# TennCare Quarterly Report

# Submitted to the Members of the General Assembly

# April 2016

## Status of TennCare Reforms and Improvements

**Departure of TennCare Director.** On March 30, 2016, Governor Haslam announced that TennCare Director and Deputy Commissioner of Health Care Finance and Administration Darin Gordon would enter the private sector at the end of June. Having taken on his role in 2006, Mr. Gordon is not only the longest serving TennCare director in state history but also the longest serving director in the country.

During his tenure, TennCare gained national recognition as a model of an innovative Medicaid managed care program. Mr. Gordon led TennCare to maintain the lowest cost trend in its history, make significant improvements in a substantial number of quality measures, and gain national recognition for innovations in managed care and payment and delivery system reform. His contributions extend beyond Tennessee, as evidenced by his service as president of the National Association of Medicaid Directors.

Mr. Gordon started his career in state government as an intern for the Senate Finance Committee in 1996, and he has more than eighteen years of experience in public health care finance and management. Prior to 2006, he held key executive management positions within TennCare, first as the Director of Managed Care Programs and subsequently as Chief Financial Officer. Mr. Gordon's last day with TennCare will be June 30. Until that time, he will continue to work on TennCare's renewal application (discussed in greater detail below) and help facilitate the transition to new leadership.

**Application to Renew the TennCare Demonstration.** As detailed in the Bureau of TennCare's previous Quarterly Report to the General Assembly, an application to renew the TennCare Demonstration was submitted to the Centers for Medicare and Medicaid Services (CMS) on December 22, 2015. The current approval period ends on June 30, 2016, and the State is seeking a renewal of the Demonstration through June 30, 2021.

The extension application, a copy of which is available on TennCare's website at http://www.tn.gov/assets/entities/tenncare/attachments/TennCareExtension.pdf, requests 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. Before negotiations on the

application could begin, however, CMS published the document for a federal comment period lasting from January 7 through February 6, 2016. Following the conclusion of the federal comment period, preliminary discussions with CMS on the renewal commenced. By the end of the January-March 2016 quarter, the State and CMS had begun discussions on such topics as TennCare's eligibility and enrollment systems, supplemental pool payments to Tennessee hospitals, and the methodology by which budget neutrality is calculated. Negotiations on these points are expected to progress throughout the April-June 2016 quarter as well. Additional information about the renewal of the TennCare Demonstration is available at http://www.tn.gov/tenncare/article/extension-of-tenncare-demonstration.

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

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)."[1]

As the January-March 2016 quarter began, negotiations regarding Amendment 27 were ongoing. The Bureau supplied CMS detailed definitions of the services to be provided under ECF CHOICES and answered all questions posed by the federal agency. In addition, the parties collaborated in drafting a set of Special Terms and Conditions (STCs) for the TennCare Demonstration, defining the manner in which ECF CHOICES would operate within TennCare's managed care system. This process culminated on February 2, 2016, when CMS issued written approval of Amendment 27. Accompanying the approval letter were amended versions of the Waiver List, Expenditure Authorities, and STCs comprising TennCare's Demonstration Agreement with CMS. On February 22, 2016, the Bureau sent CMS a letter accepting the revised materials but identifying a set of technical corrections to be made.

With federal approval of the ECF CHOICES program secured, TennCare spent much of the January-March quarter making preparations for implementation. These efforts included developing amendments to managed care contracts, finalizing program requirements, beginning to build provider networks, and making systems changes. Readiness activities will continue during the April-June 2016 quarter.

[1] 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.

CMS approved Amendment 28 on February 2, 2016. Current SSD enrollees will remain eligible in that category until they are chosen for redetermination. As part of the redetermination process, TennCare will review SSD enrollees for eligibility in all open categories of TennCare coverage. Any individual found to qualify in another category will be transferred with no interruption in coverage. Individuals who do not qualify in another category will be disenrolled from TennCare and referred to Medicare and/or the Health Insurance Marketplace.

Demonstration Amendment 30: Program Modifications. During the January-March 2016 quarter, TennCare notified the public of another amendment to be submitted to CMS. Amendment 30 outlines program changes proposed in previous years that were made unnecessary each time by the Tennessee General Assembly's passage or renewal of a one-year hospital assessment fee. Changes to the TennCare benefit package for non-exempt adults that would be necessary if the fee were not renewed in 2016 are as follows:

- A combined annual limit of eight days per person for inpatient hospital and inpatient 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 opened its public notice and comment period regarding Amendment 30 on March 17, 2016. By the conclusion of the January-March quarter no comments had been received. If the General Assembly renews the hospital assessment fee by the end of the comment period (or soon thereafter), Amendment 30 will not be submitted to CMS.

