TennCare Quarterly Report

Submitted to the Members of the General Assembly

October 2015

Status of TennCare Reforms and Improvements

Beneficiary Survey. Every year since 1993, the Center for Business and Economic Research (CBER) at the University of Tennessee in Knoxville has conducted a survey of Tennessee citizens—TennCare enrollees, individuals with private insurance, and uninsured individuals alike—to assess their opinions about health care. Respondents provide feedback on a range of topics, including demographics (age, household income, family size, etc.), perceptions of quality of care received, and behavior relevant to health care (the type of provider from whom an individual is most likely to seek initial care, the frequency with which care is sought, etc.).

CBER prepared a summary of the results of the most recent survey entitled "The Impact of TennCare: A Survey of Recipients 2015," and the Bureau of TennCare submitted the document to the Centers for Medicare and Medicaid Services (CMS) on September 22, 2015. Although the findings of a single survey must be viewed in context of long-term trends, several results from the report stand out:

- 95 percent of respondents covered by TennCare expressed satisfaction with the quality of care they had received. This level of satisfaction ties for the highest in the program's history and is the third time in five years that this peak has been attained. Furthermore, 2015 is the seventh straight year in which survey respondents have reported satisfaction levels exceeding 90 percent.
- The percentage of respondents classifying themselves as uninsured fell to 6.6 percent, the lowest level since 2004. Likewise, the percentage of respondents classifying their children as uninsured fell to 1.5 percent, the lowest level since the survey began in 1993.
- TennCare enrollees reported being able to get an appointment with a primary care physician more quickly in 2015. 42 percent of respondents stated that they were seen on the same day or the next day, as compared with 39 percent in 2014.

In summary, the report notes, "TennCare continues to receive positive feedback from its recipients, with 95 percent reporting satisfaction with the program, indicating TennCare is providing medical care in a satisfactory manner and up to the expectations of those it serves."

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

Demonstration Amendment 26: Expenditures for Hospital Pool Payments. Under the terms of the TennCare Demonstration, TennCare has the "expenditure authority" (specifically, "Expenditure Authority #4") to make certain payments to providers through "pools" that exist outside the managed care program. The recipients of funds from most of the pools are identified groups of Tennessee hospitals. The primary purpose of pool funds is to offset the costs of delivering uncompensated care, but they have some other purposes as well, such as providing support for graduate medical education programs. Currently, Expenditure Authority #4 is scheduled to expire on December 31, 2015, which is six months prior to the end date of TennCare's current approval period on June 30, 2016. Therefore, Amendment 26 requests that the expiration of Expenditure Authority #4 be synchronized with the conclusion of the approval period.

During the July-September 2015 quarter, the Bureau provided additional documentation in support of Amendment 26, including details of pool expenditures to be made during Fiscal Year 2016. As of the end of the reporting period, CMS was still reviewing the proposal.

Amendment 27: Employment and Community First CHOICES. As reported in TennCare's last Quarterly Report to the General Assembly, the Bureau submitted Demonstration Amendment 27—detailing a new program named *Employment and Community First (ECF) CHOICES*—to CMS on June 23, 2015. The text of Amendment 27, which remains available on TennCare's website at http://www.tn.gov/assets/entities/tenncare/attachments/Amendment27ECFCHOICES.pdf, provides the following concise summary of *ECF CHOICES*:

> With Amendment 27 to the TennCare demonstration, Tennessee proposes to implement within its existing managed care demonstration an integrated managed long-term services and supports (MLTSS) program that is specifically geared toward promoting and supporting integrated, competitive employment and independent, integrated community living as the first and preferred option for individuals with intellectual and developmental disabilities (I/DD).

Negotiations between TennCare and CMS during the July-September 2015 quarter focused on ensuring that CMS had all of the information necessary to approve Amendment 27. At the conclusion of the quarter, furthermore, the Bureau was nearing completion of a set of draft Special Terms and Conditions (STCs) for the TennCare Demonstration. These STCs define the manner in which ECF CHOICES would operate within TennCare's managed care system, thereby facilitating CMS's understanding and review of the proposal.

