TennCare Quarterly Report

Submitted to the TennCare Oversight Committee and the Fiscal Review Committee

April 15, 2009

Status of TennCare Reforms and Improvements

***Daniels* relief.** The state has been under an injunction for over 20 years in a case known as *Daniels.* This case involved redetermination of Medicaid eligibility for individuals who once received Supplemental Security Income (SSI) cash assistance but who have had their SSI benefits terminated by the Social Security Administration.

Under this injunction, the state was prohibited from redetermining the eligibility of individuals in the *Daniels* class until the court approved a process for doing so. As a result of the injunction, all individuals in the *Daniels* class continued to receive TennCare benefits without regard to whether or not they continued to meet Medicaid eligibility criteria. The *Daniels* class, which consists of about 154,000 persons, includes some who are Medicaid eligible under other categories, as well as many who are not (including some who have moved to other states, are incarcerated, or have too much income to qualify for Medicaid).

As part of an amendment to TennCare II in 2005, the Centers for Medicare and Medicaid Services (CMS) approved TennCare's redetermination process. When the demonstration project was renewed in 2007, CMS again approved the process.

On February 1, 2008, the state filed a motion with the U.S. District Court seeking to have the injunction in the *Daniels* case lifted so that the state could implement the CMS-approved redetermination process with the *Daniels* class members. CMS fully supported the state in this request and told the court that the process to be used for *Daniels* class members was the same one that had been approved in the TennCare terms and conditions.

On January 8, 2009, the District Court granted the state's motion and lifted the injunction. As a result of this action, the state may now begin applying its pre-existing eligibility rules and procedures to the *Daniels* class. Those persons who are eligible for active Medicaid categories will be moved to those categories and will be allowed to keep their TennCare coverage. Those who do not meet the eligibility criteria for any established Medicaid category will be disenrolled from TennCare.

American Reinvestment and Recovery Act (ARRA). On February 17, 2009, the President signed into law the American Reinvestment and Recovery Act, which allocated about $1.1 billion additional federal dollars to TennCare over the nine-quarter "recession

adjustment period" spanning the time between October 2008 and December 2010. These funds will be instrumental in helping TennCare avoid immediate budget reductions and also adjust to the changing economic climate over a period of time.

The funds will be provided solely through an increased federal match on medical assistance payments made by TennCare. Previously, the federal match rate was about 65 percent. Under ARRA, the match rate will increase to 74 percent.

ARRA funds cannot be used to add new people to the TennCare program or to add benefits. The funds are "non-recurring," which means that they will not be available once the recession adjustment period has ended and thus cannot be used to fund the continuation of any services or eligibility enhancements that might be initiated during this period.

The Act also outlines grants to be used in implementing new Health Information Technology Extension Programs and incentive funds to help encourage providers to transition to electronic health records. TennCare is still awaiting guidance from federal officials before it is certain how that money will be best used.

Implementation of new MCOs in East Tennessee. The Bureau of TennCare, through two new MCOs (AmeriChoice and BlueCare), began delivering integrated behavioral and medical coverage of approximately 400,000 enrollees in East Tennessee on January 1, 2009. No significant issues were noted during the transition. The Bureau conducted daily phone calls with both AmeriChoice and BlueCare over a two week period to ensure communication and resolution of issues. The Bureau continues to work with the behavioral health providers to assist them in becoming acclimated to the new integrated model, as well as any with other providers who need a contact from the MCOs related to contracting or implementation issues.

This implementation of new MCOs in East Tennessee completed the Bureau's statewide move to MCOs that are fully at risk and that integrate medical and behavioral health care. Implementation occurred in Middle Tennessee effective April 1, 2007, and in West Tennessee effective November 1, 2008.

Long-Term Care CHOICES program. As stated in earlier quarterly reports, the state has been in negotiations for some time with the Centers for Medicare and Medicaid Services (CMS) regarding Amendment #7 to the TennCare waiver. This waiver amendment was originally proposed in a concept paper on July 11, 2008, with a requested approval date of December 31, 2008. On January 13, 2009, four persons from the Bureau of TennCare traveled to Baltimore to meet with CMS staff and to attempt to get resolution on what the outstanding issues were and how they should be resolved.

On February 20, 2009, the state sent a letter to the Speakers, the TennCare Oversight Committee, and the members appointed to date to the Joint Committee on Long-Term Care Oversight. The purpose of the letter was to outline progress made to date on implementing the Long-Term Care CHOICES program. Topics discussed included:

- Amendment to the TennCare Section 1115 waiver
- Amendment of the Section 1915(c) HCBS waiver
- Streamlining eligibility

- Nursing facility diversification
- Single Point of Entry (SPOE)
- Stakeholder involvement
- Administrative and programmatic activities

A copy of the letter is attached at the end of this report.

