TennCare Quarterly Report

Submitted to the TennCare Oversight Committee, The Fiscal Review Committee, and Members of the General Assembly

April 15, 2011

Status of TennCare Reforms and Improvements

Amendment #12. Waiver Amendment #12 was submitted by the Bureau of TennCare to the Centers for Medicare and Medicaid Services (CMS) on February 28, 2011. Amendment #12 proposes several changes to the TennCare benefit package for adults to bring TennCare's budget into line with state revenues that are projected to be available as of July 1, 2011. Specific reductions are:

- Elimination of physical therapy, speech therapy, and occupational therapy for all adults
- Benefit limits on certain hospital services, lab and x-ray services, and health practitioners' office visits for most non-institutionalized adults (pregnancy-related services are exempt from benefit limits)
- A $2 per trip copay on non-emergency transportation for non-institutionalized, non-pregnant adults

These changes were proposed last year in Waiver Amendment #9, but the Enhanced Coverage Fee (sometimes referred to as the "hospital assessment fee") passed by the General Assembly last year postponed the need for implementation. Unless this fee is renewed for Fiscal Year 2012, however, the Bureau will have to proceed with the measures contained in Amendment #12.

Standard Spend Down. The TennCare Standard Spend Down (SSD) call-in line opened on February 22, 2011. Standard Spend Down is available through an amendment to the TennCare waiver and is designed to serve a limited number of persons who are not otherwise eligible for Medicaid but who are aged, blind, disabled, or the caretaker relative of a Medicaid eligible child and who have enough unreimbursed medical bills to allow them to "spend down" their income to the State's Medically Needy Income Standard (MNIS).

During the open enrollment period, the Department of Human Services (DHS) received 3,080 calls in just over one hour. There were 2,979 callers who were not already covered by TennCare and who were invited to apply for SSD. In response to those invitations mailed out by DHS, 1,831 individuals submitted applications.

Those approved are eligible for TennCare for one year before having to be reverified for continued eligibility. TennCare and DHS plan to open the SSD call-in line to an additional 2,500 callers once the currently pending applications have been processed.

Expansion of TennCare Director's Responsibilities. On March 31, 2011, Commissioner Mark Emkes announced the consolidation of several health-related divisions within the Department of Finance and Administration. Five programs—TennCare, planning for the Health Insurance Exchange required by the Affordable Care Act, the Office of eHealth Initiatives, the Division of State Health Planning, and Cover Tennessee[1]—will be combined into a single unit known as the Division of Health Care Finance and Administration. Oversight of this organization will be provided by Deputy Commissioner Darin Gordon, of whom Commissioner Emkes noted, "Darin has unmatched knowledge of public health care finance and management in state government, and he has proven he can meet the demands of any challenge." Gordon's role as Director of TennCare, however, remains unchanged.

EHR Provider Incentive Program. Tennessee was one of only eleven states to launch its Electronic Health Record (EHR) Incentive Program on January 3, 2011.

The EHR Incentive Program awards cash grants to Medicare and Medicaid providers to demonstrate "meaningful use" (i.e., use that is measurable in both quantity and quality) of electronic health record technology. TennCare administers Tennessee's Medicaid EHR program, the vast majority of funding for which is provided by the federal government.[2]

On January 3, TennCare opened registration to providers. Although early estimates placed the likely number of registrants for all of calendar year 2011 at 1,500, Bureau officials were pleased to find that 945 providers[3] had registered by the end of the first three months alone. In addition, as of the end of the quarter, Tennessee led the nation in the number of verified registrants.[4] Attestation, the process by which providers affirm that they meet encounter and certification requirements, begins next quarter, as does the distribution of grant monies. Additional information is located on TennCare's website at http://www.tn.gov/tenncare/hitech.html.

CMMI Grant Proposal. The Center for Medicare and Medicaid Innovation (CMMI), a division of CMS, was established by the Affordable Care Act to "test innovative payment and service delivery models to reduce program expenditures . . . while preserving or enhancing the quality of care furnished to individuals" who are dually eligible for Medicare and Medicaid (called "dual eligibles").

In December 2010, CMMI invited states to submit proposals to integrate care for dual eligibles. The request for proposals notes that the system of care available to these persons is fragmented and costly and that states play a crucial role in designing solutions to this growing problem. Grants worth up to $1 million each are available to as many as fifteen states to devise models of integrated care; recipients of the grant that fulfill all of the requirements of their contracts may then be eligible for additional funding to implement their care models.

