# TennCare Quarterly Report

# July – September 2016

# Submitted to the Members of the General Assembly

## Status of TennCare Reforms and Improvements

**Employment and Community First CHOICES.** Designed in partnership with people with intellectual and developmental disabilities, their families, advocates, and other stakeholders, Employment and Community First (ECF) CHOICES is the first managed long-term services and supports program in the nation that is focused on promoting and supporting integrated, competitive employment and independent community living as the first and preferred option for people with intellectual and other types of developmental disabilities.

The need for ECF CHOICES arose from a variety of challenges impacting the service delivery system for individuals with intellectual and developmental disabilities, including the disproportionately high cost in Tennessee of providing Home and Community-Based Services (HCBS) to individuals with intellectual disabilities; a substantial waiting list for such services; a lack of HCBS options for individuals with developmental disabilities but not intellectual disabilities; and a significant gap between the number of people with intellectual disabilities who want to work and those who are actually working.

ECF CHOICES was designed to address these issues in a number of ways. ECF CHOICES offers three different benefit packages:

- Essential Family Supports for families caring for a loved one with an intellectual or developmental disability;
- Essential Supports for Employment and Independent Living for adults with an intellectual or developmental disability who are transitioning out of school or who need support to achieve employment and independent living goals; and
- Comprehensive Supports for Employment and Community Living for adults with an intellectual or developmental disability who have more intense needs and require more comprehensive supports to achieve their employment and community living goals.

This tiered benefit structure, which is based on the needs of people supported and their families, with appropriate cost caps and expenditure controls, helped the Bureau of TennCare begin serving people

with intellectual disabilities in Tennessee more cost-effectively, allowing more Tennesseans who need these services to receive them. This includes people with intellectual disabilities on a waiting list for services and people with other kinds of developmental disabilities. In addition, the unique array of employment services and supports in ECF CHOICES helps to create a pathway to employment, even for individuals with significant disabilities, resulting in improved employment, better health and quality of life outcomes, and reduced reliance on public benefits. An employment-informed choice process further helps to ensure that people do not dismiss employment as a real option because they lack complete information and a vision of how employment could be possible for them.

After intensive preparations by TennCare (including working extensively with stakeholders, securing federal approval, building provider networks, amending managed care contracts, and making systems changes), the Tennessee General Assembly approved funding to serve up to 1,700 people in the first year of the program. ECF CHOICES went live on July 1, 2016, and—by the conclusion of the July-September quarter—had successfully enrolled 251 individuals. TennCare monitored the rollout of the program carefully and determined that provider networks were more than adequate, thereby ensuring that enrollees received ECF CHOICES benefits in a timely and appropriate manner.

Additional details about ECF CHOICES, including instructions for individuals interested in enrolling in the program, are available on the TennCare website at http://www.tn.gov/tenncare/topic/employment-and-community-first-choices.

**Beneficiary Survey.** Every year since 1993, the Boyd Center for Business and Economic Research (BCBER) 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.).

BCBER prepared a summary of the results of the most recent survey titled "The Impact of TennCare: A Survey of Recipients, 2016," and the Bureau submitted the document to the Centers for Medicare and Medicaid Services (CMS) on September 29, 2016. Although the findings of a single survey must be viewed in context of long-term trends, several results from the report are notable:

- Satisfaction with TennCare remains high. 92 percent of respondents covered by TennCare expressed satisfaction with the quality of care they had received, making 2016 the eighth straight year in which survey respondents have reported satisfaction levels exceeding 90 percent.
- More Tennesseans have health insurance. The percentage of respondents classifying themselves as uninsured fell to 5.5 percent, the lowest level in the 24-year history of the survey. When considered in terms of age, the reported uninsured rate is 6.6 percent for individuals who are age 18 or older, and 1.8 percent for individuals under age 18.

- TennCare families rarely sought initial medical care at hospitals. 96 percent of heads of households with TennCare reported seeking initial medical care for themselves at a doctor's office or clinic, and 98 percent reported doing so for their children. Furthermore, only 3 percent of heads of households with TennCare reported seeking initial medical care for themselves at hospitals, and only 2 percent reported doing so for their children.

The report concludes with this assessment: "TennCare continues to receive positive feedback from its recipients, with 92 percent reporting satisfaction with the program, indicating TennCare is providing medical care in a satisfactory manner and meeting the expectations of those it serves."

**Application to Renew the TennCare Demonstration.** On December 22, 2015, the Bureau submitted to CMS an application to renew the TennCare Demonstration. The application requested that the approval period for the Demonstration—which was scheduled to end on June 30, 2016—be extended through June 30, 2021.

Although the State's renewal request had not sought any substantive changes to the TennCare Demonstration, CMS identified a number of topics it wished to discuss. As detailed in TennCare's previous Quarterly Report to the General Assembly, negotiations between the State and CMS on these topics were productive, but the parties agreed to a temporary extension of the Demonstration through August 31, 2016, in an attempt to reach agreement on certain issues that had not been resolved.

Throughout the July-September 2016 quarter, the focal points of discussion were—

- Supplemental pool payments to Tennessee hospitals;
- The methodology by which "budget neutrality" (i.e., not spending more under the TennCare Demonstration than would have been spent in its absence) is calculated;
- The process by which enrollee cost-sharing is tracked;
- Evaluation of the TennCare Demonstration; and
- The period of time enrollees have to transfer from one TennCare health plan to another without having to show cause.

