STATE OF TENNESSEE
BUREAU OF TENNCARE
DEPARTMENT OF FINANCE AND ADMINISTRATION
310 Great Circle Road
NASHVILLE, TENNESSEE 37243

MEMORANDUM

DATE: July 15, 2010

TO: The Honorable Members of the Fiscal Review Committee
The Honorable Members of the TennCare Oversight Committee

FROM: Darin Gordon, Director, Bureau of TennCare DG/wf

SUBJECT: TennCare Quarterly and Annual Report

Pursuant to Tennessee Code Annotated, Title 3, Chapter 15, Section 510(g) and Title 71, Chapter 5, Section 104(c), I am enclosing the TennCare Quarterly and Annual Report for the period ending June 30, 2010.

As always, please feel free to contact me if you have any questions.

cc: The Honorable Members of the General Assembly

TennCare Quarterly and Annual Report

Submitted to the TennCare Oversight Committee, The Fiscal Review Committee, and Members of the General Assembly

July 15, 2010

Status of TennCare Reforms and Improvements

A. Budget Issues

During fiscal years 2009 and 2010, the State of Tennessee experienced significant revenue shortfalls. As a result, State departments and agencies were called upon to reduce their budgets during fiscal year 2011. For the Bureau of TennCare, these cuts were in addition to the reductions that were proposed in fiscal year 2010 but delayed because of the enhanced match the State received from the American Recovery and Reinvestment Act (ARRA) of 2009. Since the ARRA funds are set to expire on December 31, 2010, the Bureau of TennCare's proposed budget for fiscal year 2011 included proposed reductions and eliminations in enrollee benefits as well as the proposed provider rate reductions and eliminations of supplemental payments that had been proposed for fiscal year 2010.

Ultimately, the majority of these proposed reductions were postponed through a combination of the ARRA matching funds, CMS's approval of Amendment #10 permitting the use of an annual hospital assessment fee to offset costs, and the funds the State will not have to expend due to CMS's decision relating to how the Medicare Part D clawback is calculated. Most of these issues will have to be revisited in preparation for the fiscal year 2012 budget.

B. Waiver Issues

A number of changes were made to the TennCare waiver during this fiscal year. Changes to the waiver are made by seeking and receiving CMS approval of formal proposed amendments to the currently approved waiver and by seeking and receiving CMS approval for waiver extensions to continue the waiver after formal expiration dates. During the past year, the State negotiated four waiver amendments with CMS; filed public notice for one amendment that the State anticipates will be submitted to CMS in July 2010; and received approval from CMS for another three-year extension of the waiver, to begin on July 1, 2010, and to continue through June 30, 2013.

Amendment #7. On July 22, 2009, CMS approved Amendment #7 to the TennCare demonstration. This approval permitted the implementation of the CHOICES program outlined by the General Assembly's Long-term Care and Community Choices Act of 2008. Under Amendment #7, the State provides new community alternatives to people who would otherwise require Medicaid-reimbursed care in a Nursing Facility. Tennessee is now one of the few states in the country to deliver managed Medicaid long-term

care and the only state to do so in a manner that does not require enrollees to change their Managed Care Organization (MCO).

Major operational changes were required in order to ensure that the CHOICES program could be smoothly integrated into the existing managed care structure. MCO contract amendments had to be approved, training materials prepared, systems changes made, contracts executed with Nursing Facilities and Home and Community Based Services (HCBS) providers, an electronic visit verification system put in place, and numerous protocols covering all aspects of the program written.

The first phase of the CHOICES program was successfully implemented in Middle Tennessee on March 1, 2010. Additional information on the actual implementation and plans for finalizing statewide implementation can be found in Section E, Long-term Care, on page 5.

Amendment #8. Waiver Amendment #8 was submitted to CMS on September 28, 2009. Its purpose was to ensure compliance with the Mental Health Parity requirements of the Emergency Economic and Stabilization Act of 2008, by removing, effective January 1, 2010, the limits then in effect on inpatient and outpatient substance abuse treatment benefits for adults.

CMS approved this Amendment on December 15, 2009, and TennCare implemented a rule change to reflect the discontinuance of limits on these services.

Amendment #9. To address the State's significant revenue shortfalls, Governor Bredesen required departments and agencies throughout the State to reduce their individual budgets. In response to this request, TennCare submitted Amendment #9 to CMS on February 3, 2010. The requested benefit reductions and eliminations included, among other things, limits on inpatient hospital costs; limiting lab and x-ray procedures to eight per year; limiting provider office visits and outpatient hospital visits to eight per year each; eliminating speech, occupational and physical therapy; and imposing a copay on non-emergency transportation. These limits would not affect children, and pregnant women were to be exempt from limits on pregnancy-related services.

Amendment #10 was proposed after Amendment #9 but before CMS approved Amendment #9. The approval of Amendment #10 forestalled the need for the reductions proposed in Amendment #9. (See below for details).

Amendment #10. On May 5, 2010, the Tennessee General Assembly passed the Annual Coverage Assessment Act of 2010. This act was signed into law as Public Chapter Number 909 on May 13, 2010, and provides an important new source of revenue to the State to be generated by an annual coverage assessment on hospitals. Use of this hospital assessment fee enables the State to postpone the benefit reductions and eliminations requested in Amendment #9 and also permits the State to enroll a certain number of new applicants in the "Standard Spend Down" demonstration category. CMS's approval was needed to make use of this fee, and on May 14, 2010, the State submitted Amendment #10 to CMS.

Amendment #10 consisted of two components:

1. A proposal to add a new pool to make payments to hospitals to offset losses incurred in providing services to TennCare enrollees. Payments to hospitals from this pool would not be considered as part of the reimbursement to which the hospital was entitled under its contract with a TennCare Managed Care Organization.