Amendment 28: Closure of Standard Spend Down Category. On August 28, 2015, the Bureau notified the public of another proposal to be submitted to CMS. Amendment 28 would close a TennCare eligibility category called "Standard Spend Down" (abbreviated as "SSD"), which provides coverage to

individuals who are not otherwise eligible for Medicaid but 1) are aged, blind, disabled, or the caretaker relative of a Medicaid-eligible child and 2) have enough unreimbursed medical bills to allow them to "spend down" to a low threshold. The size of the SSD population is approximately 800 individuals, and enrollment in the category has been closed since 2013. TennCare anticipates that many SSD enrollees are eligible for health coverage through either Medicare or the Health Insurance Marketplace established by the Affordable Care Act.

Upon CMS's approval, TennCare would review members of the SSD population for eligibility in all open categories of TennCare coverage. Any individual found to qualify in another category would be automatically transferred with no interruption in coverage. Individuals who do not qualify in another category would be disenrolled from TennCare and referred to Medicare and/or the Health Insurance Marketplace. Additional details about Amendment 28 are available in the August 28 notification letter to members of the General Assembly.

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[1] to replace outdated, often paper-based approaches to medical record-keeping with electronic systems that meet rigorous certification criteria and that can improve health care delivery and quality. The federal government provides 100 percent of the funding for the incentive payments and 90 percent of the administrative costs.

Currently, Medicaid providers may qualify for the following types of payments:

- First-year payments to providers (eligible hospitals or practitioners) who either—
    - Adopt, implement, or upgrade to certified EHR technology capable of meeting "meaningful use" in accordance with CMS standards, or
    - Achieve meaningful use of certified EHR technology for any period of 90 consecutive days;
- Second-year payments to providers who have received first-year payments and who achieved meaningful use for a subsequent period of 90 consecutive days;
- Third-year and fourth-year payments to providers who continue to demonstrate meaningful use.

EHR payments made by TennCare during the July-September 2015 quarter as compared with payments made throughout the life of the program appear in the table below:

[1] 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 2015)	Cumulative Amount Paid to Date
First-year payments	61[2]	$1,690,954	$155,767,688
Second-year payments	106	$847,400	$49,557,395
Third-year payments	147	$4,306,589	$16,911,038
Fourth-year payments	31	$263,500	$1,368,505

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

- Hosting 19 technical assistance calls during the quarter for eligible professionals attesting to meaningful use;
- Responding to more than 250 inquiries submitted to the EHR Meaningful Use email box;
- Hiring of a Clinical Educator to assist with Meaningful Use training activities;
- Participation throughout the quarter in several Southeast Regional Collaboration for HIT/HIE (SERCH) calls;
- Two email notices to providers reminding them to complete any remaining Meaningful Use attestations for payment year 2014;
- Monthly newsletters distributed by the Bureau's EHR ListServ; and
- A quarterly reminder to Tennessee providers who had registered at the federal level but who have not registered or attested at the state level.

TennCare continues to schedule EHR workshops with a variety of provider organizations to maintain the momentum of the program. Events planned for October 2015, for instance, include participation in Tennessee Medical Association meetings throughout the state, as well as attendance at the 67th Annual Scientific Assembly of the Tennessee Academy of Family Physicians.

Award for Chief Information Officer (CIO). On September 2, 2015, the *Nashville Business Journal* announced the winners of the periodical's 2015 CIO Awards. The awards are presented annually to "the top technological executives in Middle Tennessee who are using IT in innovative ways to create a competitive advantage, optimize business procedures, enable company growth and impact the company's bottom line." TennCare CIO Kyle Duke was one of three individuals in the category of "Institution/Nonprofit" to be honored and is scheduled to receive the award at a ceremony hosted by the *Nashville Business Journal* on October 23, 2015.

