TennCare Quarterly Report

October – December 2016

Submitted to the Members of the General Assembly

Status of TennCare Reforms and Improvements

Approved Extension of the TennCare Demonstration. On December 22, 2015, the Bureau of TennCare submitted to the Centers for Medicare and Medicaid Services (CMS) an application to renew the TennCare Demonstration. The application requested that the approval period for the Demonstration—which was scheduled to end on June 30, 2016—be extended through June 30, 2021. On December 16, 2016, nearly one year after the application had been submitted, CMS issued written approval.

As documented in TennCare's recent Quarterly Reports to the General Assembly, negotiations between the State and CMS on the renewal request were extensive. The State's application had requested no substantive changes to the Demonstration, but CMS raised a number of subjects for discussion, including supplemental pool payments to Tennessee hospitals, budget neutrality (i.e., not spending more under the Demonstration than would have been spent in its absence), enrollee cost-sharing, and the manner in which the Demonstration would be evaluated.

Some notable elements of CMS's December 16 approval include the following:

- Continuation of TennCare's managed care service delivery system, with minor modifications;
- Continuation of TennCare's current eligibility levels and benefits package;
- Revisions to the amounts and distribution methodologies associated with the supplemental payment pools for hospitals (to be phased in over multiple years);
- Concentration of evaluation efforts on two of TennCare's programs of long-term services and supports (CHOICES and Employment and Community First CHOICES); and
- Flexibility to amend the TennCare waiver, if needed, to reflect future changes in state or federal policy.

Copies of CMS's approval letter and the revised Waiver List, Expenditure Authorities, and Special Terms and Conditions comprising the TennCare Demonstration Agreement are available on TennCare's website at http://www.tn.gov/assets/entities/tenncare/attachments/tenncarewaiver.pdf. As of the end of the October-December 2016 quarter, Bureau staff members were reviewing these materials to determine

whether any technical corrections would be needed. Submission of proposed corrections is due within 30 days of the December 16 letter from CMS.

Budget Presentation. On November 22, 2016, four members of TennCare's executive staff—Director Wendy Long, Deputy Director and Chief of Staff Will Cromer, Deputy Director and Chief Operating Officer Gabe Roberts, and Chief Financial Officer William Aaron—presented the Fiscal Year 2018 proposed budget for the Division of Health Care Finance and Administration (HCFA) to Governor Bill Haslam, Finance and Administration Commissioner Larry Martin, Budget Director David Thurman, and Chief Operating Officer Greg Adams.

The presentation document itself, which is available on HCFA's website at http://www.tn.gov/assets/entities/hcfa/attachments/HCFAbudgetFY18.pdf, concisely summarizes the manner in which TennCare has been able to deliver quality care and achieve high levels of member satisfaction while continuing to manage inflationary growth. Evidence of these achievements as highlighted by the presentation includes the following:

- Provision of health insurance to 1.5 million Tennesseans, including 39,500 individuals receiving long-term services and supports and more than half of the children born in Tennessee;
- Enrollee satisfaction levels above 90 percent for eight years in a row;
- The third highest quality scores among the states in the Southeast region;
- Accreditation of all three TennCare health plans by the National Committee for Quality Assurance; and
- Medical inflation levels well below those of commercial insurance programs and of Medicaid programs nationally (3.3 percent for TennCare as opposed to 6.5 percent for commercial plans and 6.9 percent for Medicaid programs as a whole).

In addition to these accomplishments are updates concerning four of HCFA's chief priorities: the Tennessee Health Care Innovation Initiative (discussed below under the heading of "Payment Reform"); the Employment and Community First CHOICES program, which delivers long-term services and supports to individuals with intellectual and developmental disabilities; the application to renew the TennCare Demonstration (discussed at the outset of this report); and improvements being made to processes for determining and reverifying eligibility for TennCare coverage (discussed below under the heading of "Tennessee Eligibility Determination System").

As in previous years, HCFA identified a list of areas in which expenditures were likely to increase, as well as a set of proposals for reducing program expenditures. Examples of the former included federally required increases in state Medicare spending, further investment in the development of the Tennessee Eligibility Determination System, and rising costs associated with pharmacy coverage. Potential cost-controlling measures identified by HCFA ranged from ongoing reform of payment and delivery systems to educating providers on proper approaches to prescribing opioid drugs, and from refining the Bureau's estate recovery processes to elimination of paper remittance advices for TennCare providers.

Payment Reform. Tennessee's Health Care Innovation Initiative is changing health care payment to reward providers for high-quality and efficient treatment of medical conditions, and to help in maintaining people's health over time. The Initiative has three strategies: episodes of care, long-term services and supports, and primary care transformation. Significant developments in the first and third of these strategies occurred during the October-December 2016 quarter.

Episodes of care. This strategy focuses on acute or specialist-driven health care delivered during a specified time period to treat physical or behavioral conditions such as an acute diabetes exacerbation or attention deficit and hyperactivity disorder (ADHD). Each episode has a principal accountable provider (sometimes referred to as the "quarterback") who is in the best position to influence the cost and quality of the episode. Episodes of care are implemented in groups or—in the terminology of the program—"waves."

In October 2016, evidence of the success of the first wave of episodes—comprising perinatal, acute asthma exacerbation, and total joint replacement (hip and knee)—was published. During the first year of financial accountability for Wave 1, doctors and hospitals reduced costs while maintaining quality of care. Episodes resulted in a reduction in costs of 3.4 percent in perinatal, 8.8 percent in acute asthma exacerbation, and 6.7 percent in total joint replacement. Overall, the cost of services in these three types of episodes was $6.3 million less than the previous year, even though medical costs were projected to increase by 5.5 percent nationally. Conservatively assuming a 3 percent increase would have taken place in the absence of the Initiative, the Wave 1 episodes reduced costs by $11.1 million.

