TennCare Quarterly Report

Submitted to the TennCare Oversight Committee and the Fiscal Review Committee

October 15, 2002

Status of TennCare Reforms and Improvements

Implementation of new waiver
On July 1, 2002, the new TennCare waiver was implemented. This waiver replaces the former TennCare waiver that had been in effect since January 1, 1994.

Most of the initial changes in the waiver which occurred during this quarter were in the area of eligibility. Virtually all TennCare eligibility functions—Medicaid eligibility as well as non-Medicaid eligibility—have been moved to the Department of Human Services. The intent is to have a consolidated eligibility determination and reverification process. Under the old waiver, benefits were the same for the Medicaid population and the waiver population. Under the new waiver, benefits will be different, effective January 1, 2003, so it is important to enroll individuals in the particular category that is most appropriate for them. This means evaluating all applicants for Medicaid before enrolling them in the demonstration population.

New TennCare applicants are being allowed to enroll only in two circumstances:
- They are Medicaid eligible, or
- They are determined to be "medically eligible," meaning unable to purchase insurance, and they have family incomes that are below the poverty level.

Those enrollees who were not Medicaid-eligible but enrolled in TennCare as waiver eligibles on July 1, 2002, have been sent letters telling them they must go into the county DHS office to determine if they are still eligible under the new waiver or, perhaps, eligible for Medicaid. This process is called "redetermination."

The redetermination process involves screening all current eligibles first for Medicaid and then for the new waiver eligibility criteria. In order to remain in TennCare without Medicaid eligibility, individuals must meet one of several criteria:
- They have no access to insurance and they are determined to be "medically eligible" because of certain medical conditions that they had; or
- They are in one of the "grandfathered" groups who are being allowed to stay in TennCare even if they have access to insurance.

The "grandfathered" groups include the following:
- People with Medicare but not Medicaid who were enrolled in TennCare on December 31, 2001, and who continue to lack access to insurance other than Medicare;

- Children who were enrolled in TennCare as "Uninsured Children" on December 31, 2001, with family incomes that do not exceed 200% poverty, even if they had access to insurance; and
- People who were enrolled as dislocated workers on June 30, 2002, even if they had access to COBRA, who otherwise meet the redetermination criteria.

Letters were sent out in staggered mailings. With each mailing, individuals were given up to 90 days to go through the redetermination process at DHS and prove that they met the criteria for either Medicaid or one of the new demonstration categories. Those who had not yet made an appointment at DHS within 30 days after the mailing was sent received follow-up letters reminding them that only 60 days remained.

A number of advocacy efforts have been launched to assist people in understanding the importance of following through with this process. Information line efforts at the TennCare Consumer Advocacy Line and the TennCare Partners Advocacy Line have been expanded. Materials have been printed in Spanish, and access to six other languages is provided—Bosnian, Arabic, Somali, Vietnamese, and two dialects of Kurdish (Sorani and Badinani). In addition, public service announcements (PSAs) were developed for radio and television to remind members that if they get a letter from TennCare and do not respond, they will lose their TennCare benefits. TennCare advocates developed the PSA, and it was produced by the University of Tennessee at Knoxville. The spots feature the exact envelope that members are getting in the mail from TennCare so that they can identify this envelope when it arrives in their mailbox.

The first mailing went out early in July to 13,423 individuals, most of whom had not used the TennCare program or paid premiums within at least a year's time and who were assumed to be no longer in Tennessee or no longer in need of TennCare. Three mass mailings followed the initial mailing.

- The first mass mailing went out on July 30, 2002, to 221,923 individuals in the demonstration population.
- The second mass mailing went out on August 31, 2002, to 177,208 individuals in the demonstration population.
- The third mass mailing went out on September 30, 2002, to 118,341 individuals in the demonstration population.

A final mailing occurred on October 3, 2002. This mailing went to 46,655 individuals who were dually eligible for Medicare and TennCare.

TennCare Reform Act

The TennCare Reform Act, Public Chapter 880, became effective July 1, 2002. The act codifies many of the provisions in the TennCare waiver and, as such, is being implemented through the redetermination of all enrollees in the TennCare expansion population.

