defined at T.C.A. § 56-46-203(a)) would require the submission of a plan to correct the entity's capital deficiency.

The following table compares the MCOs' net worth to the Company Action Level requirements as of September 30, 2015:

MCO	Company Action Level	Reported Net Worth	Excess/ (Deficiency)
Amerigroup Tennessee	$61,407,788	$160,078,554	$98,670,766
UnitedHealthcare Plan of the River Valley (UnitedHealthcare Community Plan)	$244,098,654	$465,398,529	$221,299,875

[8] 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 and Volunteer State Health Plan, for instance, operate Medicare Advantage Plans, while UnitedHealthcare has several lines of business in Illinois, Iowa, Virginia, and Tennessee.

MCO	Company Action Level	Reported Net Worth	Excess/ (Deficiency)
Volunteer State Health Plan (BlueCare & TennCare Select)	$109,546,612	$307,523,663	$197,977,051

All TennCare MCOs met their minimum net worth requirements and Company Action Level requirements as of September 30, 2015.

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. Selected statistics for the second quarter of Fiscal Year 2016 are as follows:

TennCare Fraud & Abuse Complaints

	Quarter
Fraud Allegations	1,634
Abuse Allegations*	1,059

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

Arrests, Convictions, and Judicial Diversion*

	Quarter
Arrests	46
Convictions	29
Instances of Judicial Diversion	13

***** *Cases adjudicated during a particular fiscal year may have no relationship to dates of arrest during the same year.*

Criminal Court: Fines & Costs Imposed

	Quarter
Court Costs & Taxes	$10,060
Fines	$24,050
Drug Funds/Forfeitures	$2,279
Criminal Restitution Ordered	$88,132

	Quarter
Criminal Restitution Received[9]	$47,432

Civil Restitution & Civil Court Judgments

	Quarter
Civil Restitution Ordered[10]	$0
Civil Restitution Received[11]	$14,638

Recommendations for Review

	Quarter
Recommended TennCare Terminations[12]	156
Potential Savings[13]	$570,397

Collaboration with CDI

During the October-December 2015 quarter, two OIG Special Agents partnered with the Cooperative Disability Investigations (CDI) Unit of the Social Security Administration (SSA). The mission of this unit is to combat fraud by investigating questionable statements and activities of claimants, medical providers, interpreters, or other service providers who facilitate or promote disability fraud. The OIG Special Agents will review information from the SSA to determine whether TennCare fraud or abuse may have occurred and, when warranted, to open an investigation.

Statewide Communication

In an effort to stay connected with local law enforcement and achieve the OIG's mission, Special Agents continue to meet in person with sheriffs and police chiefs throughout the state. These meetings further collaborative relationships and aid the mutual goal of stopping TennCare fraud and prescription drug diversion.

[9] Restitution may have been ordered in a fiscal year other than the one in which payment was actually received.

[10] 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.

[11] A recoupment may be received in a quarter other than the one in which it is ordered.

[12] 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. In reviewing these recommendations, TennCare must factor in some limitations, such as the inability to disenroll individuals in certain federally protected categories.

[13] Potential 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 estimated by TennCare to be $3,656.39).

Appendix

TAG Recommendations for Wave 4 Episodes of Care

ADHD episode design summary

Identifying episode triggers

An ADHD episode is triggered by a professional claim that has: a primary diagnosis of ADHD (ICD-9 diagnosis in the 314 code family – Hyperkinetic syndrome of childhood), or a secondary diagnosis of ADHD and a primary diagnosis of a symptom of ADHD. This professional visit must also have a procedure code that is for assessment, therapy, case management, or physician services.

Attributing episodes to quarterbacks

The quarterback is the provider or group with the plurality of ADHD-related visits during the episode; the contracting entity ID with the plurality of ADHD visits will be used to identify the quarterback.

Identifying services to include in episode spend

The length of the ADHD episode is 180 days. During this time period the following services are included in episode spend: all inpatient, outpatient, professional, and long-term care claims with a primary diagnosis of ADHD; all inpatient, outpatient, professional, and long-term care claims with a secondary diagnosis of ADHD and a primary diagnosis of a symptom of ADHD; pharmacy claims with eligible therapeutic codes.

There are three types of exclusions: business exclusions: available information is not comparable or is incomplete; clinical exclusions: patient's care pathway is different for clinical reasons: these include age (<4 or >20), attempted suicide, autism, bipolar, BPD, conduct disorder, delirium, dementia, dissociative disorders, homicidal ideation, intellectual disabilities, manic disorders, psychoses, PTSD, schizophrenia, specific psychosomatic disorders (e.g. factitious disorder) and substance abuse (prescription and illicit); high cost outlier exclusions: Episode's risk adjusted spend is three standard deviations above the mean.

