December 3, 2014

The Honorable Ron Ramsey  
Speaker of the Senate  
The Honorable Beth Harwell  
Speaker of the House of Representatives  
The Honorable Mike Bell, Chair  
Senate Committee on Government Operations  
The Honorable Judd Matheny, Chair  
House Committee on Government Operations  
and  
Members of the General Assembly  
State Capitol  
Nashville, Tennessee 37243  
and  
Mr. Darin Gordon, Deputy Commissioner  
Division of Health Care Finance and Administration  
Department of Finance and Administration  
4th Floor West  
310 Great Circle Road  
Nashville, Tennessee 37243

Ladies and Gentlemen:

Transmitted herewith is the performance audit of the Bureau of TennCare. This audit was conducted pursuant to the requirements of the Tennessee Governmental Entity Review Law, Section 4-29-111, *Tennessee Code Annotated*.

This audit is intended to aid the Joint Government Operations Committee in its review to determine whether the department should be continued, restructured, or terminated.

Sincerely,

Deborah V. Loveless, CPA  
Director

14/034-BOTC
We audited the Bureau of TennCare for the period July 2011 through October 2014. Our audit scope encompassed all sections of the bureau and included a review of internal controls and compliance with laws and regulations that are significant within the context of the audit objectives. However, a July 2014 lawsuit against the bureau in federal court limited our audit work in some bureau operational areas, as described on pages 7–8. Our audit objectives were to determine the overall current process for applying for TennCare medical/behavioral benefits; to determine the overall current process for applying for long-term care/CHOICES; to determine the overall current process for eligibility appeals regarding TennCare medical/behavioral benefits; to determine whether medical appeals regarding TennCare medical/behavioral benefits are handled in a fair manner consistent with policies and procedures; to determine whether applicants for long-term care/CHOICES are evaluated in a manner consistent with policies and procedures with regard to the medical need/level of care standards, and whether appeals of these evaluation decisions are handled in a fair manner consistent with policies and procedures; to review the status of the Tennessee Eligibility Determination System (TEDS); to follow up on a previous finding in the April 2011 Department of Finance and Administration performance audit by determining whether TennCare consistently and properly assesses, collects, and records liquidated damages against its managed care contractors (MCCs) in a timely manner; to follow up on whether the bureau ensures that liquidated damages provisions in its MCC contracts are consistent with the Grier Consent Decree; to follow up on a previous finding from the above-mentioned April 2011 performance audit by evaluating whether problems with TennCare’s provider database and filing system have been resolved; to assess the transition from disease management to risk stratification in handling TennCare enrollee health needs; and to review the status of payment reform.

For our sample design, we used nonstatistical audit sampling, which was the most appropriate and cost-effective method for concluding on our audit objectives. Based on our professional judgment, review of authoritative sampling guidance, and careful consideration of underlying statistical concepts, we believe that nonstatistical sampling provides sufficient, appropriate audit evidence to support the conclusions in our report. We present more detailed information about our methodologies in the individual report sections.
We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

**AUDIT FINDING**

The Bureau of TennCare should distribute easy-to-understand information about the CHOICES application process

TennCare primarily relies on technical policies and procedures, rules, and technical notification letters to communicate the CHOICES application process and results to applicants. This has the potential to unnecessarily confuse applicants, program staff, and advocates. TennCare and its clients would benefit from easier-to-understand information about the process (page 18).

**OBSERVATIONS**

The audit report also discusses the following issues: waits for medical appeals hearings and orders (page 10), resolution of medical appeals (page 10), the CHOICES application process (page 24), TEDS delays (page 25), risk stratification (page 26), and payment reform (page 30).

**OTHER INFORMATION**

The audit report also follows up on two Bureau of TennCare-related findings in the April 2011 Department of Finance and Administration performance audit regarding liquidated damages against TennCare managed care contractors (page 3) and TennCare’s provider database and filing system (page 4).
# Performance Audit
## Bureau of TennCare

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INTRODUCTION

PURPOSE AND AUTHORITY FOR THE AUDIT

This performance audit of the Bureau of TennCare was conducted pursuant to the Tennessee Governmental Entity Review Law, Tennessee Code Annotated, Title 4, Chapter 29. Under Section 4-29-236, the bureau is scheduled to terminate June 30, 2015. The Comptroller of the Treasury is authorized under Section 4-29-111 to conduct a limited program review audit of the agency and to report to the Joint Government Operations Committee of the General Assembly. The audit is intended to aid the committee in determining whether the bureau should be continued, restructured, or terminated.

HISTORY AND ORGANIZATION

On January 1, 1994, pursuant to an executive order signed by Governor Ned McWherter, Tennessee withdrew from the federal Medicaid program to implement a new type of health care plan called TennCare. The US Department of Health and Human Services’ Centers for Medicare and Medicaid Services (CMS), granted Tennessee approval, via a waiver, to implement a demonstration project under Section 1115 of the Social Security Act. Under this waiver, the state extended health care coverage not only to Medicaid-eligible Tennesseans, but also to uninsured and uninsurable persons, using a managed care system. The waiver has been extended numerous times and is currently extended through June 30, 2016. In 2005, TennCare underwent dramatic reform to control its escalating costs. Benefits were reduced and many uninsured and uninsurable adults were disenrolled.

The Bureau of TennCare, within the Department of Finance and Administration’s Division of Health Care Finance and Administration, is responsible for administering the program. The bureau receives its statutory authority from Title 71, Chapter 5, Part 1, Tennessee Code Annotated. As of April 2014, the bureau provided health care for approximately 1.2 million Tennesseans.

An organization chart of the bureau is on page 2.
Health Care Finance and Administration
Organizational Chart
As of September 2014

Deputy Commissioner
Director
Chief of Staff
Deputy Director
Deputy Chief of Staff

Chief Deputy General Counsel
Senior Deputy General Counsel
Deputy General Counsel

Executive Administrative Assistant/Special Projects

Executive Administrative Assistant

Chief Financial Officer

Director of Budgets
Director Business Sectors
Director Accounts
Director Contracts
Director Supplemental Payments
Director TPL/Estate Recovery
Director TennCare Informatics

Chief Operations Officer

Director of Strategic Planning and Innovation Group
Director Cover Tennessee
Director of Communications
Public Information Officer

Director of Nondiscrimination Compliance and Health Care Disparities

Director of Managed Care Operations
Assistant Director of Policy

Director of Policy

Assistant Director of Policy

Chief Information Officer

Chief CIO/Chief Technology Officer

Director of Systems Operations

Director of Encounter and Claims
Director of Product Development Eligibility
HIT Coordinator, E-Health

Director of Member Services

Member Services Deputy Director

Eligibility Policy Administrator
Eligibility Appeals Administrator
Eligibility Operations Administrator

Service Center Contracts Admin
Manager Medical Solutions
Manager Medical Appeals

Chief Medical Officer

Associate Medical Director
Director Quality Oversight
Director Provider Services
Chief Pharmacy Officer
Director of Dental

Director of Program Integrity
Assistant Director Managed Care Operations
MCO Operations Specialist
Director of Behavioral Health Operations
Director Deliverables Compliance

Director of Long Term Services and Support
Deputy of Audit and Compliance
Deputy Quality and Administration
Deputy of LTSS Operations

Director of Dental

Source: Bureau of TennCare
AUDIT SCOPE

We audited the Bureau of TennCare for the period July 2011 through October 2014. Our audit scope encompassed all sections of the bureau and included a review of internal controls and compliance with laws and regulations that are significant within the context of the audit objectives. However, a July 2014 lawsuit against the bureau in federal court limited our audit work in some bureau operational areas, as described on pages 7–8. Bureau management is responsible for establishing and maintaining effective internal controls and for complying with applicable laws, regulations, and provisions of contracts and grant agreements.

For our sample design, we used nonstatistical audit sampling, which was the most appropriate and cost-effective method for concluding on our audit objectives. Based on our professional judgment, review of authoritative sampling guidance, and careful consideration of underlying statistical concepts, we believe that nonstatistical sampling provides sufficient, appropriate audit evidence to support the conclusions in our report. We present more detailed information about our methodologies in the individual report sections.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

PRIOR AUDIT FINDINGS

Follow-up Item 1 – Liquidated Damages (Resolved)
April 2011 Department of Finance and Administration Audit, Finding 9:
“TennCare has not been consistent in properly assessing or timely collecting and recording liquidated damages against its Managed Care Contractors, and failed to ensure that a liquidated damages provision in one of its contracts was consistent with the Grier Consent Decree, resulting in a loss of revenue.”

The audit recommended that

- The Director of Managed Care Operations and the Chief Financial Officer should work together to develop policies and procedures to adequately monitor the managed care contractors’ compliance with contract requirements as they relate to properly assessing, collecting, and recording liquidated damages.
- The Chief Financial Officer should evaluate the newly implemented internal controls within Fiscal Services to ensure all liquidated damages are being received and processed from the Office of Contract Compliance and Performance.
- The Chief Financial Officer should continually evaluate these controls to ensure they are working effectively and efficiently.
- TennCare management and its Office of General Counsel should improve the process for ensuring that contract terms are consistent with requirements set forth by external entities such as the federal courts.

Since the prior audit, the bureau had adopted a new system, TeamTrack, to track all contract deliverables. To determine whether the bureau had made improvements in properly assessing, collecting, and recording liquidated damages, we obtained a list of all liquidated damages assessed between June 1, 2013, and December 31, 2013. That list contained 157 sanctions. We randomly selected a sample of 25 sanctions for our review. Specifically, we reviewed documentation stored in the bureau’s computer system that was associated with each selected sanction to determine whether policies and procedures were followed, as well as whether the dates and amounts listed in TeamTrack were accurate.

Based on our review, it appears the implementation of the new tracking system has aided the bureau to consistently record, assess, and collect liquidated damages. As noted above, TeamTrack allows for the tracking of contract deliverables and liquidated damages at all levels, improving communication at each step of the process. Based on our sample, it took an average of 55 days between the sanction and final approval to recoup the funds from the managed care contractors. The sample we reviewed had a total recoupment of $69,500.

The finding is resolved.

**Follow-up Item 2 – Provider Database**

*April 2011 Department of Finance and Administration Audit, Finding 10:*

“Problems within TennCare’s provider database and filing system weaken the functionality of enrollment administration and oversight.”

The April 2011 audit found that TennCare’s provider management information system, interChange, included many decades-old files for providers that were inactive or missing required information, resulting in some files unable to be searched. In addition, TennCare lacked a mechanism to accurately measure and track provider enrollment processing times for all providers.

The audit recommended that

- The Deputy Commissioner should ensure the provider database in interChange is purged of all non-active provider files. This would include reconciling files with missing or fragmented documentation; eliminating system-generated reporting; replacing documentation for missing files; and developing a uniform and reliable...
numbering and filing system. For any provider contained in interChange who does not have a file on site, the Deputy Commissioner should insist these providers reenroll.

- TennCare should also develop policies and procedures detailing processing times and instituting a periodic reenrollment process similar to what the managed care contractors have in place.

- TennCare should consider adopting a web-based application and enrollment system, one that could better track the application process, monitor processing lengths, keep track of required documentation, and ensure consistency for all providers during the enrollment and application process.

To assess the department’s progress in addressing this finding, we reviewed Provider Services’ policies and procedures regarding the process providers use to apply to participate in TennCare and the Provider Services’ database. We analyzed random samples of individual and group provider files and compared information in those files with information in interChange (discussed in detail below). We also interviewed the director of Provider Services and his staff.

Based on our review, Provider Services addressed problems with provider files having incorrect or missing information. However, Provider Services still does not have a formal process to track provider application processing times. In addition, provider data in interChange needs to be made less confusing or needs to be corrected.

Partially Resolved Issue:
Provider database completeness and accuracy have improved, but problems remain

We conducted a file review of a random sample of 30 individual provider files and 10 group provider files (out of a total of 39,864 paid files) who received a TennCare payment between January 2013 and September 2014. We tested for three major items:

- First, we determined that interCharge was complete by confirming that the selected paid providers were included in interChange.

- Second, we determined whether provider files contained evidence to support that the paid providers were eligible to be considered active TennCare providers. Specifically, we reviewed whether each provider file contained the following critical elements: evidence of a completed application; affiliation with a TennCare managed care organization; reenrollment meeting TennCare’s informal standard of every three years; reenrollment meeting the federal government’s formal standard of every five years; and evidence of being active in TennCare through receipt of payments. We found that two providers did not meet TennCare’s informal three-year reenrollment requirement, but all providers met the federal mandatory five-year reenrollment requirement.