The Act specifies that the composition of the TennCare program may be changed by recommendation of the Governor and the General Assembly acting to prioritize funding for the program through the general appropriations act.

The Act also requires that a program be established to ensure the collection of all medical assistance benefits, premiums, or other such costs due from the estate of a

deceased TennCare enrollee. This was begun in August 2002. (See section below entitled "Success of Fraud Detection and Prevention.")

Stabilization Plan

In order to provide increased stability for the TennCare program, it was decided that TennCare MCOs would temporarily operate under a non-risk agreement effective July 1, 2002. This arrangement will last 18 months, until December 31, 2003. The purpose of the plan is to allow a period of time to establish greater financial stability while maintaining continuity of the managed care environment for enrollees. Each MCO must demonstrate throughout the period of the Stabilization Plan that it has sufficient financial capital to insure uninterrupted delivery of health care on an ongoing basis.

Under the Stabilization Plan, MCOs are being paid an administrative fee to manage a medical fund for health care services. Efficient management of the medical fund will result in a sharing between the state and the health plan of any savings generated. Administrative bonuses will be used as rewards for the achievement of high priority targets. Changes in provider contracts are subject to TennCare approval.

During the period of the Stabilization Plan, we expect to be able to generate actuarial data that will provide an improved picture of the elements of risk in the TennCare enrollee population. Because the plans will be operating on a non-risk basis, the data will be less influenced by MCO solvency issues, enrollment shifts, and other variables which affect the actuarial calculation of risk. The data should allow us to establish improved rate structures so that MCO operations can return to a risk basis at the end of the stabilization period.

Dental carve-out

On October 1, 2002, TennCare began a new three-year dental benefits management contract with Doral Dental of Tennessee, LLC. Dental screenings and treatment are offered to TennCare children under the age of 21, who account for over 600,000 members. Adult dental benefits are limited to emergency services.

Doral Dental of Tennessee, LLC, is a subsidiary of Doral Dental, the nation's leading multi-state administrator of government dental programs, currently serving more than five million members in 18 states with a combined network of more than 11,500 dentists. Doral has assumed administration of the entire TennCare dental program, including provider networks, claims processing, and benefits management.

Doral has built dental networks for government programs nationwide while working within limited funding parameters – including helping improve TennCare dental services as a subcontractor for a number of TennCare managed care organizations (MCOs) for the past five years.

Doral has met contractual provider network requirements for delivering dental services to TennCare members, and will continue to add new dentists to the program on a regular basis.

Doral was the lowest bidder for the dental benefits management contract. The state will pay Doral a maxiumum of $6 million in the first year for administration of dental benefits management. Payments for enrollee care will be made outside the administrative fee.

Hospital payments
TennCare is allocating $100 million among 100 hospitals that provided more than 95 percent of the hospital care to TennCare patients. The hospital payments, which will be made quarterly starting in October, were part of the state's new five-year federal waiver that started on July 1, 2002.

The $100 million in quarterly payments during fiscal year 2003 will be divided among three groups of hospitals:
Safety net hospitals - $50 million
Children's hospitals – $5 million
Other essential hospitals- $45 million

Hospitals eligible for the payments experienced a high volume of TennCare or TennCare unreimbursed costs and are contracted with at least one TennCare managed care organization (MCO) as well as TennCare Select, the state's health care plan for special needs children and the back-up health care plan for the TennCare program.

The method of determining individual hospital payments was recommended by actuaries at PriceWaterhouseCoopers, which took input from key stakeholders and analyzed hospital data from the most recent Joint Annual Report of Hospitals including the number of TennCare patients and uncompensated care at the hospitals, compared to total patient volume.

The payment schedule was submitted to the Centers for Medicare and Medicaid Services (CMS) on October 1, 2002, and must meet federal approval before checks are issued.

Member survey
The University of Tennessee at Knoxville performs an annual survey of TennCare members, and the latest results released in August 2002 show that TennCare members are more satisfied with the state's managed care health insurance program than ever before, and many are more confident than ever in the quality of care received through TennCare.

The survey shows that TennCare recipients see physicians more often, visit emergency rooms less for initial care and are able to see a physician without excessive travel or waiting time. The survey concludes that there is "substantial evidence that, at least from the perspective of the recipients, the program is working as expected."