2. A proposal to make a supplemental payment to the Regional Medical Center in Memphis. Under this arrangement, the Bureau of TennCare would use a $10 million intergovernmental transfer (IGT) from Shelby County government as the nonfederal share of a supplemental payment to the Regional Medical Center to address critical care needs.

CMS approved Amendment #10 on June 30, 2010, and added two new hospital funding pools: an unreimbursed hospital cost (UHC) pool for private hospitals, and a public hospital supplemental payment (PHSP) pool for selected public hospitals. This approval meant that the State's need to implement the reductions called for in Amendment #9 could be postponed. According to the approval letter, the State may not implement reductions in benefits such as those presented in Amendment #9 in any demonstration year in which the State elects to make payments to hospitals through the unreimbursed hospital cost pool.

Amendment #11. On June 21, 2010, the Bureau of TennCare notified the members of the General Assembly of its intent to file Amendment #11 to the TennCare demonstration. This Amendment will permit the State to accept a $5 million intergovernmental transfer (IGT) from the Metropolitan Government of Nashville and Davidson County to use as the non-federal share in a supplemental payment to Nashville General Hospital to address critical care needs, subject to CMS approval. No state funds will be involved in this IGT. The State anticipates that Amendment #11 will be submitted to CMS on or after July 21, 2010.

TennCare Extension. The three-year extension of the TennCare waiver, called "TennCare II," was to expire on June 30, 2010.

On June 15, 2009, Governor Bredesen wrote a letter to Kathleen Sebelius, Secretary of the United States Department of Health and Human Services, to request another three-year extension of the waiver. On December 15, 2009, Cindy Mann, Director of the Center for Medicaid and State Operations (CMSO) in the Centers for Medicare and Medicaid Services (CMS), wrote to the State approving the request for an extension.

The new extension, provided under the authority of Section 1115(e) of the Social Security Act, begins on July 1, 2010, and continues through June 30, 2013.

C. Delivery System Issues

Completion of statewide medical and behavioral integration. On September 1, 2009, the Bureau of TennCare completed the transition to using a single managed care entity to provide all of the care to meet an enrollee's needs, including physical and behavioral health coverage.

The Bureau began integrating behavioral and medical health care delivery for Middle Tennessee members in 2007 with the implementation of two expanded MCOs. TennCare continued the process with the execution of new MCO contracts in West Tennessee in November 2008 and East Tennessee in January 2009. The transferring of behavioral health services to Volunteer State Health Plan of Tennessee for TennCare Select members completed the Bureau's phased implementation of a fully-integrated service delivery system that works with health care providers, including doctors and hospitals, to ensure that TennCare members receive all of their medical and behavioral services in a coordinated and cost-effective manner.

TennCare Select serves approximately 72,000 TennCare enrollees statewide including foster children, children receiving SSI benefits, and children receiving Nursing Facility or ICF/MR services. It also serves as the State's back-up MCO, should there be capacity problems with any of the other MCOs, and it maintains a statewide provider network.

Transition of Nursing Facilities and Home and Community Based Services (HCBS) Providers. Prior to the advent of the CHOICES program on March 1, 2010, the two Managed Care Organizations (MCOs) in Middle Tennessee had to secure contracts with Nursing Facilities that had previously been contracted directly with the Bureau of TennCare. All the Nursing Facilities in the Middle Tennessee region ultimately signed contracts with both Middle Tennessee MCOs. HCBS providers, whether new or previously serving members in the Statewide Waiver for the Elderly and Disabled, were also required to contract with the MCOs if they wanted to continue providing services for CHOICES enrollees. In anticipation of CHOICES starting in East and West Tennessee on August 1, 2010, many HCBS providers and Nursing Facilities began signing contracts with the MCOs in their area and numerous contracts had been signed prior to the end of this reporting period.

D. Legal Issues

Daniels. The State had been under an injunction for over 20 years in a case known as *Daniels.* The case involved redetermination of Medicaid eligibility for individuals who had originally qualified for Medicaid because they received Supplemental Security Income (SSI) cash assistance, but who had since had their SSI benefits terminated by the Social Security Administration.

Under the injunction, the State was prohibited from redetermining the eligibility of individuals in the *Daniels* class until the court approved a specific process to ensure that all active Medicaid categories were considered for each enrollee who no longer qualified for SSI. Such a redetermination process had been approved by CMS in 2005, had been approved by the Sixth Circuit Court, and had again been approved by CMS in 2007 when CMS approved the TennCare II waiver extension. In January 2009, the District Court lifted the injunction, allowing TennCare to proceed with redetermining the eligibility of some 147,000 individuals who made up the *Daniels* class.

The mailing of the last group of Requests for Information to those individuals who were original members of the *Daniels* class was completed in December 2009. The majority of those in the *Daniels* class continue to receive comprehensive government-sponsored health insurance; approximately 100,000 of the original 147,000 in the *Daniels* class continued to retain Medicaid or Medicare coverage. TennCare enrollees who lose SSI eligibility are now being required to undergo reverification processes like all other TennCare enrollees.

John B. *John B.* deals with the adequacy of services provided by TennCare to children under 21.

There was a significant development in the *John B.* lawsuit during the second quarter of the year. On September 15, 2009, the United States Court of Appeals for the Sixth Circuit, in response to a Mandamus Petition filed by the State seeking an order directing the District Court to rule on a motion to vacate the *John B.* Consent Decree that had been pending since November 2006, issued an order directing the District Court to respond in writing as to why the Mandamus Petition should not be granted or to submit a ruling on the State's pending motion to vacate.