These successes would not have been possible without significant input from such stakeholders as Tennessee providers, payers, patients, and employers. This feedback is central to the design of episodes of care and the other value-based payment strategies that are part of Tennessee's Health Care Innovation Initiative. For each episode, the Initiative organizes Technical Advisory Groups (TAGs) composed of experts in the field to provide clinical feedback on each episode's design. The TAG meetings for Wave 6 episodes were held this past fall (September to November 2016). Appendix A to this report comprises TAG recommendations related to Wave 6 episodes of care, which include acute diabetes exacerbation, pancreatitis, HIV, outpatient skin and soft tissue infection, neonatal age 31 weeks and less, neonatal age 32 to 36 weeks, and neonatal age 37 weeks and greater.

In addition to designing new episodes, TAGs also review existing episodes to determine how they may be improved. On November 15, 2016, for example, the TAG assigned to the ADHD episode from Wave 4 reconvened to address providers' concerns and improve the episode's design. The ADHD TAG has fifteen clinical members and originally met three times from September 2015 to October 2015. Members of this TAG were asked to review each of the episode's five design dimensions: 1) episode triggers, 2) attribution to episode quarterbacks, 3) services included in episode spend, 4) risk adjustment and episode exclusions, and 5) quality metrics. The most important change to emerge from this retrospective review is that providers will have an additional year of preview reporting before the ADHD performance period begins on January 1, 2018. This additional time will not only allow TennCare MCOs

to implement the design changes but also help providers adjust their services, coding practices, and business practices to be successful with the episode. On December 5, 2016, HCFA sent the ADHD TAG members a memo summarizing the manner in which their feedback from the November meeting had been incorporated into the episode design. The memo appears as Appendix B to this report.

Primary care transformation. The Tennessee Health Care Innovation Initiative launched a new statewide program known as "Tennessee Health Link" on December 1, 2016. Providers in the Tennessee Health Link program coordinate health care services for TennCare members with the most significant behavioral health needs. The program is designed to produce improved member outcomes, greater provider accountability and flexibility in the delivery of care, and improved cost control for the State.

Health Link providers are encouraged to ensure the best care setting for each member, offer expanded access to care, improve treatment adherence, and reduce hospital admissions. To achieve these goals, the providers commit to delivering such services as comprehensive care management, care coordination, referrals to social supports, member and family support, transitional care, health promotion, and population health management. Providers receive training and technical assistance, quarterly reports with actionable data, and other resources intended to help them succeed within the Health Link model. Compensation consists of activity payments as well as opportunities for annual outcome payments based on performance in terms of quality and efficiency.

Additional information about Tennessee Health Link is available online at http://www.tn.gov/hcfa/article/tennessee-health-link.

Incentives for Providers to Use Electronic Health Records. The Electronic Health Records (EHR) Incentive Program is a partnership between federal and state governments that grew out of the Health Information Technology for Economic and Clinical Health (HITECH) Act of 2009. The purpose of the program is to provide financial incentives to Medicaid providers[1] to replace outdated, often paper-based approaches to medical record-keeping with electronic systems that meet rigorous certification criteria and that can improve health care delivery and quality. The federal government provides 100 percent of the funding for the incentive payments and 90 percent of the funding for administrative costs.

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

- First-year payments (through the 2016 Program Year) to eligible hospitals or practitioners who either—

[1] CMS allows two types of providers to participate in the Medicaid EHR Incentive Program: medical professionals (medical and osteopathic physicians, nurse practitioners, certified nurse midwives, dentists, and physician assistants who meet certain criteria) and hospitals (acute care hospitals, critical access hospitals, and children's hospitals).

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

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

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

Payment Type	Number of Providers Paid During the Quarter	Quarterly Amount Paid (Oct-Dec 2016)	Cumulative Amount Paid to Date
First-year payments	97[2]	$2,027,567	$171,129,417
Second-year payments	21	$159,706	$54,778,476
Third-year payments	11	$445,050	$27,559,843
Fourth-year payments	7	$59,500	$3,584,175
Fifth-year payments	0	$0	$952,000

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

- Acceptance of Incentive Year 2016 meaningful use attestations based on Modified Stage 2 measures;
- Holding 24 technical assistance calls;
- Responding to 300 emails received in the EHR meaningful use mailbox;
- Conducting two onsite visits to physician offices;
- Attendance at October meetings hosted by the Tennessee Medical Association (TMA) in Chattanooga, Jackson, Kingsport, Knoxville, Memphis, and Nashville;
- Partaking in the 68th Annual Scientific Assembly of the Tennessee Academy of Family Physicians in October;
- Attending the November joint town hall meetings hosted by Amerigroup and UnitedHealthcare in Chattanooga, Johnson City, Knoxville, Memphis, and Nashville;

[2] Of the 97 providers receiving first-year payments in the October-December 2016 quarter, 3 earned their incentives by successfully attesting to meaningful use of EHR technology.

- Participation throughout the quarter in several Southeast Regional Collaboration for HIT/HIE (SERCH) calls;
- Newsletters and occasional alerts distributed by the Bureau's EHR ListServ; and
- A quarterly reminder to Tennessee providers who had registered at the federal level but who have not registered or attested at the state level.

TennCare continues to schedule EHR workshops with a variety of provider organizations to maintain the momentum of the program. The Bureau is currently making every effort to alert eligible professionals and eligible hospitals that 2016 is the last year in which they may enroll in the EHR program and begin attesting. (Enrolled providers may continue to attest—and earn payments, if eligible—through Program Year 2021.) This particular information campaign will continue through March 31, 2017, the enrollment deadline.