- Third, we reviewed interCharge entries for the 40 paid providers and noted several problems. For example, individual providers were listed inconsistently, with some providers listed by first name and then last name and other providers’ names were
listed in reverse order. In addition, there were providers with wrong National Provider Identifiers (required by the federal Health Insurance Portability and Accountability Act), TennCare identification numbers, or state tax identification numbers.

**Tracking Application Processing Times**

Although Provider Services has policies and procedures to ensure complete provider applications, there are no policies for tracking application processing times. The section has an informal 15-day standard to complete applications, and an electronic, web-based provider enrollment process allows the section to rapidly determine how long an application takes to be processed. However, the section does not complete regular reports on how long it takes to process groups of specific provider type (e.g., individual or group providers) applications.

**Recommendation**

Provider Services needs to review the interCharge database to ensure entries are correct and consistent. Additionally, Provider Services should develop and implement policies and procedures to regularly compare provider enrollment processing times against a time standard.

**Management’s Comments**

We concur. Following the 2011 Performance Audit finding, TennCare has been diligently working to implement a complete overhaul of the provider enrollment system. The transition to a new Provider Database Management System (PDMS) began in September 2012 and will conclude in December 2015. This transition was spaced over three years to allow for an orderly and non-disruptive transition of the different provider types and the transition process is currently on schedule. When the transition is complete, the remaining issues identified by the auditors should be resolved.
OBJECTIVES, METHODOLOGIES, AND CONCLUSIONS

ELIGIBILITY APPLICATION PROCESS FOR MEDICAL AND BEHAVIORAL HEALTH SERVICES

TennCare’s Eligibility Application Process and Current Litigation

TennCare’s eligibility operations are currently heavily impacted by ongoing litigation. In July 2014, the Bureau of TennCare was sued in federal court by plaintiffs represented by three nonprofit law firms—the National Health Law Program, the Southern Poverty Law Center, and the Tennessee Justice Center—for allegedly not processing Medicaid applications in a timely manner. Other defendants are the Department of Finance and Administration (which the bureau is attached to) and the Department of Human Services. In September 2014, a federal judge granted the lawsuit class action status.

The lawsuit makes the following four allegations:

- Through a combination of unlawful policy and administrative dysfunction commencing on and before October 1, 2013, and continuing after the implementation date of provisions of the Patient Protection and Affordable Care Act, Tennessee has created an array of bureaucratic barriers to enrolling in TennCare.
- Tennessee has known for months that it is violating federal law.
- Defendants’ policies and practices violate federal Medicaid requirements that all individuals wishing to make an application for medical assistance, according to Title 42, United States Code (U.S.C.), Section 1396a(a)(8), “shall have opportunity to do so, and that such assistance shall be furnished with reasonable promptness to all eligible individuals.”
- Defendants’ policies and practices violate the federal Medicaid requirement, according to 42 U.S.C. § 1396a(a)(3), to “grant an opportunity for a fair hearing before the State agency to any individual whose claim for medical assistance under the plan is denied or is not acted upon with reasonable promptness.” The defendants’ refusal to afford applicants a hearing further deprives the plaintiffs of their right to due process of law in violation of the fourteenth amendment to the United States Constitution.

Plaintiffs are seeking “declaratory and injunctive relief for themselves and the class members whom they represent to ensure that Defendants will provide timely access to medical assistance, as required by law, and will provide a hearing when there are delays.”
Impact of the Lawsuit on the Audit

Prior to the lawsuit, we were planning to review the efficiency and effectiveness of assistance provided by the bureau’s Member Services section to applicants for medical and behavioral health services. This review would have included an evaluation of assistance provided to these applicants at local Department of Human Services’ offices.

However, the lawsuit caused us to reevaluate our work. Paragraph 6.35 of *Government Auditing Standards (Yellow Book)* states: “When investigations or legal proceedings are initiated or in process, auditors should evaluate the impact on the current audit.” The standard goes on to say that “it may be appropriate for the auditors to . . . withdraw from or defer further work on the audit or a portion of the audit to avoid interfering with an ongoing investigation or legal proceeding.”

Another consideration was the amount of staff and time resources the bureau would have to commit to resolve this lawsuit, which could reduce their ability to provide us information in a timely manner. In light of these factors, we restricted our work in this area to providing a general overview of the eligibility application process as described by management in the Member Services section and the Department of Human Services.

Current Eligibility Application Process

The director of Member Services stated that there are multiple ways for individuals to apply for TennCare:

- online via the Federally Facilitated Marketplace (FFM) website www.healthcare.gov;
- over the phone by calling the FFM call center;
- completing a paper application and mailing it to the FFM; or
- visiting one of the Department of Human Services’ county offices, which employ eligibility counselors to assist individuals applying for TennCare.

The director said that if none of the above options work, TennCare has an agreement with the Area Agencies on Aging and Disabilities to assist with in-home applications for the disabled, and that certain special population groups have additional application avenues. Pregnant women can apply for presumptive eligibility through local health departments, as can individuals with breast or cervical cancer. Babies born to mothers on TennCare can be “deemed” eligible by calling TennCare’s eligibility call center. Babies born to mothers not on TennCare can be determined presumptively eligible by hospital staff immediately following birth.

The director stated that for the first six months of 2014, the FFM approved approximately 89,000 applications for TennCare coverage, while TennCare directly determined the eligibility of, and/or extended health care coverage to, an additional approximately 46,000 individuals, including approximately 27,000 non-modified adjusted gross income (MAGI) enrollees and approximately 19,000 deemed newborns. The FFM uses MAGI to calculate whether a person is eligible for a premium tax credit with which to buy commercial coverage. The FFM can only
process enrollees with MAGI assessments. Non-MAGI applicants include the elderly and people with disabilities.

**MEDICAL AND BEHAVIORAL HEALTH SERVICES APPEALS**

A medical appeal can be filed within 30 days of notice of adverse action, which includes a reduction in service, delay in service, or denial of service. The Bureau of TennCare currently has three ways to file an appeal: call center, mail, or fax.

The medical appeals process is prescribed by the Grier Consent Decree, which was revised most recently in February 2008. The decree requires that the managed care contractor (MCC) respond timely to make good faith efforts to complete the reconsideration of appeals. The MCC must complete this portion of the appeals process within 14 days for standard appeals and 5 days for medical emergency expedited situations involving immediate medical issues (may be extended an additional 9 days to obtain medical records).

TennCare has a process in place to ensure this timeframe is met. In most cases, when receiving an appeal the TennCare Solutions Unit (TSU) staff first ensures there is a valid factual dispute. Staff sends a letter to the MCC requesting verification that an adverse action has been taken within two business days. Upon receipt of this confirmation, TSU issues a letter and questionnaire requiring the MCC to reconsider its previous denial decision.

If the MCC denies the services after reconsideration, TSU sends the appeal for another internal review, such as a Medical Necessity Review, in which case a doctor reviews the case and make an independent decision. If the service is approved, the member receives the service. If denied, the appeal continues to the Legal Solutions Unit for preparation and scheduling of a hearing before an administrative law judge. Overall, the decree mandates that the reconsideration and hearing process must be completed within a maximum 45-day timeframe for expedited appeals and within a maximum 90-day timeframe for standard appeals.

Our audit objective was to determine whether medical appeals regarding TennCare medical/behavioral benefits were handled in a fair manner consistent with policies and procedures. We reviewed statute, rules, and the consent decree. We interviewed administrators and staff of the Member Services section and conducted a file review of medical appeals closed between January 1, 2014, and June 30, 2014.

From our audit work, we determined that TennCare is properly following the medical appeals process. Additionally, medical providers file many appeals and a large percentage of medical appeals are approved. The details are in the following observations.
Observation

1. The Bureau of TennCare is properly following the medical appeals process, but there is a long wait for hearings and orders

   Based on our random selection of 60 medical appeals closed between January 1, 2014, and June 30, 2014, we determined that the Bureau of TennCare is following the prescribed process for medical appeals. There are a small percentage of cases that take longer than the 90-day timeframe. Specifically, out of our sample of 60 closed appeals, approximately 5% were open longer than 90 days. However, for the time the appeal is under the bureau’s purview (from initial appeal until it is moved to the Legal Solutions Unit to be scheduled for hearing), TennCare met the prescribed timeframe for all of the appeals we reviewed.

   However, for those cases that actually make it to the hearing process, there appears to be a long wait for obtaining a hearing date and orders. Based on our calculations, 26 of 60 appeals (43%) in the sample went to hearing. Of those, there was an average of 33 days between the initial appeal date and the notice to the enrollee that the appeal had been transferred to the LSU for the scheduling of a hearing. Overall, based on the sample, the number of days between the initial appeal date and the initial order letter issuance ranged from 44 to 192 days, resulting in an average of 104 days, which is over the mandated 90-day maximum.

   The Department of Finance and Administration was accepting applications (with no closing date) for approximately 15 attorneys to staff its own Eligibility Hearing Officer Unit within the Office of General Council. These attorneys will serve as administrative hearing officers and preside over TennCare eligibility hearings. An increased number of hearing officers should help TennCare ensure that the scheduling of hearings keeps appeals within the required timeframes.

Observation

2. The majority of medical appeals are resolved in favor of the client after MCC receipt and reconsideration of additional documentation during the TennCare appeals process

   Based on a list of all medical appeals received and closed between January 1, 2014, and June 30 2014 (2,251), we determined that 1,626 (72%) were approved in favor of the enrollee, as shown in Table 1 below. There were also 473 appeals withdrawn, which were not included in our review as we wanted to review only cases that had completed the appeals process. Based on the data provided, it is unclear at what point members withdrew their appeals and while a withdrawal ends with an automatic denial, it is not a denial necessarily based on the review of the appeal documentation as would be present in a denied appeal that actually completed the process and was classified as denied in this dataset.
Table 1
Closed Medical Appeals Approved and Denied
January 1, 2014 – June 30, 2014

<table>
<thead>
<tr>
<th>Type of Service Requested</th>
<th>Approved</th>
<th>Denied</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behavioral health services</td>
<td>48</td>
<td>73</td>
</tr>
<tr>
<td>Department of Children’s Services</td>
<td>14</td>
<td>0</td>
</tr>
<tr>
<td>Dental</td>
<td>937</td>
<td>257</td>
</tr>
<tr>
<td>Intellectual disabilities</td>
<td>29</td>
<td>16</td>
</tr>
<tr>
<td>MCC change request</td>
<td>2</td>
<td>18</td>
</tr>
<tr>
<td>Medical services</td>
<td>343</td>
<td>144</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>235</td>
<td>108</td>
</tr>
<tr>
<td>Pharmacy reimbursement/billing</td>
<td>16</td>
<td>6</td>
</tr>
<tr>
<td>Reimbursement/billing</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Total</td>
<td>1626</td>
<td>625</td>
</tr>
<tr>
<td>Percentage of Total</td>
<td>72%</td>
<td>28%</td>
</tr>
</tbody>
</table>

Source: Auditor analysis of data provided by the Bureau of TennCare.

We randomly selected a sample of 60 appeals from the above population to assess whether the appropriate appeals process was followed; to determine basic facts about the appeals process, such as who most typically files appeals; and to identify potential improvements to the process.1

We determined that most of the appeals resulted in TennCare requiring the MCC to reconsider their initial denial and ask for more information,2 and most MCCs were eventually approving services. Overall, we found that of the 60 files reviewed, 34 (57%) were settled without going to a hearing. We also found that 30 of the 60 appeals (50%) were filed by service providers on behalf of the enrollees. Of these appeals, 23 (77%) were approved prior to a hearing (see Table 2).

Table 2
Breakdown of Medical Appeal Approval Status Prior to Hearing
From Random Sample

<table>
<thead>
<tr>
<th>Who Filed the Appeal</th>
<th>Approved</th>
<th>% Approved</th>
<th>Denied</th>
<th>% Denied</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advocate</td>
<td>1</td>
<td>33%</td>
<td>2</td>
<td>67%</td>
<td>3</td>
</tr>
<tr>
<td>Provider</td>
<td>23</td>
<td>77%</td>
<td>7</td>
<td>23%</td>
<td>30</td>
</tr>
<tr>
<td>Relative/Member</td>
<td>15</td>
<td>56%</td>
<td>12</td>
<td>44%</td>
<td>27</td>
</tr>
<tr>
<td>Total</td>
<td>39</td>
<td>65%</td>
<td>21</td>
<td>35%</td>
<td>60</td>
</tr>
</tbody>
</table>

1 We stratified this sample to include 45 appeals that were, based on the dates listed in the initial data, to have been closed within 90 days and 15 appeals that were not closed within 90 days because based on initial data, only 5% of appeals were closed beyond 90 days.