As of the end of the quarter, the weekly conference calls with CMS were continuing, and there was some optimism that perhaps the negotiations were moving the Amendment closer to approval.

Movement of State-only's. When services for persons with mental illness were brought under the TennCare managed care program in 1996, there was a group of people whom the Department of Mental Health and Developmental Disabilities had been serving who were not eligible for TennCare. These people had been assessed as being Severely and/or Persistently Mentally Ill and as having incomes below poverty. Even though they were not eligible for TennCare, TDMHDD asked TennCare to provide services to them through the Behavioral Health Organizations (BHOs). TennCare agreed to pick up the costs of their mental health services, using state-only dollars for which no federal matching funds were available. Over the years TennCare continued to absorb the costs for this group, even though they were not a TennCare responsibility.

On January 1, 2009, TennCare completed a process of phasing mental health services into the Managed Care Organizations. Because behavioral health services are no longer delivered separately from medical services, there was no longer a need for separate BHOs. Accordingly, the responsibility for the State-only's was moved back to TDMHDD. There are about 11,000 persons in this group, and they now receive services through the Mental Health Safety Net.

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 ($35,862,000 in state dollars) appropriated by the General Assembly.

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 do not have unreimbursed TennCare costs, and the five state mental health institutes.

The projected Essential Access Hospital payments for the third quarter of State Fiscal Year 2009 are shown in the following table.

Name of Hospital	FY 2009 3rd Qtr. EAH
Regional Medical Center (The Med)	$ 4,108,572.00
Vanderbilt University Hospital	$ 3,572,753.00
Erlanger Medical Center	$ 1,509,743.00
University of Tennessee Memorial Hospital	$ 1,244,385.00
Johnson City Medical Center Hospital - Revised	$ 1,163,559.00
Metro Nashville General Hospital	$ 900,988.00
Methodist Healthcare - Lebonheur	$ 818,063.00
Parkridge Medical Center - Revised	$ 665,448.00
Jackson Madison County General Hospital	$ 597,639.00
East Tennessee Children's Hospital	$ 431,937.00
Methodist University Healthcare	$ 360,765.00
University Medical Center	$ 345,747.00
Fort Sanders Parkwest Medical Center - Revised	$ 340,661.00
Wellmont Holston Valley Medical Center	$ 316,905.00
Saint Francis Hospital	$ 311,338.00
Fort Sanders Regional Medical Center	$ 301,606.00
Saint Jude Children's Research	$ 295,186.00
Centennial Medical Center	$ 255,580.00
Pathways of Tennessee	$ 231,906.00
Wellmont Bristol Regional Medical Center	$ 212,327.00
Tennessee Christian Medical Center	$ 210,440.00
Saint Mary's Health System	$ 202,964.00
Methodist Healthcare - South	$ 199,039.00
Indian Path Medical Center - Revised	$ 192,255.00
Delta Medical Center	$ 190,117.00
Baptist Hospital of Cocke County	$ 178,024.00
Middle Tennessee Medical Center	$ 175,350.00
Baptist Hospital	$ 173,982.00
Methodist Healthcare - North	$ 164,649.00
Dyersburg Regional Medical Center	$ 158,584.00
Baptist Memorial Hospital for Women	$ 154,517.00
Cookeville Regional Medical Center	$ 153,802.00
Morristown Hamblen Healthcare System	$ 153,399.00
Maury Regional Hospital	$ 151,025.00
Community Behavioral Health	$ 140,499.00
Blount Memorial Hospital	$ 136,372.00
Bradley Memorial Hospital	$ 135,458.00
Sumner Regional Medical Center	$ 129,117.00
Gateway Medical Center	$ 128,921.00
Ridgeview Psychiatric Hospital and Center	$ 127,595.00
Northcrest Medical Center	$ 125,505.00
Parkridge East Hospital	$ 119,405.00
Sweetwater Hospital Association	$ 118,255.00
Summit Medical Center	$ 117,511.00
Baptist Memorial Hospital - Tipton	$ 116,184.00
Cumberland Medical Center	$ 115,772.00
Fort Sanders Sevier Medical Center	$ 114,430.00
Southern Hills Medical Center	$ 111,096.00