Tennessee Eligibility Determination System. Work on the development of the Tennessee Eligibility Determination System (TEDS) continued this quarter. On October 1, HCFA began work with its systems integrator partner, Deloitte Consulting, LLP. The first phase of this work has focused on requirements validation and entry into systems design. HCFA is working toward a single release of the TEDS system that includes an eligibility worker portal that will process applications for all TennCare and CoverKids eligibility categories; a self-service member portal that will allow applicants to apply online for health coverage, create user accounts to report changes, and view notices sent to them; and a partner portal to be used by other State agencies and provider partners (such as the Department of Health) who make presumptive eligibility determinations for certain TennCare populations.

Public Forum on the TennCare Demonstration. In compliance with federal regulation—42 CFR § 431.420(c)—and the terms of its Demonstration agreement with CMS, TennCare hosted a public forum in the downtown branch of the Nashville Public Library on December 15, 2016. The purpose of the forum was to provide members of the public an opportunity to comment on the progress of the TennCare Demonstration project, which has delivered Medicaid services to eligible Tennesseans under a managed care model since 1994.

The December 15 open meeting was not the only avenue through which feedback could be offered. Notice of the forum, which appeared on the TennCare website, included an email address and a physical address to which comments could be sent. Although the Bureau received no comments through any of these outlets, additional opportunities to assess the TennCare Demonstration will be available, as TennCare is required to convene a forum on this subject each year for the foreseeable future.

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

The methodology for distributing these funds, as outlined in Special Term and Condition 53.a. of the TennCare Demonstration Agreement with CMS, specifically considers each hospital's relative contribution to providing services to TennCare members, while also acknowledging differences in payer mix and hospitals' relative ability to make up TennCare losses. Data from the Hospital Joint Annual Report is used to determine hospitals' eligibility for these payments. Eligibility is determined each quarter based on each hospital's participation in TennCare. In order to receive a payment for the quarter, a hospital must be a contracted provider with TennCare Select and at least one other Managed Care Organization (MCO), and it must have contracted with TennCare Select for the entire quarter that the payment represents. Excluded from the Essential Access Hospital payments are Critical Access Hospitals, which receive cost-based reimbursement from the TennCare program and, therefore, are not included, and the four State mental health institutes.

The Essential Access Hospital payments made during the second quarter of State Fiscal Year 2017 (for dates of service during the first quarter) are shown in the table below.

Essential Access Hospital Payments for the Quarter

Hospital Name	County	EAH Second Quarter FY 2017
Vanderbilt University Hospital	Davidson County	$3,432,915
Regional One Health	Shelby County	$3,169,454
Erlanger Medical Center	Hamilton County	$2,588,947
University of Tennessee Memorial Hospital	Knox County	$1,542,189
Johnson City Medical Center (with Woodridge)	Washington County	$1,201,426
Parkridge Medical Center (with Parkridge Valley)	Hamilton County	$976,249
LeBonheur Children's Medical Center	Shelby County	$731,246
Jackson – Madison County General Hospital	Madison County	$608,850
Metro Nashville General Hospital	Davidson County	$565,069
East Tennessee Children's Hospital	Knox County	$518,754
TriStar Centennial Medical Center	Davidson County	$514,178
Methodist Healthcare – Memphis Hospitals	Shelby County	$513,388
Saint Jude Children's Research Hospital	Shelby County	$481,658
Methodist Healthcare – South	Shelby County	$429,437
Parkridge East Hospital	Hamilton County	$402,500
TriStar Skyline Medical Center (with Madison Campus)	Davidson County	$362,675
Parkwest Medical Center (with Peninsula)	Knox County	$344,525
Baptist Memorial Hospital – Memphis	Shelby County	$317,181
Methodist Healthcare – North	Shelby County	$306,653
University Medical Center (with McFarland)	Wilson County	$298,165
Saint Francis Hospital	Shelby County	$277,609
Saint Thomas Rutherford Hospital	Rutherford County	$262,136
Pathways of Tennessee	Madison County	$241,386
Baptist Memorial Hospital for Women	Shelby County	$239,268
Wellmont – Holston Valley Medical Center	Sullivan County	$234,230

Hospital Name	County	EAH Second Quarter FY 2017
Fort Sanders Regional Medical Center	Knox County	$232,697
Saint Thomas Midtown Hospital	Davidson County	$231,424
Cookeville Regional Medical Center	Putnam County	$226,655
Ridgeview Psychiatric Hospital and Center	Anderson County	$216,601
Maury Regional Hospital	Maury County	$209,427
TriStar StoneCrest Medical Center	Rutherford County	$167,976
Blount Memorial Hospital	Blount County	$162,181
TriStar Horizon Medical Center	Dickson County	$141,258
TriStar Summit Medical Center	Davidson County	$139,669
Gateway Medical Center	Montgomery County	$138,731
TriStar Southern Hills Medical Center	Davidson County	$138,320
Sumner Regional Medical Center	Sumner County	$136,690
Skyridge Medical Center	Bradley County	$131,502
TriStar Hendersonville Medical Center	Sumner County	$124,432
Dyersburg Regional Medical Center	Dyer County	$122,924
NorthCrest Medical Center	Robertson County	$118,795
Morristown – Hamblen Healthcare System	Hamblen County	$115,839
LeConte Medical Center	Sevier County	$111,737
Methodist Medical Center of Oak Ridge	Anderson County	$104,118
Jellico Community Hospital	Campbell County	$94,593
Takoma Regional Hospital	Greene County	$93,438
Sycamore Shoals Hospital	Carter County	$67,328
Starr Regional Medical Center – Athens	McMinn County	$66,532
Skyridge Medical Center – Westside	Bradley County	$63,962
Grandview Medical Center – Jasper	Marion County	$62,662
Heritage Medical Center	Bedford County	$61,081
Bolivar General Hospital	Hardeman County	$60,652
Regional Hospital of Jackson	Madison County	$60,040
Southern Tennessee Regional Health System – Winchester	Franklin County	$59,541
Henry County Medical Center	Henry County	$55,985
Baptist Memorial Hospital – Union City	Obion County	$55,953
Henderson County Community Hospital	Henderson County	$54,591
Saint Thomas River Park Hospital	Warren County	$53,430
Hardin Medical Center	Hardin County	$51,604
Roane Medical Center	Roane County	$51,182
Lakeway Regional Hospital	Hamblen County	$50,581
Southern Tennessee Regional Health System – Lawrenceburg	Lawrence County	$46,606
PremierCare Tennessee, Inc.	Putnam County	$42,013
Hillside Hospital	Giles County	$40,253
Claiborne County Hospital	Claiborne County	$39,650
McKenzie Regional Hospital	Carroll County	$34,478
Erlanger Health System – East Campus	Hamilton County	$33,611

