TennCare Quarterly and Annual Report

Submitted to the TennCare Oversight Committee and the Fiscal Review Committee

July 16, 2007

Status of TennCare Reforms and Improvements

For the quarter and for the year:

Waiver extension. A good deal of time was spent during this year attempting to negotiate a waiver extension with CMS, since the expiration date of the TennCare waiver was June 30, 2007. The State sent a letter to CMS in June 2006 requesting a three-year extension of the waiver under the Section 1115(e) authority, which is the authority generally used when extending an existing five year Section 1115(a) waiver.

In November 2006 CMS notified the State that it was denying the State's request and directing the State to request a three-year extension under the Section 1115(a) authority. State staff and CMS staff had weekly conference calls between the first of December and the end of March. The draft documents produced during this time were reviewed by CMS and OMB staff during the April-June quarter. At the very end of June, CMS requested changes in the financing arrangements that had not previously been discussed. When the State and CMS were unable to reach agreement on these terms, CMS wrote a letter extending the existing waiver until July 13, 2007. This extension was subsequently continued until August 15, 2007.

New MCOs. Two new Managed Care Organizations were recruited to the TennCare program this year. Contracts were awarded on July 26, 2006, to AmeriGroup Corporation (AmeriGroup) and UnitedHealth Plan of River Valley, Inc. (United), called AmeriChoice. These companies began serving TennCare enrollees on April 1, 2007.

The new MCOs agreed to accept full financial risk and to be paid set monthly rates, or capitation payments, to manage and deliver care to approximately 170,000 TennCare enrollees each. One feature of the new MCOs that is different for TennCare is the use of an integrated behavioral health model. Physical and behavioral health services are being managed together, rather than separately, in order to improve coordination of care to enrollees.

The TennCare staff organized a number of readiness activities to be sure the new MCOs would be prepared to start delivering services on April 1. These activities included desk audits of required policies, procedures, and related deliverables, as well as on-site audits of claims administration, information systems testing, financial audits, medical

management, customer services processes and workflows, provider network development, and provider network adequacy. TennCare staff also worked to assure that enrollees would be ready for the change. Various materials were created for advocates, and letters were sent to all enrollees. Transition teams were set up within the Bureau and the new and exiting MCOs to assure continuity of care.

The new MCOs "went live" on April 1, 2007, and began serving their new members with very little disruption.

Standard Spend Down (SSD) program. In November 2006 CMS approved the State's request from the previous January to open a new waiver category to be called "Standard Spend Down," or SSD. The SSD program would allow enrollment of up to 100,000 aged, blind, and disabled Tennesseans, as well as caretaker relatives of Medicaid-eligible dependent children. These persons would be required to meet criteria patterned after that of the Medically Needy program, but they would belong to the demonstration population, rather than the Medicaid population. They would have to have enough unreimbursed medical bills to meet "spend down" income levels.

On January 1, 2007, the State entered the last six months of the waiver. One of the Special Terms and Conditions to which the State had agreed in accepting the waiver from CMS was to enroll no new demonstration eligibles during the last six months of the waiver. Without CMS's approval of the State's requested waiver extension, then, the State was in the position of being unable to start the SSD program, since persons in this program would be part of the demonstration population and could not therefore be enrolled during the last six months of the program. The State has told CMS that it will start enrolling persons in this program within one month after CMS approves the waiver extension. As of the end of June 2007, that approval had not yet been granted.

NCQA accreditation. Tennessee is the first state to mandate that all Medicaid Managed Care Organizations (MCOs) be accredited by the National Committee for Quality Assurance (NCQA). NCQA is an independent non-profit corporation with a mission to improve health care quality nationally. The NCQA accreditation process includes a comprehensive review of the key aspects of care and service and the overall health care delivery system of individual managed care plans.

Earlier, MCOs were notified that the contracts of MCOs failing to obtain NCQA accreditation by December 31, 2006, would be subject to termination. All MCOs completed the NCQA survey and received their ratings prior to that date.

NCQA awards its highest accreditation status of Excellent to organizations with programs for service and clinical quality that meet or exceed rigorous requirements for consumer protection and quality improvement. BlueCross BlueShield, TLC and AmeriChoice received an excellent rating.

NCQA awards an accreditation status of Commendable (the second highest rating) to organizations with well-established programs for service and clinical quality that meet rigorous requirements for consumer protection and quality improvement. PHP, UAHC, and Unison received a commendable rating.

NCQA awards an accreditation status of Provisional to organizations with programs for service and clinical quality that meet basic requirements for consumer protection and

quality improvement. Organizations awarded this status must take significant action to achieve a higher accreditation status. VHP received a Provisional rating. (VHP is the smallest MCO and ended its contract with TennCare effective April 1, 2007.)

The two new MCOs in Middle Tennessee are being required to obtain NCQA accreditation by the end of 2009.