While the parties came closer to agreement on some of these issues, CMS granted two additional temporary extensions of the Demonstration during the reporting period: one through September 30, 2016 (an online copy of which is located on TennCare's website at http://www.tn.gov/assets/entities/tenncare/attachments/TennCareIITemporaryExtensionLetter.pdf), and one through October 31, 2016 (a copy of which is available at http://www.tn.gov/assets/entities/tenncare/attachments/TennCaretemporaryExtension.pdf). The additional time afforded by these extensions was used not only to continue work on the issues identified above, but also to develop and refine drafts of the Waiver List, Expenditure Authorities, and Special Terms and Conditions that would govern the TennCare Demonstration through June 30, 2021.

**Payment Reform.** Tennessee's Health Care Innovation Initiative was launched by Governor Haslam in 2013 to change the way that health care is paid for in the State. The desired direction is to move from paying for volume to paying for value by rewarding health care providers for high-quality and efficient treatment of medical conditions, and to help in maintaining people's health over time.

The Tennessee Health Care Innovation Initiative is co-located with TennCare in the Tennessee Division of Health Care Finance and Administration (HCFA). Although its goals transcend Medicaid, there is much emphasis on Medicaid and TennCare as playing a pivotal role in meeting the Initiative's goals. All of TennCare's providers are included in the Initiative.

One strategy being used to reform health care payment approaches is episodes of care. Episodes of care focuses on health care delivered in acute health care events, such as a surgical procedure or an inpatient hospitalization. Episodes encompass care delivered by multiple providers in relation to a specific health care event. Each episode has a principal accountable provider (or "quarterback") who is in the best position to influence the cost and quality of the episode. Episodes of care are implemented in groups or—in the terminology of the program—"waves." The fifth and sixth waves are expected to be implemented in the spring of 2017.

Stakeholder input from Tennessee providers, payers, patients, and employers is central to the design of episodes of care and the other value-based payment strategies that are part of Tennessee's Health Care Innovation Initiative. For each episode, the Initiative organizes Technical Advisory Groups (TAGs) composed of experts in the field to provide clinical feedback on each episode's design. Episode TAG meetings are held in the spring and fall. The fall 2016 TAG meetings began on September 6 but had not concluded by the end of the July-September quarter.

Annual Feedback Sessions are another opportunity for stakeholders to provide input on existing episodes of care. On July 19, 2016, HCFA staff hosted an event in which providers from across Tennessee convened to discuss strengths and areas of opportunity in the design of episodes in Wave 1 (perinatal, total joint replacement (hip and knee), and asthma acute exacerbation) and Wave 2 (chronic obstructive pulmonary disease acute exacerbation; screening and surveillance colonoscopy; outpatient and non-acute inpatient cholecystectomy; acute percutaneous coronary intervention (PCI), and non-acute PCI). The meetings were held simultaneously in six cities across Tennessee (Chattanooga, Jackson, Johnson City, Knoxville, Nashville, and Memphis) and were connected via videoconference to facilitate public participation. An appendix to this report contains comments gathered from stakeholders during the Annual Feedback Sessions, as well as HCFA's responses to the comments.

**Tennessee Eligibility Determination System.** Tennessee Eligibility Determination System (or "TEDS") is the name of the system that will be used by the State to process applications and identify persons who are eligible for TennCare and CoverKids.

Instead of consolidating all aspects of the project under one vendor, the Bureau opted to procure three separate contracts to address the following functions:

- Technical advisory services;
- Strategic Program Management Office (SPMO) services; and
- Systems integration services.

By the end of Calendar Year 2015, two of the three contracts had been awarded and implemented. KPMG, LLP successfully bid on the technical advisory services contract, which went into effect on September 1, 2015. The contract for SPMO services was awarded to Public Consulting Group, Inc. and took effect on November 1, 2015.

During the July-September 2016 quarter, the State announced that the third and final contract for systems integration services—which contained a start date of October 1, 2016—had been awarded to Deloitte Consulting, LLP. Deloitte's primary responsibility will be to design, develop, implement, maintain, and operate a rules-based Medicaid eligibility determination system. The system in question will perform a variety of vital eligibility functions for the TennCare program, including—but not limited to—making eligibility determinations and redeterminations automatically; receiving application data; interfacing with federal data sources (such as the Federally Facilitated Marketplace and the Internal Revenue Service); and mailing notices and letters to enrollees.

As the July-September 2016 quarter came to a close, TennCare and Deloitte were planning a series of sessions to define in detail the requirements for the eligibility determination system, to be followed by sessions concerning the design of the system.

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

Two separate courts have heard arguments in the case. One is the U.S. District Court for the Middle District of Tennessee, where Plaintiffs originally filed suit in July 2014. The District Court granted class action status to the case and issued a preliminary injunction requiring the State to provide an opportunity for a fair hearing on any delayed adjudications of applications for TennCare coverage. TennCare took immediate action to comply with these rulings but also filed an appeal of the preliminary injunction with a second court, the U.S. Court of Appeals for the Sixth Circuit in Cincinnati.

As recounted in TennCare's previous Quarterly Report to the General Assembly, a three-judge panel for the Sixth Circuit affirmed the District Court's decision to issue a preliminary injunction.[1] The State, in

[1] The decision was not unanimous. Judge Jeffrey S. Sutton's dissenting opinion held that the injunction action was moot, noting, "The plaintiffs asked and now have received. Because the plaintiffs received all of their requested injunctive relief before class certification, the case is moot." A copy of the panel's ruling, which includes both the majority opinion and Judge Sutton's dissenting opinion, is available at http://www.opn.ca6.uscourts.gov/opinions.pdf/16a0127p-06.pdf.

turn, filed a petition for rehearing en banc, which—if granted—would have allowed the State's appeal to be heard by all of the Sixth Circuit judges instead of by a small panel. On August 1, 2016, however, the petition was denied.

