TennCare Quarterly Report

Submitted to the Members of the General Assembly

October 2014

Status of TennCare Reforms and Improvements

Two proposed amendments to the TennCare Demonstration were under active negotiation during the quarter.

- **Demonstration Amendment 23: Benefits for Pregnant Women During a Period of Presumptive Eligibility.** On July 28, 2014, the Bureau of TennCare submitted Demonstration Amendment 23 to the Centers for Medicare and Medicaid Services (CMS). Amendment 23 deals with the benefits a pregnant woman may receive from TennCare during a period of "presumptive eligibility," which is a period of temporary eligibility granted to low-income pregnant women who would likely qualify for TennCare coverage but who have not yet completed an application.

  Federal regulations limit the Medicaid services that can be furnished to presumptively eligible pregnant women to ambulatory services only. TennCare has long taken the position that all Medicaid services—ambulatory as well as non-ambulatory—are "pregnancy-related services" and should be available to pregnant women to promote their health and the health of their unborn children. Amendment 23 was developed in concert with CMS as a way of resolving this issue and achieving the state's objectives. Most members of this population are "presumptives" for only a few short weeks before becoming fully TennCare eligible, when the issue of ambulatory versus non-ambulatory services becomes moot.

  On September 5, 2014, CMS issued written approval of Amendment 23. As of the end of the quarter, Bureau staff members were reviewing the updated waiver list, expenditure authorities, and Special Terms and Conditions that had accompanied CMS's approval letter to determine whether modifications were needed.

- **Demonstration Amendment 24: CHOICES Services.** On July 23, 2014, the Bureau notified the public of another proposal to be submitted to CMS.[1] Demonstration Amendment 24 would add

[1] In addition to the general public notice, TennCare sent a separate letter of notification about Amendment 24 to the Lieutenant Governor and Speaker of the Senate, the Speaker of the House of Representatives, and the other members of the Tennessee General Assembly on July 28, 2014.

two community-based residential alternative services to the menu of benefits covered by CHOICES, TennCare's program of long-term services and supports (LTSS) for individuals who are elderly or have physical disabilities. Both of the services in question—"community living supports" (CLS) and "community living supports-family model" (CLS-FM, an "adult foster care" arrangement)—are alternatives to Nursing Facility care: each provides access to services and supports in a small shared residential setting, allowing the individual to reside in the community. Delivery of CLS and CLS-FM would adhere to recently enacted federal regulations governing the provision of home and community-based services (HCBS) and HCBS settings.

The proposal is not projected to increase program expenditures, since coverage is conditioned on a determination that provision of CLS or CLS-FM would not cost more than provision of other forms of CHOICES HCBS that the person would otherwise receive.

***Wilson v. Gordon*.** On July 23, 2014, attorneys with the Tennessee Justice Center, the Southern Poverty Law Center, and the National Health Law Program filed a class action lawsuit in the U.S. District Court for the Middle District of Tennessee against TennCare, the Tennessee Department of Finance and Administration, and the Tennessee Department of Human Services. The suit alleges that applications for TennCare are not being resolved in a timely manner and that affected applicants are not being granted hearings regarding the delay in the resolution of their applications; that individuals are not afforded a method of submitting an application directly to TennCare; and that Tennessee has not implemented a system by which hospitals may enroll certain groups of people (such as pregnant women or children) who would likely meet eligibility criteria.

In response to the suit, attorneys representing the State pointed out that the Bureau had foreseen the problem and had obtained permission from the federal government to have most TennCare applications temporarily processed by the Federally Facilitated Marketplace (FFM) until the State's own eligibility determination system was operational. The fact that information from individual applications was in the possession of the FFM and had not been forwarded to the State meant that the State's ability to respond to appeals was severely limited.

On September 2, 2014, U.S. District Judge Todd Campbell issued two orders:

- A preliminary injunction ordering the State to provide hearings regarding the reasonableness of the delay to individuals whose applications have been pending longer than 45 days (or 90 days for applications based on disability); and
- A class certification order granting "class action" status to the case.

