TennCare Quarterly Report

April – June 2018

Submitted to the Members of the General Assembly

Status of TennCare Reforms and Improvements

Amendments to the TennCare Demonstration. Four proposed amendments to the TennCare Demonstration were in various stages of development during the April-June 2018 quarter.

Demonstration Amendment 33: Supplemental Payment Pools for Tennessee Hospitals. On February 7, 2018, TennCare submitted Amendment 33 to the Centers for Medicare and Medicaid Services (CMS). Amendment 33 concerns the supplemental payments that TennCare makes to Tennessee hospitals to help offset the costs these facilities incur in providing uncompensated care. With Amendment 33, TennCare asked that CMS revisit changes imposed on the supplemental payment structure during the most recent renewal of the TennCare Demonstration in 2016.

Amendment 33 consists of three components:

- Restoration of approximately $90 million to the maximum amount TennCare is authorized to pay to hospitals each year for uncompensated care costs;
- Continuation of a special funding pool—which was scheduled to end on June 30, 2018—that supports clinics operated by Meharry Medical College; and
- Extending the implementation period of a new hospital payment structure currently scheduled to take effect on July 1, 2018.

By the end of the April-June quarter, TennCare and CMS had reached an agreement in principle that would restore the requested $90 million of uncompensated care funding and clarify TennCare's authority to continue its support of Meharry's indigent care clinics. In addition, CMS agreed to grant Tennessee certain flexibilities that would mitigate the need to delay the implementation of the new funding system. The agreement reached with CMS can be effectuated without amending the TennCare waiver. TennCare and CMS are currently working to finalize the details of the new payment system. Once these details have been finalized, TennCare expects to formally withdraw Amendment 33 from further consideration.

Demonstration Amendment 34: Program Modifications. In March and April 2018, TennCare held a public notice and comment period for another amendment to the TennCare Demonstration that was being contemplated. Amendment 34 outlined program changes that would be needed if the hospital assessment were not renewed in 2018. These changes had also been proposed in previous years, but were ultimately made unnecessary each year by the General Assembly's renewal of a one-year hospital assessment. The reductions contemplated in Amendment 34 included limits on inpatient hospital services, outpatient hospital visits, health care practitioners' office visits, and lab and X-ray services, as well as the elimination of certain kinds of therapy.

As has been the case in previous years, however, the General Assembly renewed the hospital assessment, thereby eliminating any funding gap and the need for Amendment 34 to be submitted to CMS.

Demonstration Amendment 35: Substance Use Disorder Services. In April 2018, TennCare issued public notice regarding another proposal to be submitted to CMS. Amendment 35 would amend the TennCare benefits package to cover residential substance use disorder (SUD) treatment services in facilities with more than 16 beds. The federal government classifies facilities with more than 16 beds as "institutions for mental diseases" (IMDs), and federal law prohibits the expenditure of federal Medicaid dollars for services delivered to adults in these facilities.

Despite this prohibition, the MCOs contracted with the TennCare program have historically been permitted to cover residential treatment services in facilities with more than 16 beds, if the MCO determined that such care was medically appropriate and cost-effective as compared to other treatment options. However, CMS recently issued regulations imposing new restrictions on the ability of MCOs to pay for services in these facilities. Specifically, the new federal regulation limits this option to treatment stays of no more than 15 days per calendar month.[1]

In light of this new restriction, with Amendment 35 TennCare is seeking authority to cover residential SUD treatment services in facilities that meet the definition of an IMD when medically necessary and appropriate. TennCare's proposal would allow enrollees to receive short-term services in IMDs beyond the 15-day limit in federal regulation, up to 30 days per admission.

The public notice and comment period for Amendment 35 lasted from April 20 through May 21, 2018, during which time no comments on the proposal were received. TennCare submitted Amendment 35 to CMS on May 25, 2018. As of the conclusion of the April-June 2018 quarter, CMS was continuing its review of Amendment 35.

Demonstration Amendment 36: Family Planning Providers. In June 2018, TennCare initiated its public notice and comment period for a demonstration amendment stemming from Tennessee's 2018

[1] See 42 CFR § 438.6(e).

legislative session. On April 12, 2018, the General Assembly enacted Public Chapter No. 682, establishing that it is the policy of the state of Tennessee to favor childbirth and family planning services that do not include elective abortions within the continuum of care or services, and to avoid the direct or indirect use of state funds to promote or support elective abortions.