2 The Grier Consent Decree states that appeal decisions must be supported by medical evidence and that it is the defendants’ responsibility to elicit from beneficiaries and their treating providers all pertinent medical records that support an appeal.
Possible Reasons for Initial Denials

There are several possible reasons for initial denials, but a lack of medical documentation appeared the most likely and one we had the ability to test for in our sample. Therefore, we reviewed files to determine whether the MCCs attempted to obtain additional information from providers prior to denial, during the preauthorization process. We found that while many of the initial denial letters indicate attempts to contact providers (with few results), there is no evidence in TennCare files of what type(s) of contact was made (letter, telephone call, or fax); the type of request made; and the timeframe for an expected response from the provider.

Each MCC is required, through its contract with TennCare and by federal regulation, to have in place, and follow, written policies and procedures for processing requests for initial and continuing prior authorizations of services and have in effect mechanisms to ensure consistent application of review criteria for prior authorization decisions. The policies and procedures shall provide for consultation with the requesting provider when appropriate.

According to the TennCare Medical Director, each MCC has its own process for initiating provider contact on prior authorizations, and while these processes may differ, each MCC should document any contact or attempted contact with the providers, and should retain any documentation received. However, this documentation is not required to be provided to TennCare as part of the appeals process. As a result, we could not determine whether prior authorization requests were denied for reasons such as, but not limited to:

a) treating physicians provided too little information for the request,
b) MCCs did not contact the treating physician as required, or
c) the treating physician did not respond to the MCC requests for additional information.

Verification of this documentation would help TennCare to ensure MCC compliance with contract requirements.

The Medical Director discussed further options for managing prior authorization requests and contacting treating physicians, as well as educating treating physicians about the process. Possibilities identified included

- contacting treating physicians during business hours;
- leaving detailed messages so physicians know exactly what the call is regarding;
- giving the physicians particular times to return calls or allowing them to make appointments; and
- educating providers about the process to ensure they are aware of the importance of these communicating the process to their patients.
While the MCCs and TennCare may not be doing anything wrong, appeal costs affect TennCare and consumers in both dollars and time. Based on the overall number of appeals approved, coupled with the high percentage of appeals approved prior to a hearing after the review of supporting documentation, it appears a lack of documentation at the beginning of the decision-making process could be a contributing factor. While we recognize the time constraints placed by the Grier Consent Decree on the prior authorization and appeals process, assuring that MCCs routinely contact providers and obtain complete information during the preauthorization and reconsideration process could reduce the number of medical appeals.

**LONG-TERM SERVICES AND SUPPORTS**

**CHOICES Program**

The CHOICES Program, created in 2010, is a Long-Term Services and Supports (LTSS) program that serves qualified individuals\(^3\) who receive LTSS in a nursing facility or through Home and Community Based Services (HCBS).

Our audit objectives with regard to the CHOICES Program were to determine:

- the overall process for applying for long-term care/CHOICES and for appealing CHOICES eligibility; and
- whether CHOICES applicants are evaluated in a manner consistent with policies and procedures regarding medical need/level of care standard.

Auditors interviewed program staff to learn about the CHOICES application and appeals process, and reviewed statutes and the department’s LTSS policies, procedures, and rules. We charted the detailed process to analyze the CHOICES application and appeals process. We also reviewed 60 CHOICES applications that were submitted to the department between January 1, 2014, and March 31, 2014, and which received an acuity score between 6 and 8 (meaning they missed the cutoff for certain services). Finally, we interviewed representatives from LTSS programs in Arizona, Illinois, and Wisconsin to understand other states’ practices.

Based on our audit work, we determined that the bureau followed the published CHOICES application and appeals process. However, that process is highly complex and needs to be communicated to applicants in a more easily understandable format.

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\(^3\) Individuals eligible to receive HCBS in CHOICES are limited to seniors age 65 and older, plus adults age 21 and older with physical disabilities.
**TennCare CHOICES Medical Eligibility Process as of October 28, 2014**

**CHOICES Applicant**

- **Managed Care Organization (MCO)**
  - Already Medicaid Eligible
    - An MCO-employed PAE assessor meets with the applicant to conduct a face-to-face assessment.
    - During the assessment, a pre-admission evaluation (PAE) is conducted on the applicant.

- **Area Agency on Aging and Disability (AAAD)**
  - Already Medicaid Eligible
    - An AAAD PAE assessor meets with the applicant to conduct a face-to-face assessment.
    - During the assessment, a pre-admission evaluation (PAE) is conducted on the applicant.
  - Non-Medicaid Applicant
    - Route referral to MCO
    - An AAAD PAE assessor meets with the applicant to conduct a face-to-face assessment.
    - During the assessment, a pre-admission evaluation (PAE) is conducted on the applicant.

- **Nursing Facility (NF)**
  - Already Medicaid Eligible
  - Non-Medicaid Applicant
    - An NF PAE assessor meets with the applicant to conduct a face-to-face assessment.
    - During the assessment, a pre-admission evaluation (PAE) is conducted on the applicant.

- **Hospital**
  - Already Medicaid Eligible
  - Non-Medicaid Applicant
    - Hospital discharge staff meets with the applicant to conduct a face-to-face assessment.
    - During the assessment, a pre-admission evaluation (PAE) is conducted on the applicant.

**TennCare Nurse Reviewer Conducts Level of Care Determination**

**If an applicant is applying for Home and Community Based Services:**
- The nurse reviewer looks at the applicant’s PAE and supporting medical documentations for
  - evidence that HCBS will prevent deterioration in the applicant’s health status or delay progression of a disease or disability;
  - evidence that the applicant will need HCBS on an ongoing basis; and
  - a total acuity score of 9 or above on the functional assessment and at least one significant Activity of Daily Living or related deficiency.

**If an applicant is applying for Nursing Facility services:**
- The nurse reviewer looks at the applicant’s PAE and supporting medical documentation for
  - evidence that services in a NF will improve or ameliorate the applicant’s physical or mental condition, prevent deterioration in health status, or delay progression of a disease or disability;
  - evidence that NF services has been ordered by a physician on an ongoing basis; and
  - a total acuity score of 9 or above on the functional assessment **OR** at least one significant Activity of Daily Living or related deficiency **and** an advance determination that the person’s needs cannot be safely met if enrolled in Group 3.

- The applicant’s total acuity score is below 9.
- The applicant’s total acuity score is a 9 or above.
- The applicant’s total acuity score is below 9.
- The applicant’s total acuity score is 9 or above and the applicant meets federal requirements.
The nurse reviews the PAE to determine if the applicant meets advance determination and is “at risk” for NF level of care.

Requirements met

The nurse reviews the PAE to determine if the applicant meets advance determination.

Applicant does not meet advance determination.

A letter is mailed to the applicant and the PAE assessor stating that the applicant’s application for CHOICES HCBS was denied, but the application was approved for limited HCBS in CHOICES Group 3.

Denied

End of Medical Eligibility Process for the CHOICES Program

Note: This flowchart portrays a highly simplified depiction of the CHOICES medical eligibility process.

Source: Auditor’s analysis of interviews with TennCare staff and review of TennCare’s policies, procedures, and rules.
The CHOICES application process can be considered in three parts: 1) medical eligibility determination; 2) financial eligibility determination for applicants not already enrolled in TennCare; and 3) appeal for those deemed ineligible or placed in CHOICES group 3 who believe they should be classified as group 1 or 2. Flow charts on pages 14, 15, and 17 illustrate and summarize the medical eligibility and the appeals processes. In addition, below is a summary level outline of the process.

**Medical Eligibility** – Individuals apply for CHOICES through a managed care organization, hospital, nursing facility, or Area Agency on Aging and Disability (AAAD). Applicants initially receive a face-to-face assessment using the bureau’s PAE tool. These assessments are conducted by certified PAE assessors and can be done anywhere, including a nursing facility, hospital, assisted care facility, or the applicant’s home. The PAE considers the level of assistance an applicant needs to complete eight activities of daily living: transferring, mobility, eating, toileting, orientation, communication, medication, and behavior. The assessment results are documented on the PAE application and in conjunction with medical evidence to determine an acuity score, ranging from 1 to 26. As part of the assessment, applicants also choose, if they are later found to meet eligibility requirements, if they want to be considered to receive services in a nursing facility (CHOICES Group 1), or through HCBS (CHOICES Group 2).

Bureau-employed nurse reviewers assess each PAE, which determines applicant medical eligibility for CHOICES Group 1 or 2. Applicants who do not receive an acuity score of 9 or above, but who have at least one significant documented ADL or related deficiency, are classified as “at risk” for nursing facility level of care and are considered for placement in CHOICES Group 3. CHOICES Group 3 enrollees receive more limited HCBS and other TennCare services determined by a MCC conducted assessment after they are enrolled in CHOICES. Regardless of acuity score, a person whose needs cannot be safely met with the array of services available can be determined eligible for nursing facility level of care. The bureau mails eligibility letters to applicants indicating whether or not they have been determined medically eligible for the CHOICES Program.

**Financial Eligibility Review** - After applicants are deemed medically eligible for the CHOICES Program, the bureau’s Enrollment Unit reviews the application to determine financial eligibility for TennCare. After the enrollment unit determines an applicant is financially eligible for TennCare, the applicant is enrolled in the CHOICES Program.4

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4 Because of the lawsuit against the bureau, described on pages 7–8, auditors only developed a basic understanding of, and did not audit, the financial eligibility determination process.
TennCare CHOICES Medical Eligibility Appeals Process as of October 28, 2014

Applicant can fax the appeal to TennCare.
Applicant can call TennCare for assistance from TennCare staff with writing an appeal.
Applicant can mail the appeal to TennCare.

A Long Term Services and Supports appeals nurse reads the applicant’s appeal and any additional documentation supplied to determine if the appeal should be approved.

The appeals nurse agrees with the applicant’s appeal and overturns TennCare’s original decision.

An approval letter is mailed to the applicant.

The appeals nurse disagrees with the applicant’s appeal and does not overturn TennCare’s original decision.

Appeal is sent to the independent contractor, Ascend Management Innovations, for a third-party review.

Ascend assessors conduct a face-to-face assessment with the applicant and collect supporting medical documentation that was not obtained during the CHOICES application process.

Ascend either recommends to uphold or overturn TennCare’s decision.

Ascend returns its decision, as well as all of the information that was gathered during the face-to-face assessment, to TennCare.

An approval letter is mailed to the applicant.

A letter is generated in TPAES informing the applicant that
- the appeal was reviewed by TennCare,
- an onsite assessment was conducted by Ascend, and
- the LOC remains denied.
The letter will also notify the appellant that the appeal has been referred to TennCare’s Office of General Counsel for a hearing.

End of Long Term Services and Supports Appeals Process

Note: This flowchart portrays a highly simplified depiction of the CHOICES medical eligibility appeals process.

Source: Auditor’s analysis of interviews with TennCare staff and review of TennCare’s policies, procedures, and rules.
Medical Eligibility Appeals - Applicants who are dissatisfied with their CHOICES medical eligibility decision can submit an appeal to the bureau by mail or fax within 30 days. An appeal nurse reviewer reads the appeals and reviews the original PAEs. If a nurse reviewer does not approve the appeal, the nurse reviewer submits the appeal to Ascend Management Innovation (Ascend), a third-party contractor, for additional review. Ascend staff conduct face-to-face assessments with appellants, gather supporting medical documentation, and submit the results to Ascend management and to the bureau for review. If neither Ascend nor the bureau approves the appeal, the TennCare Office of General Counsel sets the appeal for hearing before an administrative law judge.

Finding

1. The Bureau of TennCare should distribute easy-to-understand information about the CHOICES application process

As demonstrated in the flowchart and in the summary of the process described above, the CHOICES medical eligibility process contains multiple steps and is extremely complex. Much of this complexity is not controlled by TennCare, but rather is required by various federal and court requirements. TennCare uses a variety of tools to provide outreach to applicants, such as working with the AAADs to assist applicants and employing readability experts to continually assist in writing and modifying technical letters. However, TennCare primarily relies on technical notification letters to communicate the CHOICES application results to applicants, in part due to legal constraints which significantly influence official notification letter contents. While applicants work with trained enrollment facilitators, there still is the potential to confuse applicants, program staff, and advocates. TennCare and its clients would benefit from easier-to-understand information about the process, especially in conjunction with official approval and denial letters. For example, we reviewed a brochure TennCare provides as outreach for CHOICES, which discusses the different CHOICES groups and the services that are provided through CHOICES. However, this type of communication is not included with the official approval/denial letters sent to applicants, but could be useful to include.