Name of Hospital		FY 2009
Claiborne County Hospital	$	108,398.00
Methodist Medical Center of Oak Ridge	$	108,300.00
Jamestown Regional Medical Center	$	101,130.00
Humboldt General Hospital	$	98,229.00
Cleveland Community Hospital	$	97,375.00
Regional Hospital of Jackson	$	95,898.00
Skyline Medical Center	$	94,357.00
St. Mary's Medical Center of Campbell County	$	90,990.00
Henry County Medical Center	$	86,808.00
Stonecrest Medical Center	$	85,335.00
Horizon Medical Center	$	85,265.00
Hardin County General Hospital	$	83,951.00
Jellico Community Hospital	$	79,859.00
Sycamore Shoals Hospital	$	79,176.00
Southern Tennessee Medical Center	$	76,295.00
Lakeway Regional Hospital	$	71,338.00
Laughlin Memorial Hospital	$	68,620.00
Crockett Hospital	$	67,998.00
Hillside Hospital	$	64,865.00
Athens Regional Medical Center	$	63,515.00
Grandview Medical Center	$	60,675.00
River Park Hospital	$	59,991.00
Bolivar General Hospital	$	59,507.00
Bedford County Medical Center	$	59,184.00
Takoma Adventist Hospital	$	55,795.00
Scott County Hospital	$	52,648.00
United Regional Medical Center	$	48,428.00
Lincoln Medical Center	$	47,876.00
McKenzie Regional Hospital	$	47,651.00
Wellmont Hawkins County Memorial Hospital	$	47,456.00
Methodist Healthcare - Fayette	$	44,323.00
Volunteer Community Hospital	$	41,082.00
Roane Medical Center	$	40,957.00
McNairy Regional Hospital	$	38,583.00
Unicoi County Memorial Hospital	$	38,457.00
Livingston Regional Hospital	$	37,413.00
Cumberland River Hospital	$	36,192.00
Haywood Park Community Hospital	$	33,621.00
Baptist Memorial Hospital - Huntingdon	$	32,038.00
Baptist Dekalb Hospital	$	29,191.00
Decatur County General Hospital	$	28,026.00
Gibson General Hospital	$	27,776.00
Tennessee Christian Medical Center - Portland	$	25,062.00
Henderson County Community Hospital	$	24,081.00
Wayne Medical Center	$	23,523.00
White County Community Hospital	$	20,722.00
Emerald Hodgson Hospital	$	19,775.00
Women's East Pavilion	$	13,653.00
Johnson City Specialty Hospital	$	13,465.00

Name of Hospital		FY 2009
Baptist Treatment Center of Murfreesboro	$	3,552.00
Baptist Women's Treatment Center	$	2,220.00
	$	25,000,000.00

Reverification Status

Due to the court's granting of the state's motion in *Daniels,* as discussed at the beginning of this report, the Bureau of TennCare and the Department of Human Services spent a great deal of time during this quarter preparing to begin reverifying the eligibility of the 154,000 *Daniels* class members, using the reverification procedures approved by CMS in 2005 and again in 2007. This process is expected to begin in the coming quarter.

Status of Filling Top Leadership Positions in the Bureau

Mollie Mennell was appointed January 4, 2009, and serves as Deputy Director of Long Term Care responsible for program integrity and process improvement as well as the administration, policy and quality oversight of all long-term care (LTC) programs and services including Nursing Facility services, the Program of All-Inclusive Care for the Elderly (PACE), the state's 1915(c) Home and Community Based Services (HCBS) Waiver for the Elderly and Disabled, Intermediate Care Facilities for persons with Mental Retardation (ICFs/MR), and the state's three 1915(c) HCBS waiver programs for persons with mental retardation (Arlington, Statewide, and Self-Determination). Ms. Mennell brings more than eight years of state service to her new position. She has a Master's degree in Public Administration and a Bachelor of Arts degree in Political Science from the University of Tennessee, Knoxville, and is a graduate of the Tennessee Government Executive Institute

Nita Mangum was appointed January 5, 2009 to serve as the Deputy Director of Long Term Care for eligibility and enrollment. She is responsible for overseeing modifications to the state's long-term care (LTC) eligibility and enrollment processes and requirements as set forth in the Governor's Long-Term Care Community Choices Act of 2008. She will also serve as the primary liaison for contracted functions with the Department of Human Services pertaining to LTC categorical and financial eligibility determination and for application of post-eligibility provisions needed to establish patient liability for LTC services. Ms. Mangum has 25 years of experience in leadership, program development and operations, and change management. She has a Master of Science degree in Social Work from the University of Tennessee, Knoxville, and a Bachelor of Science degree in Sociology and Criminal Justice from the University of Tennessee, Martin, in addition to specialized training from the University of Memphis and the U.S. Department of Justice.

Kelly Gunderson was appointed January 15, 2009, to serve as Director of Public Affairs, responsible for overseeing public and internal communications at TennCare. She has a Bachelor of Arts degree in broadcasting from the University of Central Missouri and worked for four years as a consumer reporter and morning news anchor for

KRCG-TV, a CBS affiliate in mid-Missouri. In June of 2007 she accepted an appointment as Director of Communications for Missouri State Treasurer Sarah Steelman, where she served as a spokesperson, speechwriter, and primary media contact, as well as planning all public relations outreach.