Accordingly, Amendment 36 will request authority to establish state-specific criteria for providers of family planning services, and to exclude any providers that do not meet these criteria from participation in the TennCare program. Specifically—and as specified in Public Chapter No. 682—TennCare is proposing to exclude any entity that performed, or operated or maintained a facility that performed, more than 50 abortions in the previous year, including any affiliate of such an entity.

The designated public notice and comment period for Amendment 36 was June 13 through July 13, 2018. TennCare will proceed with submitting Amendment 36 to CMS at the conclusion of the public notice period and after all public comments have been reviewed.

Update on Episodes of Care. Episodes of care is a payment reform strategy that focuses on acute or specialist-driven health care delivered during a specified time period to treat physical or behavioral conditions such as an acute diabetes exacerbation or total joint replacement. Each episode has a principal accountable provider (sometimes referred to as the "quarterback") who is in the best position to influence the cost and quality of the episode. Episodes of care are implemented in groups or—in the terminology of the program—"waves."

Each episode is designed with significant input from stakeholders such as Tennessee providers, payers, administrators, and employers. For each episode, the program organizes Technical Advisory Groups (TAGs) composed of experts in the field to provide clinical feedback on each episode's design. A Urology TAG convened between March and April 2018 to design the program's ninth wave of episodes. The two episodes designed in Wave 9 are Cystourethroscopy and Acute Kidney and Ureter Stones. TAG recommendations concerning the design of these episodes are summarized in the Appendix to this report.

On May 30, TennCare announced that it is pausing the design of new episodes of care. This decision will allow TennCare and its managed care organizations to dedicate more resources toward maintaining and improving the existing episodes. Such efforts include continuing to improve provider communication, engagement, and analysis of episode performance data. All of the episodes in progress will continue, with the exception of two breast cancer episodes and the neonatal episodes, which are paused while TennCare works to refine the data related to those episodes. In addition, in accordance with legislation passed by the General Assembly in 2018 (Public Chapter No. 1016), TennCare is no longer implementing episodes of care for anxiety and non-emergent depression. There will be no new Technical Advisory Groups related to episodes of care this fall.

In 2018, providers are receiving reports on 46 episodes of care. Of those episodes, 27 are in a performance period, and 19 are in a preview period. Estimates indicate that the Episodes of Care

program saved Tennessee over $25 million in health care costs in calendar years 2015 (when three episodes were in a performance period) and 2016 (when eight episodes were in a performance period), while maintaining or in some cases improving quality of care.

Admission, Discharge, and Transfer Data. TennCare is continuing its work with Tennessee hospitals to coordinate the sharing of admission, discharge, and transfer (ADT) data. These data allow providers participating in TennCare's care coordination initiatives to know when their patients go to an emergency room or are admitted to or discharged from a hospital. ADT data are the most actionable, real-time electronic information in health care. While many states are working to improve the sharing and use of ADT data, Tennessee has become a leader in this area. As of the end of June, 74 percent of Tennessee hospitals are sharing ADT data with TennCare, with more hospitals set to begin sharing these data in the coming months. The ADT data are delivered to primary care and behavioral health providers via TennCare's Care Coordination Tool in a usable format that—combined with other medical and pharmacy data—gives providers a workflow for prioritizing high-risk patients and highlights members' unmet medical needs. Providers have reported that this new information enables them to reach out to patients who are over-utilizing the emergency room, and to find hard-to-reach patients who may need follow-up care.

Tennessee Eligibility Determination System. The Tennessee Eligibility Determination System (or "TEDS") is the name of the system (currently under development) that will be used by the Division of TennCare to process applications and identify persons who are eligible for the TennCare and CoverKids programs. During the April-June 2018 quarter, the focus of readiness activities was user acceptance testing, which began on April 9, 2018. This phase of the project allows staff to test TEDS using scripts and ad hoc scenarios in a simulated environment to ensure that the system is functioning effectively. Approximately 100 individuals engaged in TEDS user acceptance testing during the April-June quarter, and any defects noted were reported to Deloitte Consulting, LLP, TennCare's systems integrator partner. The first phase of implementation of the TEDS system is planned for late 2018.

