

Department of Health

March 1999

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March 15, 1999

The Honorable John S. Wilder
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The Honorable Kenneth N. (Pete) Springer, Chair
Senate Committee on Government Operations
The Honorable Mike Kernell, Chair
House Committee on Government Operations
and
Members of the General Assembly
State Capitol
Nashville, Tennessee 37243

Ladies and Gentlemen:

Transmitted herewith is the performance audit of the Department of Health. This audit, which includes a review of the Bureau of TennCare, was conducted pursuant to a request from the Joint Government Operations Subcommittee on General Welfare, Health and Human Services during the July 16, 1998, Sunset public hearing on the department's activities.

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

Sincerely,

John G. Morgan
Comptroller of the Treasury

JGM/dlj
99-012

State of Tennessee

Audit Highlights

Comptroller of the Treasury

Division of State Audit

Performance Audit
Department of Health
March 1999

AUDIT OBJECTIVES

The objectives of the audit were to evaluate the efficiency and effectiveness of the department's TennCare and TennCare Partners Programs; to determine the extent of the merger between the Departments of Health and Mental Health and Mental Retardation and to assess the effects of any merger-related changes on services to mentally ill or developmentally disabled Tennesseans; to determine the department's progress in correcting the problems identified in the February 1998 Sunset audit of the department; and to make recommendations that might result in more efficient and effective operation of the department.

TENNCARE FINDINGS

Despite TennCare's Routine Monitoring of the Adequacy of Provider Networks, the MCOs* and BHOs* Continue to Have Problems Providing Adequate Access to Some Types of Care

The TennCare Program has had access/provider network problems since its inception, and there is no evidence these problems will be solved in the near future. TennCare routinely monitors provider networks and has undertaken numerous activities to increase access; however, our survey of providers indicated a high level of frustration with the MCOs and BHOs, the low reimbursement rates, and TennCare in general. This frustration could result in more providers' leaving the program or declining to accept new patients (page 24).

The Financial Condition of Some of the Managed-Care Organizations Raises Concerns

Based on September 30, 1998 financial filings, two of the eleven managed-care organizations (nine MCOs and two BHOs) in the TennCare Program had not met their net worth requirements. In addition, as of September 30, seven organizations were reporting financial losses in fiscal year 1998. These circumstances raise concerns about the ability of some MCOs and BHOs to remain in the program and to continue to support adequate provider networks (page 27).

No Formal Assessment of TennCare Rates Has Been Completed Since the Program's Inception

Without an actuarial study to assess the adequacy of capitation rates paid to the MCOs and BHOs or the rates paid to the service providers, the bureau has no assurance these rates are adequate to maintain the necessary provider networks. Two actuarial studies are in progress—the Department of Health has contracted with William M. Mercer, Inc., to evaluate BHO rates, and the Comptroller of the Treasury has contracted with PricewaterhouseCoopers to evaluate MCO and BHO rates. The PricewaterhouseCoopers

study has a legislative due date of March 15, 1999; William M. Mercer, Inc., sent an initial draft report to the Department of Health on December 3, 1998 (page 29).

TennCare Needs to Continue to Address the Problems Identified in the EPSDT Consent Decree

Inadequacies in the state's provision of Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services resulted in a class-action complaint and a March 1998 consent decree requiring the state to take a variety of actions to improve quality of, and access to, care for Tennessee children. Since that time, the bureau (1) has prepared a detailed plan of actions to achieve compliance with the consent decree; (2) has begun implementing the action plan; and (3) has submitted two reports describing the bureau's progress. Despite the progress made, an October 1998 report from an outside review team indicates that the bureau needs to continue to work with the MCOs, the BHOs, and the Department of Children's Services to improve services to children, particularly those in, or at risk of coming into, state custody (page 31).

