TennCare Quarterly Report

Submitted to the Members of the General Assembly

October 15, 2013

Status of TennCare Reforms and Improvements

Co-Payment for Generic Medications ("Demonstration Amendment 19"). On April 26, 2013, the Bureau of TennCare submitted Demonstration Amendment 19 to the Centers for Medicare and Medicaid Services (CMS). Amendment 19 proposed a $1.50 co-payment for covered generic medications to be charged to those TennCare enrollees who now have a $3.00 co-pay on brand name drugs. This measure, which the General Assembly had incorporated into the State Budget for Fiscal Year 2014, was approved by CMS on July 16, 2013, for implementation on October 1, 2013.[1]

Notifications to TennCare Enrollees. On September 1, 2013, TennCare mailed the entire enrollee population[2] a notice informing them of their right to file an appeal when medical care is denied, delayed, or suspended. The notice, which is issued annually, identifies the circumstances under which appeals may be filed, the duties imposed on TennCare and its Managed Care Contractors (MCCs) when requests for medical care are made, and the timeframes within which appeals must be processed. To ensure the accessibility of the notice content to audiences with varying needs, a Spanish language version was printed on the reverse side, and an explanatory cover letter provided toll-free telephone numbers through which individuals with mental illness, hearing problems, or speech problems could seek assistance.

The summary of appeal rights was accompanied by other notices applicable to the recipient's age group. These supplements included:

- A statement for all enrollees of TennCare's revised privacy practices (which had been modified in accordance with stricter federal privacy laws that were to take effect on September 23, 2013);
- A notice to enrollee children under age 21 that their TennDent dental plan would be replaced by DentaQuest on October 1, 2013;

[1] TennCare submitted a corresponding amendment of Tennessee's Medicaid State Plan to CMS on September 11, 2013, and negotiations concerning the State Plan Amendment are underway.

[2] The notice was sent to all individuals enrolled in TennCare as of July 29, 2013, but not to Medicare beneficiaries who are ineligible for TennCare but receive cost-sharing and premium assistance from the program, or illegal/undocumented aliens whose emergency services are paid for by TennCare.

- Notification to enrollee children under age 21 that certain children enrolled in TennCare Standard would have a $1.50 co-pay on covered generic medications beginning on October 1, 2013; and
- A summary for enrollee adults age 21 and over of benefit changes that would take effect on October 1, 2013.

By enclosing these supplemental notices with the summary of appeal rights, the Bureau eliminated the costs and administrative burden associated with multiple mailings.

Transition from Disease Management to Population Health. On July 1, 2013, TennCare completed the transition from a "Disease Management" (DM) model of targeted health care interventions to a new model referred to as "Population Health" (PH). Whereas DM aimed to help enrollees prevent the worsening of chronic conditions that had already developed, PH is more proactive, addressing the needs of members along the entire health care continuum.

PH identifies risky behaviors likely to lead to disease in the future—poor eating habits, physical inactivity, tobacco or drug use—and assists enrollees in discontinuing such activities. The goal of this approach is to keep the healthy well and to improve the health of individuals who already have complex chronic conditions. Services delivered through PH vary according to the needs of the member and include:

- Health risk assessments;
- Preventive services reminders;
- Health coaching;
- Care coordination;
- A 24-hour-a-day / 7-day-a-week nurse line;
- Face-to-face visits (where appropriate);
- Prenatal packets for pregnant women; and
- Case management for women with high-risk pregnancies.

Implementation of PH began on January 1, 2013, when 263,989 DM members were removed from disease management categories and placed in one of two levels of health risk ("low/moderate" or "high", with "no identified risk" being added later in the year) and one of five intervention programs (Health Risk Management, Maternity, Care Coordination, Chronic Care Management, or Complex Case Management). By the completion of this process on July 1, 2013, 96 percent of the PH population with no identified risk or a low/moderate risk had been passively enrolled into appropriate programs, while the remaining 4 percent of high-risk members had been invited to participate in more intensive programs.

Request for Qualifications for Service Center. The Affordable Care Act redefined the manner in which eligibility for Medicaid and the Children's Health Insurance Program (CHIP) would be determined. In preparation for these changes, the State issued a Request for Qualifications (RFQ) for a Member Service Call Center on August 9, 2013.