Hospital Name	County	EAH Second Quarter FY 2017
DeKalb Community Hospital	DeKalb County	$31,078
Jamestown Regional Medical Center	Fentress County	$30,798
Stones River Hospital	Cannon County	$28,190
Volunteer Community Hospital	Weakley County	$26,673
Wayne Medical Center	Wayne County	$22,336
United Regional Medical Center	Coffee County	$18,640
Southern Tennessee Regional Health System – Sewanee	Franklin County	$11,455
TOTAL		**$25,000,000**

Number of Recipients on TennCare and Costs to the State

During the month of December 2016, there were 1,520,527 Medicaid eligibles and 24,671 Demonstration eligibles enrolled in TennCare, for a total of 1,545,198 persons.

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

Spending Category	Second Quarter FY 2017*
MCO services**	$1,221,700,800
Dental services	$41,817,300
Pharmacy services	$299,621,500
Medicare "clawback"***	$52,666,300

**These figures are cash basis as of December 31 and are unaudited.*

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

****The Medicare Part D clawback is money that states are required to pay to the federal government to help offset costs the federal government incurs by covering the prescription benefit for enrollees who have both Medicare and Medicaid.*

Viability of Managed Care Contractors (MCCs) in the TennCare Program

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

Entity	Standard	Authority
MCOs (services other than CHOICES and ECF CHOICES)	90% of clean claims for payment for services delivered to TennCare enrollees are processed and, if appropriate, paid within 30 calendar days of the receipt of such claims. 99.5% of all provider claims are processed, and, if appropriate, paid within 60 calendar days of receipt.	TennCare contract and in accordance with T.C.A. § 56-32-126(b)
MCOs (CHOICES and ECF CHOICES services)	90% of clean electronically submitted Nursing Facility and applicable Home and Community Based Services claims[3] are processed and paid within 14 calendar days of receipt. 99.5% of clean electronically submitted Nursing Facility and applicable Home and Community Based Services claims[4] are processed and paid within 21 calendar days of receipt.	TennCare contract

[3] Excludes Personal Emergency Response Systems (PERS), assistive technology, minor home modifications, and pest control claims. Claims for delivery of these services are handled like general MCO claims.

[4] Ibid.

Entity	Standard	Authority
Dental Benefits Manager (DBM)	90% of clean claims for payment for services delivered to TennCare enrollees are processed, and, if appropriate, paid within 30 calendar days of the receipt of such claims. 99.5% of all provider claims are processed, and, if appropriate, paid within 60 calendar days of receipt.	TennCare contract and in accordance with T.C.A. § 56-32-126(b)
Pharmacy Benefits Manager (PBM)	100% of all clean claims submitted by pharmacy providers are paid within 10 calendar days of receipt.	TennCare contract

The MCOs, the DBM, and the PBM are required to submit monthly claims data files of all TennCare claims processed to the Tennessee Department of Commerce and Insurance (TDCI) for verification of statutory and contractual prompt pay compliance. The plans are required to separate their claims data by claims processor (e.g., MCO, vision benefits manager, etc.). Furthermore, the MCOs are required to identify separately non-emergency transportation (NEMT) claims in the data files. Finally, the MCOs are required to submit separate claims data files representing a subset of electronically submitted Nursing Facility and applicable Home and Community Based Services claims for CHOICES and ECF CHOICES enrollees. TDCI then performs an analysis and reports the results of the prompt pay analyses by NEMT and CHOICES and ECF CHOICES claim types, by claims processor, and by total claims processed for the month.

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

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

During the October-December 2016 quarter, the MCOs submitted their NAIC Third Quarter 2016 Financial Statements. As of September 30, 2016, TennCare MCOs reported net worth as indicated in the table below.[5]

[5] The "Net Worth Requirement" and "Reported Net Worth" figures in the table are based on the MCOs' company-wide operations, not merely their TennCare operations.

MCO	Net Worth Requirement	Reported Net Worth	Excess/ (Deficiency)
Amerigroup Tennessee	$29,016,782	$164,605,845	$135,589,063
UnitedHealthcare Plan of the River Valley (UnitedHealthcare Community Plan)	$55,361,026	$396,744,212	$341,383,186
Volunteer State Health Plan (BlueCare & TennCare Select)	$43,251,806	$376,230,137	$332,978,331

During the October-December 2016 quarter, the MCOs were also required to comply with Tennessee's "Risk-Based Capital for Health Organizations" statute (T.C.A. § 56-46-201 *et seq.*). Risk-based capital (RBC) involves a method of calculating the minimum amount of capital necessary for a health entity to support its overall business operations depending on its size and risk profile. A health entity with a higher amount of risk is required to hold a higher amount of capital. The RBC statute gives TDCI the authority and mandate to use preventive and corrective measures that vary depending on the amount of capital deficiency indicated by the RBC calculations. A "Company Action Level" deficiency (defined at T.C.A. § 56-46-203(a)) would require the submission of a plan to correct the entity's capital deficiency.