Mr. Duke joined TennCare's Executive Staff in April 2014 after serving as Vice President of IT and Chief Information Security Officer for Cigna-HealthSpring. He oversees all aspects of the Bureau's information technology systems management.

[2] Of the 61 providers receiving first-year payments in the July-September 2015 quarter, 13 earned their incentives by successfully attesting to meaningful use of EHR technology in their first year of participation in the program.

Essential Access Hospital (EAH) Payments. The TennCare Bureau continued to make EAH payments during the July-September 2015 quarter. EAH payments are made from a pool of $100 million ($34,965,000 in State dollars) appropriated by the General Assembly and funded by the hospital assessment fee.

The methodology for distributing these funds, as outlined in Special Term and Condition 55.e. of the TennCare Demonstration Agreement with CMS, specifically considers each hospital's relative contribution to providing services to TennCare members, while also acknowledging differences in payer mix and hospitals' relative ability to make up TennCare losses. Data from the Hospital Joint Annual Report is used to determine hospitals' eligibility for these payments. Eligibility is determined each quarter based on each hospital's participation in TennCare. In order to receive a payment for the quarter, a hospital must be a contracted provider with TennCare Select and at least one other Managed Care Organization (MCO), and it must have contracted with TennCare Select for the entire quarter that the payment represents. Excluded from the Essential Access Hospital payments are Critical Access Hospitals, which receive cost-based reimbursement from the TennCare program and, therefore, are not included, and the four State mental health institutes.

The Essential Access Hospital payments made during the first quarter of State Fiscal Year 2016 for dates of service during the fourth quarter of State Fiscal Year 2015 are shown in the table below.

Essential Access Hospital Payments for the Quarter

Hospital Name	County	EAH First Quarter FY 2016
Regional Medical Center at Memphis	Shelby County	$3,363,349
Vanderbilt University Hospital	Davidson County	$3,180,780
Erlanger Medical Center	Hamilton County	$2,696,914
University of Tennessee Memorial Hospital	Knox County	$1,447,794
Johnson City Medical Center (with Woodridge)	Washington County	$1,211,056
LeBonheur Children's Medical Center	Shelby County	$711,392
Parkridge Medical Center (with Parkridge Valley)	Hamilton County	$687,107
Metro Nashville General Hospital	Davidson County	$600,107
Jackson – Madison County General Hospital	Madison County	$545,989
East Tennessee Children's Hospital	Knox County	$538,608
Methodist Healthcare – Memphis Hospitals	Shelby County	$513,251
Methodist Healthcare – South	Shelby County	$492,794
Saint Jude Children's Research Hospital	Shelby County	$419,265
University Medical Center (with McFarland)	Wilson County	$387,016
Saint Thomas Midtown Hospital	Davidson County	$355,365
TriStar Skyline Medical Center (with Madison Campus)	Davidson County	$338,317
Wellmont – Holston Valley Medical Center	Sullivan County	$305,257
Fort Sanders Regional Medical Center	Knox County	$296,455