The primary purpose of the call center—as defined in the "Scope of Services" portion of the RFQ document (available online at http://tn.gov/generalserv/cpo/sourcing_sub/documents/32101-13019.pdf)—is to assist callers who are "seeking and providing information regarding participation in TennCare and CHIP programs." Functions falling within this description include assistance with applications and eligibility redeterminations, collecting verifications and documents needed to demonstrate program eligibility, and providing an avenue through which eligibility appeals may be filed.[3] The call center is to begin operations on January 1, 2014, and will be available 12 hours a day (14 hours a day during certain open enrollment periods), 6 days a week.

The deadline for submission of a proposal to TennCare was September 16, 2013—and, as of the end of the July-September quarter—the successful bidder was to be revealed on October 2, 2013.

Incentives for Providers to Use Electronic Health Records. The Electronic Health Record (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, as its name suggests, is to provide financial incentives to Medicaid providers[4] 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 two types of payments:

- First-year payments to providers who adopted, implemented, or upgraded to certified EHR technology capable of meeting "meaningful use" (i.e., use that is measurable in both quantity and quality) standards; and
- Second-year payments to providers who earned first-year payments in Calendar Year 2011 or 2012 (or alternately demonstrated meaningful use in their first attestation) and who achieved meaningful use of EHR technology for any period of 90 consecutive days in Fiscal Year 2013 (for eligible hospitals) or Calendar Year 2013 (for eligible professionals).

First-year and second-year EHR payments made by TennCare during the July-September 2013 quarter as compared with payments made throughout the life of the program appear in the table below:

[3] The State retains the option to add aspects of the medical appeals process to the call center's responsibilities at a later point.

[4] 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).

Payment Type	Number of Providers Paid	Quarterly Amount Paid (July-Sept 2013)	Cumulative Amount Paid to Date
First-year payments	106 providers (43 physicians, 26 nurse practitioners, 32 dentists, 3 hospitals, 1 physician assistant, and 1 certified nurse midwife)	$4,950,092	$129,426,079
Second-year payments	61 providers (43 physicians, 14 nurse practitioners, 3 hospitals, and 1 physician assistant)	$1,909,044	$23,011,952

Outreach activities conducted during the quarter included:

- Posting of nine audio-enhanced PowerPoint presentations—four for Eligible Professionals, two for Eligible Hospitals, and three for both groups—on TennCare's dedicated EHR webpage at http://www.tn.gov/tenncare/ehr_page6.shtml[5];
- Monthly newsletters distributed by the Bureau's EHR ListServ; and
- A quarterly reminder issued through the Provider Incentive Payment Program ("PIPP") system to Tennessee providers who had registered at the federal level but who have not registered or attested at the state level.

Notable EHR-related events planned for the remainder of Calendar Year 2013 include six meetings between TennCare and the Tennessee Medical Association, a variety of meetings with tnREC (Tennessee's regional extension center for health information technology), and Bureau participation in the Tennessee Academy of Family Physicians Conference.

Quality Oversight Awards. As part of its joint meeting with the Bureau's Managed Care Contractors on September 11, 2013, TennCare's Division of Quality Oversight presented its third annual awards for "outstanding performance [by] contracted Managed Care Companies who showed a commitment to quality in various areas that are monitored by TennCare."

Nominations and awards were based on recommendations from TennCare's Quality Oversight staff, TennCare's Medical Director, and the MCCs themselves. While some honors—such as "2013 Highest Annual Quality Survey Score Award" and "2012 Highest NCQA-Ranked TennCare Health Plan Award"—recognized MCCs, others—like "Population Health Workgroup Award" and "CHOICES 'Above and Beyond' Award"—were bestowed on individual MCC staff members. The "Best All Around Award", which acknowledges exceptional performance across a broad spectrum of measures (including accuracy of reporting, integration of care, and adherence to TennCare guidance), was presented to BlueCare.

[5] Two additional PowerPoint presentations on TennCare's EHR webpage—entitled "Common Challenges to Achieving Stage 1 Meaningful Use" and "Timelines for 2011 Cohort"—had been posted prior to the July-September quarter.

New Pharmacy Leadership. On July 22, 2013, Dr. Rusty Hailey joined the TennCare program in the position of Chief Pharmacy Officer.