For example, stakeholders reported to auditors that the eligibility letters mailed to applicants can be difficult to understand. Auditors’ review of over 60 examples of eligibility letters (as part of the file review described on page 13) confirm they are difficult to understand, unless the reader is already familiar with the technical medical eligibility determination process. For example, an excerpt from a letter sent to an applicant about their PAE score, which was provided to us by an advocate, is shown in Exhibit 1. While TennCare reports it has continued to modify and make this standardize language in this letter easier to understand, the technical nature of the financial and medical eligibility processes are inherently complex and will always be difficult to convey to non-technical readers.
Exhibit 1
Excerpts from a Letter Sent to CHOICES Applicant
December 2012

We have approved your Pre-Admission Evaluation (PAE).

This means that you meet the medical requirements to receive care in a nursing home. It also means that you meet the medical requirements to receive home care instead of nursing home care. (These are also called Home and Community Based Services or HCBS.)

BUT, it doesn't mean that TennCare will pay for your nursing home care. TennCare can't pay for your nursing home care unless you meet all of the rules and qualify to enroll in the TennCare CHOICES in Long Term Care Program. (We call it CHOICES for short.)

To qualify for nursing home care in CHOICES:

- You must need the level of care provided in a nursing home (have an approved PAE).
- AND, you must qualify to have Medicaid pay for your long-term care. Do you have Medicaid or has an application already been filed? If not, you must file an application with your local Department of Human Services (DHS) office.

If we decide you meet all of these rules, we will enroll you in CHOICES.

If we decide you don't qualify to enroll in CHOICES, we'll send you a letter that says why. That letter will say how to appeal if you think we're wrong.

If you have questions, you can call the TennCare Long Term Services and Supports (LTSS) for free. The number is 1-877-224-0219. In Nashville, you can call 507-6964.

Note: TennCare reports they have since revised this standardized letter. However, this version was used during our audit period.

The bureau reports that the medical eligibility letters are written based on a 1987 court order in the case *Doe v. Word*. Therefore, the core language of the letters is unlikely to change. However, the bureau could assist applicants by providing an additional, simplified description of the CHOICES application process along with direct notification letters.

Recommendation

The bureau should provide easy-to-understand resources about the CHOICES application process with direct mail notification letters.

Management’s Comment

Management concurs in part with this finding. We concur that Medicaid financial and medical eligibility requirements and processes are inherently complex as a result of federal and legal requirements, and accordingly, that they can be difficult to explain and understand. We do not concur, however, with the implication that we have not taken appropriate steps to communicate these complex processes as effectively as possible with applicants and enrollees.
First and most importantly, from the applicant’s perspective, the process has been simplified to the point that all the applicant really has to do is call a phone number. If a person already has TennCare, they can call their MCO. If the person does not have TennCare, they can call a statewide toll-free number that is automatically routed to their local AAAD. If they call the wrong entity (e.g., a person who has TennCare calls the AAAD), processes are in place to ensure that the caller is promptly referred to the appropriate entity.

The availability of assistance in applying for CHOICES, including the statewide toll-free number, has been widely publicized.

The TennCare website includes a page (available at http://www.tn.gov/tenncare/long_how.shtml) which advises individuals how to seek assistance in applying for LTSS:

“How to Apply
For long-term services & supports.

Do you already have TennCare?

- Yes I already have TennCare:

If you have TennCare, you can call your TennCare health plan (MCO). The number is on your TennCare card. If you are or represent an individual with intellectual disabilities, you can call the Department of Intellectual and Developmental Disabilities (DIDD) for free at 1-800-535-9725.

- No I do NOT have TennCare:

If you don't have TennCare, contact your local Area Agency on Aging and Disability (AAAD) for free at 1-866-836-6678. Even if you don't qualify for Medicaid, they can tell you about other programs that may help.

- Do you need help with TennCare
- LTSS Medicaid Application”

A second page of the website (available at http://www.tn.gov/tenncare/long_qualify.shtml) includes an overview of how to qualify for CHOICES:

“To Qualify for CHOICES

To qualify for and remain in CHOICES, you must:

- Need the level of care provided in a nursing home; OR
- Be "at risk" of needing the level of care provided in a nursing home; AND
- Qualify for Medicaid long-term services and supports
To qualify for Medicaid long-term services and supports: (1) Your income can't be more than $2,163 per month (If it is, you may be able to set up a Qualifying Income Trust); (2) The total value of things you own can't be more than $2,000 (The home where you live doesn't count); AND (3) You can't have given away or sold anything for less than what it's worth in the last five (5) years.

There are three CHOICES groups:

**CHOICES Group 1** is for people of all ages who receive **nursing home care**. For more information about nursing home care please [click here](#).

**CHOICES Group 2** is for adults (age 21 and older) with a physical disability and seniors (age 65 and older) who qualify to receive **nursing home care**, but choose to receive HCBS instead.

**CHOICES Group 3** is for adults (age 21 and older) with a disability and seniors (age 65 and older) who **don't** qualify for nursing home care, but need a more moderate package of HCBS to delay or prevent the need for nursing home care.

To enroll in CHOICES and receive home care services:
(1) Your TennCare health plan (or Managed Care Organization) must be able to meet your needs safely at home; AND (2) If you qualify for nursing home care, the cost of your home care can't be more than the cost of nursing home care. The cost of your home care includes any home health or private duty nursing care that you need. If you **don’t** qualify for nursing home care, but do qualify for the “at risk” level of care, the cost of your CHOICES home care can’t be more than $15,000 per year. That doesn’t include the cost of any minor home modifications you may need.

[What Home Care services are covered in CHOICES?”](#) [this links to an easy-to-understand explanation of benefits]

Each of the nine AAADs are required, as part of their contracts to develop annual outreach plans and to conduct at least 16 outreach events in their region, targeting the following audiences:

(1) Individuals, and families of individuals, who are elderly or adults age twenty-one (21) or older with a physical disability;

(2) Community service agencies that may be a resource for individuals receiving LTSS; and

(3) Providers, agencies and individuals who impact the continuum of LTSS delivery including primary care providers, NFs, hospital discharge planners and the Long-Term Care (LTC) Ombudsmen.
As noted by the auditors, a brochure was developed in 2010 (current version attached) when the program began and is disseminated through outreach activities conducted by AAADs, as well as conferences, community events, and other outreach opportunities. Since 2010, more than 160,000 brochures have been printed and made available for dissemination to interested persons.

The intent of the brochure is to make people aware of the CHOICES program and the services it offers, and to direct them who to contact in order to apply. Accordingly, we do not believe that sending this information to a person who has already submitted an application and has either been approved or denied would provide additional benefit. However, we will seek input from our partners regarding what information, if any, might be helpful, to include with notices, based on their interaction with program applicants.

Once a call is made to apply for the CHOICES program, the AAAD or MCO, as applicable, follow TennCare established requirements and protocols to facilitate the person’s application for CHOICES, walking the applicant step-by-step through the medical and financial (where applicable) eligibility application processes. To accommodate individuals already in a nursing facility (typically, because they have been admitted to such a facility for Medicare Skilled Nursing Facility services upon discharge from an acute care setting), Nursing Facilities are also permitted to assist CHOICES applicants in applying for the program.

The medical component of the eligibility application is administered by trained and certified assessors located in AAADs, MCOs, Nursing Facilities and hospitals which are in turn evaluated by Registered Nurses at TennCare. Notices are sent to each applicant when an eligibility decision is ultimately made that explain the reasons for such decision.

As noted, much of the content of PAE letters that are mailed once an eligibility decision is made is driven by federal court orders. Nonetheless, TennCare has worked very hard to review and continuously improve these notices to help make the information as easy to understand as possible. TennCare employs its own readability expert and in 2013, worked with the Tennessee Justice Center to review and revise all notices pertaining to the medical eligibility process, in order to improve their readability. The excerpt above was actually revised substantially during the course of the 2013 review. The revised language is below:

“We have approved your Pre-Admission Evaluation (PAE) for nursing home care.

This means that you meet the medical rules to get care in a nursing home. It also means you meet the medical rules to get home care instead of nursing home care. (These are also called Home and Community Based Services or HCBS.)

But, before TennCare will pay for your nursing home care, there are other rules you must meet. You must meet all of the rules to enroll in the TennCare CHOICES in Long-Term Care Program (CHOICES).

To qualify for nursing home care in CHOICES:
• You must need the level of care provided in a nursing home (have an approved PAE).

We’ve already approved your PAE.

• And, you must qualify to have Medicaid pay for your long-term care.

**Do you already have Medicaid?** If so, there are other rules you must meet before TennCare can pay for long-term care. The Department of Human Services (DHS) will make sure you meet those rules. Your TennCare health plan (MCO) will help you get DHS the facts and papers they need to decide. If you don’t meet the rules for long-term care, DHS will send you a letter. It will say how to appeal if you think they made a mistake.

**What if you don’t already have Medicaid?** Then you must apply with your local DHS office. Do this as soon as you can. Your local Area Agency on Aging and Disability (AAAD) can help you apply. Call them at **1-866-836-6678**. Tell them you have an approved PAE for CHOICES and need help applying for Medicaid. Or, you can apply online or at your county office. To find your county office or to apply online, go to [www.tn.gov/humanserv](http://www.tn.gov/humanserv). The nursing home can also help you apply.

DHS will tell you what facts and papers they need from you to decide if you can get Medicaid. After they decide, DHS will send you a letter that says if you can get Medicaid. If can’t get Medicaid, their letter will tell you why. And it will tell you how to appeal if you think they made a mistake.

**And, you must be admitted to a nursing home.** That nursing home must tell TennCare the date you need us to start paying for your nursing home care.

If we decide you meet all of these rules, we’ll enroll you in CHOICES. You’ll get a letter from us that says when your CHOICES starts.”

All of the letters sent to CHOICES applicants contain numerous options for assistance if they have questions, including the LTSS Help Desk, TennCare Solutions Unit, and advocacy groups that are contracted to assist TennCare applicants and members with questions or concerns.

Because the sheer volume of information mailed to an applicant or enrollee can be overwhelming—particularly for low literacy readers, rather than mailing additional information (which would likely cost additional money), TennCare has opted to require both AAADs and MCOs to review in person with each CHOICES applicant CHOICES Education materials, developed by TennCare, which provide an easy-to-understand explanation of program eligibility requirements and benefits. This requirement has been in place since the program began. While these materials could also be mailed to applicants with approval/denial notices, we believe that an in-person review and discussion of the information, with the opportunity to ask questions is more beneficial in helping applicants understand the program, including application process.
We appreciate the concern reflected by this recommendation and will continue to review our notices and other materials for additional opportunities to improve readability and ease understanding for CHOICES program applicants. Further, as previously noted, we will engage our program partners in helping us to identify what, if any, information may be helpful to include with notices to better communicate program requirements.

**Observation**

3. **The Bureau of TennCare follows the prescribed CHOICES application process**

   While the CHOICES application process can be complex, based on the sixty pre-admission evaluations (PAEs) that our audit team reviewed (as described on page 13), it appears the bureau follows its policies and procedures when determining applicants’ medical eligibility for CHOICES. Additionally, the bureau’s process contains numerous internal controls to ensure staff follow the process and make quality decisions. For example, there are multiple internal controls in place to ensure each PAE is thoroughly reviewed. First, a nurse reviewer reviews every PAE. Second, an internal audit unit regularly reviews the application process. Third, Ascend conducts reliability reviews on a sample of approved CHOICES Group 2 PAEs.

**TENNESSEE ELIGIBILITY DETERMINATION SYSTEM (TEDS)**

   In 2010, TennCare management realized that the current eligibility computer system, ACCENT, would not meet Medicaid eligibility determination system changes required by the U.S. Patient Protection and Affordable Care Act (ACA). ACA imposed a January 1, 2014, deadline for implementing a state Medicaid eligibility determination system that meets ACA requirements. On May 8, 2012, and again in August 2012, the state released a request for proposal for the construction of a new system, the Tennessee Eligibility Determination System (TEDS). Northrop Grumman Systems Corporation (Northrop) won the bid for the project and signed a contract with the state in December 2012 for $35.7 million dollars.