**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 co-located with TennCare in the Division of Health Care Finance and Administration (HCFA). 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 principal accountable provider (or "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.

TennCare's previous Quarterly Report to the General Assembly presented TAG recommendations on the fourth set ("Wave 4") of episodes of care. The episodes in question were 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. The TAG recommendations regarding these episodes remain available as the appendix to the report located online at http://www.tn.gov/assets/entities/tenncare/attachments/leg0616.pdf.

Attached as the appendix to this report are TAG recommendations concerning the PCMH program, which the State and participating insurance companies are currently working to implement. The intent of the Initiative is to incorporate much of the advice furnished by the TAGs. In addition, TAG recommendations related to the next wave of episodes of care ("Wave 5") are expected in early Summer 2016. The Wave 5 episodes are Breast Cancer Mastectomy, Breast Cancer Medical Treatment, Breast Biopsy, Tonsillectomy, Otitis, Anxiety, and Chronic Depression.

**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[2] 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, fourth-year, and fifth-year payments to providers who continue to demonstrate meaningful use.

With CMS approval, TennCare issues incentive payments to eligible hospitals over a three-year period, while eligible practitioners must attest over a six-year period.

EHR payments made by TennCare during the January-March 2016 quarter as compared with payments made throughout the life of the program appear in the table below:

| Payment Type | Number of Providers Paid During the Quarter | Quarterly Amount Paid (Jan-Mar 2016) | Cumulative Amount Paid to Date |
|---|---|---|---|
| First-year payments | 299[3] | $7,086,203 | $164,214,386 |
| Second-year payments | 14 | $963,935 | $51,150,193 |
| Third-year payments | 52 | $6,374,511 | $23,336,549 |
| Fourth-year payments | 38 | $311,668 | $1,705,673 |
| Fifth-year payments | 17 | $144,500 | $144,500 |

The Bureau's technical assistance activities, outreach efforts, and other EHR-related projects intensified during the quarter. This increase, which coincided with newly implemented "Modified Stage 2" meaningful use measures, included:

[2] 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).

[3] Of the 299 providers receiving first-year payments in the January-March 2016 quarter, 1 earned the incentive by successfully attesting to meaningful use of EHR technology in the first year of participation in the program.

- Acceptance of meaningful use attestations involving Modified Stage 2 measures beginning on January 12, 2016;
- Conducting seven onsite visits to physician offices;
- Holding 82 technical assistance calls;
- Responding to 640 emails received in the EHR meaningful use mailbox;
- Participation throughout the quarter in several Southeast Regional Collaboration for HIT/HIE (SERCH) calls;
- Monthly newsletters and occasional alerts 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 meeting of the Tennessee Medical Association. The Bureau is also making every effort to alert eligible professionals and eligible hospitals that 2016 is the last year in which they may enroll in the EHR program and begin attesting (as specified by the HITECH Act).

**Award for General Counsel.** On January 26, 2016, *The Nashville Business Journal* announced the winners of its annual "40 Under 40" distinction, which celebrates 40 professionals under the age of 40 for their excellence in business as well as contributions to their Middle Tennessee communities. TennCare General Counsel John G. (Gabe) Roberts was one of the individuals honored.

Mr. Roberts is a licensed Certified Public Accountant who worked in the Memphis office of Ernst & Young as an auditor of publicly traded and privately held Tennessee companies. After graduating from Vanderbilt University Law School, Mr. Roberts practiced law at the Nashville firm of Sherrard & Roe, where his business law practice intersected regularly with the health care industry and regulatory environment. He joined TennCare as its General Counsel in April 2013.

Additional information about the 40 Under 40 distinction—including a brief profile of Mr. Roberts—is available online at http://www.bizjournals.com/nashville/blog/2016/01/nbj-announces-our2016-40-under-40-winners.html.

**Essential Access Hospital (EAH) Payments.** The TennCare Bureau continued to make EAH payments during the January-March 2016 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 56.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 third quarter of State Fiscal Year 2016 for dates of service during the second quarter are shown in the table below.