With the State's appeal and petition to the Sixth Circuit having both been adjudicated, activity related to the *Wilson* suit resumed in District Court. On September 16, 2016, the State filed a Motion to Decertify the Class and Dismiss the Case. The basis of the motion was that processes used by TennCare and CMS for Medicaid applications and application appeals in Tennessee had evolved substantially. As a result of this evolution, the Motion contends, there are no remaining members in the Plaintiff class originally certified by the District Court, and any eligibility issues arising in 2016 are completely different from the issues that originally prompted the *Wilson* suit. The District Court has reserved ruling on this motion pending the completion of accelerated discovery in advance of a bench trial in this case that is currently scheduled for March 28, 2017.

**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 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, fourth-year, and fifth-year payments to providers who continue to demonstrate meaningful use.

Eligible practitioners who successfully attest may receive incentive payments in up to six program years. With CMS approval, TennCare chose to divide the full amount of incentive payments available to eligible hospitals among three program years. Eligible hospitals must continue to attest annually beyond the three years of payments in order to avoid Medicare payment adjustments.

[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).

EHR payments made by TennCare during the July-September 2016 quarter as compared with payments made throughout the life of the program appear in the table below:

| Payment Type | Number of Providers Paid During the Quarter | Quarterly Amount Paid (Jul-Sept 2016) | Cumulative Amount Paid to Date |
|---|---|---|---|
| First-year payments | 99[3] | $1,688,202 | $169,101,850 |
| Second-year payments | 184 | $1,306,173 | $54,618,770 |
| Third-year payments | 148 | $1,829,702 | $27,114,793 |
| Fourth-year payments | 120 | $1,008,668 | $3,524,675 |
| Fifth-year payments | 39 | $331,500 | $952,000 |

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

- Acceptance of Incentive Year 2016 meaningful use attestations based on Modified Stage 2 measures;
- Holding 48 technical assistance calls;
- Responding to 401 emails received in the EHR meaningful use mailbox;
- Attendance at CMS's 2016 Medicaid HITECH Multi-Regional Conference, held in Chicago, IL, in July;
- Participation throughout the quarter in several Southeast Regional Collaboration for HIT/HIE (SERCH) calls;
- Monthly newsletters and occasional alerts 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. In addition, preparations were made to participate in upcoming statewide meetings of the Tennessee Medical Association and in regional workshops hosted by Amerigroup and UnitedHealthcare Community Plan. The Bureau is also making every effort to alert eligible professionals and eligible hospitals that 2016 is the last year in which they may enroll in the EHR program and begin attesting (as specified by the HITECH Act).

**Essential Access Hospital (EAH) Payments.** The TennCare Bureau continued to make EAH payments during the July-September 2016 quarter. EAH payments are made from a pool of $100 million ($35,017,500 in State dollars) appropriated by the General Assembly and funded by the hospital assessment fee.

[3] Of the 99 providers receiving first-year payments in the July-September 2016 quarter, 14 earned their incentives by successfully attesting to meaningful use of EHR technology in their first year of participation in the program.

The methodology for distributing these funds, as outlined in Special Term and Condition 56.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 2017 (for dates of service during the fourth quarter of State Fiscal Year 2016) are shown in the table below.

**Essential Access Hospital Payments for the Quarter**

| Hospital Name | County | EAH First Quarter FY 2017 |
|---|---|---|
| Regional Medical Center at Memphis | Shelby County | $3,494,251 |
| Vanderbilt University Hospital | Davidson County | $3,333,176 |
| Erlanger Medical Center | Hamilton County | $2,561,577 |
| University of Tennessee Memorial Hospital | Knox County | $1,457,096 |
| Johnson City Medical Center (with Woodridge) | Washington County | $1,093,472 |
| Parkridge Medical Center (with Parkridge Valley) | Hamilton County | $729,107 |
| LeBonheur Children's Medical Center | Shelby County | $715,194 |
| Jackson – Madison County General Hospital | Madison County | $602,242 |
| Metro Nashville General Hospital | Davidson County | $560,428 |
| Methodist Healthcare – Memphis Hospitals | Shelby County | $555,588 |
| East Tennessee Children's Hospital | Knox County | $534,806 |
| Saint Jude Children's Research Hospital | Shelby County | $438,124 |
| Methodist Healthcare – South | Shelby County | $426,599 |
| Parkwest Medical Center (with Peninsula) | Knox County | $330,909 |
| Methodist Healthcare – North | Shelby County | $324,234 |
| TriStar Centennial Medical Center | Davidson County | $313,309 |
| TriStar Skyline Medical Center (with Madison Campus) | Davidson County | $304,078 |
| Wellmont – Holston Valley Medical Center | Sullivan County | $292,606 |
| University Medical Center (with McFarland) | Wilson County | $259,217 |
| Parkridge East Hospital | Hamilton County | $256,159 |
| Saint Francis Hospital | Shelby County | $254,498 |
| Saint Thomas Rutherford Hospital | Rutherford County | $253,968 |
| Lincoln Medical Center | Lincoln County | $253,163 |
| Saint Thomas Midtown Hospital | Davidson County | $237,817 |
| Maury Regional Hospital | Maury County | $223,490 |