Among the survey findings:
- The level of enrollee satisfaction (85 percent) is the highest yet expressed by TennCare recipients, and for the first time exceeds that reported by Medicaid recipients in 1993;
- The number of heads of households satisfied with their quality of care is the highest since TennCare began in 1994;
- Parents continue to be confident in the quality of care their children receive in TennCare;
- The proportion of TennCare recipients initially seeking care for their children at hospital emergency rooms remains at the lowest level (5 percent) measured since

the inception of the program and adult use of hospital emergency rooms for initial care remains low (7 percent);
- TennCare adults and children continue to see physicians on a regular basis.

The survey also measures the number of people in Tennessee without any health care insurance, and shows that 3.9 percent of children (under 18) and 6.94 percent of adults are uninsured. The combined estimate of 6.07 percent having no health insurance in Tennessee makes the state one of the most insured states in the nation.

The TennCare recipient survey is available online at the TennCare website. See http://www.tn.gov/tenncare/news-reports.html.

Pharmacy improvements

1. **Third party recovery.** The TennCare pharmacy carve-outs provide behavioral health pharmacy services for all 1.4 million TennCare members and the complete pharmacy benefit for 217,000 dually eligible members. Some of these members are known to have commercial insurance that covers prescription drugs, and the dually eligible members have some of their prescriptions covered by Medicare. TennCare has signed a management letter with a current contractor (PCG) to collect these third party payments. As soon as the collections are current, the process will switch to on-line, real time cost avoidance at the pharmacy level.

2. **Pharmacy lock-in.** TennCare has begun work on a pharmacy lock-in program that requires high utilizing or abusive members to receive all their prescriptions from a single pharmacy. Lock-in procedures not only reduce costs for needless or duplicative prescriptions, but also improve the quality oversight of the member's care.

3. **TennCare's Centers of Excellence project.** TennCare has implemented the TennCare Centers of Excellence project with Applied Health Outcomes (AHO). Three disease-specific Centers of Excellence (diabetes, cardiovascular, and asthma) have been launched. TennCare has received approximately $900,000 from pharmaceutical manufacturers to fund the project, which includes disease management, quality improvement, cost containment, and outcomes research. Vanderbilt and the University of Tennessee, among others, will be actively engaged in the outcomes research portion of the project. The overall goal of the project is to provide physicians with evidence-based data that show the best treatment algorithm to follow for specific disease states. This approach provides physicians with the most current clinical thinking in order to effect voluntary changes in prescribing practices. Appropriate prescribing patterns that give the best outcomes will save total health care costs by reducing expenditures for emergency room visits, hospitalizations, physician visits, and other service-related costs.

4. **Long-term care pharmacy.** TennCare and Vanderbilt have begun a study of long-term pharmacy dispensing practices and reimbursement. Expected to be finished this calendar year, this report may change the current seven-day dispensing requirements in nursing facilities to a less expensive 30-day process.

5. **Generic drug mandates.** TennCare has been a national leader in generic drug utilization. Once the cost of a generic drug is lower than the brand name version

(after rebates), TennCare requires generic substitution through use of a maximum allowable cost (MAC) system. This means that TennCare sets a maximum price it will pay pharmacists for a brand name drug and all of its generic versions. Since the MAC price is well below what the brand name drug costs, the pharmacist is given an incentive to contact the provider and get approval for generic substitution.

Reverification Status

On September 30, 2002, the eligibility of 9,129 individuals who had received letters in the July 1 mailing was ended. Most of these individuals were closed because they did not contact DHS for a redetermination appointment. Additional terminations are scheduled for the end of October, the end of November, and the end of December 2002.

TennCare and DHS communicate daily about redetermination applications that are outstanding and appointments that have been made. To date, 24,870 individuals who were formerly in the demonstration population are now Medicaid-eligible, and 50,035 have been approved for TennCare Standard. There have been nearly 30,000 denials of applications for TennCare Standard.

Status of Filling Top Leadership Positions in the Bureau

Dr. Jim Gillcrist became Assistant Medical Director/ Dental Benefit Director on September 1, 2002. Dr. Gillcrist had been the Director of Oral Health Services with the Tennessee Department of Health since 1995. Prior to that, he was the Dental Director with the Metropolitan Health Department.