**Essential Access Hospital Payments for the Quarter**

| Hospital Name | County | EAH Third 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 | $721,576 |
| LeBonheur Children's Medical Center | Shelby County | $715,194 |
| Jackson – Madison County General Hospital | Madison County | $596,021 |
| Metro Nashville General Hospital | Davidson County | $560,428 |
| Methodist Healthcare – Memphis Hospitals | Shelby County | $549,849 |
| East Tennessee Children's Hospital | Knox County | $534,806 |
| Saint Jude Children's Research Hospital | Shelby County | $433,599 |
| Methodist Healthcare – South | Shelby County | $422,193 |
| Parkwest Medical Center (with Peninsula) | Knox County | $327,490 |
| Methodist Healthcare – North | Shelby County | $320,885 |
| TriStar Centennial Medical Center | Davidson County | $310,073 |
| TriStar Skyline Medical Center (with Madison Campus) | Davidson County | $300,937 |
| Wellmont – Holston Valley Medical Center | Sullivan County | $289,584 |
| University Medical Center (with McFarland) | Wilson County | $256,540 |
| Parkridge East Hospital | Hamilton County | $253,513 |
| Saint Francis Hospital | Shelby County | $251,869 |
| Saint Thomas Rutherford Hospital | Rutherford County | $251,344 |
| Lincoln Medical Center | Lincoln County | $250,548 |
| Saint Thomas Midtown Hospital | Davidson County | $235,360 |
| Maury Regional Hospital | Maury County | $221,181 |
| Baptist Memorial Hospital for Women | Shelby County | $215,189 |

| Hospital Name | County | EAH Third Quarter FY 2016 |
|---|---|---|
| Wellmont – Bristol Regional Medical Center | Sullivan County | $207,614 |
| Cookeville Regional Medical Center | Putnam County | $199,967 |
| Fort Sanders Regional Medical Center | Knox County | $192,967 |
| Pathways of Tennessee | Madison County | $191,254 |
| Ridgeview Psychiatric Hospital and Center | Anderson County | $184,156 |
| Tennova Healthcare – Physicians Regional Medical Center | Knox County | $165,575 |
| Blount Memorial Hospital | Blount County | $143,917 |
| Delta Medical Center | Shelby County | $141,651 |
| TriStar Summit Medical Center | Davidson County | $136,542 |
| TriStar StoneCrest Medical Center | Rutherford County | $128,790 |
| Rolling Hills Hospital | Williamson County | $124,590 |
| Skyridge Medical Center | Bradley County | $123,567 |
| Southern Hills Medical Center | Davidson County | $120,993 |
| NorthCrest Medical Center | Robertson County | $120,176 |
| Gateway Medical Center | Montgomery County | $119,029 |
| TriStar Horizon Medical Center | Dickson County | $117,441 |
| Sumner Regional Medical Center | Sumner County | $113,245 |
| Morristown – Hamblen Healthcare System | Hamblen County | $109,818 |
| Dyersburg Regional Medical Center | Dyer County | $103,331 |
| Baptist Memorial Hospital – Tipton | Tipton County | $93,014 |
| Methodist Medical Center of Oak Ridge | Anderson County | $87,962 |
| TriStar Hendersonville Medical Center | Sumner County | $87,788 |
| Jellico Community Hospital | Campbell County | $86,871 |
| LeConte Medical Center | Sevier County | $85,865 |
| Harton Regional Medical Center | Coffee County | $81,767 |
| Takoma Regional Hospital | Greene County | $81,090 |
| Tennova Healthcare – LaFollette Medical Center | Campbell County | $77,530 |
| Grandview Medical Center | Marion County | $75,819 |
| Baptist Rehabilitation – Germantown | Shelby County | $72,854 |
| Skyridge Medical Center – Westside | Bradley County | $72,615 |
| Southern Tennessee Medical Center | Franklin County | $65,467 |
| United Regional Medical Center and Medical Center of Manchester | Coffee County | $63,093 |
| Sycamore Shoals Hospital | Carter County | $62,670 |
| Indian Path Medical Center | Sullivan County | $62,042 |
| Lakeway Regional Hospital | Hamblen County | $60,807 |
| Roane Medical Center | Roane County | $58,881 |
| Laughlin Memorial Hospital | Greene County | $58,502 |
| Starr Regional Medical Center – Athens | McMinn County | $57,601 |
| Regional Hospital of Jackson | Madison County | $57,570 |
| Hardin Medical Center | Hardin County | $56,678 |
| Crockett Hospital | Lawrence County | $54,395 |