| Hospital Name | County | EAH First Quarter FY 2017 |
|---|---|---|
| Baptist Memorial Hospital for Women | Shelby County | $217,435 |
| Wellmont – Bristol Regional Medical Center | Sullivan County | $209,781 |
| Cookeville Regional Medical Center | Putnam County | $202,054 |
| Fort Sanders Regional Medical Center | Knox County | $194,981 |
| Pathways of Tennessee | Madison County | $191,254 |
| Ridgeview Psychiatric Hospital and Center | Anderson County | $184,156 |
| Tennova Healthcare – Physicians Regional Medical Center | Knox County | $167,303 |
| Blount Memorial Hospital | Blount County | $145,419 |
| Delta Medical Center | Shelby County | $143,130 |
| TriStar Summit Medical Center | Davidson County | $137,967 |
| TriStar StoneCrest Medical Center | Rutherford County | $130,135 |
| Skyridge Medical Center | Bradley County | $124,857 |
| Rolling Hills Hospital | Williamson County | $124,590 |
| Southern Hills Medical Center | Davidson County | $122,256 |
| NorthCrest Medical Center | Robertson County | $121,430 |
| Gateway Medical Center | Montgomery County | $120,272 |
| TriStar Horizon Medical Center | Dickson County | $118,667 |
| Sumner Regional Medical Center | Sumner County | $114,427 |
| Morristown – Hamblen Healthcare System | Hamblen County | $110,964 |
| Dyersburg Regional Medical Center | Dyer County | $104,409 |
| Baptist Memorial Hospital – Tipton | Tipton County | $93,985 |
| Methodist Medical Center of Oak Ridge | Anderson County | $88,880 |
| TriStar Hendersonville Medical Center | Sumner County | $88,704 |
| Jellico Community Hospital | Campbell County | $87,778 |
| LeConte Medical Center | Sevier County | $86,761 |
| Harton Regional Medical Center | Coffee County | $82,620 |
| Takoma Regional Hospital | Greene County | $81,937 |
| Tennova Healthcare – LaFollette Medical Center | Campbell County | $78,339 |
| Grandview Medical Center | Marion County | $76,610 |
| Skyridge Medical Center – Westside | Bradley County | $73,373 |
| Southern Tennessee Regional Health System – Winchester | Franklin County | $66,150 |
| United Regional Medical Center and Medical Center of Manchester | Coffee County | $63,751 |
| Sycamore Shoals Hospital | Carter County | $63,324 |
| Indian Path Medical Center | Sullivan County | $62,689 |
| Lakeway Regional Hospital | Hamblen County | $61,442 |
| Roane Medical Center | Roane County | $59,496 |
| Laughlin Memorial Hospital | Greene County | $59,113 |
| Starr Regional Medical Center – Athens | McMinn County | $58,202 |
| Regional Hospital of Jackson | Madison County | $58,171 |
| Hardin Medical Center | Hardin County | $57,270 |
| Crockett Hospital | Lawrence County | $54,963 |

| Hospital Name | County | EAH First Quarter FY 2017 |
|---|---|---|
| Henry County Medical Center | Henry County | $54,825 |
| Stones River Hospital | Cannon County | $53,052 |
| Wellmont Hawkins County Memorial Hospital | Hawkins County | $51,926 |
| Saint Thomas River Park Hospital | Warren County | $48,970 |
| Jamestown Regional Medical Center | Fentress County | $46,424 |
| Hillside Hospital | Giles County | $44,795 |
| Livingston Regional Hospital | Overton County | $43,773 |
| Heritage Medical Center | Bedford County | $43,256 |
| Baptist Memorial Hospital – Union City | Obion County | $42,804 |
| Claiborne County Hospital | Claiborne County | $39,164 |
| McKenzie Regional Hospital | Carroll County | $35,157 |
| Erlanger Health System – East Campus | Hamilton County | $31,398 |
| Henderson County Community Hospital | Henderson County | $28,677 |
| Volunteer Community Hospital | Weakley County | $27,285 |
| Wayne Medical Center | Wayne County | $25,683 |
| DeKalb Community Hospital | DeKalb County | $21,991 |
| McNairy Regional Hospital | McNairy County | $21,465 |
| Decatur County General Hospital | Decatur County | $18,210 |
| Baptist Memorial Hospital – Huntingdon | Carroll County | $17,330 |
| Southern Tennessee Regional Health System – Sewanee | Franklin County | $9,662 |
| **TOTAL** | | **$25,000,000** |

## Number of Recipients on TennCare and Costs to the State

During the month of September 2016, there were 1,525,590 Medicaid eligibles and 26,275 Demonstration eligibles enrolled in TennCare, for a total of 1,551,865 persons.