Dr. Hailey, who succeeds Bryan Leibowitz as head of the Pharmacy Division, earned a bachelor's degree in Pharmacy from the University of Mississippi (Oxford and Jackson, MS) and his Doctorate of Pharmacy from Rio Grande College of Pharmacy (Albuquerque, NM), as well as a Master of Business Administration degree from St. Joseph's University (Philadelphia, PA). He pursued his academic interests further by serving on the editorial advisory boards of peer-reviewed journals *Pharmacy & Therapeutics* and *Formulary*, as well as on advisory boards for the University of Mississippi's School of Pharmacy and Belmont University's College of Pharmacy.

Two aspects of Dr. Hailey's distinguished career will be especially useful in guiding TennCare's pharmacy program in the years ahead. First, his extensive leadership experience over a 20-year period—established in such roles as President of Pharmacy Operations and Senior Vice President of Cigna HealthSpring, Chief Pharmacy Officer and Senior Vice President of Coventry Health Care, and Executive Vice President of Coventry Pharmaceutical Management Services—qualifies Dr. Hailey to serve in the position of Pharmacy Director. Second, the managed care approach to health care that defines the TennCare program is very familiar to Dr. Hailey, who was both a Fellow and the President of the Academy of Managed Care Pharmacy, and who served as President of the Foundation of Managed Care Pharmacy.

Essential Access Hospital (EAH) Payments. The TennCare Bureau continued to make Essential Access Hospital payments during the July-September 2013 quarter. Essential Access Hospital payments are payments from a pool of $100 million ($34,220,000 in State dollars) appropriated by the General Assembly and funded by the Enhanced Coverage Fee.

The methodology for distributing these funds specifically considers each hospital's relative contribution to providing services to TennCare members, while also acknowledging differences in payer mix and hospitals' relative ability to make up TennCare losses. Data from the Hospital Joint Annual Report is used to determine hospitals' eligibility for these payments. Eligibility is determined each quarter based on each hospital's participation in TennCare. In order to receive a payment for the quarter, a hospital must be a contracted provider with TennCare Select and at least one other Managed Care Organization (MCO), and it must have contracted with TennCare Select for the entire quarter that the payment represents. Excluded from the Essential Access Hospital payments are Critical Access Hospitals, which receive cost-based reimbursement from the TennCare program and, therefore, do not have unreimbursed TennCare costs, and the four State mental health institutes.

The Essential Access Hospital payments made during the first quarter of State Fiscal Year 2014 for dates of service during the fourth quarter of State Fiscal Year 2013 are shown in the table below.

Essential Access Hospital Payments for the Quarter

Hospital Name	County	EAH First Quarter FY 2014
Regional Medical Center at Memphis	Shelby County	$3,498,038
Vanderbilt University Hospital	Davidson County	$3,262,097
Erlanger Medical Center	Hamilton County	$2,653,725
University of Tennessee Memorial Hospital	Knox County	$1,444,289
Johnson City Medical Center (with Woodridge)	Washington County	$954,982
Parkridge Medical Center (with Parkridge Valley)	Hamilton County	$733,344
LeBonheur Children's Medical Center	Shelby County	$732,329
Metro Nashville General Hospital	Davidson County	$686,869
Jackson – Madison County General Hospital	Madison County	$590,596
East Tennessee Children's Hospital	Knox County	$517,671
Methodist Healthcare – South	Shelby County	$466,418
Methodist Healthcare – Memphis Hospitals	Shelby County	$425,649
Saint Jude Children's Research Hospital	Shelby County	$351,847
Baptist Hospital	Davidson County	$314,078
Parkwest Medical Center (with Peninsula)	Knox County	$312,139
Physicians Regional Medical Center	Knox County	$292,475
University Medical Center (with McFarland)	Wilson County	$280,181
Pathways of Tennessee	Madison County	$270,713
Wellmont Holston Valley Medical Center	Sullivan County	$254,870
Saint Francis Hospital	Shelby County	$249,314
Centennial Medical Center	Davidson County	$242,912
Skyline Medical Center (with Madison Campus)	Davidson County	$237,797
Maury Regional Hospital	Maury County	$234,478
Ridgeview Psychiatric Hospital and Center	Anderson County	$229,287
Methodist Healthcare – North	Shelby County	$222,671
Middle Tennessee Medical Center	Rutherford County	$222,517
Fort Sanders Regional Medical Center	Knox County	$219,407
Delta Medical Center	Shelby County	$217,238
Cookeville Regional Medical Center	Putnam County	$183,838
Skyridge Medical Center	Bradley County	$178,717
Gateway Medical Center	Montgomery County	$176,105
Parkridge East Hospital	Hamilton County	$173,932
Wellmont Bristol Regional Medical Center	Sullivan County	$163,268
Blount Memorial Hospital	Blount County	$160,229
Baptist Memorial Hospital for Women	Shelby County	$143,622
Morristown – Hamblen Healthcare System	Hamblen County	$136,301
Baptist Memorial Hospital – Tipton	Tipton County	$132,539
Sumner Regional Medical Center	Sumner County	$124,081