Long term care changes. TennCare requested and received approval for a consolidation and renewal of its Home and Community Based Services (HCBS) waivers for Elderly and Disabled individuals. Increased service capacity (from 2871 to 3700 slots) and new services (such as adult day care, in-home respite, personal care attendant services, and assisted living) were requested and approved.

Upon receiving relief in *Ware v. Goetz* this quarter, the State proceeded with the consolidation of the three Elderly and Disabled HCBS waivers. Enrollees participating in the ADAPT waivers in Davidson, Hamilton, and Knox Counties and enrollees participating in the Shelby County HCBS waiver are in the process of transitioning into the statewide HCBS waiver, where they will have access to an expanded array of services. This transition is proceeding in accordance with a protocol developed by the State and approved by the Court to assure the health, safety, and welfare of all enrollees.

Implementation of "soft limits." On February 1, 2007, TennCare implemented a modification to the pharmacy program. A new process, originally called "soft limits" and now called the "Prescriber Attestation Process," was put in place to allow enrollees who are subject to a limit on outpatient drugs to obtain additional prescriptions in urgent circumstances.

TennCare Medicaid adults are limited to five prescriptions per month, of which two must be generic drugs. This limit applies to all adults aged 21 and older except for those who are in Nursing Facilities and those who are being served in Home and Community Based Services (HCBS) waiver programs.

Over 600 medications have been identified for the "Prescriber Attestation Process." When an enrollee has reached a benefit limit and his prescriber contacts TennCare and attests that the enrollee has an urgent need for one of these drugs, TennCare will provide coverage for it.

The State already had an "Auto Exemption Process," formerly called the "Short List." The Auto Exemption Process is a list of over 500 drugs that do not count against an enrollee's benefit limit.

Provider rate increase. TennCare implemented the 2.5% across the board provider increase in payment that was appropriated by the 104th Tennessee General Assembly. The increase was effective for dates of service on and after July 1, 2006.

Medicaid transformation grants. On January 25, 2007, the Centers for Medicare and Medicaid Services announced that Tennessee had been awarded a Medicaid Transformation Grant of $674,204. The grant award is allowing the State to target primary care providers in small rural counties to allow them to use an electronic prescribing system to increase efficiency and patient safety and to reduce TennCare

pharmacy costs. The program is providing computer technology for selected providers, along with training and technical assistance, to assure a smooth transition to e-prescription technology.

The State submitted a second Medicaid Transformation Grant application at the end of the year to fund a two-year program aimed at reducing infant mortality and low birthweight by improving coordination of care for pregnant mothers and their newborns and by developing a database of best practices. A decision on this application will be announced in September 2007.

Annual report. TennCare issued its second Annual Report at the end of the year; this report covered State Fiscal Year 2006. The report showed that TennCare experienced its first-ever decrease in total spending, going from $8.57 billion in FY 05 to $6.92 billion in FY 06. This reduction was the result of implementation of reforms proposed by Governor Bredesen and approved by CMS. Pharmacy reforms resulted in a reduction in expenditures from $2.45 billion to $1.22 billion.

Essential access payments. The TennCare Bureau continued to make Essential Access Hospital payments during this period. Essential Access Hospital payments are payments from a pool of $100 million ($36,265,000 in State dollars) appropriated by the General Assembly.

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

Essential Access Hospital payments for the fourth quarter of State Fiscal Year 2007 and total payments for the year are shown in the following table.

Hospital Name	FY 2007 4th Qtr EAH	Total FY 2007
Methodist Medical Center of Oak Ridge	$ 165,443.00	$ 666,908.00
Ridgeview Psychiatric Hospital and Center	$ 51,327.00	$ 205,308.00
Bedford County Medical Center	$ 69,829.00	$ 281,485.00
Blount Memorial Hospital	$ 120,818.00	$ 487,022.00
Bradley Memorial Hospital	$ 110,314.00	$ 444,679.00
Cleveland Community Hospital	$ 121,981.00	$ 491,710.00
Saint Mary's Medical Center of Campbell County	$ 72,937.00	$ 294,010.00
Jellico Community Hospital	$ 129,782.00	$ 523,157.00
Stones River Hospital	$ 51,120.00	$ 206,067.00