Estimates of TennCare spending for the first quarter of State Fiscal Year 2017 are summarized in the table below.

| Spending Category | First Quarter FY 2017* |
|---|---|
| MCO services** | $1,897,391,400 |
| Dental services | $35,771,400 |
| Pharmacy services | $231,431,300 |
| Medicare "clawback"*** | $51,948,200 |

**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 Managed Care Contractors (MCCs) in the TennCare Program

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

| Entity | Standard | Authority |
|---|---|---|
| MCOs (services other than CHOICES and ECF CHOICES) | 90% of clean claims for payment for services delivered to TennCare enrollees are processed and, if appropriate, paid within 30 calendar days of the receipt of such claims.<br><br>99.5% of all provider claims are processed, and, if appropriate, paid within 60 calendar days of receipt. | TennCare contract and in accordance with T.C.A. § 56-32-126(b) |
| MCOs (CHOICES and ECF CHOICES services) | 90% of clean electronically submitted Nursing Facility and applicable Home and Community Based Services claims[4] are processed and paid within 14 calendar days of receipt.<br><br>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 |
|---|---|---|
| Dental Benefits Manager (DBM) | 90% of clean claims for payment for services delivered to TennCare enrollees are processed, and, if appropriate, paid within 30 calendar days of the receipt of such claims.<br><br>99.5% of all provider claims are processed, and, if appropriate, paid within 60 calendar days of receipt. | TennCare contract and in accordance with T.C.A. § 56-32-126(b) |
| Pharmacy Benefits Manager (PBM) | 100% of all clean claims submitted by pharmacy providers are paid within 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 and ECF CHOICES enrollees. TDCI then performs an analysis and reports the results of the prompt pay analyses by NEMT and CHOICES and ECF CHOICES claim types, by claims processor, and by total claims processed for the month.

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

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

During the July-September 2016 quarter, the MCOs submitted their NAIC Second Quarter 2016 Financial Statements. As of June 30, 2016, TennCare MCOs reported net worth as indicated in the table below.[6]

| MCO | Net Worth Requirement | Reported Net Worth | Excess/ (Deficiency) |
|---|---|---|---|
| Amerigroup Tennessee | $29,016,782 | $157,116,550 | $128,099,768 |

[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.

| MCO | Net Worth Requirement | Reported Net Worth | Excess/ (Deficiency) |
|---|---|---|---|
| UnitedHealthcare Plan of the River Valley (UnitedHealthcare Community Plan) | $55,361,026 | $392,773,791 | $337,412,765 |
| Volunteer State Health Plan (BlueCare & TennCare Select) | $43,251,806 | $368,793,374 | $325,541,568 |

During the July-September 2016 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, 2016:

| MCO | Company Action Level | Reported Net Worth | Excess/ (Deficiency) |
|---|---|---|---|
| Amerigroup Tennessee | $104,759,436 | $157,116,550 | $48,625,939 |
| UnitedHealthcare Plan of the River Valley (UnitedHealthcare Community Plan) | $189,545,450 | $392,773,791 | $203,228,341 |
| Volunteer State Health Plan (BlueCare & TennCare Select) | $133,523,082 | $368,793,374 | $235,270,292 |

All TennCare MCOs met their minimum net worth requirements and Company Action Level requirements as of June 30, 2016.

## 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 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, MCCs, and the general public via the OIG website, fax, written correspondence, and phone calls to the OIG hotline. Cases adjudicated during a particular fiscal year may have no relationship to dates of arrest during the same year. Selected statistics for the first quarter of Fiscal Year 2017 are as follows:

| Fraud and Abuse Complaints | First Quarter FY 2017 |
|---|---|
| Fraud Allegations | 1,211 |
| Abuse Allegations* | 913 |
| **Arrest/Conviction/Judicial Diversion Totals** | **First Quarter FY 2017** |
| Arrests | 69 |
| Convictions | 43 |
| Judicial Diversions | 11 |

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

| Criminal Court Fines and Costs Imposed | First Quarter FY 2017 |
|---|---|
| Court Costs & Taxes | $1,786 |
| Fines | $30,100 |
| Drug Funds/Forfeitures | $765 |
| Criminal Restitution Ordered | $137,699 |
| Criminal Restitution Received[7] | $39,233 |
| **Civil Restitution/Civil Court Judgments** | **First Quarter FY 2017** |
| Civil Restitution Ordered[8] | $1,760 |
| Civil Restitution Received[9] | $10,667 |

| Recommendations for Review | First Quarter FY 2017 |
|---|---|
| Recommended TennCare Terminations[10] | 205 |
| Potential Savings[11] | $749,560 |

## 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.

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

[8] 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.

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

[10] 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.

[11] Potential savings are determined by multiplying the number of enrollees whose coverage would be terminated, assuming all of the State's criteria for termination are met, by the average annual cost per enrollee for MCO, pharmacy, and dental services (currently estimated by TennCare to be $3,656.39).

# Appendix

# Annual Feedback Session: Recommendations for Episodes of Care in Waves 1 and 2

Division of Health Care Finance & Administration

# MEMO

**Date: October 2016**

**Subject: Update on the Tennessee Health Care Innovation Initiative**

This memo discusses the feedback received during the episodes of care feedback session meetings held on July 19, 2016, and changes to episodes as a result of the feedback received. The meetings were an opportunity for members of the public from across Tennessee to comment on what is working well and areas for improvement in the design of episodes in Wave 1 (perinatal, total joint replacement, and asthma exacerbation) and Wave 2 (chronic obstructive pulmonary disease (COPD) acute exacerbation, colonoscopy, cholecystectomy, acute percutaneous coronary intervention (PCI), and non-acute PCI). The meetings were held simultaneously in six cities across Tennessee (Chattanooga, Jackson, Johnson City, Knoxville, Nashville, and Memphis) and connected via videoconference to make it easier for the public to participate. Members of the public were also able to submit their feedback by email. The State, and our insurance carrier partners have reviewed this feedback, and plan to incorporate these changes into the design of these episodes of care that are used for TennCare beginning in calendar year 2017. Commercial and Medicare Advantage carriers may also choose to implement these changes but there may be differences in the clinical design of commercial episodes.