Hospital Name	County	EAH First Quarter FY 2014
StoneCrest Medical Center	Rutherford County	$118,037
NorthCrest Medical Center	Robertson County	$114,729
Tennova Healthcare – Newport Medical Center	Cocke County	$110,710
Horizon Medical Center	Dickson County	$110,585
LeConte Medical Center	Sevier County	$109,840
Southern Hills Medical Center	Davidson County	$107,302
Summit Medical Center	Davidson County	$107,033
Tennova Healthcare – LaFollette Medical Center	Campbell County	$103,041
Methodist Medical Center of Oak Ridge	Anderson County	$100,604
Takoma Regional Hospital	Greene County	$92,046
Harton Regional Medical Center	Coffee County	$91,830
Sweetwater Hospital Association	Monroe County	$89,968
Henry County Medical Center	Henry County	$86,169
Baptist Memorial Hospital – Union City	Obion County	$85,339
Dyersburg Regional Medical Center	Dyer County	$83,857
Humboldt General Hospital	Gibson County	$77,962
Wellmont Hawkins County Memorial Hospital	Hawkins County	$77,377
United Regional Medical Center	Coffee County	$76,486
Lakeway Regional Hospital	Hamblen County	$75,474
Jellico Community Hospital	Campbell County	$74,678
Grandview Medical Center	Marion County	$73,041
Skyridge Medical Center – Westside	Bradley County	$72,495
Indian Path Medical Center	Sullivan County	$72,336
Athens Regional Medical Center	McMinn County	$71,119
Heritage Medical Center	Bedford County	$68,896
Regional Hospital of Jackson	Madison County	$65,759
Crockett Hospital	Lawrence County	$62,268
River Park Hospital	Warren County	$62,139
Lincoln Medical Center	Lincoln County	$60,038
Bolivar General Hospital	Hardeman County	$59,954
Southern Tennessee Medical Center	Franklin County	$59,095
Sycamore Shoals Hospital	Carter County	$58,928
Hardin Medical Center	Hardin County	$57,602
Livingston Regional Hospital	Overton County	$51,338
Wayne Medical Center	Wayne County	$50,466
Hillside Hospital	Giles County	$45,330
Roane Medical Center	Roane County	$43,291
Claiborne County Hospital	Claiborne County	$38,162
McKenzie Regional Hospital	Carroll County	$38,001
McNairy Regional Hospital	McNairy County	$34,412
Volunteer Community Hospital	Weakley County	$31,476
Jamestown Regional Medical Center	Fentress County	$30,885

Hospital Name	County	EAH First Quarter FY 2014
Gibson General Hospital	Gibson County	$28,863
Haywood Park Community Hospital	Haywood County	$28,841
Baptist Memorial Hospital – Huntingdon	Carroll County	$27,915
Henderson County Community Hospital	Henderson County	$23,819
Methodist Healthcare – Fayette	Fayette County	$23,225
DeKalb Community Hospital	DeKalb County	$21,431
Decatur County General Hospital	Decatur County	$20,672
White County Community Hospital	White County	$19,787
Emerald – Hodgson Hospital	Franklin County	$14,786
TOTAL		**$25,000,000**

Number of Recipients on TennCare and Costs to the State

At the end of the period July 1, 2013, through September 30, 2013, there were 1,191,593 Medicaid eligibles and 19,938 Demonstration eligibles enrolled in TennCare, for a total of 1,211,531 persons.