TennCare took immediate action to comply with the provisions of Judge Campbell's orders but also filed an appeal with the U.S. Court of Appeals for the Sixth Circuit in Cincinnati.

Managed Care Organization (MCO) Readiness. In December 2013, the Bureau announced that the three health plans already comprising TennCare's managed care network—Amerigroup, BlueCare, and

UnitedHealthcare—had submitted successful bids to deliver physical health services, behavioral health services, and LTSS in all three of Tennessee's grand regions beginning on January 1, 2015. During the July-September 2014 quarter, TennCare continued to coordinate with the MCOs to ensure a seamless transition to this statewide service delivery model. The efforts this quarter focused on preparations for the reassignment of approximately one-third of TennCare's members from one plan to another on January 1, 2015, and on April 1, 2015. Topics discussed have included transfer of enrollee data—such as treatment histories, claims histories, and impending surgery dates—that would accompany every reassignment. Furthermore, as the quarter concluded, TennCare finalized letters to certain members of the CHOICES population notifying them of their upcoming reassignment. Establishing contact with affected enrollees a full quarter ahead of the January 1, 2015, implementation date is expected not only to minimize transition difficulties but also to open lines of communication and build rapport between health plans and the individuals they serve. As part of the reassignment process, enrollees who are not satisfied with the new MCO to which they are transferred will have a temporary option to return to the MCO in which they were enrolled on December 31, 2014.

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 three 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 payments to providers who continue to demonstrate meaningful use.

EHR payments made by TennCare during the July-September 2014 quarter as compared with payments made throughout the life of the program appear in the table below:

[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).

Payment Type	Number of Providers Paid During the Quarter	Quarterly Amount Paid (Jul-Sept 2014)	Cumulative Amount Paid to Date
First-year payments	53[3]	$2,327,175	$143,843,049
Second-year payments	72	$1,298,282	$40,824,988
Third-year payments	34	$286,167	$4,394,134

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

- Participation throughout the quarter in five Southeast Regional Collaboration for HIT/HIE (SERCH) calls;
- Telephone assistance throughout the quarter for eligible professionals attesting to Meaningful Use (with particular emphasis on the EHR final rule that was to take effect on October 1, 2014);
- Attendance at the CMS Regional EHR Incentive Program Meeting on September 16 and 17;
- Responding to more than 500 inquiries submitted to the EHR Meaningful Use email box;
- 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.

A variety of events are already planned for the October-December 2014 quarter, including participation in six workshops hosted by the Tennessee Medical Association during the month of October.

Essential Access Hospital (EAH) Payments. The TennCare Bureau continued to make EAH payments during the April-June 2014 quarter. EAH payments are made from a pool of $100 million ($34,500,000 in State dollars) appropriated by the General Assembly and funded by the hospital assessment fee. The $100 million pool is currently being supplemented with an additional $81.3 million made available through CMS's approval of Demonstration Amendment 20. (Amendment 20 had expanded the EAH pool to address the fact that Tennessee was the only state in the country without a Disproportionate Share Hospital allotment specified in federal statute.) Of the $81.3 million in new funds, the Bureau elected to distribute $46,860,000 in the April-June 2014 quarter and $34,440,000 in the July-September 2014 quarter.

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

[3] Of the 53 providers receiving first-year payments in the July-September 2014 quarter, 10 earned their incentives by successfully attesting to meaningful use of EHR technology in their first year of participation in the program.

(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 first quarter of State Fiscal Year 2015 for dates of service during the fourth quarter of State Fiscal Year 2014 are shown in the table below.