Baptist Memorial Hospital-Huntingdon	$ 32,117.00	$ 129,464.00
McKenzie Regional Hospital	$ 40,049.00	$ 161,438.00
Sycamore Shoals Hospital	$ 61,088.00	$ 246,248.00
Claiborne County Hospital	$ 109,736.00	$ 442,349.00
Cumberland River Hospital	$ 15,757.00	$ 63,517.00
Baptist Hospital of Cocke County	$ 184,881.00	$ 745,266.00
United Regional Medical Center	$ 124,716.00	$ 502,734.00
Harton Regional Medical Center	$ 91,860.00	$ 370,293.00
Cumberland Medical Center	$ 114,005.00	$ 459,560.00
Southern Hills Medical Center	$ 121,205.00	$ 488,582.00
Tennessee Christian Medical Center	$ 439,534.00	$ 1,771,779.00
Metro Nashville General Hospital	$1,033,500.00	$ 4,134,000.00
Baptist Hospital	$ 198,685.00	$ 800,908.00
Vanderbilt University Hospital	$2,742,194.00	$ 10,968,773.00
Centennial Medical Center	$ 245,000.00	$ 987,605.00
Summit Medical Center	$ 137,394.00	$ 553,842.00
Baptist Women's Treatment Center	$ 2,756.00	$ 11,108.00
Vanderbilt Stallworth Rehabilitation Hospital	$ 32,365.00	$ 130,465.00
Decatur County General Hospital	$ 25,914.00	$ 104,460.00
Baptist DeKalb Hospital	$ 29,957.00	$ 120,758.00
Horizon Medical Center	$ 101,118.00	$ 407,610.00
Dyersburg Regional Medical Center	$ 116,344.00	$ 468,988.00
Methodist Healthcare Fayette	$ 40,648.00	$ 163,855.00
Jamestown Regional Medical Center	$ 76,101.00	$ 306,768.00
Emerald Hodgson Hospital	$ 21,364.00	$ 86,119.00
Southern Tennessee Medical Center	$ 71,801.00	$ 289,433.00
Gibson General Hospital	$ 36,018.00	$ 145,191.00
Humboldt General Hospital	$ 74,584.00	$ 300,652.00
Hillside Hospital	$ 80,906.00	$ 326,135.00
Laughlin Memorial Hospital	$ 69,981.00	$ 282,099.00
Takoma Adventist Hospital	$ 59,749.00	$ 240,853.00
Morristown Hamblen Healthcare System	$ 150,953.00	$ 608,498.00
Lakeway Regional Hospital	$ 122,426.00	$ 493,505.00
Erlanger Medical Center	$1,655,839.00	$ 6,623,356.00
Erlanger North Hospital	$ 32,115.00	$ 129,456.00
Parkridge Medical Center	$ 74,913.00	$ 301,977.00
East Ridge Hospital	$ 136,527.00	$ 550,344.00
Valley Hospital	$ 143,235.00	$ 572,940.00
Bolivar General Hospital	$ 36,523.00	$ 147,226.00
Hardin County General Hospital	$ 107,186.00	$ 432,071.00
Wellmont Hawkins County Memorial Hospital	$ 66,923.00	$ 269,768.00
Haywood Park Community Hospital	$ 47,758.00	$ 192,517.00
Henderson County Community Hospital	$ 23,618.00	$ 95,207.00
Henry County Medical Center	$ 91,769.00	$ 369,926.00
Jefferson Memorial Hospital	$ 48,673.00	$ 196,204.00
Fort Sanders Regional Medical Center	$ 273,685.00	$ 1,103,235.00
Saint Mary's Health System	$ 173,778.00	$ 700,509.00
Baptist Hospital of East Tennessee	$ 99,873.00	$ 402,594.00

University of Tennessee Memorial Hospital	$1,713,397.00	$ 6,853,588.00
East Tennessee Children's Hospital	$ 445,851.00	$ 1,783,404.00
Fort Sanders Parkwest Medical Center	$ 97,612.00	$ 393,478.00
Crockett Hospital	$ 61,825.00	$ 249,220.00
Lincoln Medical Center	$ 41,100.00	$ 165,675.00
Fort Sanders Loudon Medical Center	$ 44,899.00	$ 180,991.00
Woods Memorial Hospital	$ 35,056.00	$ 141,313.00
Athens Regional Medical Center	$ 51,432.00	$ 207,324.00
McNairy Regional Hospital	$ 38,568.00	$ 155,469.00
Jackson Madison County General Hospital	$ 627,506.00	$ 2,529,505.00
Regional Hospital of Jackson	$ 112,542.00	$ 453,663.00
Pathways of Tennessee	$ 104,651.00	$ 418,604.00
Grandview Medical Center	$ 52,613.00	$ 212,084.00
Maury Regional Hospital	$ 181,936.00	$ 733,393.00
Sweetwater Hospital Association	$ 146,461.00	$ 590,389.00
Gateway Medical Center	$ 151,531.00	$ 610,828.00
Baptist Memorial Hospital Union City	$ 96,605.00	$ 389,420.00
Livingston Regional Hospital	$ 51,697.00	$ 208,393.00
Cookeville Regional Medical Center	$ 121,560.00	$ 490,014.00
Roane Medical Center	$ 59,588.00	$ 240,200.00
Northcrest Medical Center	$ 144,825.00	$ 583,794.00
Middle Tennessee Medical Center	$ 217,589.00	$ 877,112.00
Baptist Treatment Center of Murfreesboro	$ 7,374.00	$ 29,727.00
Stonecrest Medical Center	$ 64,652.00	$ 260,615.00
Scott County Hospital	$ 83,720.00	$ 337,478.00
Fort Sanders Sevier Medical Center	$ 152,407.00	$ 614,359.00
Regional Medical Center (The Med)	$4,641,856.00	$ 18,567,424.00
Saint Jude Children's Research	$ 256,281.00	$ 1,033,080.00
Methodist Healthcare South	$ 134,581.00	$ 542,503.00
Methodist University Healthcare	$ 405,676.00	$ 1,635,297.00
Methodist Healthcare North	$ 140,693.00	$ 567,140.00
Methodist Healthcare Lebonheur	$ 804,149.00	$ 3,216,596.00
Delta Medical Center	$ 149,038.00	$ 600,781.00
Saint Francis Hospital	$ 405,173.00	$ 1,633,267.00
Community Behavioral Health	$ 74,206.00	$ 296,824.00
Baptist Memorial Hospital for Women	$ 110,103.00	$ 110,103.00
Smith County Memorial Hospital	$ 25,474.00	$ 102,685.00
Wellmont Bristol Regional Medical Center	$ 235,194.00	$ 948,078.00
Wellmont Holston Valley Medical Center	$ 242,601.00	$ 977,937.00
Indian Path Pavilion	$ 35,848.00	$ 143,392.00
Tennessee Christian Medical Center-Portland	$ 39,224.00	$ 158,111.00
Sumner Regional Medical Center	$ 157,960.00	$ 636,742.00
Hendersonville Medical Center	$ 56,460.00	$ 227,595.00
Baptist Memorial Hospital-Tipton	$ 100,786.00	$ 406,273.00
Unicoi County Memorial Hospital	$ 25,052.00	$ 100,988.00
River Park Hospital	$ 57,960.00	$ 233,637.00
North Side Hospital	$ 52,067.00	$ 209,885.00
Johnson City Specialty Hospital	$ 13,105.00	$ 52,828.00