| Hospital Name | County | EAH Third Quarter FY 2016 |
|---|---|---|
| Henry County Medical Center | Henry County | $54,259 |
| Stones River Hospital | Cannon County | $52,504 |
| Wellmont Hawkins County Memorial Hospital | Hawkins County | $51,389 |
| River Park Hospital | Warren County | $48,464 |
| Jamestown Regional Medical Center | Fentress County | $45,944 |
| Hillside Hospital | Giles County | $44,333 |
| Livingston Regional Hospital | Overton County | $43,321 |
| Heritage Medical Center | Bedford County | $42,809 |
| Baptist Memorial Hospital – Union City | Obion County | $42,362 |
| McNairy Regional Hospital | McNairy County | $39,453 |
| Claiborne County Hospital | Claiborne County | $38,760 |
| McKenzie Regional Hospital | Carroll County | $34,794 |
| Erlanger Health System – East Campus | Hamilton County | $31,073 |
| Henderson County Community Hospital | Henderson County | $28,381 |
| Volunteer Community Hospital | Weakley County | $27,003 |
| Wayne Medical Center | Wayne County | $25,417 |
| DeKalb Community Hospital | DeKalb County | $21,764 |
| Cumberland River Hospital | Clay County | $19,980 |
| Decatur County General Hospital | Decatur County | $18,022 |
| Baptist Memorial Hospital – Huntingdon | Carroll County | $17,153 |
| Emerald Hodgson Hospital | Franklin County | $9,560 |
| **TOTAL** | | **$25,000,000** |

## Number of Recipients on TennCare and Costs to the State

During the month of March 2016, there were 1,496,556 Medicaid eligibles and 28,905 Demonstration eligibles enrolled in TennCare, for a total of 1,525,461 persons.

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

| Spending Category | 3rd Quarter* |
|---|---|
| MCO services** | $1,572,653,800 |
| Dental services | $46,386,100 |
| Pharmacy services | $305,234,800 |
| Medicare "clawback"*** | $48,665,100 |

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

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

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

## Viability of MCCs in the TennCare Program

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

| Entity | Standard | Authority |
|---|---|---|
| MCOs (non-CHOICES services) | 90% of clean claims for payment for services delivered to TennCare enrollees are processed and, if appropriate, paid within 30 calendar days of the receipt of such claims.<br><br>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) |
| MCOs (CHOICES services) | 90% of clean electronically submitted Nursing Facility and applicable Home and Community Based Services claims[4] are processed and paid within 14 calendar days of receipt.<br><br>99.5% of clean electronically submitted Nursing Facility and applicable Home and Community Based Services claims[5] are processed and paid within 21 calendar days of receipt. | TennCare contract |

[4] 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.

[5] Ibid.

| Entity | Standard | Authority |
|---|---|---|
| DBM | 90% of clean claims for payment for services delivered to TennCare enrollees are processed, and, if appropriate, paid within 30 calendar days of the receipt of such claims.<br><br>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 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 January-March 2016 quarter, the MCOs submitted their National Association of Insurance Commissioners (NAIC) Annual Financial Statements. As of December 31, 2015, TennCare MCOs reported net worth as indicated in the table below.[6]

| MCO | Net Worth Requirement | Reported Net Worth | Excess/ (Deficiency) |
|---|---|---|---|
| Amerigroup Tennessee | $29,016,782 | $169,567,033 | $140,550,251 |

[6] 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 | Net Worth Requirement | Reported Net Worth | Excess/ (Deficiency) |
|---|---|---|---|
| UnitedHealthcare Plan of the River Valley (UnitedHealthcare Community Plan) | $55,361,026 | $423,305,536 | $367,944,510 |
| Volunteer State Health Plan (BlueCare & TennCare Select) | $43,251,806 | $330,831,416 | $287,579,610 |

During the January-March 2016 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 December 31, 2015:

| MCO | Company Action Level | Reported Net Worth | Excess/ (Deficiency) |
|---|---|---|---|
| Amerigroup Tennessee | $104,759,436 | $169,567,033 | $64,807,597 |
| UnitedHealthcare Plan of the River Valley (UnitedHealthcare Community Plan) | $189,545,450 | $423,305,536 | $233,760,086 |
| Volunteer State Health Plan (BlueCare & TennCare Select) | $133,523,082 | $330,831,416 | $197,308,334 |

All TennCare MCOs met their minimum net worth requirements and Company Action Level requirements as of December 31, 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 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 third quarter of Fiscal Year 2016 are as follows:

## TennCare Fraud & Abuse Complaints

| | Quarter |
|---|---|
| Fraud Allegations | 1,261 |
| Abuse Allegations* | 917 |

** 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 | 76 |
| Convictions | 48 |
| Instances of Judicial Diversion | 14 |

** 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 | $9,511 |
| Fines | $37,250 |
| Drug Funds/Forfeitures | $2,914 |
| Criminal Restitution Ordered | $117,027 |
| Criminal Restitution Received[7] | $25,319 |

## Civil Restitution & Civil Court Judgments

| | Quarter |
|---|---|
| Civil Restitution Ordered[8] | $4,849 |
| Civil Restitution Received[9] | $16,547 |

## Recommendations for Review

| | Quarter |
|---|---|
| Recommended TennCare Terminations[10] | 177 |

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

[8] 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.