Number of Recipients on TennCare and Costs to the State

As of the end of the quarter, there were 1,439,772 enrollees on TennCare: 869,004 Medicaid eligibles and 570,768 Uninsureds and Uninsurables.

During the first quarter of FY 2003, TennCare spent $887,090,298.32 (net projected drug rebates) for managed care services. These expenditures included: payments to the managed care organizations, payments to the behavioral health organizations, and payments for pharmacy services for the dual eligibles and behavioral health pharmacy carve-outs.

Viability of MCOs in the Tenncare Program

Claims payment analysis

The prompt pay requirements of T.C.A. § 56-32-226(b) mandate that each health maintenance organization ensure that 90 percent of claims for payment for services delivered to a TennCare enrollee are paid within 30 days of the receipt of such claims and 99.5 percent of all provider claims are processed within 60 days of receipt.

In August 2002, the Tennessee Department of Commerce and Insurance (TDCI) requested data files of all TennCare processed claims from TennCare MCOs for the month of July 2002. TDCI also requested data files of pended TennCare claims as of July 31, 2002, and a paid claims triangle from July 1, 2001, through July 31, 2002.

TDCI's analyses of these data files indicated that Xantus Healthplan of Tennessee and Universal Care of Tennessee were not in compliance with the statute. Premier Behavioral Health, Tennessee Behavioral Health, Better Health Plans, Memphis Managed Care Corporation, Preferred Health Partnership, Volunteer State Health Plan, OmniCare Health Plan, John Deere Health Plan and Victory Health Plans were in compliance.

For the two MCOs out of compliance with prompt pay requirements in July, TDCI requested claims payment data for August to assess whether the MCOs were back in compliance. For August, TDCI requested data files of all TennCare processed claims, TennCare pended claims and paid claims triangles from Xantus Healthplan of Tennessee and Universal Care of Tennessee. TDCI has not completed its follow-up analyses for Xantus and Universal.

For MCOs that were in compliance in July 2002, TDCI will request and analyze claims data files for October 2002.

Net worth requirement

TDCI is unable to determine excess or deficient net worth for TennCare HMOs at September 30, 2002, because third quarter 2002 NAIC financial statements will not be submitted until December 1, 2002.

Listed below is each MCO's net worth requirement compared to net worth reported at June 30, 2002, on the NAIC second quarterly statement. Universal Care of Tennessee, Memphis Managed Care and Xantus reported a net worth deficiency.

MCO/BHO	REPORTED NET WORTH	NET WORTH REQUIREMENT	Note	EXCESS/(DEFICIENT) NET WORTH
Better Health Plans	3,350,920	2,956,800	(1)	394,120
John Deere	75,854,594	12,377,685		63,476,909
Memphis Managed Care	4,624,917	7,201,830		-2,576,913
OmniCare	5,416,133	4,544,249		871,884
PHP	16,270,488	6,821,720		9,448,768
Premier Behavioral Health	2,265,149	6,918,195		4,653,046
TBH	11,652,307	5,514,875		6,137,432
Universal	5,637,208	6,522,000	(1) (2)	-884,792
VHP	6,506,350	1,816,510		4,689,840

MCO/BHO	REPORTED NET WORTH	NET WORTH REQUIREMENT	Note	EXCESS/(DEFICIENT) NET WORTH
Volunteer	54,991,616	16,673,233		38,318,383
Xantus	-77,237,383	7,998,884		-85,236,267

(1)These MCOs did not begin operations until July 1, 2001. The net worth requirement has been increased above the statutory minimum based on projected premium revenue.

(2)Universal has been placed under the Administrative Supervision of the Commissioner of Commerce and Insurance as a result of identified financial and claims processing operations problems. Further regulatory actions by TDCI are subject to the response of the Centers for Medicare and Medicaid Services and the TennCare Bureau to the request by Universal for additional funding. The collectibility of this receivable is pending resolution by the Centers for Medicare and Medicaid Services and the TennCare Bureau. If this receivable is deemed uncollectible, TDCI will adjust Universal's reported net worth from $5,637,208 to ($40,349,575).