Terrence M. Leve was appointed March 30, 2009, to serve as General Counsel, responsible for directing and managing the legal office for the Bureau of TennCare related to compliance with the *John B.* Consent Decree, the *Grier* lawsuit, and negotiation, direction and oversight of departmental litigation in state and federal courts and administrative tribunals. Mr. Leve earned his Juris Doctorate and Bachelor of Arts degree from the University of Southern California, and possesses 17 years of progressively responsible experience serving as an executive and legal professional in an international corporate setting.

Number of Recipients on TennCare and Costs to the State

At the end of the third quarter (January through March 31, 2009), there were 1,200,588 Medicaid eligible and 31,973 uninsured/uninsurable persons enrolled in TennCare, for a total of 1,232,561 persons.

TennCare spending for the third quarter of State Fiscal Year 2008-2009 is summarized in the table below.

	3rd Quarter*
Spending on MCO services**	$1,007,652,550
Spending on BHO services***	$72,393,000
Spending on dental services	$42,107,700
Spending on pharmacy services	$192,745,500
Medicare "clawback"	$39,780,400

**These figures are cash basis as of Mar. 31 and are unaudited.*
***This figure includes Integrated Managed Care MCO expenditures.*
****Although the BHOs ceased their participation in the regular MCO program effective December 31, 2008, there are still some "run-out" claims from prior quarters and TennCare continues to pay separately for behavioral health services delivered to TennCare Select enrollees.*

Viability of MCOs in the TennCare Program

Claims Payment Analysis

The prompt pay requirements of T.C.A. § 56-32-226(b) mandate that each managed care organization ("MCO") and behavioral health organization ("BHO") ensure that 90 percent of clean claims for payment for services delivered to a TennCare enrollee are paid within 30 calendar days of the receipt of such claims and 99.5 percent of all provider claims are processed within 60 calendar days of receipt. TennCare's contract with its Dental Benefit Manager ("DBM") requires the DBM to also process claims in

accordance with this statutory standard. TennCare's contract with its Pharmacy Benefits Manager ("PBM") requires the PBM to pay 100 percent of all clean claims submitted by pharmacy providers within 10 calendar days of receipt. As stated previously in this document, the BHOs are no longer separate participants in the TennCare program, except for TennCare Select.

Prior to January 1, 2009, the Tennessee Department of Commerce and Insurance (TDCI) requested the MCOs, BHOs, DBM and PBM to submit claims data by month on a quarterly basis to test compliance with the prompt pay requirements. Starting January 1, 2009, the plans were required to submit to TDCI claims data on a monthly basis. For example, the February 2009 data was required to be submitted to TDCI no later than March 15, 2009, for analysis. 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 and BHOs are required to separately identify non-emergency transportation ("NEMT") claims in the data files. TDCI then performs and reports the results of the prompt pay analyses by NEMT claim type, by subcontractor, by TennCare contract and then by total claims processed for the month.

If an MCO or BHO 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 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.

During the quarter ended March 31, 2009, TDCI analyzed monthly data files of all processed TennCare claims submitted by the MCOs, BHOs and the DBM during November 2008 through February 2009. During this same time period, TDCI analyzed the monthly data files submitted by TennCare's new PBM, SXC, for the months of October 2008 through February 2009. TDCI also requested data files of pended TennCare claims and paid claims triangle lags to ensure that the claims data submitted was complete and accurate.

The analyses of the claims data found the following contractors were out of compliance based on total claims processed for the month:

- Volunteer State Health Plan (VSHP) – November and December 2008 and January 2009
- AMERIGROUP Tennessee – January and February 2009
- SXC – November and December 2008 and January 2009 [(A)]

[(A)] These results are preliminary. SXC has until April 17, 2009 to dispute these results.

TDCI will levy an administrative penalty against VSHP in the amount of $60,000 for its failure to meet the prompt pay standards for August 2008 through January 2009. TDCI will levy an administrative penalty against AMERIGROUP. The total amount of that penalty will be calculated once AMERIGROUP is back in compliance.

Net Worth Requirement

By statute, the minimum net worth requirement for each TennCare MCO and BHO 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, 2008, including payments made under the "stabilization plan." On March 1, 2009, the MCOs and BHOs submitted their NAIC 2008 Annual Financial Statement. As of December 31, 2008, TennCare MCOs/BHOs reported net worth as indicated in the table below.

	Net Worth Requirement	Reported Net Worth	Excess/ (Deficiency)
AMERIGROUP Tennessee	18,170,414	54,588,298	36,417,884
UnitedHealthcare Plan of the River Valley (AmeriChoice)	41,501,178	225,550,877	184,049,699
Preferred Health Partnership	6,715,961	44,681,797	37,965,836
UAHC Health Plan	7,159,013	13,099,677	5,940,664
Unison Health Plan	6,120,722	10,314,877	4,194,155
Volunteer (BlueCare & Select)	25,326,692	26,856,301	1,529,609
Premier Behavioral Systems	3,437,659	8,583,355	5,145,696
Tennessee Behavioral Health	6,735,554	19,468,860	12,733,306

All TennCare MCOs and BHOs met their minimum net worth requirements as of December 31, 2008.