The following table compares the MCOs' net worth to the Company Action Level requirements as of September 30, 2016:

MCO	Company Action Level	Reported Net Worth	Excess/ (Deficiency)
Amerigroup Tennessee	$104,759,436	$164,605,845	$59,846,409
UnitedHealthcare Plan of the River Valley (UnitedHealthcare Community Plan)	$189,545,450	$396,744,212	$207,198,762
Volunteer State Health Plan (BlueCare & TennCare Select)	$133,523,082	$376,230,137	$242,707,055

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

Success of Fraud Detection and Prevention

The mission of the Tennessee Office of Inspector General (OIG) is to identify, investigate, prosecute, and arrest persons who commit fraud or abuse against the TennCare program and to recoup money owed to the State of Tennessee. The OIG receives case information from a variety of sources, including local law enforcement, the TennCare Bureau, Health Related Boards (HRB), the Department of Human Services (DHS), other State agencies, health care providers, MCCs, and the general public via the OIG website, fax, written correspondence, and phone calls to the OIG hotline. Cases adjudicated during a particular fiscal year may have no relationship to dates of arrest during the same year. Selected statistics for the second quarter of Fiscal Year 2017 are as follows:

Fraud and Abuse Complaints	Second Quarter FY 2017
Fraud Allegations	857
Abuse Allegations*	681
Arrest/Conviction/Judicial Diversion Totals	**Second Quarter FY 2017**
Arrests	47
Convictions	59
Judicial Diversions	13

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

Criminal Court Fines and Costs Imposed	Second Quarter FY 2017
Court Costs & Taxes	$4,006
Fines	$60,250
Drug Funds/Forfeitures	$1,540
Criminal Restitution Ordered	$169,662
Criminal Restitution Received[6]	$17,432
Civil Restitution/Civil Court Judgments	**Second Quarter FY 2017**
Civil Restitution Ordered[7]	$0
Civil Restitution Received[8]	$8,957

Recommendations for Review	Second Quarter FY 2017
Recommended TennCare Terminations[9]	169
Potential Savings[10]	$617,930

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

[7] This total reflects dollars identified for recoupment by the OIG in such non-criminal contexts as civil cases, administrative hearings, and voluntary reimbursements to TennCare.

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

[9] Recommendations that enrollees' TennCare coverage should be terminated are sent to the TennCare Bureau for review and determination of appropriate action. These recommendations are based on information received and reviewed by the OIG. The Bureau determines whether these referrals meet the criteria for termination. In reviewing these recommendations, TennCare must factor in some limitations, such as the inability to disenroll individuals in certain federally protected categories.

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

Statewide Communication

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

Appendix A

TAG Recommendations for Wave 6 Episodes of Care

Acute diabetes exacerbation episode design summary

Identifying episode triggers

An acute diabetes exacerbation episode is triggered by either an inpatient admission or observation outpatient claim where the primary diagnosis is one of the defined diabetic ketoacidosis (DKA) or hyperglycemic hyperosmolar state (HHS) trigger codes. An inpatient admission or observation claim where the primary diagnosis is one of the defined Type I, Type II, secondary, or gestational diabetes trigger codes and the secondary diagnosis is one of the defined DKA or HHS codes is also a potential trigger.

Attributing episodes to quarterbacks

The quarterback is the facility where the patient is treated. The contracting entity ID will be used to identify the quarterback.

Identifying services to include in episode spend

Services to include in episode spend are: all medical services and specific medications during the triggering window; specific care after discharge; specific imaging and testing and specific medications up to 30 days after the triggering event.

Excluding episodes

There are three types of exclusions. Business exclusions: available information is not comparable or is incomplete. Clinical exclusions: patient's care pathway is different for clinical reasons. These include patients diagnosed with osteomyelitis, pericarditis, HIV, history of cardiac arrest, peritonitis, other CNS infections or cystic fibrosis. Patients who received an organ transplant are excluded. Episodes are also excluded if patients are age 65 or older. High-cost outlier exclusions: episode's risk-adjusted spend is three standard deviations above the mean.

Determining quality metrics performance

Quality metrics tied to gain sharing are: percentage of valid episodes with follow-up care in the first 14 days of the post-trigger window; percentage of valid episode with diabetes counseling during the episode window.

Quality metrics not tied to gain sharing are: percentage of valid episodes with a relevant readmission in the post trigger window; percentage of valid episodes with a relevant emergency department (ED) visit in the post-trigger window; percentage of valid episodes with intensive care unit (ICU) utilization in the trigger window; percentage of valid episodes

with diabetes-related medications in the post-trigger window; percentage of valid episodes with computerized tomography (CT) scan or magnetic resonance imaging (MRI) usage in the trigger window; the average length of stay of the trigger window for inpatient-triggered episodes.

Pancreatitis episode design summary

Identifying episode triggers

A pancreatitis episode is triggered by either an inpatient admission or observation outpatient claim where the primary diagnosis is one of the defined acute or chronic pancreatitis trigger codes. An inpatient admission or observation claim with a primary diagnosis of the defined symptoms, findings, related disorders, or potential etiologies with a secondary diagnosis code from the defined acute or chronic pancreatitis diagnosis codes is also a potential trigger.

Attributing episodes to quarterbacks

The quarterback is the facility where the patient is treated. The contracting entity ID will be used to identify the quarterback.

Identifying services to include in episode spend

Services to include in episode spend are: all medical services and specific medications during the triggering window; specific care after discharge, specific imaging and testing, specific surgical and medical procedures and specific medications up to 30 days after the triggering event.

Excluding episodes

There are three types of exclusions. Business exclusions: available information is not comparable or is incomplete. Clinical exclusions: patient's care pathway is different for clinical reasons. These include patients diagnosed with cystic fibrosis or an immunity disorder or patients who received an organ transplant. Episodes are also excluded if they are age 65 or older. High-cost outlier exclusions: episode's risk-adjusted spend is three standard deviations above the mean.