Determining quality metrics performance

Quality metrics tied to gain sharing are: percentage of valid episodes that meet the minimum care requirement. The minimum care requirement is set at 5 visits/claims with a related diagnosis code during the episode window. These may be a combination of physician visits, therapy visits, level I case management visits, or pharmacy claims for treatment of ADHD.

Quality metrics not tied to gain sharing are: average number of physician visits per valid episode; average number of therapy visits per valid episode; average number of level I case management visits per valid episode; percentage of valid episodes with medication by age group (4 and 5, 6 to 11, and 12 to 20); percentage of valid episodes for which the patient has a physician, therapy, or level I case management visit within 30 days of the triggering visit.

ODD episode design summary

Identifying episode triggers

An ODD episode is triggered by a professional claim that has: a primary diagnosis of ODD (ICD-9 diagnosis code 313.81 – Oppositional defiant disorder), or a secondary diagnosis of ODD and a primary diagnosis of a symptom of ODD. This professional visit must also have a procedure code that is for assessment, therapy, case management, or physician services.

Attributing episodes to quarterbacks

The quarterback is the provider or group with the plurality of ODD-related visits during the episode. The contracting entity ID with the plurality of ODD visits will be used to identify the quarterback.

Identifying services to include in episode spend
The length of the ODD episode is 180 days. During this time period the following services are included in episode spend: all inpatient, outpatient, professional, and long-term care claims with a primary diagnosis of ODD; all inpatient, outpatient, professional, and long-term care claims with a secondary diagnosis of ODD and a primary diagnosis of a symptom of ODD; pharmacy claims with eligible therapeutic codes.

Excluding episodes
Clinical exclusions: age (<4 or >18), antisocial personality disorder, attempted suicide, autism, BPD, conduct disorder, delirium, dementia, disruptive mood dysregulation disorder, dissociative disorders, homicidal ideation, intellectual disabilities, manic disorders, psychoses, PTSD, schizophrenia, specific psychosomatic disorders (e.g. factitious disorder) and substance abuse (prescription and illicit); high cost outlier exclusions: Episode's risk adjusted spend is three standard deviations above the mean.

Determining quality metrics performance
Quality metrics tied to gain sharing are: percentage of valid episodes that meet the minimum care requirement. The minimum care requirement is set at 6 therapy and/or level I case management visits with a related diagnosis code during the episode window. Quality metrics not tied to gain sharing are: percentage of valid episodes with no coded behavioral health comorbidities for which the patient received behavioral health medications; percentage of valid episodes that had a claim with ODD as the primary diagnosis in the prior year; average number of visits (physician, therapy, and case management) per valid episode; average number of therapy or level I case management visits per valid episode.

Bariatric Surgery episode design summary

Identifying episode triggers
A bariatric surgery episode is triggered by: a professional claim that has one of the defined procedure codes for bariatric surgery or a facility claim that has a diagnosis code relevant to severe obesity or indicated comorbidities of obesity.

Attributing episodes to quarterbacks
The quarterback is the physician or physician group that performed the procedure. The contracting entity ID of the physician (or group) on the professional claim will be used to identify the quarterback.

Identifying services to include in episode spend
Services to include in episode spend are: all medical services and medications during the bariatric procedure. Specific evaluation and management, medications, procedures, imaging, testing, anesthesia, pathology, and care after discharge up to 30 days after discharge from the facility where the bariatric procedure was performed.

Excluding episodes
Clinical exclusions: BPD/BPD-DS, adjustable gastric band placement, and revision procedures.

Determining quality metrics performance
Quality metrics tied to gain sharing are: percent of valid episodes where the patient receives relevant follow-up care within 30 days of discharge. Quality metrics not tied to gain sharing are: percent of total episodes performed in an accredited facility, e.g. through MBSAQIP; percent of valid episodes with relevant admission or observation care within 30 days of discharge; percent of valid episodes with relevant ED visits within 30 days of discharge; percent of valid episodes with relevant

reoperations, including major abdominal procedures and wound debridement, within 30 days of discharge

CHF acute exacerbation episode design summary

Identifying episode triggers
A congestive heart failure acute exacerbation episode is triggered by an inpatient admission or ED/Observation/IV infusion center outpatient claim, where either: the primary diagnosis is one of the defined acute or unspecified CHF trigger codes; the primary diagnosis is one of the defined chronic CHF codes, with a secondary diagnosis code from the acute or unspecified CHF trigger or signs and symptom codes; or the primary diagnosis is one of the defined CHF signs and symptom codes, with a secondary diagnosis code from the acute, chronic, or unspecified CHF trigger codes.