FINANCIAL ISSUES:

Xantus Healthplan of Tennessee, Inc. (Xantus)

On February 6, 2009, Chancery Court of Davidson County issued the Final Order Terminating the Liquidation and Discharging the Liquidator in the liquidation of Xantus Healthplan of Tennessee, Inc.

Tennessee Coordinated Care Network d/b/a Access MedPlus (TCCN)

No change from previous report.

Universal Care of Tennessee (Universal)

On March 3, 2009, Chancery Court of Davidson County issued the Final Order Terminating the Liquidation and Discharging the Liquidator in the liquidation of Universal Care of Tennessee, Inc.

Success of Fraud Detection and Prevention

The Office of Inspector General (OIG) was established over four years ago (July 1, 2004). The mission of the OIG is: *To identify, investigate, and prosecute persons who commit fraud or abuse against the TennCare program.* 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 (MCC), OIG data mining, and the general public via the OIG web site, fax, written correspondence, and phone calls to the OIG hotline. The statistics for the third quarter of the 2008 - 2009 fiscal year are as follows:

***NOTE**: Included are the fiscal year totals (FYT) and the grand totals to date -- since the OIG was created (July 2004)*

Summary of Enrollee Cases

	Quarter	FYT	Grand Total
Cases Received	4,041	17,610	117,928
Cases Closed*	3,505	16,850	115,306

***Cases are closed when there is inadequate information provided to investigate the complaint, the information has been researched and determined to be unfounded, the case was referred to another agency (as per appropriate jurisdiction), or prosecuted by the OIG and closed. This number also includes reports the OIG runs for the TennCare Bureau regarding potential fraud or abuse.*

Summary of Enrollee Abuse Cases

	Quarter	Grand Total[2]
Abuse Cases Received	**3,396**	**49,872**
Abuse Cases Closed	**1,058**	**13,399**
Abuse Cases Referred [1]	**2,338**	**37,320**

[1] Abuse cases may be referred to the appropriate Managed Care Organization (MCO), the TennCare Bureau, or DHS for further review.

[2] Totals are for the last 33 months (eleven quarterly reports)

Summary of Provider Cases

	Quarter	FYT	Grand Total
Cases opened	11	46	1,265
Cases closed	17	40	1,052
Cases referred to TBI*	1	12	166
Cases referred to HRBs**	1	6	95

***The OIG refers **provider cases** to the TBI Medicaid Fraud Unit (as per state and federal law) and assists with these investigations as requested.*

***Health Related Boards*

Summary of Arrests & Convictions

	Quarter	FYT	Grand Total
Arrests	51	205	920
Convictions	46	113	429
Diversions*	3	27	155

Note: *Special Agents were in the field making arrests effective February 2005.*
***Judicial Diversion**: A guilty plea or verdict subject to expungement following successful completion of probation. Tennessee Code Annotated § 40-35-313*
***Pre-trial Diversion**: Prosecution was suspended and if probation is successfully completed, the charge will be dismissed. Tennessee Code Annotated § 40-15-105*

Court Fines & Costs Imposed

	Quarter	FYT	Grand Total
Fines	$23,750.00	$70,700.00	$220,761.50
Court Costs & Taxes	$4,314.58	$20,529.48	$83,362.59
Restitution (ordered)	$24,816.17	$90,547.94	$1,206,308.95
Drug Funds	$353.00	$6,660.00	$35,214.50

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

Arrest Categories

Category	Number
Drug Diversion/Forgery RX	321
Drug Diversion/Sale RX	315
Access to Insurance	55
Doctor Shopping	70
Operation Falcon III	32
Operation Falcon IV	16
False Income	43
Ineligible Person Using Card	16
Living Out Of State	13
Asset Diversion	7
Theft of Services	10
ID Theft	19
Aiding & Abetting	3
GRAND TOTAL	**920**

TennCare Case Referrals & Recoupments

	Quarter	FYT	Grand Total
Recoupment **1**	$41,068.62	$1,475,237.28	$1,545,840.27
Recommended TennCare Terminations **2**	2,078	12,699	46,996
Potential Savings**3**	$6,965,372.80	$42,566,540	$165,143,760.80

Footnotes for the *TennCare Case Referrals and Recoupments* table

1 The total in the last column reflects dollars collected by the OIG and sent to the TennCare Bureau from February 15, 2005, (when a Fiscal Manager and an attorney joined the OIG staff to facilitate and document this process) through March 31, 2009.

2 Enrollee recommendations sent to the TennCare Bureau for consideration based on reports run from *file net* (i.e. Prisoner Report, State Wage Report, the Deceased Report, the Department of Human Resources Report, and the PARIS Report).