Determining quality metrics performance

Quality metrics tied to gain sharing are: percentage of valid episodes with follow-up care in the first 14 days of the post-trigger window; percentage of valid episodes with nutritional counseling during the episode window.

Quality metrics not tied to gain sharing are: percentage of valid episodes with a new narcotics prescription in the post-trigger window; percentage of valid episodes with multiple narcotics prescriptions within the post-trigger window; percentage of valid episodes with a relevant readmission in the post-trigger window; percentage of valid episodes with a relevant ED visit in the post-trigger window; percentage of valid episodes with an endoscopic retrograde cholangiopancreatography (ERCP) performed during the trigger window; percentage of valid episodes with a relevant laboratory test in the first 14 days of the post-trigger window; percentage of valid episodes with the cholecystectomy performed during the trigger window for valid episodes with a cholecystectomy performed.

Human Immunodeficiency Virus (HIV) episode design summary

Identifying episode triggers

An HIV episode is triggered by a pharmacy claim with a medication code for HIV-specific antiretroviral therapy (ART). It must be confirmed by a professional evaluation and management claim with a primary or secondary diagnosis of HIV or an AIDS-defining illness on the day of the ART pharmacy claim or within 179 days after to be a potential trigger.

Attributing episodes to quarterbacks

The quarterback is the physician or physician group with the most encounters for HIV-related evaluation and management. Quarterbacks are attributed according to a hierarchy based on the types of encounters and diagnoses. The contracting entity ID will be used to identify the quarterback.

Identifying services to include in episode spend

Services to include in episode spend are: specific associated care, specific testing, specific medications and specific surgical and medical procedures during the episode window.

Excluding episodes

There are three types of exclusions. Business exclusions: available information is not comparable or is incomplete. Clinical exclusions: patient's care pathway is different for clinical reasons. These include patients with cardiac arrest, cystic fibrosis, multiple sclerosis or a spinal cord injury. Episodes are also excluded if the patient is younger than 1 (<1) years of age or older than 64 (>64) years of age on the day of the triggering event. High-cost outlier exclusions: episode's risk-adjusted spend is three standard deviations above the mean.

Determining quality metrics performance

Quality metrics tied to gain sharing are: percentage of valid episodes that have an ART pharmacy claim in at least four of the five defined time intervals during the episode window; percentage of valid episodes with coding for viral status.

Quality metrics not tied to gain sharing are: percentage of valid episodes that have an ART pharmacy claim in none, one, or two of the five defined time intervals during the episode window; percentage of valid episodes where the patient did not have an ART prescription in the one year prior to the episode; percentage of valid episodes with viral load under 200 copies/mL for episodes with viral status reporting; percentage of valid episodes where all of the ART medications used during the episode window are on the current Preferred Drug List (PDL); percentage of valid episodes with one or more HIV-related hospitalization; percentage of valid episodes with one or more HIV-related ED visit; percentage of valid episodes with screening for chlamydia, gonorrhea, or syphilis for episodes where the patients are 14 years or older; percentage of valid episodes with screening for hepatitis C.

Skin and soft tissue infections episode (SSTI) design summary

Identifying episode triggers

An SSTI episode is triggered by a professional claim where the primary diagnosis is an SSTI diagnosis code. A professional claim with a primary diagnosis of an SSTI specific sign, symptom, or predisposing comorbidity and a secondary diagnosis code from among the SSTI diagnosis codes is also a potential trigger.

Attributing episodes to quarterbacks

The quarterback is the physician or physician group that diagnoses the SSTI. The contracting entity ID will be used to identify the quarterback.

Identifying services to include in episode spend

Services to include in episode spend are: care for specific diagnoses, specific imaging and testing, specific medications and specific surgical and medical procedures during the trigger window; care for specific diagnoses, care for specific complications, specific imaging and testing, specific surgical and medical procedures and specific medications up to 30 days after the triggering event.

Excluding episodes

There are three types of exclusions. Business exclusions: available information is not comparable or is incomplete. Clinical exclusions: patient's care pathway is different for clinical reasons. These include patient receiving care in an inpatient setting at initial diagnosis or within one day of initial diagnosis, complicated skin and soft tissue infections at initial diagnosis or prior to the episode, sepsis or shock at initial diagnosis, diabetic and pressure ulcers at initial diagnosis or prior to the episode, gangrene at initial diagnosis or prior to the episode, post-surgical wound infections at initial diagnosis or prior to the episode, second and third degree burns at initial diagnosis or prior to the episode and multiple myeloma during the episode or prior to the episode. Episodes are also excluded if the patient is younger than 1 (<1) month of age or older than 64 (>64) years of age on the day of the triggering event. High-cost outlier exclusions: episode's risk-adjusted spend is three standard deviations above the mean.

Determining quality metrics performance

Quality metrics tied to gain sharing are: percentage of bacterial cultures obtained for valid episodes that had an incision and drainage; percentage of first-line antibiotics filled for valid episodes that had an antibiotic prescription filled within the seven days after initial diagnosis.

Quality metrics not tied to gain sharing are: percentage of valid episodes with an inpatient admission during the post-trigger window; percentage of valid episodes with an ED visit during the post-trigger window; percentage of valid episodes where ultrasound imaging was obtained during the episode window; percentage of valid episodes where non-ultrasound imaging was obtained during the episode window; percentage of valid episodes where an incision and drainage was performed during the episode window; percentage of episodes that filled a second antibiotic during days 15-30 of the episode window for valid episodes that had an antibiotic prescription filled within the first 15 days after initial diagnosis.

<u>Neonatal: 37 weeks and greater episode design summary</u>

Identifying episode triggers

A gestational age 37 weeks or greater neonatal episode is triggered by an inpatient facility claim with a diagnosis of live birth. The inpatient facility claim must be confirmed by either the presence of a diagnosis indicating a gestational age of 37 weeks or greater or by the absence of any gestational age diagnosis.