Three days after this Sixth Circuit Order was issued, the District Court ruled on the state's Motion to Vacate, denying that motion in all respects. The State filed a Notice of Appeal, asking the Sixth Circuit to determine whether the Decree should be vacated in whole or in part. Briefing on this appeal occurred through December 2009. The Sixth Circuit granted a stay of all proceedings pending the outcome of TennCare's appeal of the District Court's denial of our Motion to Vacate. Oral Arguments on this were heard on April 27, 2010. TennCare is currently awaiting the ruling.

E. Quality of Care

HEDIS/CAHPS report. TennCare published the annual report of HEDIS/CAHPS data in September 2009. The full name for HEDIS is Healthcare Effectiveness Data Information Set, and the full name for CAHPS is Consumer Assessment of Health Plans Surveys. In 2006 Tennessee became the first state in the nation to require that all of its MCOs be accredited by NCQA (the National Committee for Quality Assurance). This report provides data that enables the State to compare the performance of its MCOs against national norms and benchmarks and to compare performance among MCOs. This report is shared with CMS each year and posted on the TennCare website at http://tn.gov/tenncare/forms/hedis09.pdf.

As with last year's report, improved performance was noted for most child health measures, many of which exceeded the HEDIS 2008 Medicaid National Average. Specifically, there was an increase in rates from HEDIS 2008 to HEDIS 2009 for the following:

- Childhood immunization status (all antigens with the exception of Hepatitis B)
- Appropriate testing for children with pharyngitis (an inflammation of the throat)
- Appropriate treatment of children with upper respiratory infection
- Well-child visits in the first 15 months of life
- Children and adolescents' access to primary care practitioners (ages 12-24 months and 25 months-6 years)

Statewide averages for child CAHPS results exceeded the prior year's results for all repeated measures except "Rating of All Health Care."

Chronic disease management, an area of opportunity identified first in the 2008 HEDIS/CAHPS Report, continues to improve across the State. All numerators of the "Comprehensive Diabetes Care" and "Use of Appropriate Medications for People with Asthma" measures that could be compared with HEDIS 2008 rates demonstrated improvement. Additionally, all of the asthma numerators were higher than the HEDIS 2008 Medicaid National Average. Conversely, the diabetes rates were generally lower than that average, indicating the need to better manage this disease.

Targeted preventive care—as measured by HEDIS 2009 rates for women's health screenings—presents additional opportunities for improvement. Compared to HEDIS 2008, however, there were improvements in screening rates for breast cancer and chlamydia screening among 21 to 24-year old women. Rates for cervical cancer declined.

F. Long-term Care

CHOICES was successfully implemented in Middle Tennessee on March 1, 2010. About 8,600 Middle Tennessee enrollees who were receiving Nursing Facility (NF) services or who were participating in the

State's Home and Community Based Services (HCBS) 1915(c) waiver for persons who are elderly and/or disabled were automatically moved into the CHOICES program. As of the end of this fiscal year, an additional 865 individuals entered Nursing Facilities as CHOICES Group 1 members. An additional 547 persons were added to the program as CHOICES Group 2 (HCBS) members. These individuals had not previously been served either in a Nursing Facility or the 1915(c) waiver.

TennCare, the Managed Care Organizations (MCOs), and various groups of stakeholders met almost weekly for the past year in order to prepare for the implementation. The MCOs successfully built their provider networks to accommodate the CHOICES population. One hundred percent of all Middle Tennessee Nursing Facilities have been contracted with one or both of the Middle Tennessee MCOs. Over 135 discrete HCBS providers have been contracted with one or both MCOs. Many of these providers are new to the program.

With implementation of the CHOICES program, the MCOs became responsible for coordination of all medical, behavioral, and long-term care provided to their members. They identified designated care coordinators to handle referrals for members interested in Consumer Direction, handled payments to Nursing Facilities (previously handled within the Bureau of TennCare), and are responsible for making payments to HCBS providers furnishing in-community services to CHOICES members.

Both MCOs completed all of their member assessments within the allotted timeframe under the Contractor Risk Agreement. The Electronic Visit Verification (EVV) System was fully operational on March 1, 2010. The EVV is the system that is being used by each HCBS provider to log in his arrival time at a member's home and to log out upon departure. This system ensures that services that have been ordered are actually provided. There is a backup system in place to ensure that no enrollee goes without needed care should a primary caregiver not log into the system. The Bureau's electronic PAE submission system (TennCare Preadmission Evaluation Screening, or TPAES) was fully operational on March 1, 2010, with access for the Area Agency on Aging and Disabilities (AAADs), the MCOs, and DHS.

With the successful implementation of the program in March, plans moved forward to finalize the statewide implementation of CHOICES by moving it into the MCOs covering East and West Tennessee. The same level of operational activity is currently taking place to ensure that the planned August 1, 2010, integration goes as smoothly.

The Bureau will continue to assist all of the MCOs with transition and implementation through daily monitoring calls, continued monitoring of provider issues, and evaluation of members' satisfaction with their CHOICES/MCO experience. In addition, the Bureau is conducting weekly conference calls with the AAADs to monitor any issues they may have functioning as the Single Point of Entry (SPOE) for CHOICES enrollment. The Bureau also provides on-going technical assistance to the care coordinators, as well as executive staff, in all MCOs.

After August 1, 2010, the Statewide Home and Community Based Waiver for the Elderly and Disabled will be terminated. It will no longer be needed once CHOICES is fully implemented.

G. Beneficiary Survey

Beneficiary survey. A report entitled "The Impact of TennCare: A Survey of Recipients 2009" was published in August 2009, by the Center for Business and Economic Research (CBER) at the University of

Tennessee, Knoxville. The survey has been done each year since 1993, the year before TennCare began, so it is a rich source of longitudinal data about the TennCare program.