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[1] Cover Tennessee, in turn, contains the CoverTN, CoverKids, CoverRx, and AccessTN programs.
[2] The federal government covers 90% of administrative costs and 100% of the incentive payments.
[3] The registration total consists of 501 physicians, 294 nurse practitioners, 33 acute care hospitals, 23 physicians assistants, 21 certified nurse midwives, and 14 dentists.
[4] Verification consists of making sure that a provider has a valid Medicaid identification number and Tennessee Health Care license, and has no sanctions.

On February 1, 2011, TennCare submitted a planning grant proposal to CMMI.

John B. The *John B.* lawsuit addresses the adequacy of services provided by TennCare to children under the age of 21. On November 30, 2010, the United States Court of Appeals for the Sixth Circuit ruled on the State's appeal to vacate the consent decree governing TennCare's actions in this arena since 1998. Specifically, the Court vacated the portion of the Consent Decree concerning network adequacy; remanded the case to the District Court for the Middle District of Tennessee to determine whether other portions should be vacated; and ordered that the case be reassigned to another judge of the same court.

Since assuming responsibility for the case, Judge Thomas A. Wiseman, Jr. has taken several steps to move the matter closer to resolution. In the January-March quarter alone, Judge Wiseman issued several orders, the most important of which outlined the primary issue to be resolved at trial, provided a schedule for discovery, and set an October 31, 2011 trial date.

The October trial is expected to last four weeks and will address the question of whether TennCare is in current, substantial compliance with the requirements of the consent decree.

"Money Follows the Person" Program Grant. On January 7, 2011, TennCare submitted a grant proposal to CMS to participate in the Money Follows the Person (MFP) demonstration program. The principle of MFP is that long-term care should support (or "follow") the patient instead of the institutions (such as Nursing Facilities) in which such services have traditionally been provided. According to CMS's grant invitation, MFP funding awarded to states will "balance their long-term care systems and help Medicaid enrollees transition from institutions to the community." This goal is entirely consistent with CHOICES, the TennCare program implemented in 2010 that shifts the emphasis of long-term care from Nursing Facilities to home and community based settings.

On February 22, 2011, CMS awarded TennCare an MFP grant worth approximately $1.8 million in the first year and $37 million through 2016. These funds are required to be used for additional Home and Community Services supports and for the transition of nursing home patients back into the community. Operations are scheduled to begin in October.

PACE Grant Proposal. On December 21, 2010, TennCare invited non-profit organizations to submit grant proposals to begin the development of a Program of All-Inclusive Care for the Elderly (PACE) site in Tennessee. The grant awards up to $1 million in funding through a contract that supports the selected organization in developing the infrastructure for the future establishment of a PACE program, subject to a recurring appropriation passed by the Tennessee General Assembly that is sufficient to support the actual establishment of the program. In the interim, the grant increases long-term care system capacity to deliver care in home and community based settings.

The grantee may use its award monies for such activities as:

- Purchasing equipment necessary to supply home and community based services
- Building renovation for an Adult Day Health Center
- Training and technical assistance

This grant lays the groundwork for the State's second PACE program (following the one established by Alexian Brothers Community Services in Hamilton County in 1998).

Three organizations submitted proposals by the February 25, 2011 deadline. On March 30, 2011, TennCare announced that Methodist Healthcare in Memphis had been awarded the grant. The projected contract start date is May 1, 2011.

Recovery Audit Contractor Program. In compliance with the Affordable Care Act, TennCare implemented its Recovery Audit Contractor (RAC) program on February 1, 2011. The function of a RAC is to review claims submitted by TennCare providers to detect and recover overpayments and to identify and correct underpayments. Health Management Systems, Inc. (HMS) is the company with which TennCare has contracted to perform such services through January 31, 2014. Payment to HMS will be made on a contingency basis (i.e., a percentage of overpayments recovered and an equivalent percentage fee for underpayments found). Providers who are the subject of an adverse determination by HMS may file an appeal in accordance with TennCare Rules located online at http://www.tn.gov/sos/rules/1200/1200-13/1200-13-18.20110218.pdf.

Maintenance of Coverage Trust Fund. In accordance with TCA § 71-5-1005(g), the Bureau reports the following:

- CMS approved the annual coverage assessment as part of Amendment #10 to the TennCare demonstration. The effective date of the approval was July 1, 2010.
- As of the end of the quarter, the balance of the Trust Fund was $263,476,824.
- No funds from the Trust Fund have been used for purposes other than those outlined by the Annual Coverage Assessment Act of 2010.