Hospital Name	County	EAH First Quarter FY 2016
TriStar Centennial Medical Center	Davidson County	$272,334
Methodist Healthcare – North	Shelby County	$253,515
Saint Francis Hospital	Shelby County	$246,090
Parkridge East Hospital	Hamilton County	$230,380
Maury Regional Hospital	Maury County	$229,567
Parkwest Medical Center (with Peninsula)	Knox County	$224,024
Saint Thomas Rutherford Hospital	Rutherford County	$224,005
Pathways of Tennessee	Madison County	$216,560
Wellmont – Bristol Regional Medical Center	Sullivan County	$210,797
Cookeville Regional Medical Center	Putnam County	$194,327
Ridgeview Psychiatric Hospital and Center	Anderson County	$193,264
Tennova Healthcare – Physicians Regional Medical Center	Knox County	$190,954
Methodist Hospital – Germantown	Shelby County	$174,174
Baptist Memorial Hospital for Women	Shelby County	$152,380
Skyridge Medical Center	Bradley County	$141,730
Blount Memorial Hospital	Blount County	$133,267
Gateway Medical Center	Montgomery County	$131,614
TriStar Horizon Medical Center	Dickson County	$129,597
TriStar StoneCrest Medical Center	Rutherford County	$121,469
TriStar Summit Medical Center	Davidson County	$120,204
NorthCrest Medical Center	Robertson County	$119,942
Delta Medical Center	Shelby County	$119,130
Dyersburg Regional Medical Center	Dyer County	$116,196
LeConte Medical Center	Sevier County	$114,409
Morristown – Hamblen Healthcare System	Hamblen County	$113,004
Southern Hills Medical Center	Davidson County	$111,621
Heritage Medical Center	Bedford County	$108,978
Sumner Regional Medical Center	Sumner County	$103,952
Takoma Regional Hospital	Greene County	$98,037
Tennova Healthcare – Newport Medical Center	Cocke County	$93,368
Sweetwater Hospital Association	Monroe County	$92,145
Laughlin Memorial Hospital	Greene County	$91,668
Rolling Hills Hospital	Williamson County	$90,176
Methodist Medical Center of Oak Ridge	Anderson County	$88,520
TriStar Hendersonville Medical Center	Sumner County	$83,467
Harton Regional Medical Center	Coffee County	$82,291
Henry County Medical Center	Henry County	$81,381
Tennova Healthcare – LaFollette Medical Center	Campbell County	$79,628
Grandview Medical Center	Marion County	$78,057
Sycamore Shoals Hospital	Carter County	$76,607

Hospital Name	County	EAH First Quarter FY 2016
Skyridge Medical Center – Westside	Bradley County	$75,330
Regional Hospital of Jackson	Madison County	$73,669
Baptist Memorial Hospital – Union City	Obion County	$71,741
Lakeway Regional Hospital	Hamblen County	$71,284
Indian Path Medical Center	Sullivan County	$63,276
Wellmont Hawkins County Memorial Hospital	Hawkins County	$60,539
Jellico Community Hospital	Campbell County	$60,499
Hardin Medical Center	Hardin County	$59,340
McNairy Regional Hospital	McNairy County	$58,415
Starr Regional Medical Center – Athens	McMinn County	$57,720
River Park Hospital	Warren County	$54,740
Henderson County Community Hospital	Henderson County	$47,135
Roane Medical Center	Roane County	$43,852
United Regional Medical Center	Coffee County	$41,844
Hillside Hospital	Giles County	$40,161
Crockett Hospital	Lawrence County	$39,964
Livingston Regional Hospital	Overton County	$37,405
McKenzie Regional Hospital	Carroll County	$35,705
Volunteer Community Hospital	Weakley County	$33,487
Bolivar General Hospital	Hardeman County	$31,106
Wayne Medical Center	Wayne County	$30,142
Erlanger Health System – East Campus	Hamilton County	$27,364
Baptist Memorial Hospital – Huntingdon	Carroll County	$27,220
DeKalb Community Hospital	DeKalb County	$24,286
Emerald Hodgson Hospital	Franklin County	$10,131
TOTAL		**$25,000,000**

Number of Recipients on TennCare and Costs to the State

During the month of September 2015, there were 1,442,312 Medicaid eligibles and 18,925 Demonstration eligibles enrolled in TennCare, for a total of 1,461,237 persons.

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

Spending Category	1st Quarter*
MCO services**	$1,928,220,200
Dental services	$34,911,400
Pharmacy services	$231,801,400
Medicare "clawback"***	$44,147,100

**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[3] 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[4] are processed and paid within 21 calendar days of receipt.	TennCare contract

[3] 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.