Stakeholder input from Tennessee providers, payers, patients, and employers has shaped the design of episodes of care and the other value-based payment strategies that make up Tennessee's Health Care Innovation Initiative. The Initiative has held 859 meetings with stakeholders to date and continues to regularly seek stakeholder input. In the Episodes of Care strategy, the design of each episode is informed by a Technical Advisory Group (TAG) composed of expert clinicians representing a diversity of relevant specialties, provider types, and urban and rural practices from across Tennessee. A similar episodes feedback session was held in the summer of 2015 as well.

For more information about episodes of care in Tennessee in general, go to http://tn.gov/hcfa/section/strategic-planning-and-innovation-group.

**Wave 1 Episodes**

*Asthma Acute Exacerbation episode of care:*

Comment: Expand the definition of the appropriate medications quality metric to include oral and/or injectable corticosteroids filled during the trigger window in the hospital setting (e.g. Emergency Department, Observation and/or inpatient stay) and the post-trigger window rather than just in the post-trigger window.
Response: Guidelines for medication use during an acute asthma exacerbation now recommend giving early systematic glucocorticoids (e.g. prednisone, prednisolone, methylprednisolone, beclomethasone, betamethasone, dexamethasone, hydrocortisone and triamcinolone) to all patients who have a moderate or severe exacerbation. These medications are often prescribed in the hospital setting and therefore should be included in the quality metric for appropriate medications. The appropriate medications will be included in the quality metric during both the trigger and post-trigger window.

*Perinatal episode of care:*

Comment: Exclude patients who had a previous C-Section from the quality metric.
Response: The NQF-endorsed measure for C-sections excludes previous C-section, but the measure is not based on claims data. The State is interested in including a non-claims-based measure in future years, and is procuring a vendor to facilitate the collection of non-claims-based measures. For calendar year 2017, that vendor will not be in place, and so the C-section measure will continue to include patients who have had a previous C-section. Since the quality metric for C-section rate is set at 41.0%, there is room for providers to meet the quality metric and perform C-sections when necessary.

Comment: Exclude patients who deliver prior to 35 weeks from the Group B streptococcus screening quality metric or update the Group B streptococcus screening quality metric to capture births that occurred before 35 weeks.
Response: Patients who deliver earlier than 35 weeks are less likely to receive a Group B streptococcus screening, which may impact the outcome of the quality metric. Currently, there is no data available to show the gestational age of the baby at time of delivery. In future years, it may be possible to link the mother's and baby's claims data. The quality metric threshold for Group B streptococcus screening is set at 85.0% to give providers room to meet the quality metric even if the screening cannot be performed under certain circumstances, such as a premature birth. For these reasons, the logic for the Group B streptococcus screening quality metric will not change for calendar year 2017.

Comment: Exclude episodes from screening quality measures if the patient changes Managed Care Organizations (MCOs) during the episode window.
Response: Stakeholders were concerned that prenatal care such as screenings delivered prior to the MCO switch were not included in the claims and would negatively impact the Quarterback's quality metrics. Each of the quality measures has room for providers who are providing group B step screenings and HIV screenings but have some patients for whom the associated claims data is not available. The thresholds for each of those two quality measures are 85 percent, so if a provider has patients who change MCOs in 15 percent of the episodes, the provider would still pass the quality measure. Patients who switched MCOs during the episode window will continue to be included as valid episodes.

Comment: Remove the inconsistent enrollment business exclusion that excludes episodes with gaps in coverage totaling more than 45 days during the episode window.
Response: The inconsistent enrollment business exclusion for the perinatal episode states that an episode is excluded if there are gaps in coverage totaling more than 45 days during the episode window. To create a fair policy, TennCare will remove the 45 day gap in coverage exclusion starting in 2017.

*Total Joint Replacement episode of care:*

Comment: Exclude codes not directly related to the hip and knee replacement from the episode spend in the post-trigger window.
Response: The Total Joint Replacement (TJR) episode is designed to capture the care provided to a patient after discharge from the hospital following the procedure. While some complications not directly related to the knee and hip are important to include within the post-trigger window, ICD-10[12] codes relating to "Diseases of the musculoskeletal system and connective tissue" and "Congenital anomalies" that affect the spine and upper extremities (i.e. above the hip and pelvis) will no longer be included in the episode spend in the post-trigger window.

**Wave 2 Episodes**

*Cholecystectomy episode of care:*

Comment: Exclude episodes with chronic pancreatitis in the trigger window.
Response: The cholecystectomy episode is intended as a non-emergent cholecystectomy episode and to capture non-acute cholecystectomy procedures. Since patients with acute pancreatitis may undergo an emergent cholecystectomy, patients with acute pancreatitis are excluded from the cholecystectomy episode. However, the cholecystectomy episode is still capturing some patients with chronic pancreatitis that have an acute exacerbation and, as a result, undergo an emergent cholecystectomy procedure. To ensure a comparable patient population and to reflect the original intent of the episode definition as much as possible, patients with chronic pancreatitis during the trigger window will now also be excluded from the cholecystectomy episode. Patients with chronic pancreatitis are identified as a diagnosis code for chronic pancreatitis on either an inpatient, outpatient or a profession claim during the trigger window of the cholecystectomy episode.