Provider Assessments of the TennCare Program Are Negative

Provider assessments (including a Division of State Audit survey of over 1,500 TennCare providers) disclose problems with claims processing, reimbursement rates, medical-necessity standards, drug formularies, referral/prior authorization, and other administrative procedures. Because of these problems, managed-care networks may have difficulty attracting new providers and retaining existing ones. These problems may also compromise the quality of care TennCare enrollees receive (page 37).

Weaknesses in TennCare's Formularies Are a Source of Provider Dissatisfaction

The bureau does not adequately monitor the timeliness of authorizations for prior approvals and medical necessity. Providers recently surveyed had the following complaints: the formularies were restrictive, the approval process was slow, and the MCOs were not responsive to their needs (page 43).

Appeals Are Not Adequately Monitored

Enrollees have the right to contest in writing any action the MCO or BHO takes to deny, reduce, terminate, or suspend a covered service ordered or prescribed by a particular provider. The TennCare Appeals Unit works to resolve these appeals, collects data regarding appeals, and reports monthly to the TennCare Division of Quality Improvement and quarterly to the Health Care Financing Administration (HCFA). Even though the data are available, TennCare does not monitor or analyze appeals resolution. Analyses of how, why, and where appeals are resolved and how many decisions are appealed can reveal programmatic deficiencies and areas for improvements (page 48).

The TennCare Management Information System Is Inefficient

The TennCare Management Information System (TCMIS) is over ten years old and cannot efficiently meet the state's decision-making and reporting needs. Most of the system's programs and applications are designed to process payments to the MCOs, BHOs, and nursing homes. To generate information requested by the legislature, HCFA, and others, TCMIS staff must, in many cases, write special programs; often, such requests are given a lower priority by system management (page 53).

MCO/BHO Coordination Efforts Do Not Ensure Enrollees Receive Appropriate Services

With the implementation of the TennCare Partners Program, the BHOs became responsible for mental health and substance abuse services, and the MCOs retained responsibility for providing primary health care. Each MCO contracts with a BHO to ensure TennCare enrollees receive appropriate mental health services. Although the state outlined a framework for coordination, the MCOs and BHOs have failed to establish solid working relationships. Poor communication between the MCOs and BHOs and weak monitoring by TennCare hinder efficient and effective service delivery. Unless coordination improves, TennCare cannot ensure enrollees receive all needed physical and mental health services (page 56).

MCOs and BHOs Have Not Made Sufficient Effort to Detect Fraud and Abuse

Although the waiver assigns joint responsibility to the MCOs, BHOs, and TennCare for the detection of provider fraud and abuse and although their contract requires the MCOs and the BHOs to report fraud to the Tennessee Bureau of Investigation (TBI) and the Department of Health, only four of the 11 MCOs/BHOs have fraud policies and detection units in place. Failing to detect fraud and abuse could adversely affect the TennCare Program by reducing the funds available for legitimate services (page 61).

TennCare Partners Does Not Provide a Complete Continuum of Care for Enrollees With Substance Abuse Problems

The TennCare Partners Program is not providing a full-range of substance abuse treatment services. Under the state's contract with the BHOs, substance abuse benefits are limited to inpatient hospital and outpatient substance abuse treatment. Residential treatment, such as social-setting detoxification and counseling, is not covered under the contract. However, according to provider groups, only about 10% of substance abusers need medical detoxification—the other 90% benefit more from other services, including those provided by residential treatment facilities (page 63).

Case Management Services Have Not Been Offered and Provided As Required

TennCare Partners has not ensured that all enrollees suffering from serious mental health problems have access to case management services within seven days of their discharge from care, although the BHOs are required by their contract to offer this service. For the first eight months of 1998, only 605 (14%) of the 4,219 clients discharged by Tennessee Behavioral Health (TBH) providers received or were offered case management services within seven days of their release. Likewise, only 719 (18%) of the 4,003 clients released by providers aligned with Premier actually received case management services within the seven days. Although the BHOs eventually increased their offering of such services during calendar year 1998, failure to provide comprehensive post-discharge treatment to a highly vulnerable population could result in the return to institutionalized care for persons afflicted with serious mental disorders (page 65).