The survey found that during the past year, the number of uninsured children in Tennessee has declined, while the number of uninsured adults has increased. According to CBER's report, there are an estimated 616,967 uninsured Tennesseans, which represents about 10 percent of the State's population. Although the number of uninsured persons is somewhat higher now than a year ago, the difference is not statistically significant. However, the percentage of uninsured children (3.7 percent) is down more than 1 percent from last year (4.9 percent), and the percentage of uninsured adults (11.9 percent) is higher than last year (10.6 percent).

"The substantial decrease in the number of uninsured children can be partially attributed to the CoverKids program and an increase in the number of children covered by TennCare as a result of declining economic conditions," the report noted.

The study also looked at where Medicaid/TennCare recipients initially seek medical care — the doctor's office or the hospital emergency room. Since 1994, there has been a general decline in the percentage of Medicaid/TennCare recipients who seek initial health care at hospital emergency rooms. Interestingly, TennCare recipients continue to see doctors more regularly than non-TennCare recipients. Eighty-seven percent of TennCare heads of household see a physician at least every few months, as do 69 percent of TennCare children. By comparison, 63 percent of all other heads of household and 61 percent of all children see doctors that frequently. "More frequent usage of physicians may indicate increased preventative medical care through annual visits but may also reflect that the population of TennCare adults is one that has greater need for medical services," the report said.

In summary, the report notes "TennCare recipients' experience with medical care remains positive, with the gap between their experiences and those of all Tennesseans narrowing somewhat compared to 2008. TennCare continues to receive positive feedback from its recipients, indicating the program is providing health care in a satisfactory manner and up to the expectations of those it serves." The report is available on-line at http://cber.bus.utk.edu/tncare/tncare09.pdf. The next Beneficiary Survey will be available in August 2010.

H. Other Activities

Affordable Care Act (ACA). With the passage of the Patient Protection and Affordable Care Act (PPACA) of 2010 and the Health Care and Education Reconciliation Act of 2010, known collectively as the Affordable Care Act (ACA), in March 2010, the Bureau of TennCare began analyzing each section of the law to determine what impact the new law would have on the Bureau and TennCare enrollees. Some provisions of the law became effective immediately, which has led to the development of revised rules and policies. Other provisions have later effective dates, and TennCare will implement those changes as required. TennCare is currently working with, and will continue to work with, other agencies to ensure compliance with ACA provisions.

Medicaid Leadership Institute. On June 16, 2010, TennCare Director and Deputy Commissioner of the Tennessee Department of Finance and Administration, Darin Gordon, was selected to participate as a Fellow in the 2011 class of the *Medicaid Leadership Institute*, a national initiative managed by the Center for Health Care Strategies (CHCS). Mr. Gordon is one of six Medicaid directors chosen to be part of this

initiative designed to enhance the leadership capacity of Medicaid directors to help their programs serve as national models for high-quality, cost-effective care.

"Medicaid plays a huge, often underappreciated role in the U.S. health care system. At a time when national health care reform implementation will greatly affect their programs and responsibilities, these six remarkable leaders form an exceptionally talented class for the *Medicaid Leadership Institute*," said Tommy Thompson, former Governor of Wisconsin, who chairs the program's national advisory committee. "These directors are well positioned to blaze a trail for their states and the nation in achieving better quality care for every taxpayer dollar invested in publicly financed health care."

Fellows in the 2011 class of the *Medicaid Leadership Institute* were competitively selected based on their commitment to public service and improvement of public programs, vision for their agency and for Medicaid's role in promoting high-quality, cost-effective care, commitment to using data and analytics for program policy improvement and evaluation, and willingness to consider participating in a joint transformational project with other selected Fellows.

Bus Pass Program. Beginning in August 2009, the Bureau of TennCare began a Bus Pass Program (BPP) as a part of an effort to provide more cost effective non-emergency medical transportation (NEMT) to members. The BPP is designed to operate in localities, primarily metropolitan areas, that have existing public transportation to serve the general community. The first location to use BPP was the Memphis/Shelby County area. Additional locations were added on October 1, 2009 (Nashville/Davidson County, Murfreesboro, Clarksville, Franklin, and Chattanooga) and December 1, 2009 (Knoxville, Kingsport, and Jackson).

The general requirements for enrollees to participate in BPP are:

- Members must be within ¼ mile of a bus stop on both the origination and the destination stops;
- Members will not be required to change buses or trolleys more than once each leg of the trip; and
- The use of a bus or trolley cannot increase travel time more than 60 minutes as compared to transportation directly between the origination and destination of the trip.

If the member's needs are such that bus transportation is not appropriate, he can provide a written physician's statement to that effect to his Managed Care Organization and he will be excluded from the BPP.

Flood. No report on the activities of this past year would be complete without some mention of the Middle Tennessee flood which occurred on the first weekend in May. The TennCare building is located in Metro Center in Nashville, an office park made possible by the construction of a levee that has worked well for years to hold back the Cumberland River. However, its strength came into question during the first week of May and no Metro Center office park employee was allowed to enter the area. Although TennCare employees were unable to return to the building for four days, TennCare remained operational due to the efforts of many TennCare employees to remotely manage many of TennCare's day-to-day operations. Computer servers remained functional, claims were paid, and enrollees' services and appeals were monitored.

Essential Access Hospital (EAH) 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.

The projected Essential Access Hospital payments for the fourth quarter of State Fiscal Year 2010 are shown in the table below. This table also reflects payments year-to-date.