Comment: Exclude episodes that penalize providers for care that happens outside of the Quarterback's influence, especially when care is geographically remote from the provider.
Response: The cholecystectomy episode attempts to capture the span of care

[12] ICD-10 is the International Classification of Diseases, Tenth Edition.

provided to a patient that is related to the cholecystectomy procedure. While services not related to the cholecystectomy are not included in spend, in some cases services delivered by another provider will be included in the episode if they are related. The accountable "Quarterback" provider will be rewarded for influencing the other providers of services related to the cholecystectomy, whether it be through conversations with the patient or other providers. The goal of the program is to encourage coordination of care between the Quarterback, the patient, and other providers that could be involved in caring for a patient undergoing a cholecystectomy. Therefore, all care related to the cholecystectomy will remain in the episode.

Comment: Exclude Emergency Department (ED) visits from the pre-trigger window.
Response: The pre-trigger window of procedural episodes is meant to capture preoperative work-up and care related to the upcoming procedure, and therefore ED visits before the procedure are not included. The State will maintain the current pre-trigger window spend inclusion rules, which do not include ED visits.

Comment: Concern around influencing cost of care before a patient's first visit with the provider.
Response: The pre-trigger window of procedural episodes is important in capturing preoperative work-up and care related to the procedure. Using targeted inclusion prevents holding providers accountable for care that is unrelated to the procedure. It is possible for cholecystectomy-related services from a provider who is not the Quarterback to be included in the episode. One goal of the Episodes of Care program is to encourage coordination and communication among the different providers involved in a patient's care, and in part to encourage the Quarterback to coordinate with providers who may be interacting with patients before their first visit with the Quarterback.

*Screening and surveillance colonoscopy episode of care:*

Comment: Exclude diagnostic colonoscopies from the colonoscopy episode.
Response: As a result of input from the colonoscopy TAG, diagnostic colonoscopies are not included in the screening and surveillance colonoscopy episode. The

current codes and logic used to identify colonoscopies are specific to screening and surveillance colonoscopies.

Comment: Revise post-polypectomy/biopsy bleeding quality metric so providers are not discouraged to remove large polyps.
Response: This quality metric is implemented as an informational quality metric recognizing that there may be multiple drivers of variation, such as patient variation. Thus, this quality metric is not tied to gain-sharing and does not affect payment. Additionally, this quality metric was incorporated based on feedback from the TAG. Therefore, the current quality metric will remain as an information-only measure.

Comment: Track repeat colonoscopies that happen outside of the episode window to monitor patients receiving inappropriate second procedures.
Response: The colonoscopy episode has a quality metric that tracks repeat colonoscopies occurring both within and outside the episode spend window. While the post-trigger window for tracking spend in the colonoscopy episode is only 14 days, the quality metric tracks colonoscopies in the 60-day window following the triggering colonoscopy. The current quality measure is therefore responsive to the comment and will remain the same.

Comment: Since the Qualified Clinical Data Registry (QCDR) only measures if a bowel preparation was performed, include an additional quality metric for inadequate bowel preparation in order to hold providers accountable.
Response: QCDR has a metric for adequacy of bowel preparation. In addition to the QCDR metric, providers are also being held accountable for poor bowel preparation through the repeat colonoscopy quality metric and inclusion of colonoscopy procedure spend in the 14 days following the triggering colonoscopy. Since providers are being held accountable for poor bowel preparation through QCDR, quality metrics, and spend, an additional quality metric will not be added.

Comment: Shorten pre-trigger window from one month to two weeks, and lengthen the post-trigger window from two weeks to one month.
Response: Our current design was based on the advice of our colonoscopy TAG. Accountability in the pre-trigger window for the colonoscopy episode is limited to

office visits, relevant imaging and testing, and relevant medications. In the post-trigger window, accountability is limited to specific complications, anesthesia, imaging and testing, medications, procedures, and office visits. In data presented to the TAG, these services generally occurred within one month pre-trigger and two weeks post-trigger. Therefore, the current pre-trigger and post-trigger window lengths will remain.

Comment: Shorten the 60-day post-trigger window.
Response: The colonoscopy episode has a single 14-day post-trigger window for spend inclusion. The 60-day window does not include any spend, but is used solely to capture repeat colonoscopies for the repeat colonoscopy quality metric.

Comment: Concern around holding providers accountable for high facility costs.
Response: The cost of facility services is one of several sources of variation and sources of value within episodes, alongside professional services, imaging services, laboratory services, post-acute services, and others. In the past, there has been no reward for providers who engage with their facilities on efforts to improve quality and reduce costs of the overall care associated with a procedure. Facility cost will remain a key component of the total cost of the episodes in which it is relevant, including colonoscopy.

Comment: Do not hold providers accountable for concurrent procedures (e.g. esophagogastroduodenoscopy (EGD) and colonoscopy).
Response: Based on the current spend inclusion, providers are not being held accountable for unrelated concurrent procedures. Although concurrent procedures may occasionally occur, concurrent procedures that are not screening and surveillance colonoscopies are not included within the colonoscopy episode. Spend inclusion rules are intended to only capture care that is related to a screening and surveillance colonoscopy.

Comment: Exclude Emergency Department (ED) visits in the post-trigger window.
Response: While all ED visits are not included in the episode, relevant ED visits are included within the episode post-trigger window. Relevant ED visits are included with the intent of capturing colonoscopy complications that result in an ED visit and encouraging necessary post-procedure follow-ups that may prevent ED visits. The

goal of the program is to encourage appropriate provider involvement and care coordination in a patient's care, before, during, and after the procedure.