Universal Care of Tennessee

During the third quarter, TDCI continued to work closely with Universal to identify and correct claims processing errors. The Administrative Supervisor and TDCI examiners are closely monitoring Universal's cash balances, including review and approval of disbursements prior to the release of checks for claims payments. TDCI and Universal have developed procedures to facilitate issuing claims payment checks weekly.

Providers in Universal's network are most concerned about payments for claims with dates of service prior to April 12, 2002. As mentioned above, the TennCare Bureau and the Centers for Medicare and Medicaid Services are currently working together to achieve a resolution of the funding issues surrounding these claims.

TDCI examiners were on site in August to verify Universal's cash position and amounts reported as claims payable. TDCI contracted consultants were on site in August to assess Universal's claims processing operations.

Memphis Managed Care

On June 12, 2002, TDCI received MMCC's revised plan of corrective action relative to its net worth deficiency as of March 31, 2002. Additionally, MMCC signed Amendment Number 1 to the Amended and Restated Contractor Risk Agreement which states that beginning May 1, 2002, MMCC will not be at risk for medical expenses incurred by its TennCare enrollees.

Because MMCC's underlying assumptions were reasonable, the TennCare Bureau and TDCI approved this plan of corrective action. At June 30, 2002, MMCC reported net worth of $4,624,917. Although the net worth deficiency has not been eliminated, this reported net worth is $3,894,997 in excess of the $729,920 net worth projected in the corrective action plan submitted by MMCC.

TDCI will continue to monitor closely MMCC's progress in eliminating its net worth deficiency.

Xantus Healthplan of Tennessee
Xantus continues to be on a "no-risk" reimbursement for reasonable cost in accordance with the contract amendment between Xantus and the TennCare program.

Success of Fraud Detection and Prevention

1. Program Integrity continues to work cases referred by MCO/BHO's, general public via Web site, faxes, letters, and phone calls via the hotline. Results of Case Reviewer/Investigators are listed below;

   A. Summary of Enrollee Cases :
      a. Cases closed 5,261
      b. Recommended Terminations 2,394
      d. Other Adjustments to Active Cases not Terminated
         1. Income Adjusted 99
         2. Health Ins. Added 159

   B. Summary Relating to Provider Cases:
      a. Cases closed 43
      b. Active Cases 56
      c. Cases referred to TBI (1) 21
      d. Cases referred to HRB's (2) 3
      e. Cases referred to FBI 1

      (1) TBI/MFCU takes the lead in cases once they are referred and Program Integrity continues to assist as requested.
      (2) Provider cases validated by PIU have resulted in the following actions during this quarter by the prosecutor;
         a. revocation of physician's license and $50,000 in civil penalties, and
         b. Indictment by US Attorney's Office of physician on multiple charges, including Medicaid fraud and drug diversion.

2. Overpayments recovered for Nursing Home Recipients - called PA68's. These overpayments are directly related to under reporting of recipient income and/or assets.
   For the Quarter Ending 9/30/02 $146,145

   Note: These collections resulted from joint efforts of TennCare Fiscal Service, DHS, and Program Integrity.

3. Continue to work with U.S. Attorney's Office, HHS-OIG, FBI, TBI, Commerce and Insurance, Health Related Boards, DEA and CIGNA in order to share information and help identify and prosecute Providers who violate the law.

4. Continuing to reach out to the District Attorneys across the state to solicit their help and support in prosecuting recipients who commit fraud against the TennCare Program. This outreach has been effective, as evidenced by an increase in referrals to PIU by various Drug Task Forces.

5. This unit provided training and/or updates to the following organizations during this quarter;
    a. District Attorney and staff located in the 11th Judicial District
    b. Middle Tennessee Fraud Task Force, which includes representatives from the FBI, TBI, HHS-OIG, IRS, US Postal Service, TVA, and United States Attorney's Office.
    c. Department of Health, Health Related Boards, Director of Investigations.

6. Estate Recovery Legislation was passed and went into effect on August 29, 2002, relating to Medicaid recipients who are 55 years of age or older and the program has paid for long term care. This program has been moved from the Long Term Care Unit to Program Integrity. Attorneys, executors, and/or responsible parties must now obtain a release from the state prior to the estate being probated. Program Integrity Unit is currently receiving between 40 and 50 release requests per work day.