Johnson City Medical Center Hospital	$ 713,213.00	$ 2,852,852.00
Woodridge Psychiatric Hospital	$ 90,733.00	$ 362,932.00
Wayne Medical Center	$ 24,322.00	$ 98,041.00
Volunteer Community Hospital	$ 31,390.00	$ 126,535.00
White County Community Hospital	$ 35,877.00	$ 144,621.00
University Medical Center	$ 323,309.00	$ 1,303,282.00
		$100,000,000.00

Reverification Status

Efforts formerly directed at reverification during the past year were directed toward assessing the eligibility of TennCare Standard adults for Medicaid categories, since the TennCare Standard adult categories were terminated in 2005. Those TennCare Standard adults who were not found eligible in a Medicaid category were disenrolled, after having the opportunity to exercise all appeal rights.

We have now started a monthly process for TennCare Standard children who have turned 19 and who are therefore no longer eligible for TennCare Standard. Those who are not found eligible in an active Medicaid category are disenrolled.

Status of Filling Top Leadership Positions in the Bureau

For the quarter:

Phillip Forslund was appointed May 1, 2007, as the Deputy of Long-Term Care Administration in the Division of Long-Term Care. He is responsible for oversight and review of the daily, internal operations of the Long-Term Care Division. Mr. Forslund possesses over 25 years of experience in administration, operations, and finance within health care, managed care, and long term care systems. Mr. Forslund has a Master of Science Degree in Health Care Administration, a B.S. Degree in Accounting, and an Associate of Arts Degree in Business Administration.

Richard Strecker was appointed May 1, 2007, as the Deputy of Long-Term Care Operations in the Division of Long-Term Care. He is responsible for oversight of all daily, external operations of the Long-Term Care Division, including contracted functions performed by other State Agencies acting as lead operating agencies for TennCare's Home and Community Based Services (HCBS) Waiver Programs. Mr. Strecker was previously employed with the State of Missouri Department of Mental Health, Division of Mental Retardation and Developmental Disabilities (MRDD) and the Division of Comprehensive Psychiatric Services (CPS). He possesses over 24 years of progressively responsible experience in operation of HCBS programs. Mr. Strecker has a Master of Science Degree in Clinical Psychology and a Bachelor of Arts Degree in Psychology and Speech.

Kathleen Green was appointed April 16, 2007, as the Deputy of Home and Community Based Services (HCBS) Waiver Programs. Ms. Green was previously employed with the Missouri Department of Mental Health as the Director of Federal Programs (Medicaid

Home and Community Based Waiver Programs). She has 25 years experience in Medicaid and related activities, including 18 years in the Federal Programs Unit of the Missouri Department of Mental Health's Division of Mental Retardation and Developmental Disabilities, overseeing its 1915(c) Home and Community Based Services Waiver Programs. Ms. Green has a Master's Degree in Public Administration and a Bachelor of Science Degree in Accounting.

For the year:

Darin Gordon was appointed July 17, 2006, as Deputy Commissioner of the Department of Finance and Administration and Director of TennCare. Mr. Gordon had approximately 10 years experience in finance and related positions and has been with the Bureau of TennCare since 1999. He previously served as Chief Financial Officer and Director of Managed Care Programs.