Essential Access Hospital Payments for the Quarter

Hospital Name	County	EAH First Quarter FY 2015
Vanderbilt University Hospital	Davidson County	$7,769,796
Regional Medical Center at Memphis	Shelby County	$7,286,804
Erlanger Medical Center	Hamilton County	$6,210,875
University of Tennessee Memorial Hospital	Knox County	$3,555,026
Johnson City Medical Center (with Woodridge)	Washington County	$2,988,186
Metro Nashville General Hospital	Davidson County	$1,839,313
LeBonheur Children's Medical Center	Shelby County	$1,697,823
Parkridge Medical Center (with Parkridge Valley)	Hamilton County	$1,566,120
East Tennessee Children's Hospital	Knox County	$1,267,177
Jackson – Madison County General Hospital	Madison County	$1,265,262
Methodist Healthcare – South	Shelby County	$1,062,565
Methodist Healthcare – Memphis Hospitals	Shelby County	$989,834
Saint Jude Children's Research Hospital	Shelby County	$977,305
University Medical Center (with McFarland)	Wilson County	$933,049
Saint Thomas Midtown Hospital	Davidson County	$913,167
Centennial Medical Center	Davidson County	$689,776
Physicians Regional Medical Center	Knox County	$680,948
Methodist Healthcare – North	Shelby County	$657,538
Skyline Medical Center (with Madison Campus)	Davidson County	$637,578
Saint Francis Hospital	Shelby County	$591,377
Saint Thomas Rutherford Hospital	Rutherford County	$585,368
Parkwest Medical Center (with Peninsula)	Knox County	$574,966
Wellmont Holston Valley Medical Center	Sullivan County	$562,962
Pathways of Tennessee	Madison County	$554,536
Maury Regional Hospital	Maury County	$547,368
Fort Sanders Regional Medical Center	Knox County	$503,474
Ridgeview Psychiatric Hospital and Center	Anderson County	$486,162
Skyridge Medical Center	Bradley County	$455,225
Gateway Medical Center	Montgomery County	$415,084
Cookeville Regional Medical Center	Putnam County	$412,137

Hospital Name	County	EAH First Quarter FY 2015
Delta Medical Center	Shelby County	$401,875
Parkridge East Hospital	Hamilton County	$390,122
Methodist Hospital – Germantown	Shelby County	$386,738
Blount Memorial Hospital	Blount County	$362,410
Wellmont Bristol Regional Medical Center	Sullivan County	$357,504
Baptist Memorial Hospital for Women	Shelby County	$344,108
Haywood Park Community Hospital	Haywood County	$335,018
NorthCrest Medical Center	Robertson County	$317,557
Rolling Hills Hospital	Williamson County	$285,302
Southern Hills Medical Center	Davidson County	$279,568
LeConte Medical Center	Sevier County	$274,058
Horizon Medical Center	Dickson County	$272,181
Sumner Regional Medical Center	Sumner County	$266,032
Tennova Healthcare – Newport Medical Center	Cocke County	$257,013
Takoma Regional Hospital	Greene County	$243,963
Methodist Medical Center of Oak Ridge	Anderson County	$240,367
Heritage Medical Center	Bedford County	$239,747
Baptist Memorial Hospital – Tipton	Tipton County	$231,307
StoneCrest Medical Center	Rutherford County	$230,307
Summit Medical Center	Davidson County	$227,868
Tennova Healthcare – LaFollette Medical Center	Campbell County	$227,516
Dyersburg Regional Medical Center	Dyer County	$218,733
Morristown – Hamblen Healthcare System	Hamblen County	$217,208
Henry County Medical Center	Henry County	$211,381
Sweetwater Hospital Association	Monroe County	$180,534
Sycamore Shoals Hospital	Carter County	$178,240
Harton Regional Medical Center	Coffee County	$173,592
Grandview Medical Center	Marion County	$168,562
Indian Path Medical Center	Sullivan County	$167,366
Regional Hospital of Jackson	Madison County	$161,389
Baptist Memorial Hospital – Union City	Obion County	$155,305
Lakeway Regional Hospital	Hamblen County	$152,259
Jellico Community Hospital	Campbell County	$151,013
Wellmont Hawkins County Memorial Hospital	Hawkins County	$150,058
Hardin Medical Center	Hardin County	$138,535
Crockett Hospital	Lawrence County	$138,240
Athens Regional Medical Center	McMinn County	$136,247
River Park Hospital	Warren County	$134,496
Southern Tennessee Medical Center	Franklin County	$131,339
Livingston Regional Hospital	Overton County	$130,231
Tennova Healthcare – Jefferson Memorial Hospital	Jefferson County	$125,909