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

Spending Category	1st Quarter*
MCO services**	$879,325,700
Dental services	$38,736,800
Pharmacy services	$181,110,900
Medicare "clawback"***	$42,741,000

**These figures are cash basis as of September 30 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 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.	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[6] 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[7] are processed and paid within 21 calendar days of receipt.	TennCare contract

[6] 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.

[7] 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. 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 TennCare Contract (i.e., East, Middle, or West Grand Region) and by subcontractor (e.g., claims processed by a vision benefits manager). Furthermore, the MCOs are required to identify separately non-emergency transportation (NEMT) claims in the data files. Finally, the MCOs are required to submit separate claims data files representing a subset of electronically submitted 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 subcontractor, by TennCare contract, and by total claims processed for the month.

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

Net worth requirement. By statute, the minimum net worth requirement for each TennCare MCO is calculated based on premium revenue for the most recent calendar year, as well as any TennCare payments made to the MCO that are not reported as premium revenue.

During this quarter, the MCOs submitted their National Association of Insurance Commissioners (NAIC) Second Quarter 2013 Financial Statements. As of June 30, 2013, TennCare MCOs reported net worth as indicated in the table below.[8]

MCO	Net Worth Requirement	Reported Net Worth	Excess/ (Deficiency)
Amerigroup Tennessee	$17,323,202	$95,170,439	$77,847,237

[8] 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, for instance, operates a Medicare Advantage Plan in Middle Tennessee, while UnitedHealthcare has several lines of business in Illinois, Iowa, Virginia, and Tennessee. Volunteer State Health Plan, by contrast, conducts only TennCare business.

MCO	Net Worth Requirement	Reported Net Worth	Excess/ (Deficiency)
UnitedHealthcare Plan of the River Valley (UnitedHealthcare Community Plan)	$64,481,178	$466,783,297	$402,302,119
Volunteer State Health Plan (BlueCare & TennCare Select)	$35,639,453	$233,142,540	$197,503,087

All TennCare MCOs met their minimum net worth requirements as of June 30, 2013.

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 staff receives case information from a variety of sources, including local law enforcement, the TennCare Bureau, Health Related Boards (HRB), the Department of Human Services (DHS), other state agencies, health care providers, Managed Care Contractors (MCCs), and the general public via the OIG website, fax, written correspondence, and phone calls to the OIG hotline. The statistics for the first quarter of Fiscal Year 2014 are as follows:

Summary of Enrollee Cases

	Quarter	Grand Total to Date (since creation of OIG in July 2004)
Cases Received	2,587	153,320
Abuse Cases Received*	1,386	74,824

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

Court Fines & Costs Imposed

	Quarter	Grand Total to Date (since creation of OIG in July 2004)
Fines	$35,400	$749,405
Court Costs & Taxes	$7,728	$239,663
Court Ordered Restitution (Criminal Cases)	$75,641	$2,244,001
Drug Funds/Forfeitures	$1,924	$437,860

The OIG aggressively pursues enrollees who have apparently committed fraud or abuse against the TennCare program. The primary criminal case types are: prescription drug cases (drug diversion, drug seekers, doctor shopping, and forging prescriptions), child not in the home, reporting a false income,

access to other insurance when one is enrolled in an "uninsured" category, and ineligible individuals using a TennCare card.

Arrest Categories

Category	Quarter	Grand Total to Date (since creation of OIG in July 2004)
Drug Diversion/Forgery RX	6	544
Drug Diversion/Sale RX	16	757
Doctor Shopping	16	297
Access to Insurance	0	55
Operation FALCON III	0	32
Operation FALCON 2007	0	16
False Income	1	81
Ineligible Person Using Card	0	20
Living Out Of State	3	32
Asset Diversion	0	7
ID Theft	3	68
Aiding & Abetting	0	7
Failure to Appear in Court	1	4
Child Not in the Home	4	23
DEA Task Force	0	38
GRAND TOTAL	**50**	**1,981**

OIG Case Recoupment & Recommendations

	Quarter	Grand Total to Date (since February 2005)[9]
Non-Criminal Case Recoupment[10]	Currently unavailable	$2,442,894
Recommended TennCare Terminations [11]	100	50,012
Potential Savings[12]	$365,639	$176,021,518

[9] On February 15, 2005, a Fiscal Manager and an attorney joined the OIG staff to facilitate and document recoupment and recommended terminations.

[10] 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.

[11] 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.

[12] 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, $3,656.39).