Essential Access Hospital Payments for the Quarter and the Year

Hospital Name	EAH Fourth Quarter FY2010	EAH FY2010 Payments YTD
Methodist Medical Center of Oak Ridge	$ 138,186.00	$ 414,558.00
Ridgeview Psychiatric Hospital and Center	$ 125,298.00	$ 375,894.00
Bedford County Medical Center	$ 57,963.00	$ 173,889.00
Blount Memorial Hospital	$ 122,767.00	$ 368,301.00
Skyridge Medical Center	$ 145,984.00	$ 437,952.00
Skyridge Medical Center - West	$ 116,564.00	$ 349,692.00
Saint Mary's Medical Center of Campbell County	$ 85,897.00	$ 257,691.00
Jellico Community Hospital	$ 80,435.00	$ 241,305.00
Baptist Memorial Hospital - Huntingdon	$ 41,046.00	$ 123,138.00
McKenzie Regional Hospital	$ 42,275.00	$ 126,825.00
Sycamore Shoals Hospital	$ 78,775.00	$ 236,325.00
Claiborne County Hospital	$ 124,980.00	$ 374,940.00
Baptist Hospital of Cocke County	$ 101,752.00	$ 305,256.00
United Regional Medical Center	$ 53,762.00	$ 161,286.00
Harton Regional Medical Center	$ 63,869.00	$ 191,607.00
Cumberland Medical Center	$ 81,986.00	$ 245,958.00
Southern Hills Medical Center	$ 97,041.00	$ 291,123.00
Metro Nashville General Hospital	$ 921,557.00	$ 2,764,671.00
Baptist Hospital	$ 168,075.00	$ 504,225.00
Vanderbilt University Hospital	$ 3,178,412.00	$ 9,535,236.00
Centennial Medical Center	$ 248,972.00	$ 746,916.00
Skyline Medical Center (with Madison Campus)	$ 245,821.00	$ 737,463.00
Summit Medical Center	$ 120,791.00	$ 362,373.00
Decatur County General Hospital	$ 25,705.00	$ 77,115.00
Horizon Medical Center	$ 84,103.00	$ 252,309.00
Dyersburg Regional Medical Center	$ 115,361.00	$ 346,083.00
Methodist Healthcare - Fayette	$ 24,234.00	$ 72,702.00
Jamestown Regional Medical Center	$ 34,459.00	$ 103,377.00

Hospital Name	DA Fourth Quarter FY2010	DA FY2010 Payment YTD
Emerald Hodgson Hospital	$ 16,472.00	$ 49,416.00
Southern Tennessee Medical Center	$ 52,760.00	$ 158,280.00
Gibson General Hospital	$ 33,389.00	$ 100,167.00
Humboldt General Hospital	$ 95,478.00	$ 286,434.00
Hillside Hospital	$ 41,708.00	$ 125,124.00
Takoma Regional Hospital	$ 68,879.00	$ 206,637.00
Morristown - Hamblen Healthcare System	$ 135,539.00	$ 406,617.00
Lakeway Regional Hospital	$ 108,417.00	$ 325,251.00
Erlanger Medical Center	$ 1,830,214.00	$ 5,490,642.00
Erlanger East	$ 11,963.00	$ 35,889.00
Parkridge Medical Center (with Parkridge Valley)	$ 452,996.00	$ 1,358,988.00
Parkridge East Hospital	$ 204,239.00	$ 612,717.00
ABS Lincs TN, Inc.	$ 71,809.00	$ 215,427.00
Bolivar General Hospital	$ 74,739.00	$ 224,217.00
Hardin Medical Center	$ 111,731.00	$ 335,193.00
Wellmont Hawkins County Memorial Hospital	$ 41,260.00	$ 123,780.00
Haywood Park Community Hospital	$ 31,877.00	$ 95,631.00
Henderson County Community Hospital	$ 24,250.00	$ 72,750.00
Henry County Medical Center	$ 72,686.00	$ 218,058.00
Jefferson Memorial Hospital	$ 59,526.00	$ 178,578.00
Fort Sanders Regional Medical Center	$ 280,866.00	$ 842,598.00
Saint Mary's Medical Center	$ 171,309.00	$ 513,927.00
University of Tennessee Memorial Hospital	$ 1,256,490.00	$ 3,769,470.00
East Tennessee Children's Hospital	$ 420,901.00	$ 1,262,703.00
Parkwest Medical Center (with Penninsula)	$ 525,587.00	$ 1,576,761.00
Crockett Hospital	$ 57,010.00	$ 171,030.00
Lincoln Medical Center	$ 42,946.00	$ 128,838.00
Woods Memorial Hospital	$ 40,539.00	$ 121,617.00
Athens Regional Medical Center	$ 69,133.00	$ 207,399.00
McNairy Regional Hospital	$ 40,624.00	$ 121,872.00
Jackson - Madison County General Hospital	$ 623,574.00	$ 1,870,722.00
Regional Hospital of Jackson	$ 158,787.00	$ 476,361.00
Pathways of Tennessee	$ 192,027.00	$ 576,081.00
Grandview Medical Center	$ 61,266.00	$ 183,798.00
Maury Regional Hospital	$ 157,516.00	$ 472,548.00
Sweetwater Hospital Association	$ 136,219.00	$ 408,657.00
Gateway Medical Center	$ 164,615.00	$ 493,845.00
Baptist Memorial Hospital - Union City	$ 59,867.00	$ 179,601.00
Livingston Regional Hospital	$ 57,534.00	$ 172,602.00
Cookeville Regional Medical Center	$ 159,867.00	$ 479,601.00
Roane Medical Center	$ 59,323.00	$ 177,969.00
NorthCrest Medical Center	$ 156,319.00	$ 468,957.00
Middle Tennessee Medical Center	$ 221,327.00	$ 663,981.00