   On October 1, 2013, the federal government implemented its own computer system, the ACA Federal Marketplace, for the public to sign up for health care. The ACA Federal Marketplace was designed to communicate with states’ Medicaid eligibility determination systems; however, Tennessee’s Medicaid eligibility determination system was not ready for public use by October 1, 2013, and remains unready as of October 2014. As a result, the department does not have a functioning system that can process Medicaid applications and must rely on the ACA Federal Marketplace to process applications.
TEDS will be distributed in two separate releases:

- Release 1: A worker portal, which will provide TennCare workers access to TEDS. Northrop is currently working to complete Release 1, which consists of four testing phases. As of October 2014, the TEDS team has completed 99% of the first phase and 80% of the second phase. The first two testing phases must be completed before testing phases three and four can begin.

- Release 2: A client web portal, which will allow the general public to apply for TennCare through a web portal.

The state has paid Northrop only for the work completed. As of September 29, 2014, Northrop has received $4.68 million dollars for its work on TEDS.

Neither the bureau nor Northrop were able to provide auditors with a date when the system will “go live” for public use. Until that time, Medicaid applicants in Tennessee must apply for Medicaid through the ACA Federal Marketplace, which has experienced technical issues.

Our audit objective was to review the status of TEDS. We interviewed the bureau’s program staff and information technology staff, as well as Northrop’s project managers, to inquire about TEDS’ current project schedule and implementation delays. Additionally, we reviewed contract documentation and written communications between the bureau and Northrup. Our work resulted in the following observation.

**Observation**

4. **The Bureau of TennCare contracted with KPMG to assess and advise the bureau about TEDS delays**

Northrop project managers provided two major explanations for TEDS delays:

- The bureau requested TEDS be fully tested before it is available for public use. Therefore, complex testing on Release 1 must be conducted before work on Release 2 can begin; and

- Federal regulation changes caused some delays in the project’s testing. When a regulation changes, project staff must make adjustments to the system and test all of the changes. The federal government issued initial Medicaid regulations in August 2011. Changes were subsequently issued in March 2012, January 2013, and July 2013. Additional new regulations are expected to be released in November 2014.

Because there have been multiple delays with the TEDS project, the department has contracted with KPMG for $1.2 million dollars to monitor the progress of Northrop. KPMG began its review on August 18, 2014, and is scheduled to present a final report to the department in December 2014.
IMPROVING HEALTH COORDINATION THROUGH RISK STRATIFICATION

In order to improve patient health and control costs, the bureau is working to improve patient health coordination through tools such as risk stratification, which involves identifying patient sub-populations whose health, and therefore eventual costs, may be improved by providing additional services.

Our audit objective was to assess the transition from disease management to risk stratification in handling TennCare enrollee health needs. We reviewed TennCare, federal, and medical professional organization reports and analyzed data from TennCare managed care organizations (MCOs) related to risk stratification. We also interviewed the Chief Medical Officer and other TennCare officials responsible for risk stratification.

Based on our review, the bureau is making steady progress in improving health coordination by implementing risk stratification with its MCOs and other techniques.

Observation

5. The Bureau of TennCare is using risk stratification to move away from disease management and toward population health management

Traditional medical models have emphasized a fee-for-service reimbursement system which does not necessarily focus on optimizing patients’ health. In order to improve patient health, which may contribute to controlling costs, there is increasing interest in preventing and more actively managing health conditions.

The bureau has adopted risk stratification, one commonly accepted approach to improving patients’ health. As part of this approach, providers identify sub-populations of patients who may be helped by additional services. According to the U.S. Agency for Healthcare Research and Quality, examples of such groups include “patients needing reminders for preventive care or tests; patients overdue for care or not meeting management goals; patients who have failed to receive follow-up after being sent reminders; and patients who might benefit from discussion of risk reduction.” Risk stratification identifies such patient groups.

According to the American Academy of Family Physicians, risk stratification “begins with a periodic and systematic assessment of each patient's health risk status, using criteria from multiple sources to develop a personalized care plan.” This assessment of the patient's health status “may be reflected by a score or placement in a specific category, based on the most current information available.” The health risk category “may fluctuate due to expenditures or significant changes in the patient's health.”

TennCare’s Approach to Population Health Management Using Risk Stratification - The bureau’s Chief Medical Officer stated that TennCare had moved away from targeting specific diseases through disease management and toward a more holistic approach using risk stratification.
The bureau’s contracted managed care organizations (MCOs) were required to stratify their enrollees, including CHOICES clients, by July 2013. While risk stratification is required under MCO contracts, the MCOs have the flexibility to use their own standards. The MCOs use predictive modeling, including individual patient’s claims history, pharmacy utilization, lab results, referrals, lifestyle choices, and health risk assessments, to assign clients into one of three needs. (See risk categories in Table 3, below.) The majority of bureau clients, also shown in Table 3, are placed in the lowest risk category.

### Table 3
**Description of TennCare Risk Stratification Levels and Number of Enrollees by Risk Stratification Level April 2014**

<table>
<thead>
<tr>
<th>Risk Level</th>
<th>Criteria for Selection</th>
<th>Number of Enrollees</th>
<th>Percent of Enrollees</th>
</tr>
</thead>
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<tr>
<td>0 No identified risk</td>
<td>Lack of any identified health risks, any identified chronic conditions, or claims history. Not pregnant.</td>
<td>674,240</td>
<td>55%</td>
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<tr>
<td>1 Low or moderate risk</td>
<td>All members that do not meet the Level 0 or Level 2 criteria.</td>
<td>524,604</td>
<td>42%</td>
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<tr>
<td>2 High risk</td>
<td>Top 3% of members to be most at risk for adverse health outcomes and referrals.</td>
<td>37,848</td>
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<tr>
<td><strong>Total</strong></td>
<td></td>
<td>1,236,692</td>
<td>100%</td>
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</table>

Source: Bureau of TennCare.

**Risk Level Programs** - MCOs offer their enrollees a variety of programs based on their risk stratification, as shown in Table 4. Enrollees are stratified regardless of their interest in participating in programs. For Level 0 and Level 1 programs, enrollees have to “opt out” if they choose not to participate (they are automatically enrolled after being stratified). For Level 2 programs, enrollees have to voluntarily enroll, or “opt in,” to participate.

Because some programs’ participation is voluntary, enrollee participation rates vary greatly between the risk stratifications. According to the bureau, 100% of enrollees in Risk Levels 0 and 1 participate in the respective risk stratification programs; however, only 18% of Risk Level 2 enrollees participate.

Qsource, TennCare’s contracted external quality review organization, reviewed each MCO’s public health risk stratification process through a quality improvement evaluation element in its 2014 Annual Quality Survey. The results, released in May and July 2014, reported that the MCOs met all the criteria for population health management.
<table>
<thead>
<tr>
<th>Program Name</th>
<th>Risk Level</th>
<th>Goal</th>
<th>Minimum Interventions</th>
<th>Number of Enrollees Participating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wellness</td>
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<td>To keep members healthy as long as possible.</td>
<td>• One non-interactive educational quarterly communication.</td>
<td>674,332</td>
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</table>
| Low-Risk Maternity      | 1          | To engage pregnant women into timely prenatal care and to deliver a healthy, term infant without complications. | • Telephonic screening for risk factors.  
• Prenatal packets sent by mail (a non-interactive intervention).  
• Follow-up calls to assess if the member has been for a first prenatal visit. These calls will be to those who received initial screening and indicated they did not have prenatal appointment. Assistance will be provided.  
• Calls to all pregnant members in their ninth month to assess or assist them with a post-partum appointment. | 16,509                             |
| Health Risk Management  | 1          | To prevent, reduce or delay exacerbation and complications of a condition or health risk behavior. | • One to four non-interactive communications each year, dependent upon level of risk.  
• Offering individual support for self-management if the member wants to be engaged.  
• Availability of 24/7 nurse line.  
• Availability of health coach/registered nurse.  
• Availability of weight management or tobacco cessation support, as applicable. | 510,718                             |
<table>
<thead>
<tr>
<th>Program Name</th>
<th>Risk Level</th>
<th>Goal</th>
<th>Minimum Interventions</th>
<th>Number of Enrollees Participating</th>
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<tbody>
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<td>Care Coordination*</td>
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<td>To assure members get the services they need to prevent or reduce an adverse health outcome.</td>
<td>• Provide short-term services tailored to the member’s needs at a given time (e.g., assistance in making and keeping needed medical and/or behavioral health appointments, hospital discharge instructions, health coaching, and referrals related to the members’ immediate needs).</td>
<td>12,904</td>
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</table>
| Chronic Care Management      | 2          | To improve the quality of life, health status, and utilization of services of members with multiple chronic conditions by providing intense self-management education and support. | • Monthly interactive health coaching contacts with a face-to-face visit as appropriate.  
• Clinical reminders about gaps in care.  
• Development and implementation of plan of care.  
• Provision of after-hours assistance for urgent or emergent needs. | 2,804                             |
| High-Risk Pregnancy          | 2          | To engage pregnant women into timely prenatal care and aim for delivery of a healthy, term infant without complications.  | • One interactive contact per month of pregnancy to provide intense case management.  
• Prenatal packets. | 3,054                             |
| Complex Case Management      | 2          | To move members to optimal levels of health and well-being by providing timely coordination of quality services and self-management support. | • Monthly interactive member contacts to provide individual self-management support, including a face-to-face visit as deemed appropriate by the MCO.  
• Providing clinical reminders around gaps in care.  
• Providing after-hours assistance with urgent or emergent needs. | 1,061                             |

* This short-term program is available to all members, regardless of any other programs they are enrolled in. Therefore, these participants may be counted in more than one program.

Source: Bureau of TennCare.
PAYMENT REFORM

The Tennessee Health Care Innovation Initiative, announced by Governor Bill Haslam in March 2013 during a joint session of the General Assembly, aims to control escalating public and private health care costs statewide by moving away from a fee-for-service model (where there is no built-in incentive to avoid unnecessary medical services), and toward rewarding providers for outcomes and value. The bureau plays an important role in this initiative because its MCOs enroll more than 1.2 million TennCare clients, as well as additional enrollees in their commercial business.

Our audit objective was to review the status of bureau payment reform, which is one aspect of the initiative. We reviewed the Tennessee Health Care Innovation Plan and related documentation. We also interviewed Division of Health Care Finance and Administration staff and stakeholders involved in implementing the initiative.

Based on our review, the bureau has taken adequate initial steps to implement payment reform, but these efforts are too new to draw conclusions on their impact.

Observation

6. The Division of Health Care Finance and Administration is leading medical payment reform through the Tennessee Health Care Innovation Initiative

The Tennessee Health Care Innovation Plan includes several approaches to payment reform. For example, it seeks to financially reward acute care providers based on successfully achieving a patient’s desired outcome during an “episode of care,” rather than making simple fee-for-service payments regardless of outcome. The initiative describes an “episode” as a clinical situation with predictable start and end points. For example, most procedures; hospitalizations; acute outpatient care (e.g., broken bones); behavioral health conditions (e.g., depression or substance abuse treatment); and some forms of cancer treatments are all classified as episodes.

The initiative required TennCare, among other providers, to adopt an episode payment approach for a first wave of three episodes by January 2014: perinatal care, total joint replacements, and acute asthma exacerbations. A total of 75 episodes will be implemented over the initiative’s first 5 years. This strategy is retrospective because provider performance (including cost and quality) will be calculated after an episode’s services.

A major component of this strategy is the Principal Accountable Provider (sometimes referred to as a “quarterback”), who is the provider “in the best position to influence the quality and cost of the overall outcome of the episode.” The quarterback is eligible for financial incentives to reduce costs and improve quality of care. Quarterbacks can include hospitals (e.g., those that admit acute asthma patients) and physicians (e.g., an orthopedic surgeon in charge of a joint replacement or an obstetrician delivering a baby).
Similar to the care episode payment approach, the initiative also aims to increase the number of long-term patients in appropriate Home and Community-based Services (HCBS), thus helping to maintain the clients’ independence and reducing the need (and, therefore, cost) for institutionalization. For example, quarterbacks can also be given incentives to help nursing facilities return patients to their homes after shorter stays without being readmitted to the hospital.

**Stakeholder Input**

A major initiative component is the “engagement of a broad range of stakeholders.” Governor Haslam asked the Division of Health Care Finance and Administration, the bureau’s administrative organizational home, to lead this engagement effort. The bureau conducted public roundtables; formed a provider stakeholder group and a payer coalition; assembled technical advisory groups of providers (TAGs) to develop criteria for specific episodes of care; and held both group and individual meetings with large employers and other purchasers of health care to improve on how to pay for health care.