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

[10] 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.

| | Quarter |
|---|---|
| Potential Savings[11] | $647,181 |

## Collaboration with CDI

During the January-March 2016 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.

## Training

During the January-March 2016 quarter, an OIG Special Agent completed Basic Firearms Instructor School. This 40-hour training session was sponsored by the Federal Bureau of Investigation.

[11] 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 Patient Centered Medical Home Program

Patient Centered Medical Home TAG recommendation summary

The PCMH TAG recommended the following areas as **sources of value** for the PCMH program: appropriateness of care setting and forms of delivery, increased access to care, improved treatment adherence, medication reconciliation, appropriateness of treatment, enhanced chronic condition management, referrals to high-value medical and behavioral health care providers, reduced readmissions through effective follow-up and transition management

The PCMH TAG recommended the following **care improvement model** in 3 stages.

During stage 1, providers are in transition. Stage 1 includes: Primary PCMH prioritization and focus on patients with chronic conditions and existing PCP contact, enhanced access and continuity (e.g., office-hours, after-hours access), providing self-care support and community resources including wraparound support, planning and managing care by developing evidence-based care plan with input from patient and their family, referring to high-value providers, and a greater emphasis on diagnosis and treatment of low-acuity behavioral health needs.

In stage 2, in the emerging model, there would be an additional prioritization and focus on patient groups including: chronic conditions and patients at risk of developing chronic condition. Additional priorities to include: practice at top of license including use of extenders, joint decision-making with behavioral health providers and other specialists, improving integrity of care transitions, and addressing social determinants of health.

Stage 3 is the steady state transformation. During this stage, there would be a broader focus on all patients including healthy individuals. Additional priorities to include: multi-disciplinary team-based care including regular interactions in-person, full IT connectivity across providers including interoperable records, co-location of behavioral and physical healthcare where feasible, and health and wellness screenings, outreach, and engagement.

TAG members made recommendations on **patient engagement** including ways to educate patients (orient patients on PCMH program, teach patients how to stay engaged in one's own health), eliminate barriers to care (actively address social determinants of health), and incentivize patients to engage (allow formal incentives if feasible).

TAG members recommended a set of **requirements for providers** participating in PCMH. These requirements include: stated commitment to the program, minimum panel size requirement of [500] patients with a single MCO with vision to broaden as we scale up to be inclusive of multiple MCOs over time, TennCare practice type (i.e., adults, pediatrics, internal medicine, geriatrics) with one or more PCPs, use of Care Coordination Tool, designation of PCMH Director (no licensure requirement), complete Tennessee specific framework of NCQA activities. The program will not have an Electronic Health Record requirement or licensure requirements for personnel.

The TAG made the following recommendations regarding **provider training and practice transformation services**. An initial assessment should be used to develop a tailored curriculum for each site to establish baseline level of readiness for transformation.

TAG members recommended that practice transformation support curriculum be tailored for each primary care practice site based on the needs identified in the pre-transformation assessment. The curriculum may include content structured through the following: learning collaboratives, large format in-person trainings, live webinars, recorded trainings, on-site coaching. The TAG also recommended a semi-annual assessment to conduct assessments of progress toward each practice transformation milestone every six months and to document progress.

The PCMH TAG recommended that **provider reports** include the following information: basic information (e.g., attributed beneficiaries), required activity milestone completion, practice support progress review (e.g., training milestones), quality performance report, total cost of care, utilization performance report.

**Quality metrics** will be used to assess the quality of PCMH providers. The TAG recommended the following quality measures for adults and children. Family practices would be accountable for both sets of metrics. Core Quality Metrics for adults include: Diabetes (nephropathy), Diabetes (retinal exam), Diabetes (BP <140/90), Asthma medication management, Adult BMI screening, Antidepressant medication management, Controlling high blood pressure. Core Quality Metrics for Children include: Immunizations for adolescents, EPSDT screening rate, Asthma medication management, ADHD/ADD Follow-up Care, Childhood immunizations, Weight assessment and nutritional counseling