Patti Killingsworth was appointed February 1, 2007, as Chief of Long Term Care Operations. She oversees and directs the Long Term Care and Developmental Disability Services Section, with responsibility for all activities related to long term care facilities, including nursing homes and oversight of the state's 1915(c) Home and Community Based Services (HCBS) waivers. She previously served as Director of Member Services.

Tracy Purcell was appointed February 1, 2007, as Director of Member Services. She oversees the processing of all TennCare medical, behavioral health, pharmacy, and dental appeals by TennCare enrollees. She also coordinates communications with members and directs eligibility policy. Prior to this appointment, Ms. Purcell served as Director of Eligibility Services for the Bureau of TennCare.

Marilyn Wilson was appointed August 16, 2006, as TennCare Public Affairs Director. She is responsible for all media relations and media planning applicable to the Bureau of TennCare. She previously served as Information Officer for both the Department of Commerce and Insurance and the Bureau of TennCare.

Jeanne Jordan, MD, was appointed February 1, 2007, as Associate Medical Director. She provides input on all aspects of medical policy and medical decision-making related to children enrolled in TennCare. She was previously Chief Medical Officer of Tulane University Hospital and Clinic and Assistant Dean of Tulane University Hospital

Judy Womack was appointed February 1, 2007, as the Director of Quality Oversight. She is responsible for monitoring the quality of care delivered by the managed care contractors. Ms. Womack previously served in the Bureau of TennCare as Managed Care Director, Quality Oversight Division.

Kim Hagan was appointed on February 15, 2007, as Director of Eligibility Services. Her responsibilities include coordinating eligibility policy and assuring appropriate implementation of eligibility policy at the Department of Human Services, which determines TennCare eligibility under a contract with TennCare. She is also responsible for oversight of eligibility appeals, which are processed by the Department of Human Services, and implementation of enrollee notices related to eligibility, MCC enrollment, and benefit changes. Prior to this appointment, Ms. Hagan served as an attorney with TennCare's Office of General Counsel.

Nancy Heaney was appointed July 17, 2006, as Personnel Director. She has been employed by the State of Tennessee for 24 years, with 11 years experience in Human Resources.

Number of Recipients on TennCare and Costs to the State

At the end of the quarter and the end of the year, there were 1,151,753 Medicaid eligibles and 35,015 uninsured/uninsurable persons enrolled in TennCare, for a total of 1,186,768 persons.

Projections of TennCare spending for the fourth quarter and the year are summarized in the table below. These are not final numbers, since the fiscal year will not close for accounting purposes until late fall 2007.

	4th Quarter	Total
Spending on MCO services	$750,800,000	$2,779,400,000
Spending on BHO services	$104,603,900	$418,240,000
Spending on dental services	$36,000,000	$144,240,000
Spending on pharmacy services	$215,492,700	$665,000,000
Medicare "clawback"	$96,048,900	$220,762,700

Viability of MCOs in the TennCare Program

Claims payment analysis

The prompt pay requirements of T.C.A. § 56-32-226(b) mandate that each managed care organization ("MCO") and behavioral health organization ("BHO") ensure that 90% of clean claims for payment for services delivered to a TennCare enrollee are paid within 30 calendar days of the receipt of such claims and 99.5% of all provider claims are processed within 60 calendar days of receipt. TennCare's contract with its Dental Benefit Manager requires that the DBM also process claims in accordance with this statutory standard.

TennCare's contract with its Pharmacy Benefits Manager requires that the PBM must pay 95% of all clean claims within 20 calendar days of receipt and the remaining 5% of clean claims within the following 10 calendar days.

To monitor prompt pay compliance, TDCI requests the MCOs, BHOs, DBM and PBM to submit claims data by month on a quarterly basis. If the contractor has not processed claims timely in accordance with statutory and/or contractual requirements, the contractor is required to submit claims data on a monthly basis until it processes claims timely for three consecutive months. If an MCO or BHO does not comply with the prompt pay requirements, 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 determined, and the TennCare Bureau can also assess liquidated damages pursuant to the terms of the TennCare Contract. If the DBM or PBM do not

meet their contractual prompt pay requirements, only the TennCare Bureau can assess applicable liquidated damages against these entities.

During fiscal year 2007, TDCI requested data files of all processed TennCare claims from all TennCare contractors from May 2006 through April 2007. (Some contractors also had to submit claims data for May 2007 if they were on monthly reporting as described above.) TDCI also requested data files of pended TennCare claims and paid claims triangle lags to ensure that the claims data submitted was complete and accurate.