We interviewed representatives from two TennCare managed care organizations and one provider group, the Tennessee Medical Association. While not all groups raised issues, we heard several concerns about the initiative’s payment reform efforts, including

- lack of adequate time for implementation (e.g., there may not be enough time to process data relating to the first three episodes of care or for doctors in small rural practices to adjust to initiative demands);
- lack of transparency allowing doctors to be fully informed about what is required of them (e.g., they cited a lack of clear, fair payment methodology based on claims data and adjusted for risk, as well as a lack of clear quality guidelines);
- concerns about how high cost cases, which may not be in a doctor’s control, will be handled (e.g., many clients have several diseases, or comorbidities, which make outcomes difficult to measure);
- providers, such as the quarterback, are financially responsible but may not have control over providers in episodes of care, such as specialists and mid-level health professionals (e.g., nurse practitioners and physician assistants);
- limited resources for doctors in small rural practices, making compliance with initiative requirements, such as electronic health records, difficult;
- lack of patient compliance with doctor’s directions, which could penalize providers;
- lack of an appeals mechanism regarding data and designations related to financial incentives; and
- TAG members include insurance company members in addition to clinicians.
**Expected Results**

The division estimates the initiative will produce $7.7 billion in health care cost avoidance through fiscal year 2020 in Tennessee. The division expects $1.1 billion of those savings to be achieved in fiscal years 2015 through 2017 ($385 million of these savings related to TennCare). These financial estimates assume the initiative will cover over 80% of Tennesseans. Additionally, the division claims that the positive impact will extend beyond health care cost savings to allow reallocation of resources to areas that impact health, such as education and economic development.
APPENDICES

APPENDIX 1
Title VI and Other Information

The Tennessee Human Rights Commission (THRC) issues a report, *Tennessee Title VI Compliance Program* (available on its website), that details agencies’ federal dollars received, Title VI complaints received, whether each agency’s Title VI implementation plan was filed in a timely manner, and any THRC findings taken on an agency.

Below are staff and board member demographics, as well as a summary of the information in the latest THRC report for the Bureau of TennCare.

According to the THRC’s fiscal year 2013 report, the bureau filed its annual implementation plan on September 24, 2012, which was before the due date. During the reporting period, THRC received and closed two complaints regarding the bureau. Additionally, THRC issued no findings based on its review of the bureau’s implementation plan.

The bureau received an estimated $6,548,154,400 from the federal government in fiscal year 2014.

The following table details bureau staff by job title, gender, and ethnicity as of August 2014:

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APPENDIX 2
Performance Measures Information

In April 2013, the General Assembly passed the Tennessee Governmental Accountability Act of 2013. This changed the state’s requirements for department performance measures. The Bureau of TennCare reported two measures in the Governor’s new customer-focused program.

As stated in the Tennessee Governmental Accountability Act of 2013, “accountability in program performance is vital to effective and efficient delivery of government services, and to maintain public confidence and trust in government.” In accordance with this act, all executive-branch state agencies are required to submit annually to the Department of Finance and Administration a strategic plan and program performance measures. The bureau’s priority goals, as reported for August 2014 on the Governor’s Customer Focused Government Monthly Results website, are as follows:

Priority Goals and Measures

Priority Goal 1: Ensure that TennCare members’ medical services appeals receive a timely resolution in accordance with federal law and the Grier Consent Decree.

Purpose of the Goal: Federal law requires medical appeals for Medicaid to be processed within 90 days.

Measuring the Goal:

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Source: Bureau of TennCare Appeals Tracking Database.

Priority Goal 2: Ensure TennCare and Children’s Health Insurance Program (CHIP) spending remains within budget limits.

Purpose of the Goal: Maintaining budget neutrality is a key concept in continuing the TennCare programs as an 1115 Demonstration program. TennCare is demonstrating that its approach to delivering medical services to members is more cost-efficient than operating TennCare’s program under the traditional federal fee-for-service. Submitting the CMS-64 report is a required activity that supports the federal funding drawn by the bureau and is the report of record for CMS when reviewing state and federal expenditures for the program. With respect to CHIP expenditures, TennCare is obligated to maintain spending within an established annual allotment from CMS. The CM-21 report tracks TennCare’s spending on CHIP services.
Measuring the Goal:

<table>
<thead>
<tr>
<th></th>
<th>Baseline</th>
<th>Current</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHIP spending compared to the CHIP allotment for Tennessee</td>
<td>$71,860,915</td>
<td>$53,375,387</td>
<td>$64,674,824</td>
</tr>
<tr>
<td>TennCare spending compared to what would have been spent without the 1115 Demonstration</td>
<td>$2,695,039,349</td>
<td>$1,940,228,641</td>
<td>$2,425,535,414</td>
</tr>
<tr>
<td>CMS 64 and CMS 21 reports will be submitted within 30 days of the quarter-end</td>
<td>Status: On schedule</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: Claims data received from managed care organizations and the state’s accounting system, Edison. The budget neutrality reports are prepared by the Bureau of TennCare’s Fiscal Office through efforts of the bureau’s Healthcare Informatics Unit and the Division of Accounts. The CMS-64 report is prepared by the Division of Accounts.

We did not audit, sample, or test this information, the procedures used to determine the information, or controls over the validity of the information.
## APPENDIX 3

### Budget Information

**Estimated Budget**

For the Fiscal Year Ended June 30, 2014

<table>
<thead>
<tr>
<th>Source</th>
<th>Amount</th>
<th>Percent of Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>State</td>
<td>$3,213,525,200</td>
<td>32%</td>
</tr>
<tr>
<td>Federal</td>
<td>$6,548,154,400</td>
<td>65%</td>
</tr>
<tr>
<td>Other*</td>
<td>$299,573,700</td>
<td>3%</td>
</tr>
<tr>
<td>Total</td>
<td>$10,061,253,300</td>
<td>100%</td>
</tr>
</tbody>
</table>

* The vast majority of this revenue (94%) comes from the pharmacy program’s drug rebates.

Source: State budget for fiscal year 2015.

### Account Details

<table>
<thead>
<tr>
<th>Account</th>
<th>State</th>
<th>Federal</th>
<th>Other*</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>TennCare Administration</td>
<td>$121,634,100</td>
<td>$153,507,400</td>
<td>$1,443,800</td>
<td>$276,585,300</td>
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<tr>
<td>TennCare Medical Services</td>
<td>2,179,993,900</td>
<td>4,851,391,900</td>
<td>274,421,000</td>
<td>7,305,806,800</td>
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<tr>
<td>Supplemental Payments</td>
<td>270,403,400</td>
<td>638,210,700</td>
<td>23,708,900</td>
<td>932,323,000</td>
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<tr>
<td>Intellectual Disabilities Services</td>
<td>322,219,700</td>
<td>590,338,000</td>
<td>0</td>
<td>912,557,700</td>
</tr>
<tr>
<td>Medicare Services</td>
<td>319,274,100</td>
<td>314,706,400</td>
<td>0</td>
<td>633,980,500</td>
</tr>
<tr>
<td>Total</td>
<td>$3,213,525,200</td>
<td>$6,548,154,400</td>
<td>$299,573,700</td>
<td>$10,061,253,300</td>
</tr>
</tbody>
</table>

Source: State budget for fiscal year 2015.
As reported in the prior audit, the Division of Health Care Finance and Administration did not properly terminate ineligible enrollees, which resulted in total questioned costs of $2,023.

[Note: As of January 2014, DHS no longer determines eligibility, the Bureau of TennCare does.]

Finding

In the prior audit, we reported that the Division of Health Care Finance and Administration (HCFA) did not terminate some ineligible enrollees’ benefits. The same problem reported in the prior audit also existed for one enrollee during the year ended June 30, 2013. In addition, another enrollee improperly received benefits when a valid social security number had not been provided.

Enrollee’s Benefits Not Terminated Properly – System Error

The Department of Human Services (DHS) is responsible for eligibility determinations for TennCare Medicaid and TennCare Standard. HCFA’s Medicaid management information system, interChange, receives eligibility data files daily from the DHS eligibility system, ACCENT. All enrollees for Medicaid and TennCare Standard must update their information with DHS and have their TennCare coverage redetermined annually since individual circumstances change over time.

When DHS terminates an enrollee’s TennCare coverage, ACCENT automatically triggers interChange to mail the enrollee a Request for Information (RFI) packet in order to gather updated information to determine if the enrollee is either eligible to receive the same TennCare coverage or if the enrollee is eligible for a different category of TennCare coverage. If DHS determines that the enrollee is no longer eligible for benefits based on the updated information or if the enrollee fails to respond to the RFI, HCFA mails the enrollee a 20-day advance termination notice. If the enrollee submits the requested information to DHS prior to the termination date specified (20 days from the date of the termination notice) and DHS determines that the enrollee meets all eligibility requirements, the enrollee will continue to be eligible for the applicable Medicaid category. According to the Rules of the Tennessee Department of Finance and Administration, Bureau of TennCare, Chapter 1200-13-13-.02(6)(b)(6), if DHS determines that the enrollee is eligible for a different category, the enrollee should be terminated from the previous Medicaid category and opened in the appropriate category. However, according to Chapter 1200-13-13-.03(3)(a), if DHS determines that the enrollee is no longer eligible for TennCare benefits, then the enrollee should be terminated from the TennCare program.

If the enrollee files an appeal to dispute the termination of his or her benefits or files a new application within 40 days of the termination notice, the enrollee will continue to receive TennCare benefits while the appeal is being resolved. If DHS determines that the enrollee is no
longer eligible for benefits based on the updated information or if the enrollee fails to respond to the termination notice, HCFA is to close the enrollee’s benefits.

For each enrollee, HCFA pays a monthly fee (called a capitation payment) to a managed care organization that provides medical services. We tested a sample of 60 TennCare enrollees who had a capitation payment during the year ended June 30, 2013, to determine if the enrollees were eligible for TennCare coverage and to determine if the enrollees’ eligibility had been redetermined during the audit period. Of the 60 enrollees tested for eligibility and redetermination, HCFA did not properly terminate eligibility benefits for one enrollee (1.7%).

HCFA mailed an RFI to the enrollee on November 21, 2012, requesting the enrollee to respond to DHS by January 2, 2013. DHS received the RFI within the allotted timeframe; however, DHS found that the enrollee was ineligible based on the information provided in the RFI. Therefore, HCFA mailed the individual a 20-day termination notice on January 25, 2013, stating that the enrollee’s Medicaid benefits would end on February 14, 2013. The enrollee submitted a new application on January 31, 2013, which continued her Medicaid benefits until the new application was processed. DHS completed an interview with the enrollee on February 12, 2013, and requested the enrollee submit income verifications. The enrollee submitted the requested verifications on February 19, 2013, and the DHS eligibility counselor determined on that date that the enrollee was not eligible for Medicaid due to exceeding the income limits; however, the enrollee’s benefits remained open in InterChange. We notified the Director of Eligibility Services that this enrollee was still receiving TennCare benefits on September 23, 2013. HCFA mailed the enrollee a termination notice on September 27, 2013, which resulted in a termination date of October 17, 2013.

The Director of Eligibility Services stated that DHS sent a denial notification on February 19, 2013, based on the determination made by the eligibility counselor on that date. However, old data on the Ridmatch file in ACCENT indicated that the enrollee was being reviewed for TennCare Standard eligibility. InterChange interpreted the data to mean that the enrollee’s eligibility should remain open until it received either an approval or denial regarding the TennCare Standard eligibility. The Director of Eligibility Services stated that the old data in ACCENT was from a previous action, and the eligibility counselor should have removed the data when the denial occurred on February 19, 2013.

The total questioned costs in the sample for the enrollee’s benefits not properly terminating during the audit period for fiscal year ended 2013 were $469. Federal questioned costs totaled $310, and the remaining $159 were state-matching funds. The total capitation amounts we tested in our sample were $137,176 from a population of $4,993,382,187. Office of Management and Budget Circular A-133 requires us to report all known questioned costs when likely questioned costs exceed $10,000 for a federal compliance requirement. We believe likely questioned costs exceed $10,000 for this condition.

The total questioned costs for this enrollee’s benefits not properly terminating after the audit period ended were $1,193. Federal questioned costs totaled $787, and the remaining $406 were state-matching funds.
Under special circumstances, HCFA assigns a pseudo social security number (SSN) to a person who does not have a valid SSN as issued by the Social Security Administration (SSA) upon application for Medicaid or TennCare Standard. SSNs are only assigned to newborns whom the SSA has not issued a valid SSN; adoption assistance children; undocumented aliens receiving emergency services only and who cannot obtain a valid SSN; individuals applying for SSNs; or individuals who have not obtained a SSN based on religious objections.