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

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 Essential Access Hospital payments for the third quarter of State Fiscal Year 2011 are shown in the table below.

Essential Access Hospital Payments for the Quarter

Hospital Name	County	EAH Third Quarter FY 2011
Regional Medical Center at Memphis	Shelby County	$4,009,617
Vanderbilt University Hospital	Davidson County	$3,067,589
Erlanger Medical Center	Hamilton County	$1,780,356
Johnson City Medical Center (with Woodridge)	Washington County	$1,384,124
University of Tennessee Memorial Hospital	Knox County	$1,296,650
Metro Nashville General Hospital	Davidson County	$961,664
Methodist Healthcare - LeBonheur	Shelby County	$820,482
Jackson - Madison County General Hospital	Madison County	$683,819
Parkridge Medical Center (with Parkridge Valley)	Hamilton County	$518,939
Parkwest Medical Center (with Peninsula)	Knox County	$451,752
East Tennessee Children's Hospital	Knox County	$429,518
Methodist Healthcare - South	Shelby County	$401,416
Methodist University Healthcare	Shelby County	$384,454
Saint Jude Children's Research Hospital	Shelby County	$350,321
Saint Francis Hospital	Shelby County	$325,971
Pathways of Tennessee	Madison County	$276,395
Centennial Medical Center	Davidson County	$272,322
Skyline Medical Center (with Madison Campus)	Davidson County	$268,215
Saint Mary's Medical Center	Knox County	$265,332
Wellmont Holston Valley Medical Center	Sullivan County	$260,937
Fort Sanders Regional Medical Center	Knox County	$236,951
Maury Regional Hospital	Maury County	$234,727
Delta Medical Center	Shelby County	$207,841
Methodist Healthcare - North	Shelby County	$205,311
University Medical Center	Wilson County	$187,484
Baptist Hospital	Davidson County	$186,988
Skyridge Medical Center	Bradley County	$184,617
Middle Tennessee Medical Center	Rutherford County	$182,399
Parkridge East Hospital	Hamilton County	$181,789
Wellmont Bristol Regional Medical Center	Sullivan County	$178,344
Gateway Medical Center	Montgomery County	$172,948
Ridgeview Psychiatric Hospital and Center	Anderson County	$167,170
Cookeville Regional Medical Center	Putnam County	$165,387

Hospital Name	County	EAH Third Quarter FY 2011
NorthCrest Medical Center	Robertson County	$142,941
Baptist Memorial Hospital for Women	Shelby County	$141,735
Morristown - Hamblen Healthcare System	Hamblen County	$138,953
Fort Sanders Sevier Medical Center	Sevier County	$135,878
Summit Medical Center	Davidson County	$130,181
Dyersburg Regional Medical Center	Dyer County	$122,834
Sumner Regional Medical Center	Sumner County	$118,904
Southern Hills Medical Center	Davidson County	$110,898
Jellico Community Hospital	Campbell County	$107,721
Methodist Medical Center of Oak Ridge	Anderson County	$106,284
Sweetwater Hospital Association	Monroe County	$106,089
Blount Memorial Hospital	Blount County	$99,879
Horizon Medical Center	Dickson County	$99,199
Saint Mary's Medical Center of Campbell County	Campbell County	$97,663
StoneCrest Medical Center	Rutherford County	$97,457
Baptist Hospital of Cocke County	Cocke County	$96,445
Baptist Memorial Hospital - Tipton	Tipton County	$88,580
Bolivar General Hospital	Hardeman County	$88,347
Hardin Medical Center	Hardin County	$87,442
Wellmont Hawkins County Memorial Hospital	Hawkins County	$83,487
Jamestown Regional Medical Center	Fentress County	$81,329
Humboldt General Hospital	Gibson County	$80,658
Sycamore Shoals Hospital	Carter County	$77,231
Henry County Medical Center	Henry County	$76,486
Regional Hospital of Jackson	Madison County	$75,813
Cumberland Medical Center	Cumberland County	$75,301
Harton Regional Medical Center	Coffee County	$73,442
North Side Hospital	Washington County	$72,190
Roane Medical Center	Roane County	$68,150
Grandview Medical Center	Marion County	$67,956
Lakeway Regional Hospital	Hamblen County	$66,798
United Regional Medical Center	Coffee County	$66,111
Southern Tennessee Medical Center	Franklin County	$65,439
Heritage Medical Center	Bedford County	$64,187
Erlanger North Hospital	Hamilton County	$61,362
Baptist Memorial Hospital - Union City	Obion County	$58,749
Saint Mary's Jefferson Memorial Hospital, Inc.	Jefferson County	$58,054
Athens Regional Medical Center	McMinn County	$57,074
Takoma Regional Hospital	Greene County	$56,793