The analyses of the claims data during fiscal year 2006-2007 found the following contractors were out of compliance for at least one month:

- Doral Dental – July 2006 and October 2006
- Memphis Managed Care Corporation – May 2006
- Preferred Health Partnership of Tennessee – August 2006, September 2006, December 2006, January 2007, February 2007, March 2007 and April 2007.[1]
- UAHC Health Plan of Tennessee – November 2006, December 2006, January 2007 and March 2007[2]
- Windsor Health Plan – January 2007 and May 2007[3]
- Volunteer State Health Plan (TennCare Select) – February 2007[4]
- UnitedHealthcare Plan of the River Valley's vision subcontractor Spectera – May 2007[5]

Net worth requirement

By statute, the minimum net worth requirement for each TennCare MCO and BHO is established based on calendar year premium revenue. The TennCare MCOs and BHOs reported TennCare premiums for Calendar Year 2006 on their NAIC annual financial statements submitted to TDCI on March 1, 2007. As of December 31, 2006, TennCare MCOs/BHOs reported net worth as indicated in the table below. TDCI's calculations for the net worth requirement reflect payments made for the calendar year ending December 31, 2006, including payments made under the "stabilization plan."

[1] TDCI and PHP entered into a consent order in which PHP paid a $50,000 administrative penalty for its failure to comply with statutory prompt pay requirements.
[2] TDCI is in the process of levying a $10,000 administrative penalty for UAHC's failure to comply with statutory prompt pay requirements.
[3] Effective April 1, 2007, WHP no longer contracted with the TennCare Program to provide medical services to TennCare enrollees. The claims processed in May 2007 were claims with dates of service prior to April 1, 2007. The volume of "run out" claims being processed is significantly decreasing each month.
[4] VSHP has two (2) separate contracts with TennCare: Bluecare and TennCare Select. VSHP processed all BlueCare claims in accordance with the statutory prompt pay requirements.
[5] UPRV/AmeriChoice met the statutory prompt pay requirement based on total claims (medical and vision) processed for the month of May. Effective April 1, 2007, Spectera is UPRV's vision subcontractor for the Middle Tennessee Grand Region.

	Net Worth Requirement	Reported Net Worth	Excess/ (Deficiency)
UnitedHealthcare Plan of the River Valley (formerly John Deere)	17,339,431	157,938,399	140,598,968
Memphis Managed Care	8,777,597	30,480,574	21,702,977
Preferred Health Partnership	6,583,291	33,552,547	26,969,256
UAHC Health Plan	7,230,835	11,699,216	4,468,381
Unison Health Plan	3,746,386	5,451,597	1,705,211
Volunteer (BlueCare & Select)	25,703,132	30,758,110	5,054,978
Windsor Health Plan	6,291,309	8,182,072	1,890,763
Premier Behavioral Systems	7,026,272	27,493,548	20,467,276
Tennessee Behavioral Health	6,606,592	19,290,585	12,683,993

Each TennCare MCO and BHO is required to submit quarterly NAIC financial statements which are analyzed to ensure it is maintaining the minimum statutory net worth determined from the NAIC annual financial statement. The MCOs and BHOs submitted their quarterly financial statements reporting results of operations for the quarter January 1, 2007 through March 31, 2007 to TDCI on June 1, 2007.

As of March 31, 2007, TennCare MCOs/BHOs reported net worth as indicated in the table below.

	Net Worth Requirement	Reported Net Worth	Excess/ (Deficiency)
UnitedHealthcare Plan of the River Valley (d/b/a AmeriChoice)	17,339,431	178,707,438	161,368,007
Memphis Managed Care	8,777,597	30,805,993	22,028,396
Preferred Health Partnership	6,583,291	33,969,013	27,385,722
UAHC Health Plan	7,230,835	12,083,788	4,852,953
Unison Health Plan	3,746,386	5,523,890	1,777,504
Volunteer (BlueCare & Select)	25,703,132	30,775,667	5,072,535
Windsor Health Plan	6,291,309	7,710,459	1,419,150
Premier Behavioral Systems	7,026,272	32,621,639	25,595,367
Tennessee Behavioral Health	6,606,592	20,743,502	14,136,910

Please note that no financial information was provided for AmeriGroup because it did not begin its TennCare operations in Middle Tennessee until April 1, 2007. Its first NAIC financial statement for the quarter April 1, 2007 through June 30, 2007 is required to be filed on September 1, 2007.

FINANCIAL ISSUES:

Xantus Healthplan of Tennessee, Inc. (Xantus)

During the period July 1, 2006 through June 30, 2007, Xantus paid $1,505 to providers for run-out claims, bringing the total run-out claims paid during the period August 1, 2003

through June 30, 2007 to $34,684,941. As of June 30, 2007, all run-out claims have been processed and paid.

The Xantus Liquidation will file a motion with the Davidson County Chancery Court to receive approval to pay medical claims with dates of service prior to April 1, 1999. Each provider with unpaid claims will receive a pro-rata distribution of estate assets.

Tennessee Coordinated Care Network d/b/a Access MedPlus (TCCN)

On June 15, 2007, the TCCN Liquidation filed a motion with the Davidson County Chancery Court to make a final distribution of remaining estate assets to medical providers. If this motion is approved without objection, the Liquidation will distribute approximately $11.8 million, resulting in providers ultimately receiving approximately 60% of the total computed payable of claims debt.