Comment: Only include medications that are prescribed by the Quarterback.
Response: To ensure that providers are appropriately being held accountable for care related to the colonoscopy, only medications associated with the colonoscopy procedure are included in spend. Since medications related to the colonoscopy may not always be prescribed by the Quarterback, it is important to include medications regardless of the prescribing physician.

**All Episodes**

During the July 19th meeting, some stakeholders recommended changes that would apply to all episodes. This section describes those comments.

Comment: Episodes of Care program should be modeled after the Centers for Medicare and Medicaid Services (CMS) Physician Quality Reporting System (PQRS).
Response: During the formation of the Episodes of Care program, the Initiative strived to incorporate lessons learned from the best practices of various payment innovation programs around the country. For example, the post-trigger window lengths of several hospital-based episodes reflect those used in the CMS Bundled Payments for Care Improvement (BPCI) program. In addition to modeling after the CMS BPCI program, the Initiative also references the CMS PQRS program in determining the quality measures to be incorporated into the Episodes of Care program. While the CMS PQRS program only addresses quality, the Episodes of Care program addresses both quality and cost. By sourcing best practices from each program, the Episodes of Care program is able to take a more holistic approach for payment innovation and targeting improvements in healthcare. The State will continue to follow this type of approach in the future design of the Episodes of Care program.

Comment: Increase transparency around the types of services being included in the care categories shown in reports.
Response: Providers can learn which types of services are included in the care categories using the care category definitions in the glossary of the Detailed

Business Requirements, which are available on the Initiative's website (http://tn.gov/hcfa/section/strategic-planning-and-innovation-group). For each reporting care category, the glossary offers definitional information on the bill form, bill type, place of service, and revenue codes. By offering patient level data by category instead of specific codes, the reports provide actionable information without overwhelming providers or releasing confidential negotiated rates.

Comment: Update providers if a finalized payment reform appeals process has been finalized with BlueCross BlueShield and Amerigroup.
Response: The appeals process for TennCare MCOs has two levels. The first step is with the MCO, and the second step is with the Tennessee Department of Commerce and Insurance (TDCI). In the case that providers would like to dispute or appeal an episode report, the providers should contact the appropriate MCO. In the case the MCOs are unable to address the provider's complaint regarding the episode value-based payments, then providers' next step in the appeals process is with TDCI. Providers should contact MCOs to resolve disputes regarding episodes as they occur during the quarterly reporting periods. Providers can contact MCOs at the following phone numbers:

Amerigroup: 615-232-2160;
BCBST: 800-924-7141 (Option 4)
United: 615-372-3509

Comment: Limited access may negatively impact providers if facility is high-cost.
Response: Facility cost is one of several sources of variation and sources of value within episodes. Providers may improve their performance through a variety of methods, and the method chosen by any given provider will depend on the particular nature of that provider's practice and performance. Providers may choose to engage with facilities on ways to improve efficiency and quality. Providers may also improve on other aspects of the episode, such as professional services, imaging services, laboratory services, post-acute services, and many others.

Comment: Include cost of each line item in the provider claim level detail reports to help providers identify line items for appeal.

Response: The reports that providers receive include patient-level detail with costs broken into categories. The reports balance containing enough actionable information so that providers know what areas they should look at to improve versus displaying other providers' negotiated rates, which are often confidential.

Comment: Incorporate a more comprehensive set of risk factors by extending the risk factor look-back period.

Response: To ensure a robust risk adjustment model that captures relevant conditions, risk factors have customized time frames, during which potential risk factors are flagged. The longest look-back period is usually a year. While the length of the look-back does not always capture the entirety of a patient's comorbidities, the intent is to balance extending the look-back to capture the most comprehensive set of factors, and the timing of the risk factors to ensure statistical significance as a driver of cost of care being provided. For the next calendar year, the look-back periods will remain the same.

Comment: Difference in MCO risk adjustment methods should be accounted for.

Response: There is no off-the-shelf risk adjustment tool available for episodes, and so insurance carriers have created different formulas, although all have the same general approach. Also, inherent differences between MCOs necessitate some difference between risk adjustment specifics to ensure fairness. For example, the various MCOs have different reimbursement policies, which then impact the risk factors that may be flagged as significant, and are in the final model. The differences in risk adjustment ensure that risk adjustment is being tailored toward each MCO's specific policies and reimbursement policies. In addition, accurate coding by providers will ensure fairness in risk adjustment.

Comment: Do not utilize ICD-10 diagnosis codes that map to multiple conditions in risk-adjustment, since it makes it difficult to accurately predict risk.

Response: While some ICD-10 codes may map to multiple diagnoses, it is beneficial to incorporate these into risk adjustment, because with each additional diagnosis code, we have a more comprehensive profile of the patient. To further specify a primary diagnosis that may map to multiple diagnoses, providers should code a secondary diagnosis, since secondary diagnoses are considered in risk adjustment as well.

Comment: Concern around providers being disadvantaged by the populations they choose to care for.

Response: Different providers care for different patient populations in some cases. In order to achieve a fair comparison in episode spend across Quarterbacks, risk adjustment and episode exclusions are employed. Episode exclusions ensure that the remaining episodes are comparable by excluding episodes based on business (e.g. a dual eligibility exclusion) and clinical exclusions (e.g.: if patient has conditions that may lead to a different care pathway). Risk adjustment takes into account the various comorbidities or conditions that a patient may have.