The TennCare Partners Program Lacks a Well-Defined Set of Performance Measures and a Focus on Program Outcomes

Without a defined set of performance measures, it is difficult for the external quality review organization, advocacy groups, HCFA, and the bureau's quality improvement unit to adequately monitor the outcomes of the TennCare Partners Program and, thus, to determine the program's overall effectiveness (page 68).

The Management Structure of TennCare's Two BHOs Raises Questions About a Lack of Competitiveness and Increased Vulnerability for the State

Magellan Behavioral Health Services essentially manages both of the BHOs that contract with TennCare for mental health services. Magellan owns 50% of one BHO and is in the process of acquiring 100% of the other BHO. This arrangement may limit TennCare's ability to promote cost savings through competitiveness in provision of services. Also, the arrangement could potentially leave the state vulnerable if the company were to drop out of the TennCare Program (page 69).

The Fiscal Division Does Not Sufficiently Monitor Vendor Contracts to Ensure Satisfactory Compliance With Contract Requirements

TennCare's Fiscal Division is responsible for processing and administering all bureau contracts, except the MCO and BHO contracts. As of October 19, 1998, the Fiscal Division was administering 34 service contracts totaling over \$400 million—contract amounts for fiscal year 1999 alone totaled \$220 million. The division has no policies addressing contract monitoring or actions to be taken when vendors fail to comply with contract provisions, although division management stated that some individual contracts are written to include monitoring requirements and penalties for noncompliance. TennCare can choose not to renew the contract of a vendor that does not comply with its contract. However, without adequate monitoring, the division has no basis on which to make such decisions (page 71).

The Submission of Encounter Data Is Still Problematic

Encounter data detail services provided to managed-care patients and enable TennCare staff and others to evaluate the impact of the program on enrollees. Despite significant improvements in the timeliness of submission and the quality of encounter data, considerable problems still plague the MCOs' and BHOs' submission of encounter data and the bureau's effort to ensure the accuracy of the data (page 73).

The Bureau Does Not Have a Conflict-of-Interest Policy for Persons Who Make or Give Advice on Decisions Concerning Drug Formularies

The Bureau of TennCare does not have a conflict-of-interest policy that requires members of various formulary committees and boards to periodically submit statements disclosing potential personal and professional conflicts of interest. The bureau also has not developed procedures describing how and under what situations committee members should recuse themselves from participation in formulary decisions for which they may have a potential conflict of interest (page 75).

Home-Based, Long-Term Care for TennCare Enrollees Is Severely Limited

With the exception of Shelby, Davidson, Knox, and Hamilton Counties, TennCare does not pay for assisted-care services in the home for enrollees requiring long-term care. Moreover, services in those counties are limited to a relatively small population—400 in Shelby County and 50 in each of the remaining counties (page 77).

* MCOs – managed-care organizations

* BHOs – behavioral health organizations

MERGER-RELATED ISSUES

The audit discusses the following issues related to the proposed merger of the Department of Mental Health and Mental Retardation with the Department of Health: the extent of consolidation between the departments, the lack of a written management plan to coordinate state health and mental health programs, and the effect of the proposed consolidation on the delivery of services to mentally ill and developmentally disabled Tennesseans (page 80).

FOLLOW-UP OF FEBRUARY 1998 AUDIT FINDINGS

The audit discusses our evaluation of the Department of Health's actions to correct deficiencies identified in the February 1998 Sunset audit of the department. Included in the text are the original February 1998 findings and management's comments, the department's September 1998 follow-up responses, and our evaluation of the department's follow-up activities and the current status of those activities (page 87).

OBSERVATIONS AND COMMENTS

The audit also discusses the following issues: the status of public health in Tennessee, the current role of the county health departments, TennCare cost savings, TennCare enrollee satisfaction issues, the results of an investigation of TennCare, and the department's role in Families First home visits (page 9).