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 of 2009. 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 Certified Electronic Health Record Technology (as defined by CMS) that meets rigorous 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

[2] CMS allows two types of providers to participate in the Medicaid EHR Incentive Program: medical professionals (medical and osteopathic physicians, nurse practitioners, certified nurse midwives, dentists, and physician assistants who meet certain criteria) and hospitals (acute care hospitals, critical access hospitals, and children's hospitals).

the funding for administrative costs. Tennessee's EHR program[3] has issued payments for six program years to Medicaid providers meeting relevant eligibility requirements.

EHR payments made by TennCare during the April-June 2018 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 (Apr-Jun 2018)	Cumulative Amount Paid to Date[4]
First-year payments	0	$0	$180,842,691
Second-year payments	78	$663,000	$58,419,759
Third-year payments	73	$617,667	$34,647,704
Fourth-year payments	92	$782,000	$6,309,845
Fifth-year payments	59	$501,500	$3,544,502
Sixth-year payments	78	$649,098	$1,648,432

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

- Communicating with and assisting providers via emails (including targeted emails to eligible professionals attesting to "meaningful use" of EHR technology), technical assistance calls, webinars, and onsite visits;
- Acceptance of Program Year 2017 meaningful use attestations for returning eligible professionals[5];
- Submission of Tennessee's 2018 EHR Annual Report to CMS;
- Participation throughout the quarter in several Southeast Regional Collaboration for HIT/HIE (SERCH) calls; and
- Newsletters and alerts distributed by TennCare's EHR ListServ.

Although enrollment of new providers concluded on April 30, 2017, TennCare's EHR Incentive Program team continues to work with a variety of provider organizations to maintain the momentum of the program. The focus of outreach efforts has shifted from new enrollments to providers who attested to EHR requirements only once or who have not attested in recent years. TennCare emphasized this

[3] In April 2018, CMS announced that its EHR programs would be renamed "Promoting Interoperability (PI) Programs." While Tennessee's EHR initiative falls within the scope of CMS's PI Programs, TennCare will continue to refer to its initiative as "EHR Incentive Program" for purposes of clarity and consistency in communications with providers.

[4] Cumulative totals associated with first-year, second-year, and third-year payments reflect recoupments of payments from previous quarters. The need for these recoupments was identified through standard auditing processes.

[5] The deadline for submitting 2017 attestations had originally been set for March 31, 2018. As a result of problems reported by providers in the concluding weeks of the attestation period, CMS allowed the deadline to be extended to April 30, 2018.

strategy in exhibits at the April 2018 Amerigroup Community Care and UnitedHealthcare Provider Information Expos in Chattanooga, Johnson City, Knoxville, Memphis, and Nashville.

Wilson v. Gordon. *Wilson v. Gordon* is a class action lawsuit filed against the Division of TennCare by the Tennessee Justice Center, the Southern Poverty Law Center, and the National Health Law Program. The suit, which is being heard by the U.S. District Court for the Middle District of Tennessee, alleges federal noncompliance in the Medicaid application and appeals process TennCare has been using since implementation of the Affordable Care Act.

In the fall of 2016, the State filed a Motion to Decertify the Class and Dismiss the Case. The basis of the motion was that processes used by TennCare and CMS for Medicaid applications and application appeals in Tennessee had evolved substantially. The State argued that there were no remaining members in the Plaintiff class originally certified by the District Court, and that any eligibility issues arising in 2016 and thereafter were completely different from the issues that originally prompted the *Wilson* suit.

Oral argument and supplemental briefing on the State's Motion took place during the first half of Calendar Year 2017. On June 5, 2018, Judge William L. Campbell, Jr.[6] denied the Motion, finding that there continue to be members in the Plaintiff class. As a result, the case will proceed to trial on October 9, 2018.

Essential Access Hospital (EAH) Payments. The Division of TennCare continued to make EAH payments during the April-June 2018 quarter. EAH payments are made from a pool of $100 million ($34,395,000 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 53.a. 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 fourth quarter of State Fiscal Year 2018 (for dates of service during the third quarter) are shown in the table below.

[6] The *Wilson* suit was previously assigned to Judge Curtis Collier, but—pursuant to an administrative order entered on January 18, 2018—was reassigned to Judge Campbell.