[4] 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 claims processor (e.g., MCO, vision benefits manager, etc.). Furthermore, the MCOs are required to identify separately non-emergency transportation (NEMT) claims in the data files. Finally, the MCOs are required to submit separate claims data files representing a subset of electronically submitted Nursing Facility and applicable Home and Community Based Services claims for CHOICES enrollees. TDCI then performs an analysis and reports the results of the prompt pay analyses by NEMT and CHOICES claim types, by claims processor, and by total claims processed for the month.

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

Net worth and company action level requirements. According to Tennessee's "Health Maintenance Organization Act of 1986" statute (T.C.A. § 56-32-101 *et seq.*), the minimum net worth requirement for each TennCare MCO is calculated based on premium revenue for the most recent calendar year, as well as any TennCare payments made to the MCO that are not reported as premium revenue.

During the July-September 2015 quarter, the MCOs submitted their National Association of Insurance Commissioners (NAIC) Second Quarter 2015 Financial Statements. As of June 30, 2015, TennCare MCOs reported net worth as indicated in the table below.[5]

MCO	Net Worth Requirement	Reported Net Worth	Excess/ (Deficiency)
Amerigroup Tennessee	$18,895,648	$157,867,945	$138,972,297

[5] 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)	$67,602,074	$413,132,143	$345,530,069
Volunteer State Health Plan (BlueCare & TennCare Select)	$37,185,058	$359,764,211	$322,579,153

During the July-September 2015 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 June 30, 2015:

MCO	Company Action Level	Reported Net Worth	Excess/ (Deficiency)
Amerigroup Tennessee	$61,407,788	$157,867,945	$96,460,157
UnitedHealthcare Plan of the River Valley (UnitedHealthcare Community Plan)	$244,098,654	$413,132,143	$169,033,489
Volunteer State Health Plan (BlueCare & TennCare Select)	$109,546,612	$359,764,211	$250,217,599

All TennCare MCOs met their minimum net worth requirements and Company Action Level requirements as of June 30, 2015.

Success of Fraud Detection and Prevention

The mission of the Tennessee Office of Inspector General (OIG) is: *To identify, investigate, and prosecute persons who commit fraud or abuse against the TennCare program and to recoup money owed to the State of Tennessee.* The OIG 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. Selected statistics for the first quarter of Fiscal Year 2016 are as follows:

TennCare Fraud & Abuse: Cases Received

	Quarter
Fraud Allegations	1,402
Abuse Allegations*	760

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

Arrests, Convictions, and Judicial Diversion*

	Quarter	FY 16 to Date
Arrests	70	70
Convictions	31	31
Instances of Judicial Diversion	13	13

** Cases adjudicated during a particular fiscal year may have no relationship to arrests during the same year.*

Criminal Court: Fines & Costs Imposed

	Quarter
Court Costs & Taxes	$5,269
Fines	$10,650
Drug Funds/Forfeitures	$1,018
Criminal Restitution Ordered	$198,245
Criminal Restitution Received[6]	$41,612

Civil Restitution & Civil Court Judgments

	Quarter
Civil Restitution Ordered[7]	$36,054
Civil Restitution Received[8]	$14,353

Recommendations for Review

	Quarter
Recommended TennCare Terminations[9]	161

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

[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. In reviewing these recommendations, TennCare must factor in some limitations, such as the inability to disenroll individuals in certain federally protected categories.

	Quarter
Potential Savings[10]	$588,679

Collaboration with CDI

During the July-September 2015 quarter, two OIG Special Agents partnered with the Cooperative Disability Investigations (CDI) Unit of the Social Security Administration (SSA). The mission of this unit is to combat fraud by investigating questionable statements and activities of claimants, medical providers, interpreters, or other service providers who facilitate or promote disability fraud. The OIG Special Agents will review information from the SSA to determine whether TennCare fraud or abuse may have occurred and, when warranted, to open an investigation.

Statewide Communication

In an effort to stay connected with local law enforcement and achieve the OIG's mission, Special Agents continue to meet in person with sheriffs and police chiefs throughout the state. These meetings further collaborative relationships and aid the mutual goal of stopping TennCare fraud and prescription drug diversion.

[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).