3 There were 2,078 enrollee terminations *recommended* by the OIG to the TennCare Bureau for their review during the first quarter. The TennCare Bureau uses $3,351.96 as

the average annual cost per enrollee for MCO, Pharmacy, BHO, and Dental services (effective FY 08-09).

Investigative Sources

	Quarter	FYT	Grand Total
OIG Hot Line	854	2,568	19,978
OIG Mail Tips	52	152	3,202
OIG Web Site	258	904	6,857
OIG Email Tips	151	440	2,902

Other Investigative Sources for this Quarter

Data Mining……. 2,645
Fax……..73
Cash for Tips……. 9

Case Types for this Quarter (*sample*)

Drug Diversion……406
Drug Seeker……. 94
Income/Other Assets……747
Using Another Person's Card… …31
Out of State……. 1,960
Transfer of Assets……. 3
Abusing ER……. 38
Dr. Shopping……253
Other Insurance……. 203

The Office of Inspector General participated in the following activities during the second quarter:

Meetings with Law Enforcement Officials and other State Agencies:
*Various Judicial Task Forces, District Attorneys, and Sheriffs & Chiefs of Police
*TBI Drug Diversion Task Force
*Middle Tennessee Law Enforcement Committee (in Brentwood)
*FBI National Academy Graduates – Regional Meeting in Nashville
*Law Enforcement Accreditation Coalition of Tennessee (LEACT)
*MCC Roundtable
*Regional Drug Diversion Task Force at the TBI

Media:
*Interview and article by the *Commercial Appeal*, Memphis newspaper
*Electronic and print media throughout the State of Tennessee

Training:
*FBI National Academy Retraining Session - Nashville
*Accounting CEU classes – Fiscal Manager
*Edison Training
*Leadership Middle Tennessee
*TIES Training – Nashville

*TIBRS Training – Memphis
*West Tennessee Drug Diversion Task Force
*POST certified training for all Commissioned personnel

Other OIG Activities:

*The OIG reached a benchmark this quarter – the 900th arrest occurred for TennCare Fraud.

*A mock accreditation on-site was held for the OIG. Three law enforcement professionals who are Accreditation Managers at their agency, reviewed the CALEA files and documentation to support compliance to determine the OIG's readiness for a formal on-site for re-accreditation scheduled for this summer. The assessors were very complementary of the OIG's compliance with the standards. **The OIG is the only Office of Inspector General agency that has achieved international law enforcement accreditation**.

*The OIG staff continues to work with the state's contractor, Medstat, to produce and review fraud and abuse detection reports. The OIG generates proactive reports for identifying TennCare fraud. Targeted queries are generated on a routine basis. The goal behind these reports and queries is to assist with a successful OIG investigation and prosecution of individuals who have violated the law as it pertains to TennCare fraud.

*Two employee vacancies occurred during this quarter: One transferred to another State agency and the other passed away.

*Training continued for OIG personnel during this quarter. The Special Agents started their annual In-Service training that includes POST required courses, instruction regarding new policies and procedures, all qualifications with approved weapons, a legal update, accreditation updates, etc.

*All CEU training began for OIG "professional" staff members, i.e. attorneys, an accountant, registered nurses, and information technology personnel.

*All personnel completed an on-line training regarding the topic of **"*Ethics*"**.

*The Inspector General is participating in the 2008 – 2009 ***Leadership Middle Tennessee*** class.

*The OIG Legal Division continues to assist OIG staff members by providing legal advice on issues including how to meet the requirements of various statutes and drafting and reviewing documents that have legal implications. The Legal Division facilitates the case preparation process and works closely with various District Attorneys toward a successful prosecution of OIG cases. They review all legal matters of the OIG.

*The Inspector General and the Deputy Inspector General over Criminal Investigations have continued to make visits to various Tennessee counties. In each jurisdiction visited, there is a courtesy call to the Sheriff and Chief of Police. The goal is to continue to solidify the collaboration between local law enforcement and the OIG. More visits are planned for the next quarter.

*The ***Doctor Shopping*** legislation (approved by the Governor and the General Assembly, June 2007) has generated 70 arrests as of this writing for Doctor Shopping.

The OIG continues to mail letters and posters and provide presentations to notify licensed medical providers and law enforcement agencies in the state about this new law. As a result, positive feedback has been received.

Case Narrative EXAMPLES

The following are a few examples of TennCare fraud investigations, arrests, and prosecutions conducted by the Office of Inspector General during the third quarter, FY 2008 – 2009:

Six people were charged with TennCare fraud in **Coffee County** in a roundup stemming from an undercover investigation targeting individuals selling prescription drugs.