Essential Access Hospital Payments for the Quarter

Hospital Name	County	EAH Fourth Quarter FY 2018
Vanderbilt University Hospital	Davidson County	$3,652,292
Regional One Health	Shelby County	$3,216,140
Erlanger Medical Center	Hamilton County	$2,258,399
University of Tennessee Memorial Hospital	Knox County	$1,666,652
Johnson City Medical Center (with Woodridge)	Washington County	$1,151,981
Parkridge Medical Center (with Parkridge Valley)	Hamilton County	$864,997
LeBonheur Children's Medical Center	Shelby County	$770,710
Metro Nashville General Hospital	Davidson County	$554,536
Jackson – Madison County General Hospital	Madison County	$525,180
East Tennessee Children's Hospital	Knox County	$479,290
TriStar Skyline Medical Center (with Madison Campus)	Davidson County	$473,961
Saint Jude Children's Research Hospital	Shelby County	$409,472
Methodist Healthcare – Memphis Hospitals	Shelby County	$408,893
TriStar Centennial Medical Center	Davidson County	$367,639
Parkridge East Hospital	Hamilton County	$357,795
Methodist Healthcare – South	Shelby County	$345,033
Delta Medical Center	Shelby County	$306,238
Parkwest Medical Center (with Peninsula)	Knox County	$286,797
Baptist Memorial Hospital for Women	Shelby County	$266,102
Saint Thomas Midtown Hospital	Davidson County	$257,058
Methodist Healthcare – North	Shelby County	$251,979
Saint Francis Hospital	Shelby County	$231,026
University Medical Center (with McFarland)	Wilson County	$226,838
Saint Thomas Rutherford Hospital	Rutherford County	$210,289
Baptist Memorial Hospital – Memphis	Shelby County	$197,002
Fort Sanders Regional Medical Center	Knox County	$193,449
Wellmont – Holston Valley Medical Center	Sullivan County	$186,927
Erlanger North Hospital	Hamilton County	$185,902
Pathways of Tennessee	Madison County	$185,668
Ridgeview Psychiatric Hospital and Center	Anderson County	$180,838
Maury Regional Hospital	Maury County	$168,830
TriStar StoneCrest Medical Center	Rutherford County	$158,600
Methodist Le Bonheur Germantown Hospital	Shelby County	$157,629
TriStar Horizon Medical Center	Dickson County	$151,915
Tennova Healthcare	Knox County	$149,111
Wellmont – Bristol Regional Medical Center	Sullivan County	$140,210
TriStar Summit Medical Center	Davidson County	$138,487
Cookeville Regional Medical Center	Putnam County	$136,499
Rolling Hills Hospital	Williamson County	$133,494
Blount Memorial Hospital	Blount County	$130,221

Hospital Name	County	EAH Fourth Quarter FY 2018
Gateway Medical Center	Montgomery County	$125,027
TriStar Southern Hills Medical Center	Davidson County	$122,543
Dyersburg Regional Medical Center	Dyer County	$112,776
Lincoln Medical Center	Lincoln County	$110,047
Morristown – Hamblen Healthcare System	Hamblen County	$106,829
Skyridge Medical Center	Bradley County	$105,970
LeConte Medical Center	Sevier County	$96,650
Sumner Regional Medical Center	Sumner County	$95,962
Methodist Medical Center of Oak Ridge	Anderson County	$87,506
Takoma Regional Hospital	Greene County	$84,687
TriStar Hendersonville Medical Center	Sumner County	$82,775
Tennova Healthcare – Newport Medical Center	Cocke County	$78,212
Saint Francis Hospital – Bartlett	Shelby County	$75,410
Jellico Community Hospital	Campbell County	$70,720
Tennova Healthcare – Harton Regional Medical Center	Coffee County	$69,339
Indian Path Medical Center	Sullivan County	$68,505
Starr Regional Medical Center – Athens	McMinn County	$67,485
Tennova Healthcare – LaFollette Medical Center	Campbell County	$63,631
NorthCrest Medical Center	Robertson County	$61,899
Parkridge West Hospital	Marion County	$60,869
Henry County Medical Center	Henry County	$58,304
Southern Tennessee Regional Health System – Winchester	Franklin County	$53,465
Regional Hospital of Jackson	Madison County	$52,727
Wellmont Hawkins County Memorial Hospital	Hawkins County	$52,520
Roane Medical Center	Roane County	$46,046
Sycamore Shoals Hospital	Carter County	$45,530
Saint Thomas River Park Hospital	Warren County	$43,101
Southern Tennessee Regional Health System – Lawrenceburg	Lawrence County	$41,834
Heritage Medical Center	Bedford County	$40,545
Skyridge Medical Center – Westside	Bradley County	$39,467
Hardin Medical Center	Hardin County	$38,710
Bolivar General Hospital	Hardeman County	$37,424
Baptist Memorial Hospital – Union City	Obion County	$36,063
Erlanger Health System – East Campus	Hamilton County	$35,990
McKenzie Regional Hospital	Carroll County	$35,895
Lakeway Regional Hospital	Hamblen County	$35,793
Hillside Hospital	Giles County	$34,780
Starr Regional Medical Center – Etowah	McMinn County	$34,149
Livingston Regional Hospital	Overton County	$34,074
TrustPoint Hospital	Rutherford County	$30,931
United Regional Medical Center	Coffee County	$28,494