Universal Care of Tennessee (Universal)

On February 16, 2007, Universal received $20,000,000 from TennCare in compromise and settlement of the $75,000,000 claim filed against the State of Tennessee in the Claims Commission by Universal prior to it being placed in liquidation.

Success of Fraud Detection and Prevention

The Office of Inspector General (OIG) was established three years ago (July 1, 2004). The mission of the OIG is: *To identify, investigate, and prosecute persons who commit fraud or abuse against the TennCare program.* The OIG staff receives case information from a variety of sources including: local law enforcement, the Tennessee Bureau of Investigation (TBI), the TennCare Bureau, Health Related Boards (HRB), the Department of Human Services (DHS), other state agencies, health care providers, Managed Care Contractors (MCC), OIG data mining, and the general public via the OIG web site, faxes, letters, and phone calls to the OIG hotline. The statistics for the fourth quarter of the 2006 - 2007 fiscal year are as follows:

***NOTE**: Included are the fiscal year totals (FYT) and the grand totals to date -- since the OIG was created (July 2004)*

Summary of Enrollee Cases

	Quarter	FYT	Grand Total
Cases Received	2,925	19,532	76,219
Cases Closed*	2,851	18,244	76,565

***Cases are closed when there is inadequate information provided to investigate the complaint, the information has been researched and determined to be unfounded, the case was referred to another agency (as per appropriate jurisdiction), or prosecuted by the OIG and closed. This number also includes reports the OIG runs for the TennCare Bureau regarding potential fraud or abuse.*

Summary of Enrollee Abuse Cases

	Quarter	FYT

Abuse Cases Received	2,357	16,605
Abuse Cases Closed	1,142	5,783
Abuse Cases Referred [1]	1,215	11,649

[1] Abuse cases may be referred to the appropriate Managed Care Organization (MCO), the TennCare Bureau, or DHS for further review.

Summary of Provider Cases

	Quarter	FYT	Grand Total
Cases opened	66	294	936
Cases closed	20	157	766
Cases referred to TBI*	0	16	74
Cases referred to HRBs**	7	30	73

***The OIG refers **provider cases** to the TBI Medicaid Fraud Unit (as per state and federal law) and will assist with these investigations as requested.*
***Health Related Boards*

Summary of Arrests & Convictions

	Quarter	FYT	Grand Total
Arrests	58	189	455
Convictions	14	68	150
Diversions*	12	33	59

Note: *Special Agents were not in the field making arrests until February 2005.*
***Judicial Diversion**: A guilty plea or verdict subject to expungement following successful completion of probation. Tennessee Code Annotated § 40-35-313*
***Pre-trial Diversion**: Prosecution was suspended and if probation is successfully completed, the charge will be dismissed. Tennessee Code Annotated § 40-15-105*

Court Fines & Costs Imposed

	QUARTER	FYT	GRAND TOTAL
Fines	**$6,116.50**	**$30,716.50**	**$62,291.50**
Court Costs & Taxes	**$3,800.50**	**$16,055.80**	**$30,871.30**
Drug Funds	**$462.00**	**$1,728.50**	**$3,738.00**
Restitution (ordered)	**$73,258.51**	**$316,603.44**	**$835,682.79**

There is an aggressive push to pursue enrollees who have committed fraud or abuse against the TennCare program. The primary criminal case types are: drug cases (drug diversion, drug seekers, and forged prescriptions), reporting a false income, access to insurance, and living outside of the State of Tennessee.

Arrest Categories

Drug Diversion/Forged Prescription	307
Access to Insurance	52

Operation Falcon III	32
False Income	20
Ineligible Person Using Card	17
Living Out Of State	9
Asset Diversion	6
Theft of Services	6
ID Theft	4
TennCare Fraud	2
GRAND TOTAL	**455**

TennCare Referrals & Recoupments

	Quarter	FYT	Grand Total
Pharmacy Lock-in **(1)**	74	211	884
Recoupment **(2)**	$63,921.68	$360,085.51	$980,885.22
Recommended TennCare Terminations **(3)**	902	10,658	21,118
Potential Savings **(4)**	$2,976,600	$35,371,800	$78,905,077

Footnotes for the *TennCare Referral and Recoupments* table

(1) The total in the last column is for the time period of September 2004 through June 30, 2007. Pharmacy lock-in referrals are sent to the TennCare Bureau for consideration.

(2) The total in the last column reflects dollars collected by the OIG and sent to the TennCare Bureau from February 15, 2005, (when a Fiscal Manager and an attorney joined the OIG staff to facilitate and document this process) through June 30, 2007.

(3) Enrollee recommendations sent to the TennCare Bureau for consideration based on reports run from *file net* (i.e. Prisoner Report, State Wage Report, the Deceased Report, and the PARIS Report). Reports are run upon availability on *file net*.