Hospital Name	DAH Fourth Quarter FY 2010	DAH FY 2010 Payments YTD
StoneCrest Medical Center	$ 76,939.00	$ 230,817.00
Fort Sanders Sevier Medical Center	$ 121,824.00	$ 365,472.00
Regional Medical Center at Memphis	$ 4,328,739.00	$12,986,217.00
Saint Jude Children's Research Hospital	$ 339,550.00	$ 1,018,650.00
Methodist Healthcare - South	$ 259,782.00	$ 779,346.00
Methodist University Healthcare	$ 359,929.00	$ 1,079,787.00
Methodist Healthcare - North	$ 161,366.00	$ 484,098.00
Methodist Healthcare - LeBonheur	$ 829,099.00	$ 2,487,297.00
Delta Medical Center	$ 189,306.00	$ 567,918.00
Saint Francis Hospital	$ 472,022.00	$ 1,416,066.00
Community Behavioral Health	$ 110,866.00	$ 332,598.00
Baptist Memorial Hospital for Women	$ 137,788.00	$ 413,364.00
Riverview Regional Medical Center - North	$ 21,364.00	$ 64,092.00
Wellmont Bristol Regional Medical Center	$ 219,763.00	$ 659,289.00
Wellmont Holston Valley Medical Center	$ 329,305.00	$ 987,915.00
Indian Path medical center (with Indian Path Pavillion)	$ 124,239.00	$ 372,717.00
Portland Medical Center	$ 15,550.00	$ 46,650.00
Sumner Regional Medical Center	$ 109,993.00	$ 329,979.00
Baptist Memorial Hospital - Tipton	$ 97,750.00	$ 293,250.00
River Park Hospital	$ 54,129.00	$ 162,387.00
Johnson City Specialty Hospital	$ 14,551.00	$ 43,653.00
Johnson City Medical Center (with Woodridge)	$ 984,588.00	$ 2,953,764.00
Wayne Medical Center	$ 25,695.00	$ 77,085.00
Volunteer Community Hospital	$ 50,287.00	$ 150,861.00
White County Community Hospital	$ 22,418.00	$ 67,254.00
University Medical Center	$ 163,510.00	$ 490,530.00
TOTAL	**$25,000,000.00**	**$75,000,000.00**

Reverification Status

The eligibility of TennCare enrollees continues to be redetermined in accordance with TennCare's rules and policies.

Status of Filling Top Leadership Positions in the Bureau

The following top leadership positions have been filled during the past year:

Raymond G. McIntire, R. Ph was appointed August 23, 2009, as the Associate Director of Pharmacy Operations and is responsible for overseeing the day-to-day operations of the pharmacy program, including point-of-sale claims processing and related messaging, provider and member communications, and pharmacy network issues. Dr. McIntire possesses a Bachelor of Science degree in Pharmacy from

Northeast Louisiana University. He has over seven years experience as a Manager of Clinical Services for RESTAT (a Pharmacy Benefits Manager, or PBM) where he gained extensive knowledge in managed care pharmacy, specifically in the areas of formulary management and pharmacy claims analysis, and over 15 years of experience with retail pharmacy as a staff pharmacist, pharmacy manager, district manager, and account manager.

Jeanine C. Miller, Ph.D. was appointed August 23, 2009, and serves as the Director of Mental Retardation (MR) Home and Community Based Services (HCBS) Waiver Programs responsible for the day-to-day administrative oversight of the State's three 1915(c) HCBS Waiver Programs (Arlington, Statewide, and Self-Determination) for persons with mental retardation. Dr. Miller most recently served as the Director of Mental Health for the Tennessee Department of Correction and has strong operational and administrative experience as both a psychologist and administrator of mental health programs, serving the needs of people with mental illness, mental retardation, and the special needs population. Dr. Miller possesses a Ph.D. of Philosophy in Clinical Psychology and a Master of Arts in Clinical Psychology from Vanderbilt University, and a Bachelor of Arts degree in Psychology from Skidmore College. In addition, she is a graduate of the Tennessee Government Executive Institute.

Jarrett J. Hallcox was appointed October 1, 2009, as the Director of Long-term Care Project Management. He is responsible for creating and executing project work plans to implement key initiatives and improvements in the Division of Long-term Care, including the TennCare CHOICES in Long-term Care Program. Mr. Hallcox was previously employed by the University of Tennessee for a number of years, and was awarded the Exemplary Service Award, three Vice Presidential Citations, and the Robert S. Hutchison Award, the highest award given by the University of Tennessee's Institute for Public Services. Mr. Hallcox possesses a Master's Degree in Public Administration and a Bachelor of Arts Degree with a double major in Political Science and History from the University of Tennessee, Knoxville.

Carolyn Fulghum was appointed February 28, 2010, as the Director of Quality and Administration for Elderly and Disabled Services in the Division of Long-term Care, responsible for quality and administration activities. Ms. Fulghum possesses significant experience in public health management, operations, and project management, and has been serving as the TennCare Project Director in the Division of Quality Oversight, Bureau of TennCare since 2008. Ms. Fulghum possesses a Bachelor of Science in Social Work degree from Austin Peay State University and a Master's in Social Work degree from the University of Tennessee.

Kimberly Carroll was appointed February 28, 2010, as the Director of Long-term Care Systems Management in the Division of Long-term Care, responsible for the development and implementation of comprehensive enrollment and claims activities involved in the implementation of the CHOICES Program. Ms. Carroll has over 23 years of experience in the Tennessee Medicaid/TennCare Program. In her most recent role, she served as a Managed Care Program Manager, responsible for coordinating and managing the PACE Program while overseeing the claims functions for all nursing home and home and community based waiver services claims.

Debbie Coleman was appointed February 28, 2010, as the Director of Long-term Care PreAdmission Evaluation (PAE) Nursing and Support Services, Division of Long-term Care, responsible for overseeing the functions of a PAE Nursing and Support Services Unit. In this role, she is responsible for overseeing the planning, development, and implementation of critical functions of the CHOICES Program. Ms. Coleman has more than five years of experience with the TennCare Program working as a Public Health Nurse Consultant Manager and approximately seven years experience in the Department of Health as a

Public Health Nurse 2. Ms. Coleman possesses a Bachelor of Business Administration Degree in Marketing from Middle Tennessee State University and an Associate of Arts Degree in Nursing from Columbia State Community College, Franklin, Tennessee.