Hospital Name	County	EAH Fourth Quarter FY 2018
Tennova Healthcare – Jefferson Memorial Hospital	Jefferson County	$28,380
Volunteer Community Hospital	Weakley County	$28,026
Claiborne County Hospital	Claiborne County	$27,770
Saint Thomas DeKalb Hospital	DeKalb County	$23,856
Saint Thomas Stones River Hospital	Cannon County	$23,237
Henderson County Community Hospital	Henderson County	$23,155
Jamestown Regional Medical Center	Fentress County	$21,823
Milan General Hospital	Gibson County	$21,013
Wayne Medical Center	Wayne County	$17,854
Decatur County General Hospital	Decatur County	$13,709
Kindred Hospital – Chattanooga	Hamilton County	$12,854
Southern Tennessee Regional Health System – Sewanee	Franklin County	$11,391
Houston County Community Hospital	Houston County	$10,169
TOTAL		**$25,000,000**

Number of Recipients on TennCare and Costs to the State

During the month of June 2018, there were 1,406,310 Medicaid eligibles and 13,752 Demonstration eligibles enrolled in TennCare, for a total of 1,420,062 persons.

Estimates of TennCare spending for the fourth quarter of State Fiscal Year 2018 are summarized in the table below.

Spending Category	Fourth Quarter FY 2018*
MCO services**	$1,703,117,200
Dental services	$39,518,300
Pharmacy services	$264,341,800
Medicare "clawback"***	$56,600,000

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

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

****The Medicare Part D clawback is money that 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 Managed Care Contractors (MCCs) in the TennCare Program

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

Entity	Standard	Authority
MCOs (services other than CHOICES and ECF CHOICES)	90% of clean claims for payment for services delivered to TennCare enrollees are processed and, if appropriate, paid within 30 calendar days of the receipt of such claims. 99.5% of all provider claims are processed, and, if appropriate, paid within 60 calendar days of receipt.	TennCare contract and in accordance with T.C.A. § 56-32-126(b)
MCOs (CHOICES and ECF CHOICES services)	90% of clean electronically submitted Nursing Facility and applicable Home and Community Based Services claims[7] are processed and paid within 14 calendar days of receipt. 99.5% of clean electronically submitted Nursing Facility and applicable Home and Community Based Services claims[8] are processed and paid within 21 calendar days of receipt.	TennCare contract

[7] 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.

[8] Ibid.

Entity	Standard	Authority
Dental Benefits Manager (DBM)	90% of clean claims for payment for services delivered to TennCare enrollees are processed, and, if appropriate, paid within 30 calendar days of the receipt of such claims. 99.5% of all provider claims are processed, and, if appropriate, paid within 60 calendar days of receipt.	TennCare contract and in accordance with T.C.A. § 56-32-126(b)
Pharmacy Benefits Manager (PBM)	100% of all clean claims submitted by pharmacy providers are paid within 15 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 and ECF CHOICES enrollees. TDCI then performs an analysis and reports the results of the prompt pay analyses by NEMT and CHOICES and ECF 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 Division of TennCare may 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 TennCare may 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 reported on the National Association of Insurance Commissioners (NAIC) Annual Financial Statement 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 April-June 2018 quarter, the MCOs submitted their NAIC First Quarter 2018 Financial Statements. As of March 31, 2018, TennCare MCOs reported net worth as indicated in the table below.[9]

MCO	Net Worth Requirement	Reported Net Worth	Excess/ (Deficiency)
Amerigroup Tennessee	$30,058,528	$224,254,975	$194,196,447

[9] 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.