Attributing episodes to quarterbacks

The quarterback is the facility where the newborn was delivered and initial care was received. The contracting entity ID will be used to identify the quarterback.

Identifying services to include in episode spend

Services to include in episode spend are: all medical services, procedures, laboratory testing, imaging, pathology, medications and additional care during the trigger window; all medical services, procedures, laboratory testing, imaging, pathology, medications and additional care after discharge are included up to seven days post-discharge (post-trigger window) *except* for presentations out of the control of a provider (e.g., accidental trauma).

Excluding episodes

There are three types of exclusions. Business exclusions: available information is not comparable or is incomplete. Clinical exclusions: patient's care pathway is different for clinical reasons. These include patients delivered in an emergency room setting, a hospitalization longer than (>)30 days during the episode window, multiple births of triplets or greater, birth weight of less than 2,000 grams, post-term infants, maternal death, certain major disorders (e.g., neurologic and nervous system, cardiovascular, respiratory, gastrointestinal, renal, hepatobiliary, genitourinary, hematologic, and immunologic disorders), and certain congenital anomalies (e.g., neurologic and nervous system, cardiovascular, respiratory, gastrointestinal, renal, hepatobiliary, genitourinary, musculoskeletal, chromosomal, and other anomalies). Episodes are also excluded if the patient is older than 64 (>64) years of age on the day of the triggering event. High-cost outlier exclusions: episode's risk-adjusted spend is three standard deviations above the mean.

Determining quality metrics performance

Quality metrics tied to gain sharing are: percentage of valid episodes where the newborn received a hearing screen during the initial hospitalization; percentage of valid episodes where the newborn received a critical congenital heart disease screen during the initial hospitalization; percentage of valid episodes where the newborn received a blood spot screen during the initial hospitalization; percentage of valid episodes where the newborn received a hepatitis B vaccination during the initial hospitalization.

Quality metrics not tied to gain sharing are: percentage of valid episodes with a first pediatric visit within the first three days after discharge; percentage of valid episodes with a

first pediatric visit within the first five days after discharge; percentage of valid episodes with a readmission during the 30 days after initial hospitalization; percentage of valid episodes with a presentation to the emergency department during the 30 days after initial hospitalization; percentage of all episodes where the patient had a patient discharge status of "expired" on any inpatient or outpatient claim during the trigger window or within the 30 days after initial hospitalization.

Neonatal: 32 to 36 weeks episode design summary

Identifying episode triggers

A gestational age 32 to 36 weeks neonatal episode is triggered by an inpatient facility claim with a diagnosis of live birth and a diagnosis of a gestational age of 32 to 36 weeks.

Attributing episodes to quarterbacks

The quarterback is the facility where the newborn was delivered and initial care was received. The contracting entity ID will be used to identify the quarterback.

Identifying services to include in episode spend

Services to include in episode spend are: all medical services, procedures, laboratory testing, imaging, pathology, medications and additional care during the trigger window; all medical services, procedures, laboratory testing, imaging, pathology, medications and additional care after discharge are included up to seven days post-discharge (post-trigger window) *except* for presentations out of the control of a provider (e.g., accidental trauma).

Excluding episodes

There are three types of exclusions. Business exclusions: available information is not comparable or is incomplete. Clinical exclusions: patient's care pathway is different for clinical reasons. These include patients delivered in an emergency room setting, multiple births of triplets or greater, birth weight of less than 1,000 grams, maternal death, certain major disorders (e.g., neurologic and nervous system, cardiovascular, respiratory, gastrointestinal, renal, hepatobiliary, genitourinary, hematologic, and immunologic disorders), and certain congenital anomalies (e.g., neurologic and nervous system, cardiovascular, respiratory, gastrointestinal, renal, hepatobiliary, genitourinary, musculoskeletal, chromosomal, and other anomalies). Episodes are also excluded if the patient is older than 64 (>64) years of age on the day of the triggering event. High-cost outlier exclusions: episode's risk-adjusted spend is three standard deviations above the mean.

Determining quality metrics performance

Quality metrics tied to gain sharing are: percentage of valid episodes where the newborn received a hearing screen during the initial hospitalization; percentage of valid episodes where the newborn received a critical congenital heart disease screen during the initial hospitalization; percentage of valid episodes where the newborn received a blood spot screen during the initial hospitalization; percentage of valid episodes where the newborn received a hepatitis B vaccination during the initial hospitalization.

Quality metrics not tied to gain sharing are: percentage of valid episodes with a first pediatric visit within the first three days after discharge; percentage of valid episodes with a first pediatric visit within the first five days after discharge; percentage of valid episodes with a readmission during the 30 days after initial hospitalization; percentage of valid episodes with a presentation to the emergency department during the 30 days after initial hospitalization; percentage of all episodes where the patient had a patient discharge status of "expired" on any inpatient or outpatient claim during the trigger window or within the 30 days after initial hospitalization.

<u>Neonatal: 31 weeks or less episode design summary</u>

Identifying episode triggers

A gestational age 31 weeks or less neonatal episode is triggered by an inpatient facility claim with a diagnosis of live birth and a diagnosis of a gestational age of 31 weeks or less.

Attributing episodes to quarterbacks

The quarterback is the facility where the newborn was delivered and initial care was received. The contracting entity ID will be used to identify the quarterback.

Identifying services to include in episode spend

Services to include in episode spend are: all medical services, procedures, laboratory testing, imaging, pathology, medications and additional care during the trigger window; all medical services, procedures, laboratory testing, imaging, pathology, medications and additional care after discharge are included up to seven days post-discharge (post-trigger window) *except* for presentations out of the control of a provider (e.g., accidental trauma).