"Audit Highlights" is a summary of the audit report. To obtain the complete audit report which contains all findings, recommendations, and management comments, please contact

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Performance Audit Department of Health

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Performance Audit Department of Health

INTRODUCTION

PURPOSE AND AUTHORITY FOR THE AUDIT

This performance audit of the Department of Health was conducted pursuant to a request from the Joint Government Operations Subcommittee on General Welfare, Health and Human Services during the July 16, 1998, Sunset public hearing on the department's activities. The Comptroller of the Treasury is authorized under Section 4-29-111 to conduct a limited program review audit of the department and to report the results to the Joint Government Operations Committee of the General Assembly. The audit is intended to aid the committee in determining whether the department should be continued, restructured, or terminated.

OBJECTIVES OF THE AUDIT

The objectives of the audit were

1. to evaluate the efficiency and effectiveness of the department's TennCare and TennCare Partners programs;
2. to determine the extent of the merger between the Departments of Health and Mental Health and Mental Retardation and to assess the effects of any merger-related changes on services to mentally ill or developmentally disabled Tennesseans;
3. to determine the department's progress in correcting the problems identified in the February 1998 Sunset audit of the department; and
4. to recommend possible alternatives for legislative or administrative action that may result in more efficient and effective operation of the Department of Health.

SCOPE AND METHODOLOGY OF THE AUDIT

The Department of Health's activities and procedures were reviewed, with the focus on procedures in effect at the time of field work (September to December 1998). The audit was conducted in accordance with generally accepted government auditing standards. The methods included

1. interviews with regional and central office staff of the Department of Health;
2. interviews with state officials and representatives from the health industry and client advocacy groups;

3. reviews of department files, documents, and reports;
4. a survey of providers in the TennCare and TennCare Partners programs;
5. reviews of statutes and state and federal rules and regulations;
6. reviews of consultants' reports and prior audit reports and documents; and
7. interviews with, and a review of reports and documents from, the TennCare program's managed-care and behavioral health organizations.

The Division of Health Care Facilities, part of the department's Office of Health Licensure and Regulations, was reviewed as part of the audit of the Board for Licensing Health Care Facilities released in December 1998. An audit of the Division of Health Related Boards, also part of the Office of Health Licensure and Regulations, was released in March 1999. And the department's eleven Health Advisory Entities (and their associated programs) were reviewed in a separate audit released in July 1997.

ORGANIZATION AND RESPONSIBILITIES

The primary statutory responsibility of the Department of Health is protecting and improving the health of Tennesseans and Tennessee's visitors. The department is organized into offices, divisions, and bureaus, some of which report directly to the Commissioner of Health; others report directly to the State Health Officer. (See organization chart on the following page.)