Hospital Name	County	EAH Third Quarter FY 2011
River Park Hospital	Warren County	$56,771
Community Behavioral Health	Shelby County	$56,435
Lincoln Medical Center	Lincoln County	$55,462
Skyridge Medical Center - West	Bradley County	$54,220
McNairy Regional Hospital	McNairy County	$52,094
Haywood Park Community Hospital	Haywood County	$47,062
Crockett Hospital	Lawrence County	$46,400
Livingston Regional Hospital	Overton County	$45,367
Claiborne County Hospital	Claiborne County	$40,805
Volunteer Community Hospital	Weakley County	$40,227
Hillside Hospital	Giles County	$34,781
Riverview Regional Medical Center - North	Smith County	$34,019
Gibson General Hospital	Gibson County	$32,104
Wayne Medical Center	Wayne County	$30,442
Methodist Healthcare - Fayette	Fayette County	$30,043
McKenzie Regional Hospital	Carroll County	$24,007
White County Community Hospital	White County	$22,454
Baptist Memorial Hospital - Huntingdon	Carroll County	$21,689
Henderson County Community Hospital	Henderson County	$20,289
Portland Medical Center	Sumner County	$19,112
Emerald Hodgson Hospital	Franklin County	$15,254
Johnson City Specialty Hospital	Washington County	$15,094
TOTAL		$25,000,000

Reverification Status

The eligibility of TennCare enrollees continues to be redetermined in accordance with TennCare's rules and policies.

Status of Filling Top Leadership Positions in the Bureau

The following top leadership position was filled during the last quarter:

Leonard (Tony) Mathews was appointed January 16, 2011, to serve as the Assistant Deputy of Long-Term Care Operations. In this role, Mr. Mathews will work alongside the current Deputy of Long-Term Care Operations, who is retiring, to manage daily internal operations of the TennCare Division of Long-Term Care. In addition, he will oversee Nursing Facility Services, a segment of the Bureau's annual Long-Term Care budget totaling nearly $1 billion. This responsibility includes monitoring the contracted functions of the Department of Health's Health Care Facilities Division, an office responsible for Nursing

Facilities' compliance with federal conditions of participation established by CMS. Mr. Mathews has served the State of Tennessee since 2001, first in the Department of Finance and Administration, and most recently as the Budget Director of the Department of Environment and Conservation. His tenure includes financial, programmatic, and operations management in the field of health care, distinguished particularly by the assistance he offered TennCare and the Cover Tennessee initiative while Budget Coordinator for Finance and Administration's Budget Division.

Number of Recipients on TennCare and Costs to the State

At the end of the period January 1, 2011, through March 31, 2011, there were 1,163,521 Medicaid eligibles and 33,151 Demonstration eligibles enrolled in TennCare, for a total of 1,196,672 persons.

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

	3rd Quarter*
Spending on MCO services**	$987,830,000
Spending on dental services	$46,752,000
Spending on pharmacy services	$200,805,000
Medicare "clawback"***	$32,200,000

**These figures are cash basis as of March 30 and are unaudited.*

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

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

Viability of MCCs in the TennCare Program

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

Entity	Standard	Authority
MCOs	90% of clean claims for payment for services delivered to TennCare enrollees are paid within 30 calendar days of the receipt of such claims.	T.C.A . § 56-32-126(b)
MCOs	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[5] are processed and paid with 14 calendar days of receipt.	TennCare contract

[5] 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.