Number of Recipients on TennCare and Costs to the State

At the end of the period April 1, 2010 through June 30, 2010, there were 1,152,252 Medicaid eligibles and 28,843 Demonstration eligibles enrolled in TennCare, for a total of 1,181,095 persons.

Projections of TennCare spending for the fourth quarter and for 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 2010.

Projected Spending for 4th Quarter and Year-to-Date

Expenditure	4th Quarter	Year to date
Spending on MCO services**	$1,074,225,600	$4,185,951,700
Spending on BHO services***	$0	$5,095,900
Spending on dental services	$49,102,400	$161,788,800
Spending on pharmacy services	$180,888,100	$710,837,100
Medicare "clawback" (credit balance – no payments)	$0	$130,598,643

**These figures are cash basis as of June 30 and are unaudited.*

***This figure includes Integrated Managed Care MCO expenditures.*

****Since BHO expenditures are now integrated into MCOs, this amount will continue to decline to zero.*

Viability of MCCs in the TennCare Program

Claims Payment Analysis

The prompt pay requirements of T.C.A. § 56-32-126(b) mandate that each Managed Care Organization (MCO) ensure that 90 percent 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 percent of all provider claims are processed within 60 calendar days of receipt. In addition, the TennCare contract requires MCOs providing long-term care services to CHOICES enrollees to process 90 percent of clean electronically submitted Nursing Facility and applicable Home and Community Based services (HCBS) claims (excluding PERS, assistive technology, minor home modifications, and pest control claims) within 14 calendar days of receipt and 99.5 percent of these claims within 21 calendar days of receipt.

TennCare's contract with its Dental Benefit Manager (DBM) requires the DBM to also process claims in accordance with the statutory standard for MCOs. Furthermore, TennCare's contract with its Pharmacy Benefits Manager (PBM) requires the PBM to pay 100 percent of all clean claims submitted by pharmacy providers within 10 calendar days of receipt.

The MCOs, the DBM, and the PBM are required to submit monthly claims data files of all TennCare claims processed to the Tennessee Department of Commerce and Insurance (TDCI) for verification of statutory and contractual prompt pay compliance. The plans are required to separate their claims data by TennCare Contract (i.e. East, Middle, or West Grand Region) and by subcontractor (i.e. claims processed by a vision benefits manager). Furthermore, the MCOs are required to separately identify non-emergency transportation (NEMT) claims in the data files. Finally, beginning with the submission of March processed claims in April, the MCOs are now required to submit separate claims data files representing a subset of electronically submitted Nursing Facility and applicable HCBS claims for the CHOICES enrollees in the Middle Tennessee Grand Region. TDCI then performs and reports the results of the prompt pay analyses by NEMT and CHOICES claim types, by subcontractor, by TennCare contract and by total claims processed for the month.

During the quarter ended June 30, 2010, TDCI analyzed monthly data files of all processed TennCare claims submitted by the plans for March, April, and May 2010. 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 found that all TennCare MCOS and the DBM complied with the statutory prompt pay requirements and the PBM complied with its contractual prompt pay requirements.

Net Worth Requirement

By statute, the minimum net worth requirement for each TennCare MCO is calculated based on premium revenue for the most recent calendar year. TDCI's calculations for the net worth requirement reflect payments made for the calendar year ended December 31, 2009, including payments made under the "stabilization plan." The TennCare Contract further requires the TennCare MCOs to establish an enhanced net worth based on projected additional annual premiums for the CHOICES program. During this quarter, the MCOs submitted their National Association of Insurance Commissioners (NAIC) First Quarter 2010 Financial Statement. As of March 31, 2010, TennCare MCOs reported net worth as indicated in the table below.

	Net Worth Requirement	Reported Net Worth	Excess/ (Deficiency)
AMERIGROUP Tennessee	$16,133,399	$95,305,728	$79,172,329
UnitedHealthcare Plan of the River Valley (AmeriChoice)	$43,370,119	$285,640,681	$242,270,562
Volunteer (BlueCare & Select)	$28,764,984	$86,151,135	$57,386,151

All TennCare MCOs met their minimum net worth requirements as of March 31, 2010.

Success of Fraud Detection and Prevention

The Office of Inspector General (OIG) was established six 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 TennCare Bureau, Health Related Boards (HRB), the Department of Human Services (DHS), other state agencies, health care providers, Managed Care Contractors (MCC), and the general public via the OIG web site, fax, written correspondence, and phone calls to the OIG hotline. The statistics for the fourth quarter of the 2009 - 2010 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	**1,688**	**7,335**	**128,267**
Cases Closed*	**1,605**	**5,801**	**124,145**

**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.*

Summary of Enrollee Abuse Cases

	Quarter	Grand Total*
Abuse Cases Received	**1,421**	**57,946**
Abuse Cases Closed	**1,129**	**18,801**
Abuse Cases Referred**	**83**	**39,783**

**Totals are for the last 48 months (sixteenth quarterly report)*

***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 received	**25**	**189**	**1,582**
Cases referred to TBI*as part of the Provider Fraud Task Force**	**8**	**36**	**228**
Cases referred to HRBs***	**17**	**28**	**130**

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

*****Provider Fraud Task Force** – this group is made up of representatives of the Attorney General's Office, the TennCare Bureau, the Tennessee Bureau of Investigation, and the OIG; OIG's participation began during the 4th quarter of FY 2008-2009.*

****Health Related Boards*

Summary of Arrests & Convictions

	Quarter	FYTD	Grand Total
Arrests	**73**	**266**	**1,240**
Convictions	**31**	**134**	**609**
Diversions*	**9**	**53**	**233**

Note: *Special Agents were in the field making arrests effective 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	FYTD	Grand Total
Fines	**$21,650.00**	**$84,960.00**	**$341,432.00**
Court Costs & Taxes	**$10,459.83**	**$37,597.61**	**$130,720.94**
Restitution (ordered)	**$35,123.20**	**$217,626.88**	**$1,643,901.31**
Drug Funds/Forfeitures	**$1,506.00**	**$353,367.90**	**$394,836.90**

The OIG aggressively pursues enrollees who have apparently committed fraud or abuse against the TennCare program. The primary criminal case types are: drug cases (drug diversion, drug seekers, doctor shopping, and forging prescriptions), reporting a false income, access to other insurance, and ineligible individuals using a TennCare card.