Attributing episodes to quarterbacks
The quarterback is the facility where the patient is treated. The contracting entity ID on the facility claim will be used to identify the quarterback.

Identifying services to include in episode spend
Services to include in episode spend are: all medical services and medications during the trigger window. Specific anesthesia, evaluation and management, medications, procedures, imaging, testing, and care after discharge up to 30 days after discharge from facility where the CHF acute exacerbation was treated.

Risk adjusting and excluding episodes
Episodes affected by factors that make them inherently more costly than others are risk adjusted. The TAG has recommended a specific list of factors for testing. Episodes which are not comparable or affected by factors that make them inherently more costly but that cannot be risk adjusted for are excluded. There are three types of exclusions: business exclusions: available information is not comparable or is incomplete; clinical exclusions: patient's care pathways is different for clinical reasons - these are active cancer, ESRD, heart transplant, pregnancy, history of and/or concurrent ECMO, and presence or placement of VAD; high cost outlier exclusions: Episode's risk adjusted spend is three standard deviations above the mean.

Determining quality metrics performance
Quality metrics tied to gain sharing are: percent of valid episodes where the patient receives relevant follow-up care within 30 days of discharge; quality metrics not tied to gain sharing are: percent of valid episodes where the patient receives relevant follow-up care within 7 days of discharge; percent of valid episodes with relevant admission or observation care within 30 days of discharge; percent of valid episodes with relevant ED visits within 30 days of discharge; percent of total episodes with patient mortality within the episode window; percent of total episodes where patients received quantitative symptom/activity assessment during episode window.

CABG episode design summary

Identifying episode triggers
A CABG episode is triggered by: a professional claim that has one of the defined primary procedure codes for CABG or an inpatient facility claim that has a diagnosis code relevant to CABG (e.g., coronary occlusion). CABG procedures that are concurrent with heart valve replacement or repair procedures will not trigger episodes.

Attributing episodes to quarterbacks

The quarterback is the facility where the CABG was performed. The contracting entity ID of the facility on the inpatient facility claim will be used to identify the quarterback.

Identifying services to include in episode spend
Services to include in episode spend are: all medical services and medications during the facility stay where the CABG is performed; specific evaluation and management, medications, anesthesia, pathology, procedures, imaging, testing, and care after discharge up to 30 days after discharge from the facility where the procedure was performed.

Excluding episodes
Clinical exclusions: patient's care pathways is different for clinical reasons - these are emergent procedures, pre-existing endocarditis, and pre-existing pneumonia; high cost outlier exclusions: episode's risk adjusted spend is three standard deviations above the mean.

Determining quality metrics performance
Quality metrics tied to gain sharing are: percent of valid episodes performed by a surgeon participation in a Qualified Clinical Data Registry; percent of valid episodes where the patient receives relevant follow-up care within 30 days of discharge. Quality metrics not tied to gain sharing are: percent of valid episodes with relevant readmission or observation care within 30 days of discharge; percent of total episodes with patient mortality within the episode window; percent of valid episodes where the patient has a major morbidity within the episode window.

<u>Heart valve replacement and repair episode</u>

Identifying episode triggers
A heart valve replacement and repair episode is triggered by: a professional claim that has one of the defined procedure codes for heart valve replacement or repair or an inpatient facility claim that has a diagnosis code relevant to heart valve replacement or repair episode. Heart valve replacement and repair that is concurrent with CABG will trigger a heart valve episode.

Attributing episodes to quarterbacks
The quarterback is the facility where the heart valve replacement or repair procedure was performed. The contracting entity ID of the facility on the inpatient facility claim will be used to identify the quarterback.

Identifying services to include in episode spend
Services to include in episode spend are: all medical services and medications during the facility stay where the heart valve replacement or repair procedure is performed; specific evaluation and management, medications, anesthesia, pathology, procedures, imaging, testing, and care after discharge up to 30 days after discharge from the facility where the procedure was performed.

Excluding episodes
Clinical exclusions: patient's care pathways is different for clinical reasons - these are acute ischemia-related admissions, pre-existing endocarditis, and pre-existing pneumonia. High cost outlier exclusions: episode's risk adjusted spend is three standard deviations above the mean.

Determining quality metrics performance
Quality metrics tied to gain sharing are: percent of valid episodes performed by a surgeon participation in a Qualified Clinical Data Registry; percent of valid episodes where the patient receives relevant follow-up care within 30 days of discharge.

Quality metrics not tied to gain sharing are: percent of valid episodes with relevant readmission or observation care within 30 days of discharge; percent of total episodes with patient mortality within the episode window; percent of valid episodes where the patient has a major morbidity within the episode window.