A **Cumberland County** woman was arrested for the second time in four months for TennCare Fraud involving *doctor shopping*. She was indicted on two counts of fraudulently using TennCare to obtain Lortab. She failed to disclose to her doctor she had seen other physicians within a 30 day period and received prescriptions for the same or similar controlled substance.

A woman from **Montgomery County** was charged with TennCare fraud for allegedly lying to the state to obtain TennCare. She apparently under-reported her income so she could be enrolled in the TennCare program.

A **Pickett County** woman was arrested a second time for TennCare fraud involving the resale of a prescription medication – Percocet. In her previous arrest, she was charged with selling Oxycontin to an undercover agent.

TennCare fraud charges were lodged against six people in **Warren County** in a roundup stemming from an undercover investigation. Drugs involved were: a generic for Dilauded and Hydrocodone.

A woman from **Alabama** was charged with TennCare fraud by deliberately giving false statements regarding her address and state of residence during her recertification interview regarding her eligibility to receive TennCare benefits. She was arrested by the OIG in 2008 for obtaining a prescription for Hydrocodone by means of a false statement.

A **Monroe County** woman was charged with TennCare fraud by altering a prescription for Lortab and attempted to have TennCare pay for it.

A **Davidson County** woman was arrested for posing as an employee of a doctor's office and calling in prescription to a pharmacy to obtain Hydrocodone on two separate occasions. She apparently used her daughter's TennCare benefits to pay for the first prescription and attempted to use it for the second one.

Plans for next quarter:

a. Continue to exchange information with local, state, and federal government agencies.
b. Continue to work with Medstat to improve reports that would assist with the data mining function of the OIG.

c. Provide presentations and training for interested parties regarding TennCare fraud and the role of the OIG.
d. Continue staff training and develop best practices.
e. Continue to track the *Tips for Cash* pay incentive program for information that leads to a successful conviction for TennCare fraud. This program is a result of legislation from the 104th General Assembly.
f. Continue the process for re-accreditation (a three year process). The OIG was accredited in November 2006. The re-accreditation on-site and review will occur in the 2009-2010 fiscal year.
g. Continue using the Doctor Shopping Law on investigations regarding suspected chronic abusers of the TennCare program.

STATE OF TENNESSEE
BUREAU OF TENNCARE
DEPARTMENT OF FINANCE AND ADMINISTRATION
310 Great Circle Road
NASHVILLE, TENNESSEE 37243

MEMORANDUM

TO: The Honorable Ron Ramsey, Speaker of the Senate
The Honorable Kent Williams, Speaker of the House of Representatives

The Honorable Members of the TennCare Oversight Committee
The Honorable Members of the Joint Committee on Long-Term Care Oversight

FROM: Darin J. Gordon, Director, Bureau of TennCare

SUBJECT: Long-Term Care Community Choices Act of 2008

DATE: February 20, 2009

As you may know, the Bureau of TennCare has been hard at work since the summer on implementing various aspects of the Long Term Care Community Choices Act of 2008, passed unanimously by the General Assembly last year. We are building a new program, and we have given it a name. We are calling it the CHOICES program, to emphasize the priority that we are placing on making choices available to Tennesseans in need of long-term care.

Although we have been reporting on our progress in the Quarterly Reports that we file with the TennCare Oversight Committee and the Fiscal Review Committee every three months, we thought you might be interested in an overview of our accomplishments to date. These activities can be grouped in seven general areas.

1. **Amendment to the TennCare Section 1115 waiver.** One of our first steps was the development of an amendment to the TennCare waiver to include all of the components of the Act that require federal approval to implement. This amendment is referred to as "Amendment 7." We sent a concept paper for Amendment 7 to CMS in early July, and we followed that up with a visit to CMS staff in Baltimore in August to discuss the amendment and to make CMS aware of the deadline under which we have been operating. We requested approval by December 31, 2008, in order to be able to implement Amendment 7 by July 1, 2009.

   CMS responded to our request for a quick approval by beginning a series of weekly phone conferences with our staff in September, with the purpose being to keep the lines of communication open and to work on problems and issues as they came up. We have been very engaged in these conference calls and have followed up quickly regarding any requested information. In an effort to bring conclusion to any remaining issues, we had an additional in-person meeting in January to meet with the various federal review team members.

The weekly phone conferences are continuing. Last week CMS sent us drafts of several large sections of the Special Terms and Conditions, or STCs, and they sent another section this week. Since the STCs are the "heart" of the approval document, we believe we may be moving close to completion of this critical step.

2. **Amendment of the Section 1915(c) HCBS waiver.** The Long Term Care Community Choices Act of 2008 envisioned making Home and Community Based Services, or HCBS for short, available to more people. We did not want to wait until Amendment 7 was approved to add new persons, however. For many years we have had a Section 1915(c) HCBS waiver for persons who are elderly and persons who have disabilities. This waiver covers an array of HCBS for people who would otherwise qualify for TennCare-reimbursed Nursing Facility care. This waiver will be subsumed under Amendment 7 when the CHOICES program is implemented.