MCO	Net Worth Requirement	Reported Net Worth	Excess/ (Deficiency)
UnitedHealthcare Plan of the River Valley (UnitedHealthcare Community Plan)	$65,141,772	$402,218,192	$337,076,420
Volunteer State Health Plan (BlueCare & TennCare Select)	$47,825,838	$496,583,640	$448,757,802

During the April-June 2018 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 March 31, 2018:

MCO	Company Action Level	Reported Net Worth	Excess/ (Deficiency)
Amerigroup Tennessee	$110,985,558	$224,254,975	$113,269,417
UnitedHealthcare Plan of the River Valley (UnitedHealthcare Community Plan)	$221,464,280	$402,218,192	$180,753,912
Volunteer State Health Plan (BlueCare & TennCare Select)	$160,340,902	$496,583,640	$336,242,738

All TennCare MCOs met their minimum net worth requirements and Company Action Level requirements as of March 31, 2018.

Success of Fraud Detection and Prevention

The mission of the Tennessee Office of Inspector General (OIG) is to identify, investigate, prosecute, and arrest 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 Division of TennCare, Health Related Boards, the Department of Human Services (DHS), other State agencies, health care providers, MCCs, and the general public via the OIG website, fax, written correspondence, and phone calls to the OIG hotline. Cases adjudicated during a particular fiscal year may have no relationship to dates of arrest during the same year. Selected statistics for the fourth quarter of Fiscal Year 2018 are as follows:

Fraud and Abuse Allegations	Fourth Quarter FY 2018
Fraud Allegations	1,356
Abuse Allegations*	1,072
Criminal Investigations	**Fourth Quarter FY 2018**
Criminal Cases Opened	19
Criminal Cases Closed	39
Arrests	31
Convictions	17
Judicial Diversions	9

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

Criminal Court Fines and Costs Imposed	Fourth Quarter FY 2018
Court Costs & Taxes	$909
Fines	$14,500
Drug Funds/Forfeitures	$133
Criminal Restitution Ordered	$159,096
Criminal Restitution Received[10]	$67,563
Administrative Fees	$42
Civil Restitution/Civil Court Judgments	**Fourth Quarter FY 2018**
Civil Restitution Ordered[11]	$0
Civil Restitution Received[12]	$4,161
Administrative Fees Awarded	$0
Administrative Fees Received[13]	$0

Recommendations for Review	Fourth Quarter FY 2018
Recommended TennCare Terminations[14]	81
Potential Savings[15]	$296,168

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

[11] 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.

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

[13] Administrative fees may have been awarded in a fiscal year other than the one in which payment was actually received.

[14] Recommendations that enrollees' TennCare coverage should be terminated are sent to the Division of TennCare for review and determination of appropriate action. These recommendations are based on information received and reviewed by the OIG. TennCare determines whether these referrals meet the criteria for termination. Reviews of these recommendations must factor in some limitations, such as the inability to disenroll individuals in certain federally protected categories.

[15] 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).

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.

Appendix

TAG Recommendations for Wave 9 Episodes of Care

Cystourethroscopy episode design summary

Identifying episode triggers

A Cystourethroscopy episode is triggered by a professional claim with a cystourethroscopy procedure code along with an associated outpatient facility claim. The professional claim with the cystourethroscopy procedure code with office place of service codes may also trigger an episode. The procedure can take place in either an outpatient or office setting.

Attributing episodes to quarterbacks

The quarterback is the provider who performs the cystourethroscopy. The contracting entity or tax identification number of the associated professional claim is used to identify the quarterback.