(4) There were 902 enrollee terminations recommended by the OIG to the TennCare Bureau for their review during the fourth quarter. The TennCare Bureau uses $3,592.32 as the average annual cost per enrollee for Medical, Pharmacy Services, BHO, and Dental, and $3,082.44 for Medical and Pharmacy Services -- (an average of $3,300 was used in calculating the total figure in the above table). [NOTE: Previous reports reflected the number $4,181.04 as the average annual cost per enrollee, as per the TennCare Bureau.]

Investigative Sources

	Quarter	FYT	Grand Total
OIG Hot Line	959	3,826	12,997
OIG Mail Tips	54	324	2,719
OIG Web Site	329	1,656	4,420
OIG Email Tips	183	501	2,090

The OIG staff provided presentations or attended meetings for the following organizations/contacts during this quarter:

a Meetings with local law enforcement officials: the Judicial Task Forces, District Attorneys, Sheriffs and Chiefs of Police

b. Presentations included:
*LEACT - Law Enforcement Accreditation Coalition of Tennessee
*Tennessee Sheriff's Association Meeting

*Tennessee Chief's of Police Meeting
*District Attorney's Conference
*Benton County Sheriff's Department
*Tricare

c. Other Meetings included:
*Law Enforcement Committee Monthly Meeting (Brentwood, Tn)
*East Tennessee Medicaid Fraud Investigation Group
*TBI Drug Diversion Task Force
*Commerce & Insurance
*CoverTn work group

The OIG staff continues to work with the state's contractor, Medstat, to develop the fraud and abuse detection software system. The OIG is working with this vendor to initiate proactive reports for identifying TennCare fraud. Targeted queries are generated on a routine basis. The goal behind these reports and queries is to assist with a successful OIG investigation and prosecution of individuals who have violated the law as it pertains to TennCare fraud.

Three employee vacancies occurred during this quarter due to one transfer to another State agency and two resignations (these employees took jobs in the private sector). There will be an evaluation of these vacancies.

Training continued for OIG personnel during this quarter. The Special Agents began completing an annual In-Service training that includes POST required courses, new policies and procedures, all qualifications with approved weapons, a legal update, etc. All continuing education hours have begun for OIG "professional" staff members, i.e. attorneys, accountant, registered nurses, and information technology personnel. There was a required training class for the entire staff on "ethics". The Deputy Inspector General, CID, completed the TLEEDS class - a leadership class for Tennessee law enforcement executives. The Deputy Inspector General, PID, completed a high level investigative training class and was selected for the next TGMI class.

The OIG Legal Division has assisted OIG staff members by providing legal advice on issues including how to meet the requirements of various statutes and drafting and reviewing documents that have legal implications. The Legal Division facilitates the case preparation process and works closely with various District Attorneys toward a successful prosecution of OIG cases. They review all legal matters of the OIG and advise on pending legislative issues.

The Inspector General and the Deputy Inspector General over Criminal Investigations have continued visits to various Tennessee counties. In each jurisdiction visited, there is a courtesy call to the Sheriff and Chief of Police. The goal is to continue to solidify the collaboration between local law enforcement and the OIG. More visits are planned for the next quarter.

The OIG continues to maintain accredited status by complying with the standards of the Commission on Accreditation for Law Enforcement Agencies (CALEA). The OIG was accredited in November 2006. The State of Tennessee OIG is the only Inspector General agency to achieve law enforcement accreditation both nationally and internationally. A re-accreditation on-site and hearing will occur in during the 2009 - 2010 fiscal year.

The OIG website was completed during the fourth quarter. This will be helpful with the "Tips for Cash" Program by providing updates on the resolution of cases as they occur.

An OIG Special Agent has been selected to attend the summer session of the FBI National Academy in Quantico, Virginia. This is a very prestigious school that is often referred to as the Harvard of law enforcement. The State of Tennessee only receives about twelve slots a year so the competition in the law enforcement community is keen. Once SA John Morgan graduates, the OIG will have seven NA graduates.

Plans for next quarter:

a. Continue to exchange information with local, state, and federal government agencies.
b. Continue to work with Medstat to improve reports that would assist with the data mining function of the OIG.
c. Provide presentations and training for interested parties regarding TennCare fraud and the role of the OIG.
d. Continue staff training and develop best practices.
e. Track the newly created pay incentive program for tips that lead to a successful conviction for TennCare fraud. This program is a result of legislation from the 104th General Assembly and is a law.
f. Continue to review information for possible fraud and abuse of the newly created programs: CoverTn, Cover Kids, CoverRX, and Access Tennessee -- as they link to TennCare cases.
g. Continue to implement legislated programs pertaining to the OIG (last session): data mining and providing administrative hearings for the recovery of money owed to the TennCare program.
h. Continue the process for re-accreditation (a three year process). The OIG was accredited in November 2006.
i. Begin using the newly created Doctor Shopping Law on investigations regarding suspected chronic abusers of the TennCare program.