   At the beginning of the state fiscal year, the Section 1915(c) HCBS waiver had an enrollment cap of 3,700 people. We requested an amendment to the waiver to be able to add 2,300 more people, for a total of 6,000, and in September we were notified that our request had been approved. Over half of the new spaces in the waiver have been filled, and we are continuing to receive applications every week. Nearly 5,000 Tennesseans have received HCBS during the current program year which began on October 1, 2008.

3. **Streamlining eligibility.** One of the issues often mentioned as an obstacle to receipt of HCBS is the eligibility determination process. We have been working with the Department of Human Services to streamline this process by eliminating unnecessary paperwork wherever we can. SSI eligibles are a case in point. We know that SSI eligibles have incomes below the SSI federal benefit level and that their income and assets have already been verified by the Social Security Administration. There is no need for the state to require a new application or to take several weeks to check their financial eligibility again, so these processes have been eliminated. SSI eligibles can now, be enrolled almost immediately if they meet the medical criteria.

   TennCare determines medical (or level of care) eligibility for HCBS. For years, this has been a paper-based process, which requires that applications be completed by Area Agencies on Aging and Disability and faxed, mailed, or delivered to TennCare. TennCare is in the process of testing a new online system that, going forward, will allow these applications to be submitted and reviewed electronically. This will facilitate even more timely review and approval of medical eligibility, so that HCBS can begin faster.

4. **Nursing facility diversification.** The Long-Term Care Community Choices Act of 2008 has as its goal changing the balance of long-term care services so that there will be more HCBS available to people who need long-term care. Nursing Facilities are perfectly situated to assist in the expansion of HCBS. Responding to the Governor's and the General Assembly's interest in helping existing Nursing Facilities "gear up" to be ready for this change, we sent out Requests for Proposals (RFPs) to TennCare-participating Nursing Facilities to ask for their identification of projects that would help them make the necessary modifications to be ready for CHOICES, and to diversify their businesses by beginning to deliver the same kinds of quality care they deliver in their facilities in people's home as well. As of today, we have awarded more than $2.7 million to 26 Nursing Facilities for projects that will help them prepare to deliver HCBS such as adult day care, personal care, and homemaker services.

5. **Single Point of Entry.** An innovative component of the Long-Term Care Community Choices Act of 2008 was the establishment of a Single Point of Entry (SPOE) for persons in need of long-term care. We have been working with the Area Agencies on Aging and Disability to set up this system. When

the system is complete, persons who need long-term care and persons who are interested in HCBS, along with their families, will have a place to go to get answers to their questions and help in determining the course of action that makes the most sense for them.

6. **Stakeholder involvement.** Maintaining relationships with stakeholders and soliciting their ideas have been key activities associated with implementing the CHOICES program. We have been holding at least biweekly discussions with a representative group of advocacy and provider organizations including the AARP, Tennessee Disability Coalition, Tennessee Commission on Aging and Disability, Tennessee Association of Area Agencies on Aging and Disability, Tennessee Association of Home Care, and the Tennessee Association of Homes and Services for the Aged. In addition, we are holding at least biweekly implementation meetings with the MCOs and weekly calls with organizations representing the Nursing Facility industry. We believe these relationships are critical in assuring the success of the CHOICES program.

7. **Administrative and programmatic activities.** Finally, we have been working on the variety of administrative and programmatic details that must be finalized in order to support implementation of the new CHOICES program. These details include designing models for care coordination and consumer direction, developing a quality management strategy, drafting amendments for MCO contractor risk agreements, and working to define the change requirements associated with our TennCare Management Information System. We are working on drafting new requirements for adult care homes, which will be small, home-like community-based residential alternatives to Nursing Facilities, and on ensuring that there are adequate consumer protections in place to protect our most vulnerable citizens.

We hope this letter gives you a flavor of the kinds of things we have been doing. The TennCare staff has been working toward implementation of CHOICES with great anticipation. We are eagerly waiting for CMS approval of Amendment 7, which must happen in order for us to set a final date for implementation. We estimate that we will need about six months after the date of approval to have everything in place and ready for the full integration of long term care services into the existing managed care delivery system.

We will continue to work with our stakeholders and our Congressional delegation to assist in facilitating CMS's approval as quickly as possible. We recognize that the change in Administrations and subsequent staff changes in key leadership positions may have inadvertently contributed to some of the delays, but we remain committed toward concluding this part of the process and moving ahead with full implementation of CHOICES.

Please let me know if you have comments or questions. We welcome any suggestions you might have for anything else we can do to make the CHOICES program a success.

cc: Melvin Everette, Executive Director, TennCare Oversight Committee