According to the TennCare Medicaid and TennCare Standard Policy Manual (December 2009), “A newborn can be added to its mother’s case without having to wait for the enumeration process to conclude. In most situations, the enumeration process (completion of SS-5) now occurs for newborns at the hospital. The newborn must be enumerated by age one or before he/she can be approved in any other TennCare Medicaid category (whichever occurs first).” We tested 11 enrollees with a pseudo SSN who received TennCare benefits for a time period greater than one year. Of the 11 enrollees tested, 10 received benefits for more than one year for valid reasons. However, HCFA did not properly close one child’s (9%) eligibility benefits after the child reached the age of one and had not provided DHS with a valid SSN.

This enrollee was assigned a pseudo SSN when he was born on May 15, 2012. HCFA mailed a letter on March 28, 2013, requesting the enrollee provide his SSN to DHS. After the enrollee had not provided a SSN, HCFA subsequently mailed a 20-day termination notice on June 6, 2013. DHS closed the household’s Medicaid and Food Stamp benefits on June 5, 2013, due to the child’s mother not providing proof of income, and the child’s Medicaid was already set to terminate on June 26, 2013, for not providing a valid SSN. The child’s mother appealed all case closures on June 26, 2013, which continued all benefits for all case members until the appeals were resolved. DHS resolved the appeals regarding the income verification on August 28, 2013, and continued the household’s Medicaid and Food Stamp benefits with no lapse in coverage; however, DHS improperly continued the child’s Medicaid with the other appeal resolutions, as no valid SSN was ever provided.

We notified the Director of Eligibility Services that this enrollee was still receiving TennCare benefits on October 28, 2013. The DHS eligibility counselor removed the child’s Medicaid benefits effective December 1, 2013. On December 4, 2013, the child’s mother provided the valid SSN, and the child became eligible for benefits with the rest of the family.

The total questioned costs for this enrollee’s benefits not properly terminating after the audit period were $361. Federal questioned costs totaled $237, and the remaining $124 were state-matching funds.

The 2012 annual risk assessment listed the potential risk that ineligible enrollees will receive services even though they do not have an official social security number. HCFA had controls in place to mitigate this risk, but the controls did not prevent this oversight by the DHS employee.
Recommendation

The Director of Member Services and the Director of Eligibility Services should reevaluate the control that was implemented due to the prior audit finding to review cases that are in pending status for an extended period of time. Also, the Director of Member Services and the Director of Eligibility Services should ensure that an enrollee’s benefits are terminated when the enrollee does not provide a valid social security number within the allotted timeframe.

Management’s Comment

We concur in part. We concur that these two cases were errors; however, the controls we have in place would have and did catch the issues for proper handling.

In the first case, the enrollee was held open in error because a certain data field in the DHS ACCENT system was not manually deleted. Because the TennCare system is programmed to treat that data element as if the child is still being reviewed for TennCare eligibility, she remained eligible for services pending completion of that review. In April of 2012 TennCare created a new report to identify enrollees who are held open in a pending status for more than 90 days. The enrollee in question was on that report (ELG-0481-M) and was in queue to be manually researched by TennCare staff when it was identified by audit staff.

Although it was correct for the child in the second case to have coverage without an SSN up to his first birthday, it was an error for the DHS Appeals staff to continue this child’s eligibility after he turned one and once the family’s appeal was resolved. However, the quarterly systematic processes would have identified him for termination in the subsequent quarter had the child’s SSN not been provided in December 2013. In fact, the 90-day pseudo SSN letter was mailed to the child on October 1, 2013 and a termination notice was mailed in December. That termination was not effectuated, however, because the verified SSN was provided by the family prior to the termination date. Therefore, although the controls in place to end coverage for enrollees without an SSN were temporarily interrupted by manual intervention, they were systematically reinstated the next time the quarterly noticing process ran.

As we work towards implementation of the new Tennessee Eligibility Determination system in 2014, we believe that issues such as those identified in these two findings will be reduced. The new system will rely on more real time data comparisons and fewer manual processes. The first finding will become obsolete because the eligibility review process for Medicaid and Standard will be streamlined. The second finding will no longer occur because monthly rules will run to identify all individuals who are inappropriately open with a pseudo SSN. Systematic processes will work to appropriately close those individuals in a timely manner.
The Division of Health Care Finance and Administration paid a dental claim for services that were not supported, resulting in total questioned costs of $91

Finding

Out of a sample of 61 fee-for-service claims that the Division of Health Care Finance and Administration (HCFA) paid during the audit period for the Medical Assistance Program, one claim (1.6%) could not be supported by documentation. As part of our examination, we reviewed items such as medical records; service logs; office visit and procedure notes; and physician orders to determine if the services billed on providers’ claims had actually been provided. For this one claim, the provider refused to cooperate with multiple requests to provide documentation supporting the dental claim. HCFA management also tried to get the provider to provide the documentation. Therefore, we could not determine if the costs were allowable or the services were provided.

The Code of Federal Regulations, Title 2, Part 225, Appendix A, requires costs to be adequately documented. Without proper documentation supporting the dental claim, we could not determine whether the dental claim was appropriate or if the services were provided.

The total amount of questioned costs for the dental claim was $91 out of a total of $112,934 tested. Federal questioned costs totaled $60; the remaining $31 was state-matching funds. The total amount of the population sampled was $2,351,325,152. Office of Management and Budget Circular A-133 requires us to report all known questioned costs when likely questioned costs exceed $10,000 for a federal compliance requirement. We believe likely questioned costs exceed $10,000 for this condition.

Recommendation

The Deputy Commissioner of HCFA should investigate all claims from the uncooperative provider to determine if the provider can provide supporting documentation for the claims submitted. The Deputy Commissioner should then seek reimbursement for any unsupported claims and take disciplinary action against the provider as appropriate.

Management’s Comment

We concur with the fact that we were unable to produce the documents to support the medical necessity of the claim, but do not concur that it is appropriate to extrapolate this circumstance to the entire population given the extremely unique circumstances surrounding the case. We believe that this circumstance was an isolated incident and that it was not reasonable to project the questioned costs to the entire population. The Division of Health Care Finance and Administration has done everything within our authority to compel the provider to submit the requested records. This is a very unique case, unlike any case we have experienced to date at HCFA. The provider failed to cooperate with our medical records request to determine if a paid claim was allowable or adequately documented. HCFA took every possible action and went to
extraordinary lengths to obtain adequate medical records as shown in the following events timeline, including notifying the provider that failure to provide the requested information would result in termination of his Medicaid Provider Number in Tennessee for cause and that this would be shared with other State Medicaid Programs including Georgia where the provider resides and currently practices.

A timeline of the events for this issue is shown below.

**2013-09-20**: The auditor began trying to contact the dental provider in Knoxville, Tennessee to obtain records for services that were performed as part of our sampled claim.

**2013-09-23**: The auditor contacted a dentist’s office that operates in the same shopping center as the sampled dentist to inquire if this office had taken over the business of the dentist. This dentist office informed the auditor that the dentist had closed his business abruptly, and they did not know where he went.

**2013-10-04**: After requesting assistance from HCFA’s Director of Audit and Investigation, it was discovered that the dental provider had operated a business in Alabama. Through extensive internet research, the auditor found the dentist’s location in Mobile, Alabama; however, the telephone number was disconnected. The auditor contacted a nearby business to the dentist’s Mobile location and learned that the dentist’s office had a For Sale sign in front of the business.

**2013-10-08**: HCFA’s Director of Audit and Investigation provided current contact information for the dentist, who was practicing in Douglasville, Georgia. HCFA’s Director of Audit and Investigation spoke with the dentist and stated that his records were maintained electronically and that it could take him some time to fulfill the request.

**2013-10-09**: The auditor spoke to the dentist on the phone, and he confirmed the fax number and mailing address of his current practice facility. The auditor faxed and mailed a records request to the Georgia office location. The deadline for response to the request was October 31, 2013.

**2013-10-31**: The deadline passed without a response to the request.

**2013-11-06**: The auditor left a voice mail message for the dentist to inquire about the status of our request.

**2013-11-07**: The auditor contacted the dentist by phone. The auditor told the dentist that the records had not been received and asked if he had sent them. The dentist stated that he had not sent them. He then said that the records were located in a storage unit that was padlocked because he had not paid the bill. He stated that he would get paid on Friday, November 15th, and would then pay his bill for the storage unit. Once he got inside the storage unit, he would have to boot up his server and insisted that it would be even more time to do that. The auditor told him that he did not know if this delay would be acceptable. He then told the auditor that the service was only for an examination and that it was foolish to audit it. The auditor had not mentioned the services performed for the sampled claim; therefore, confirming the dentist’s receipt of the letter. The auditor communicated this message to HCFA management.
2013-11-12: With coordination from HCFA’s Dental Director, General Counsel, Senior Associate General Counsel, and Chief Medical Officer, HCFA mailed a letter to the dentist that gave him a deadline of November 25, 2013 for the auditor to receive the records. The letter explained that section 8(b) of his Provider Agreement with Delta Dental required that he maintain medical records supporting his claims for services provided to patients for no fewer than five years from termination of his Provider Agreement. Section 8(d) of the Provider Agreement required that he, as a condition of participation in TennCare, provide such records to, among other authorities, the Comptroller of the State of Tennessee upon request for, among other reasons, fiscal audits. Section 8(c) of the Provider Agreement authorizes him to release such medical records for such purposes. The letter advised that, in the event the Comptroller has not received the records by the above-specified date, the State of Tennessee will consider terminating his TennCare/Medicaid Provider ID number for cause, which would be effective against him even though he is not currently practicing dentistry within the State of Tennessee. Such a termination would, by law, require HCFA to report this termination as a Program Integrity violation to the Office of the Inspector General as well as requiring us to notify the Georgia Medicaid and CHIP programs. These notifications may result in adverse action against him by these programs.

2013-11-25: The auditor did not receive the records by the second deadline.

2013-12-9: As of this date, the auditor has not received any records. As a result, one dental claim not supported will be a finding against HCFA.

2013-12: HCFA’s Dental Director contacted the provider by phone to encourage him to submit the requested dental records ASAP to avoid any adverse actions against him by the State.

2013-12-17: The auditor again reached out to the provider by phone and told him he had already missed two deadlines and that we needed the records ASAP.

2014-1-8: The auditor spoke with the provider by phone. The provider indicated he is still attempting to provide the records.

2014-2-11: As of this date, the auditor has not received any records.

2014-2-11: HCFA’s Dental Director presented this case to HCFA’s PRC Committee for termination of provider’s TennCare/Medicaid Provider ID number for cause because of failure of provider to submit medical records as requested by auditors with the Comptroller of the Treasury supporting claim for service. The Committee voted in favor of termination of the provider’s TennCare Provider Number which is in process.

2014-2-27: HCFA’s Program Integrity Division has opened an investigation and will be sending a demand letter requesting documentation to support all claims paid to this provider to determine if the provider can provide supporting documentation for the claims submitted. HCFA management will seek reimbursement for any unsupported claims.
The following template is an example of the denial letter that CHOICES HCBS applicants receive.

<Applicant Name>
<Applicant Address>
<Applicant Address>

<Today’s Date>

RE: Applicant: <Applicant Name>
    Date of Birth: <Applicant DOB>
    Date At-Risk PAE is Approved to Start: <PAE Approved Effective Date>
    PAE Control Number: <Last 5 digits of PAE Control Number, including Recert or Rev>

Dear <Applicant Name>:

You applied to get home care (Home and Community Based Services or HCBS) through the TennCare CHOICES in Long-Term Care Program (CHOICES).

There are two groups in CHOICES that receive home care. Group 2 is for people who qualify to receive care in a nursing home, but want home care instead. Group 3 is for people who don’t qualify to receive care in a nursing home. They are “at risk” of going into a nursing home unless they receive home care.

We reviewed your application, called a Pre Admission Evaluation or PAE. Your PAE has been denied for CHOICES Group 2. You don’t meet the medical rules to get the level of care provided in a nursing home. To find out why you don’t meet the medical rules for CHOICES Group 2, read the sections below called “How to qualify for nursing home level of care in CHOICES” and “Why you don’t qualify for nursing home level of care in CHOICES.”