Arrest Categories

Drug Diversion/Forgery RX	413
Drug Diversion/Sale RX	479
Access to Insurance	55
Doctor Shopping	101
Operation Falcon III	32
Operation Falcon IV	16
False Income	53
Ineligible Person Using Card	17
Living Out Of State	13
Asset Diversion	7
Theft of Services	11
ID Theft	38
Aiding & Abetting	3
Failure to Appear in Court	2
GRAND TOTAL	**1,240**

TennCare Case Referral & Recoupment

	Quarter	1 Yr	Grand Total
Recoupment *	$36,491.00	$339,491.00	$1,914,400.74
Civil Case Recoupment **	$23,129.01	$161,577.56	$596,727.16
Recommended TennCare Terminations ***	219	496	49,158
Potential Savings †	$800,749	$1,813,576.50	$173,048,873.00

**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, 2010.*

***The Grand Total for this column is based on recoupment tracked by the OIG Legal Division since FY 2006.*

****Enrollee termination recommendations sent to the TennCare Bureau for consideration based on information received by the OIG.*

†There were 219 recommended enrollee terminations by the OIG to the TennCare Bureau for their review during the third quarter. The TennCare Bureau uses $3,656.39 as the average annual cost per enrollee for MCO, Pharmacy, BHO, and Dental services (effective FY 08-09). [NOTE: Prior reports reflect $3,351.96, as the average annual cost per enrollee.]

Investigative Sources

	Quarter	1 Yr	Grand Total
OIG Hot Line	953	3,513	24,392
OIG Mail Tips	71	377	3,696
OIG Web Site	215	894	8,009
OIG Email Tips	267	1,013	4,037

Other Investigative Sources for this Quarter

Fax	131
Cash for Tips (pending)	7

Case Types for this Quarter (*sample*)

Drug Diversion	279
Drug Seeker	88
Income/Other Assets	226
Using Another Person's Card	27
Out of State	118
Transfer of Assets	10
Abusing ER	45
Dr. Shopping	309
Other Insurance	192

The Office of Inspector General participated in the following activities during the Fourth Quarter:

Meetings with Law Enforcement Officials and other State Agencies

- Various Judicial Task Forces, District Attorneys, Sheriffs, and Chiefs of Police
- Provider Fraud Task Force meeting at the TennCare Bureau
- TBI Drug Diversion Task Force
- Middle Tennessee Law Enforcement Committee (in Brentwood)
- FBI National Academy Graduates
- MCC Roundtable
- Nursing Home Meeting with the TennCare Bureau and Mental Health

Media

- Interview – News Channel 5 TV, Nashville
- Electronic and print media throughout the State of Tennessee reported the arrests and convictions of the OIG

Training

- Leadership Nashville
- Leadership Franklin
- Tennessee Government Executive Institute Alumni Meetings
- Tennessee Government Management Institute Alumni Meetings
- FBI National Academy Alumni Meetings
- OIG In-Service Training for all commissioned personnel began
- Police Radio Training - radios were re-banded by TEMA
- Simunitions Training

Other OIG Activities

- Inspector General Deborah Faulkner graduated from the 2009–2010 *Leadership Franklin* class.
- Deputy Inspector General David Griswold (CID) graduated from the 2009 – 2010 *Leadership Nashville* class.

Current OIG staffing has 27 fewer positions than the original staffing level:

- 3 employees took the Voluntary Buyout in 2008
- 8 positions were eliminated in 2009
- 6 positions were eliminated in the 2011 budget
- 3 IS employees were transferred to the TennCare Bureau
- 1 Paralegal transferred to the Department of Health
- 1 Special Agent transferred to the State Law Enforcement Training Academy
- 1 Attorney resigned
- 1 Special Agent resigned
- 1 ASA 4 retired
- 2 additional positions are vacant: ASA 4 and a Registered Nurse

The Inspector General, the Deputy Inspector General over Criminal Investigations, and all of the Special Agents have continued to make visits to various Tennessee counties. In each jurisdiction visited, there is planned meeting with the Sheriff, Chief of Police, and members of the Drug Task Force. 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 *Doctor Shopping* legislation (approved by the Governor and the General Assembly, June 2007) has generated 101 arrests as of this writing for violation of this law. The OIG continues to mail letters and posters and provide presentations to notify licensed medical providers and law enforcement agencies in the State about this new law. As a result, positive feedback has been received.

Plans for next quarter:

- Continue to exchange information with local, state, and federal government agencies.
- Provide presentations and training for interested parties regarding TennCare fraud and the role of the OIG.
- Continue staff training and develop best practices.
- Continue to track the *Tips for Cash* incentive program regarding information that leads to a successful arrest and conviction for TennCare fraud. This program is a result of legislation from the 104th General Assembly.
- Continue using the Doctor Shopping Law on investigations regarding suspected chronic abusers of the TennCare program.
- The OIG will continue to participate as an active member of the *TennCare Provider Fraud Task Force* with other members including the Attorney General's Office, the TennCare Bureau, and the Tennessee Bureau of Investigation.
- Ensure all policies and procedures are reviewed, revised as needed, and distributed to the OIG staff.