Identifying services to include in episode spend

The Cystourethroscopy episode begins 30 days prior to the trigger window and extends to the day before the trigger window. The trigger window spans the duration of the triggering procedure and associated hospitalization. The post-trigger window begins the day after the trigger window and extends for 30 days. Episode spend is calculated on the basis of claims related to the cystourethroscopy.

Excluding episodes

There are three types of exclusions. Business exclusions: available information is not comparable or is incomplete (e.g., third party liability, non-continuous eligibility, left against medical advice). Clinical exclusions: patient's care pathway is different for clinical reasons, such as age (<6 months or >64 years), episodes with active cancer management, neurological disorders, and Bilateral Inguinal Hernia. High-cost outlier exclusions: episode's risk-adjusted spend is three standard deviations above the mean.

Determining quality metrics performance

There are two types of quality metrics: those tied to gain sharing and those that are for information only (and not tied to gain sharing). The quality metrics tied to gain sharing are: lower difference in average morphine equivalent dose per day between the pre-trigger window and during the trigger and post-trigger window, lower percentage of valid episodes with a related emergency department visit during the post-trigger window, and lower percentage of valid episodes with one or more cystourethroscopy during the post-trigger window.

Quality metrics not tied to gain sharing are: average morphine equivalent dose per day during the pre-trigger window, average morphine equivalent dose per day during the trigger and post-trigger window, percentage of valid episodes with complications during the post-trigger window, percentage of valid episodes with no opioid prescriptions up to 60 days before the pre-trigger window for individuals who received an opioid prescription

during the episode (opioid naïve prescriptions), percentage of valid episodes with related follow-up care during the post-trigger window, and percentage of valid episodes with any admission during the post-trigger window.

Acute Kidney and Ureter Stones episode design summary

Identifying episode triggers

A potential trigger for an Acute Kidney and Ureter Stones episode is an emergency department, observation, or inpatient facility claim with either a primary diagnosis of acute kidney or ureter stones or a primary diagnosis of a sign or symptom of the acute condition, and a secondary diagnosis of acute kidney or ureter stones.

Attributing episodes to quarterbacks

The quarterback is the facility where the patient initially presents with acute kidney and ureter stones. The contracting entity or tax identification number of the facility claim is used to identify the quarterback.

Identifying services to include in episode spend

The Acute Kidney and Ureter Stones episode does not have a pre-trigger window, and the episode begins on the day of the triggering encounter and associated hospitalization (trigger window) and ends 30 days following discharge from the facility where the acute kidney and ureter stones were diagnosed (post-trigger window). Services included in the episode spend during the day when the acute kidney and ureter stones were diagnosed or for the duration of admission (trigger window) are all professional and facility medical services. Services included in the episode spend on the day when the patient is discharged and up to 30 days following discharge from the facility where acute kidney and ureter stones were diagnosed (post-trigger window) are relevant care, evaluation and management with relevant diagnoses, relevant complications, relevant imaging and testing, relevant procedures, and relevant medications.

Excluding episodes

There are three types of exclusions. Business exclusions: available information is not comparable or is incomplete (e.g., third party liability, non-continuous eligibility, left against medical advice). Clinical exclusions: patient's care pathway is different for clinical reasons, such as age (<10 years or >64 years), connective tissue disorders, and cystic fibrosis. High-cost outlier exclusions: episode's risk-adjusted spend is three standard deviations above the mean.

Determining quality metrics performance

There are two types of quality metrics: those tied to gain sharing and those that are for information only (and not tied to gain sharing). The quality metrics tied to gain sharing are:

lower difference in average morphine equivalent dose per day during the 30 days prior to the trigger window and average morphine equivalent dose per day during the episode window, and lower percentage of valid episodes with a related emergency department visit during the post-trigger window.

Quality metrics not tied to gain sharing are: average morphine equivalent dose per day during the 30 days prior to the trigger window, average morphine equivalent dose per day during the trigger and post-trigger window, percentage of valid episodes with complications during the post-trigger window, percentage of total episodes with a kidney or ureter stone removal procedure during the episode window, percentage of valid episodes with no opioid prescriptions up to 90 days before the trigger who received an opioid prescription during the episode (opioid naïve prescriptions), percentage of valid episodes with a related admission during the post-trigger window, percentage of valid episodes with any admission during the trigger window, and percentage of valid episodes with more than one related CT scan during the episode window.