BUT, your PAE is approved for CHOICES Group 3. This group is for people “at risk” of going into a nursing home. This home care will help delay or prevent your need for nursing home care. The kind and amount of care you’ll get depends on what you need. But, before TennCare will pay for this kind of home care, there are other rules you must meet. To find out the other rules you must meet, read the section below called “Getting Home Care in CHOICES Group 3.”

Do you think we’re wrong? Do you think you qualify for CHOICES Group 2? Do you have more information about the kinds of help you need? This could include medical records from your doctor or anyone else who has given you health care. The record must show that you need help with the kinds of ADLs listed below, and how much help you need. Please contact <Submitter Name>. <Submitter Name> can send us more information and we will take another
look at your PAE. They have 30 days to send us more information. Or, someone can help you send us a new PAE. You can file an appeal, but you must file your appeal **within 30 days of receiving this letter**. Keep reading to find out how to file an appeal.

**How to qualify for nursing home level of care:**

To qualify for the level of care provided in a nursing home, you must meet one of the rules below:

1. You must have a total score of at least 9 on the TennCare level of care scale. Your score is based on how much help you need with activities of daily living (ADLs) like:
   - Transfers (moving from one place to another, like from bed to a chair)
   - Walking or using a wheelchair
   - Eating
   - Toileting
   - Knowing where you are and who your friends and family are (called orientation)
   - Expressing wants and needs
   - Understanding and following simple instructions
   - Taking medicine
   - Behaviors like wandering that place you at risk if you have dementia.

2. OR, you must meet the medical rules for people “at risk” of nursing home placement but not qualify to enroll in CHOICES Group 3 for other reasons. You might not be in one of the groups that can enroll in CHOICES Group 3. Only people age 65 or older or adults age 21 and older with physical disabilities can enroll in Group 3. Or TennCare might not be able to safely meet your needs with the care you could get in CHOICES Group 3 like:
   - Up to $15,000 in CHOICES home care.
   - Other Medicaid services, like home health, that you can get from your health plan,
   - Services you could get through other insurance (including Medicare) or through other programs like Meals on Wheels.
   - Care provided for free by family members or friends.

**Why you don’t qualify for nursing home level of care:**

Based on the facts and papers we received, your score on the TennCare level of care scale is **insert acuity score**. And we think you **will** qualify for CHOICES Group 3. We think your needs can be safely met with the care you can get in CHOICES Group 3. So, you don’t meet the medical rules to get care in a nursing home. This is based on TennCare Rules 1200-13-01-.10(4) and 1200-13-01-.05(3).

We looked at your PAE and these medical records that we got with it to decide.

(Please select from the following those which apply)
- <History and physical from your physician or from a recent hospital stay >
- <Current Physician or FNP progress notes >
- <PT/OT Assessments>
This decision affects your right to enroll in CHOICES Group 1 for nursing home care. It also affects your right to enroll in Group 2 for more HCBS than you can get in Group 3. It does not change other TennCare services you may get.

Do you think we’re wrong? Do you think you qualify for nursing home level of care? Do you have more information about the kinds of help you need? This could include medical records from your doctor or anyone else who has given you health care. The record must show that you need help with the kinds of ADLs listed above, and how much help you need. Please contact <Submitter Name>. <Submitter Name> can send us more information and we will take another look at your PAE. They have 30 days to send us more information. Or, someone can help you send us a new PAE.

You have the right to appeal this decision.

You must file your appeal within 30 days of the date of this letter. You must give us your appeal in writing. Tell us your name, current address, and telephone number. Give us the facts we need to show you qualify now for nursing home level of care. Include the PAE control number from the top of page 1 of this letter.

Mail your appeal to:   TennCare Long-Term Services and Supports
c/o CHOICES Appeals
310 Great Circle Road
Nashville, TN 37243

Or, you can fax your appeal to 1-615-734-5411.

If you appeal, TennCare will take another look at your case.

If TennCare still says you don’t qualify, you’ll get a fair hearing. You’ll get a letter that says when and where your hearing will be. You may speak for yourself at the hearing. Or, you can have a friend, relative, or lawyer speak for you. If you decide to get a lawyer, please give him a
copy of this letter. Hearings are conducted according to state law (Tennessee Uniform Administrative Procedures Act, TCA 4-5-101).

**After 30 days**, it’s **too late** to appeal this decision.

Do you have questions? Call TennCare Long-Term Services and Supports (LTSS) for free at **1-877-224-0219**. In Nashville, call **507-6964**.

**Do you need help with this letter?**
Is it because you have a health, mental health, or learning problem or a disability? Or, do you need help in another language? If so, you have a right to get help, and TennCare can help you. Call TennCare Solutions at **1-800-878-3192**.

- **Do you have a mental illness and need help with this letter?**
  The TennCare Advocacy Program can help you. Call them for free at **1-800-758-1638**.

- **If you have a hearing or speech problem**, call us on a TTY/TDD machine. Our **TTY/TDD number is 1-866-771-7043**.

¿Habla español y necesita ayuda con esta carta? Llámenos gratis al **1-800-878-3192**.

**We do not allow unfair treatment in TennCare.** No one is treated in a different way because of race, color, birthplace, religion, language, sex, age, or disability. Do you think you’ve been treated unfairly? Do you have more questions or need more help? If you think you’ve been treated unfairly, call the Family Assistance Service Center for free at **1-866-311-4287**. In Nashville, call **743-2000**.
Getting Home Care in CHOICES Group 3

Before TennCare will pay for your home care in CHOICES Group 3, there are other rules you must meet. You must meet all of the rules to enroll in CHOICES Group 3.

To qualify for home care in CHOICES:

- You must be age 65 and older OR an adult age 21 and older with physical disabilities.
- AND, the State must be able to safely meet your needs in the home or community setting with the services you can get in CHOICES.
- AND, you must qualify for Medicaid in one of the groups that can get CHOICES home care. This includes people receiving SSI (Supplemental Security Income) payments, and people that qualify for Medicaid because they are receiving long-term care.

**Do you already have Medicaid?** If so there are other rules you must meet before TennCare can pay for long term care. The Department of Human Services (DHS) will make sure you meet those rules. Your TennCare health plan (MCO) will help you get DHS the facts and papers they need to decide. If you don’t meet the rules for long-term care, DHS will send you a letter. It will say how to appeal if you think they made a mistake.

**What if you don’t already have Medicaid?** Then you must apply with your local DHS office. Do this as soon as you can. Your local Area Agency on Aging and Disability (AAAD) can help you apply. Call them at 1-866-836-6678. Tell them you have an approved PAE for CHOICES Group 3, and need help applying for Medicaid. Or, you can apply online or at your county office. To find your county office or to apply online, go to www.tn.gov/humanserv.

DHS will tell you what facts and papers they need from you to decide if you can get Medicaid. After they decide, DHS will send you a letter that says if you can get Medicaid. If can’t get Medicaid, their letter will tell you why. And it will tell you how to appeal if you think they made a mistake.

If we decide you meet all of these rules, we will enroll you in CHOICES Group 3. You’ll get a letter from us that says when your CHOICES starts.

What if we decide you don’t qualify to enroll in CHOICES? We’ll send you a letter that says why. That letter will say how to appeal if you think we made a mistake.
CHOICES Home Care

Here are the kinds of home care you could get in TennCare CHOICES. The kind and amount of care you get depends on what you need. The total cost of these kinds of care can’t be more than $15,000 per calendar year, not counting minor home modifications. To keep getting home care, your MCO must still be able to safely meet your needs at home.

- **Personal care visits** (up to 2 visits per day, lasting no more than 4 hours per visit; there must be at least 4 hours between each visit.) – Hands-on help with self care tasks like getting out of bed, taking a bath, getting dressed, eating meals, or using the bathroom. Do you need this kind of hands-on care? If you do, the worker giving your personal care visits can also help with household chores like fixing meals, cleaning, or laundry. And they can run errands like grocery shopping or picking up your medicine. They can only help with those things for you, not for other family members who aren’t in CHOICES. And they can only do those things if there’s no one else that can do them for you.

- **Attendant care** (up to 1,080 hours per calendar year) – The same kinds of help you’d get with personal care visits, but for longer periods of time (more than 4 hours per visit or visits less than 4 hours apart). You can only get attendant care when your needs can’t be met with shorter personal care visits.

  Do you need hands-on help with self-care tasks and also need help with household chores or errands? If so, your attendant care limit increases to up to 1,400 hours per calendar year. This higher limit is only for people who also need help with household chores or errands.

  How much attendant care you get depends on your needs.

- **Home-delivered meals** (up to 1 meal per day).

- **Personal Emergency Response System** - A call button so you can get help in an emergency when your caregiver is not around.

- **Adult day care** (up to 2,080 hours per calendar year) - A place that provides supervised care and activities during the day.

- **In-home respite care** (up to 216 hours per calendar year) - Someone to come and stay with you in your home for a short time so your caregiver can get some rest.

- **In-patient respite care** (up to 9 days per calendar year) – A short stay in a nursing home or assisted care living facility so your caregiver can get some rest.

- **Assistive technology** (up to $900 per calendar year) – Certain low-cost items or devices that help you do things easier or safer in your home like grabbers to reach things.

- **Minor home modifications** (up to $6,000 per project; $10,000 per calendar year; and $20,000 per lifetime) – Certain changes to your home that will help you get around easier and safer in your home like grab bars or a wheelchair ramp.

- **Pest control** (up to 9 units per calendar year) - Spraying your home for bugs or mice.
What is Estate Recovery and what does it mean for you?

Your “estate” is made up of the things you own that you leave behind when you die. It includes your money, your home, other property, or other things you own.

**Estate recovery** is using the value of things you leave behind when you die to pay TennCare back for care you received while you were living.

**Why you have to pay TennCare back for your care**

TennCare, including CHOICES services, are paid for by the State and federal government. If TennCare pays for any of your care, TennCare is required by federal law to try to get paid back for that care after your death.

TennCare must ask to be repaid for money it spent on your care if you are:
- Any age and got nursing home care if you weren’t expected to return home
- Or age 55 and older and got nursing home care, home care, home health or private duty nursing.

TennCare must ask to be repaid for these services:
- Nursing home care
- Home care (CHOICES home care as well as home health or private duty nursing)
- Hospital care and prescription drugs you got while you’re in CHOICES.

TennCare can also ask to be paid back for the cost of any other services we paid for.

TennCare can’t ask for the money back until after your death. TennCare can’t ask for more money back than we paid for your care. And TennCare can’t ask your family to pay for your care out of their own pockets.

**Sometimes TennCare may not have to get the money back from your estate.**

These times are:
- If you leave very little money or property when you die
- If your care did not cost much
- If the things you left can’t be used to pay people you owe through probate court. An example is life insurance money.

But these times do not happen by themselves. The person handling your things after you die must get a Release from TennCare. It says you don’t owe TennCare money. If your things have to go through Probate court, the Release must be filed there.

**Sometimes TennCare must let your money or property stay in the family longer.**

These times are if you leave your money or property to:
- Your surviving husband or wife
- Your child who is under age 21 when you die
- Or your child of any age who is blind or permanently and totally disabled.
TennCare won’t try to get repaid until this family member dies or the child turns age 21. But the person who handles your things must file the TennCare Release in Probate Court.

Sometimes TennCare must let just your HOME stay in the family longer.
This happens when one of these family members lives in the home when you die:
- Your surviving husband or wife
- Your child who is under age 21 when you die
- Your child of any age who is blind or permanently and totally disabled
- Your child who lived in the home and took care of you if this care kept you out of a nursing home or home care for 2 years
- Or your brother or sister who helped make the house payments if they lived there for a year before you got nursing home or home care.

By law, TennCare should not take the house until these family members die or the child turns 21. But the person who handles your things must file the TennCare Release in Probate court.

TennCare may leave your money and property in the family because of undue hardship.

But the State does not do this very often. The family must prove that losing the money or property in your estate will cause an undue hardship. For example, if your property is a family farm and the family’s only income, then the person handling your things can ask the State not to take the property. The State may or may not agree.

The person handling your things after you die may apply for a Release in one of three ways:

1. They can get the Release online at [www.tn.gov/tenncare/forms/releaseform.pdf](http://www.tn.gov/tenncare/forms/releaseform.pdf)
2. They can get the Release from the Probate Court Clerk’s office by asking for a “Request for Release from Estate Recovery”.
3. They can get the Release from TennCare by sending a letter or fax to:

   Bureau of TennCare  
   Estate Recovery Unit  
   310 Great Circle Road  
   Nashville, TN 37243  
   FAX: (615) 413-1941

All of the information asked for in the Release must be included. And they must provide any other information TennCare requests to decide if the Release will be given.