Hospital Name	County	EAH First Quarter FY 2015
Henderson County Community Hospital	Henderson County	$105,104
McNairy Regional Hospital	McNairy County	$101,208
Roane Medical Center	Roane County	$100,938
Skyridge Medical Center – Westside	Bradley County	$99,611
Bolivar General Hospital	Hardeman County	$88,236
McKenzie Regional Hospital	Carroll County	$87,785
Claiborne County Hospital	Claiborne County	$86,795
Hillside Hospital	Giles County	$85,579
Volunteer Community Hospital	Weakley County	$79,165
United Regional Medical Center	Coffee County	$76,738
Jamestown Regional Medical Center	Fentress County	$72,624
Wayne Medical Center	Wayne County	$67,791
Methodist Healthcare – Fayette	Fayette County	$67,450
Erlanger Health System – East Campus	Hamilton County	$65,571
DeKalb Community Hospital	DeKalb County	$61,700
Baptist Memorial Hospital – Huntingdon	Carroll County	$48,769
White County Community Hospital	White County	$40,230
Emerald Hodgson Hospital	Franklin County	$36,707
TOTAL		**$59,440,000**

Number of Recipients on TennCare and Costs to the State

During the month of September 2014, there were 1,291,280 Medicaid eligibles and 19,604 Demonstration eligibles enrolled in TennCare, for a total of 1,310,884 persons.

Estimates of TennCare spending for the first quarter of State Fiscal Year 2015 are summarized in the table below.

Spending Category	1st Quarter*
MCO services**	$1,121,320,800
Dental services	$28,711,100
Pharmacy services	$178,923,800
Medicare "clawback"***	$27,284,400

**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 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.	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. 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. 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 2014 Financial Statements. As of June 30, 2014, TennCare MCOs reported net worth as indicated in the table below.[6]

MCO	Net Worth Requirement	Reported Net Worth	Excess/ (Deficiency)
Amerigroup Tennessee	$17,550,992	$116,111,714	$98,560,722

[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)	$64,885,278	$517,337,683	$452,452,405
Volunteer State Health Plan (BlueCare & TennCare Select)	$34,942,038	$294,561,107	$259,619,069

All TennCare MCOs met their minimum net worth requirements as of June 30, 2014.

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 2015 are as follows:

TennCare Fraud & Abuse: Cases Received

	Quarter
TennCare Fraud Cases	1,343
TennCare Abuse Cases*	799

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

Criminal Court: Fines & Costs Imposed

	Quarter
Court Fines	$29,400
Court Costs & Taxes	$0
Court Ordered Restitution	$69,013
Drug Funds/Forfeitures	$805

The OIG aggressively pursues enrollees who have committed fraud or abuse against the TennCare program. The primary criminal case types are: prescription drug cases (illegal sale of prescription medication, drug seekers, doctor shopping, and forging prescriptions), gaining TennCare eligibility by claiming a child who does not actually live in the home, and ineligible individuals using TennCare recipients' benefits.

Arrest Totals

	Quarter	FY to Date
Individuals Arrested	54	54
Criminal Counts / Charges	209	209

OIG Case Recoupment & Civil Court Judgments

	Quarter
Consent Orders & Civil Judgments[7]	$106,411
Recoupments Received[8]	$123,867

Recommendations for Review

	Quarter
Recommended TennCare Terminations[9]	128
Potential Savings[10]	$468,017.92

During the July-September 2014 quarter, two OIG Special Agents collaborated with the Social Security Administration's Cooperative Disability Investigations (CDI) Unit. This Unit's mission 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 at the state and federal levels. The work of the CDI Unit supports the strategic goal of ensuring the integrity of Social Security programs with zero tolerance for fraud and abuse. This work ties in closely with OIG's mission of stopping TennCare fraud.

OIG/CDI Unit Statistics

	Quarter
Allegations Received	30
Cases Opened	27
Cases Closed	25
Claims Denied or Ceased	25
SSA Savings	$2,253,125

[7] 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.

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

[9] 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.

[10] 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).

	Quarter
Medicaid/Medicare Savings	$1,785,151
Total Savings	$4,038,276