Entity	Standard	Authority
	99.5% of clean electronically submitted Nursing Facility and applicable Home and Community Based Services claims[6] are processed and paid within 21 calendar days of receipt.	
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.	TennCare contract and in accordance with T.C.A . § 56-32-126(b)
DBM	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,[7] and the PBM are required to submit monthly claims data files of all TennCare claims processed to the Tennessee Department of Commerce and Insurance (TDCI) for verification of statutory and contractual prompt pay compliance. The plans are required to separate their claims data by TennCare Contract (i.e., East, Middle, or West Grand Region) and by subcontractor (i.e., claims processed by a vision benefits manager). Furthermore, the MCOs are required to identify separately non-emergency transportation (NEMT) claims in the data files. Finally, the MCOs are required to submit separate claims data files representing a subset of electronically submitted NF and applicable HCBS claims for the CHOICES enrollees. TDCI then performs an analysis and reports the results of the prompt pay analyses by NEMT and CHOICES claim types, by subcontractor, by TennCare contract and by total claims processed for the month.

If an MCO does not comply with the prompt pay requirements based on the total claims processed in a month, TDCI has the statutory authority to levy an administrative penalty of $10,000 for each month of non-compliance after the first instance of non-compliance was reported to the plan. The TennCare Bureau can also assess liquidated damages pursuant to the terms of the TennCare Contract. If the DBM and PBM do not meet their contractual prompt pay requirements, only the TennCare Bureau can assess applicable liquidated damages against these entities.

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

TDCI's calculations for the net worth requirement reflect payments made for the calendar year ended December 31, 2010. The TennCare Contract further requires the TennCare MCOs to establish an enhanced net worth based on projected additional annual premiums for the CHOICES program. During this quarter, the MCOs submitted their NAIC 2010 Annual Financial Statement. As of December 31, 2010, TennCare MCOs reported net worth as indicated in the table below.

[6] Ibid.

[7] Since Delta Dental did not begin operations until October 1, 2010, the previous DBM's compliance with prompt pay requirements continues to be analyzed during its claims run-out period.

	Net Worth Requirement	Reported Net Worth	Excess/ (Deficiency)
AmeriGroup Tennessee	$17,616,712[8]	$150,602,541	$132,985,829
UnitedHealthcare Plan of the River Valley (UnitedHealthcare Community Plan)	$53,559,633[9]	$350,599,955	$297,040,322
Volunteer State Health Plan (BlueCare & TennCare Select)	$34,651,682	$104,921,560	$70,269,878

All TennCare MCOs met their minimum net worth requirements as of December 31, 2010.

Success of Fraud Detection and Prevention

The mission of the OIG is: *To identify, investigate, and prosecute persons who commit fraud or abuse against the TennCare program.* The OIG staff receives case information from a variety of sources including: local law enforcement, the TennCare Bureau, Health Related Boards (HRB), the Department of Human Services (DHS), other state agencies, health care providers, Managed Care Contractors (MCCs), and the general public via the OIG web site, fax, written correspondence, and phone calls to the OIG hotline. The statistics for the third quarter of the 2010 - 2011 fiscal year are as follows:

***NOTE**: Included are the grand totals to date -- since the OIG was created (July 2004).*

Summary of Enrollee Cases

	Quarter	Grand Total
Cases Received	1,539	132,430
Abuse Cases Received*	1,019	61,426

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

Court Fines & Costs Imposed

	Grand Total
Fines	$439,412.00
Court Costs & Taxes	$168,601.38
Restitution (ordered)	$1,710,408.97
Drug Funds/Forfeitures	$409,543.90

[8] As a result of the implementation of CHOICES, TennCare MCOs must now maintain the higher of two net worth requirements: the one established by TCA § 56-32-112 and the one identified in the TennCare Contractor Risk Agreement. This development accounts for the increase in AmeriGroup's requirement from $16,133,399 in the previous quarter.

[9] UnitedHealthcare's net worth requirement increased from $51,414,330 in the previous quarter for the same reason AmeriGroup's did. (See footnote 8.)

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	460
Drug Diversion/Sale RX	544
Doctor Shopping	144
Access to Insurance	55
Operation Falcon III	32
Operation Falcon IV	16
False Income	67
Ineligible Person Using Card	19
Living Out Of State	15
Asset Diversion	7
ID Theft	40
Aiding & Abetting	3
Failure to Appear in Court	2
GRAND TOTAL	**1,404**

OIG Case Recoupment & Recommendations

	Grand Total
Court Ordered Recoupment	$3,602,404.14[10]
Recommended TennCare Terminations [11]	49,307
Potential Savings[12]	$173,443,763.12

[10] This total 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, 2011.

[11] Enrollee recommendations sent to the TennCare Bureau for review and consideration for appropriate action, based on information received and reviewed by the OIG.

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