Excluding episodes

There are three types of exclusions. Business exclusions: available information is not comparable or is incomplete. Clinical exclusions: patient's care pathway is different for clinical reasons. These include patients delivered in an emergency room setting, multiple births of triplets or greater, maternal death, certain major disorders (e.g., neurologic and nervous system, cardiovascular, respiratory, gastrointestinal, renal, hepatobiliary, genitourinary, hematologic, and immunologic disorders), and certain congenital anomalies (e.g., neurologic and nervous system, cardiovascular, respiratory, gastrointestinal, renal, hepatobiliary, genitourinary, musculoskeletal, chromosomal, and other anomalies). Episodes are also excluded if the patient is older than 64 (>64) years of age on the day of the triggering event. High-cost outlier exclusions: episode's risk-adjusted spend is three standard deviations above the mean.

Determining quality metrics performance

Quality metrics tied to gain sharing are: percentage of valid episodes where the newborn received a hearing screen during the initial hospitalization; percentage of valid episodes where the newborn received a critical congenital heart disease screen during the initial hospitalization; percentage of valid episodes where the newborn received a blood spot screen during the initial hospitalization; percentage of valid episodes where the newborn received a hepatitis B vaccination during the initial hospitalization; percentage of valid episodes where the newborn was discharged from a facility that participates in the Vermont Oxford Network (VON).

Quality metrics not tied to gain sharing are: percentage of valid episodes with a first pediatric visit within the first three days after discharge; percentage of valid episodes with a first pediatric visit within the first five days after discharge; percentage of valid episodes with a readmission during the 30 days after initial hospitalization; percentage of valid episodes with a presentation to the emergency department during the 30 days after initial hospitalization; percentage of all episodes where the patient had a patient discharge status of "expired" on any inpatient or outpatient claim during the trigger window or within the 30 days after initial hospitalization.

Appendix B

Update on the ADHD Episode of Care

TN Division of Health Care Finance & Administration

MEMO

Date: December 5, 2016
Subject: Update on the ADHD Episode of Care

TO: ADHD TAG Members and all ADHD service providers

This memo discusses the changes to the design of the Attention-Deficit/ Hyperactivity Disorder (ADHD) episode for the 2017 calendar year based on your feedback from the TAG follow-up meeting held on November 15, 2016. For each episode, the state convenes a group of expert Tennessee clinicians who volunteer their time to recommend a clinical design of an episode. The TAG originally met three times from September 2015 to October 2015 to make clinical recommendations on the design of the ADHD episode, and reconvened to follow-up after some Tennessee providers raised concerns about the episode. Thank you to the participants in the original ADHD TAG who were able to participate in the follow-up meeting.

The most important change is that providers will have an additional year of preview reporting before the ADHD performance period begins January 1, 2018. This additional time will allow TennCare MCOs to implement the design changes. Providers will also have additional time to make changes to their services, coding practices, and business practices to be successful with the episode.

Stakeholder input from Tennessee providers, payers, patients, and employers is an essential part of the design of episodes of care and the other value-based payment strategies that make up Tennessee's Health Care Innovation Initiative. We will continue to seek and encourage input from our stakeholders.

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

Changes to the ADHD episode of care based on TAG feedback

Change: The performance period for the ADHD episode of care will be delayed one year.

Explanation: After receiving feedback from the TAG members, TennCare has decided to delay the start of the ADHD episode by one year. The performance period will now begin January 1, 2018. Preview reports will continue to be sent each quarter until the new performance period begins. The design changes in this memo will be effective starting with the May 1, 2017, preview reports.

Change: Exclude Level I Case Management from ADHD episode for one year.

Explanation: In 2014, 607 valid ADHD episodes with no behavioral health comorbidities had level I case management. However, according to the TAG, patients with only uncomplicated ADHD should not be receiving level I case management. To ensure that we are fairly comparing patients, episodes with level I case management will be excluded for one year. Within that year, it is expected that providers improve coding to ensure that more severe patients with comorbidities are risk adjusted or excluded. The design question of whether to include level I case management will be revisited prior to the first performance period in 2018.

Change: Exclude homeless patients from the ADHD episode.

Explanation: The TAG members felt that child homelessness was associated with a unique ADHD patient journey and should be excluded.

Change: Exclude children who are in state custody through the Department of Children's Services (DCS).

Explanation: The consensus of the TAG members was the children with ADHD in DCS custody could have additional behavioral health comorbidities that might not be able to be diagnosed.

Change: Exclude disruptive mood dysregulation disorder (DMDD) from the ADHD episode.

Explanation: DMDD is a relatively new diagnosis that TAG members noted should be excluded as it follows a similar clinical pathway as bipolar disorder.

Change: A new quality metric tied to gain sharing will be added to measure the use of long-acting medications.

Explanation: The TAG recommended a new quality measure on the ratio of long-acting stimulants (numerator) to all stimulants prescribed (denominator) grouped by age: 4 to 5 years, 6 to 11 years, and 12 to 20 years. All three quality metrics will be linked to gain sharing; therefore a provider will only be rewarded for efficiency if most of their prescriptions are for long-acting medications.

Change: The utilization of therapy quality metric will be updated to stratify episodes by age.

Explanation: The utilization of therapy captures the average number of therapy visits per valid episode. The quality metric will be divided into three age groups: 4 to 5 years, 6 to 11 years, and 12 to 20 years, based on the TAG recommendation. The 4 to 5 years age group will be linked to gain-sharing.

Change: The TAG recommends that risk adjustment for risk factors that are grouped together be split where applicable.

Explanation: In some cases, risk adjustment factors have been grouped together and not counted individually. The TAG members felt that these risk factors were additive and should be considered separately. Note that risk adjustment is based on payers' analysis of their data; whether individual factors are associated with higher cost members depends on the result of that analysis.