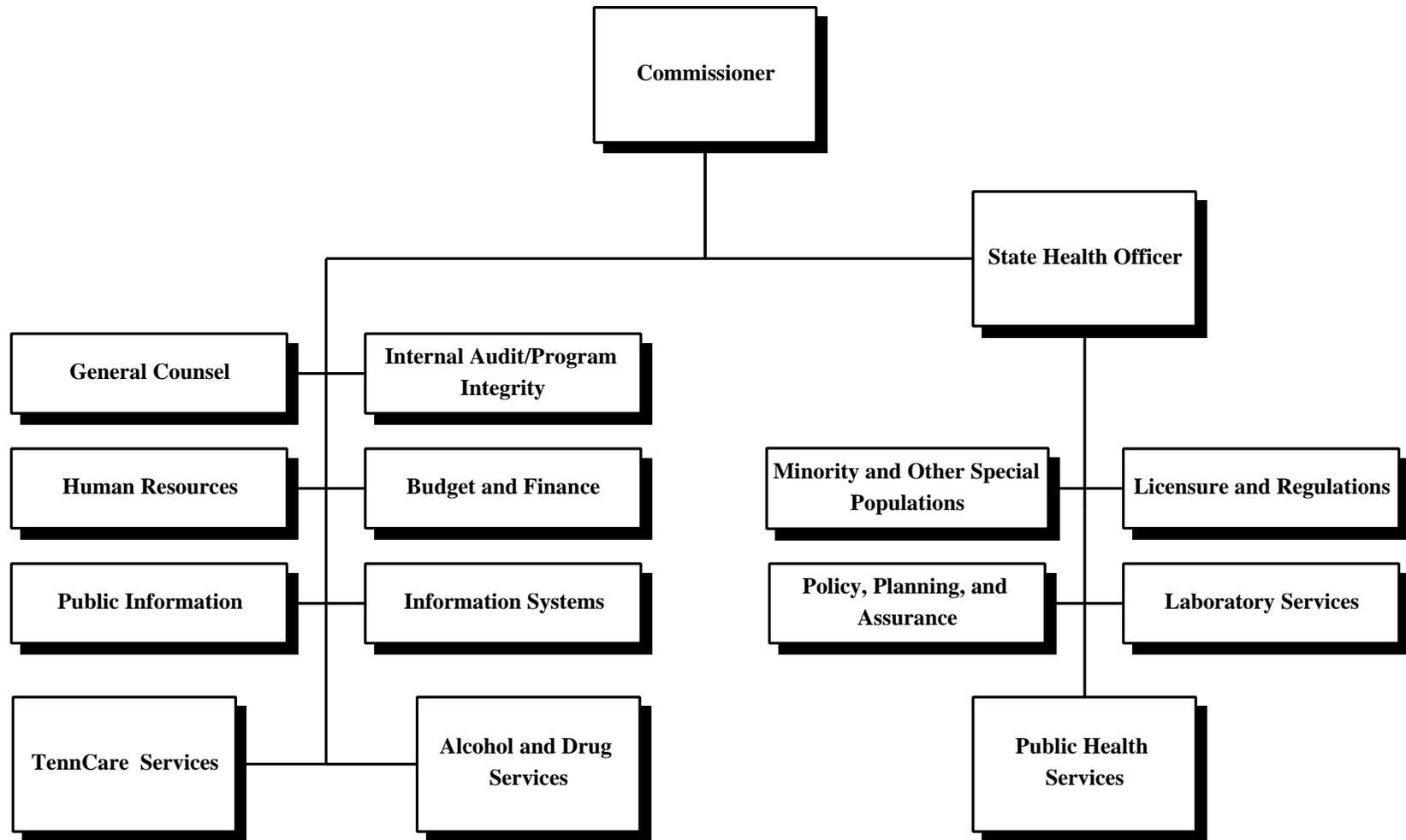
The Bureaus of TennCare and Alcohol and Drug Abuse Services report directly to the Commissioner of Health. The Bureau of TennCare is responsible for the implementation of the Section 1115A waiver, a demonstration project allowing Tennessee to replace its Medicaid program with a system of managed care. The bureau provides oversight, planning, and funding for three service areas: TennCare Medical and Mental Health Services, Waiver and Crossover Services, and Long-term Care. The Bureau of Alcohol and Drug Abuse Services is responsible for planning and developing prevention and treatment services to decrease the incidence and prevalence of alcohol and other drug abuse. The bureau funds (1) treatment and rehabilitation services for thousands of Tennesseans each year through community-based outpatient and residential treatment facilities across the state and (2) activities designed to prevent alcohol and drug abuse among youth through early intervention and outreach.

In addition, the following divisions/offices report directly to the Commissioner: General Counsel, Human Resources, Public Information, Internal Audit/Program Integrity, Budget and Finance, and Information Systems. The Information Systems Division collects, analyzes, and disseminates health-related data including vital records information and alcohol and drug abuse information, and provides information systems support to the various programs within the Department of Health.

The Bureau of Health Services Administration, which reports directly to the State Health Officer, directs, supervises, plans, and coordinates health service delivery for the state. The bureau contains an array of programs and services and through a network of regional offices,

Department of Health

December 1998



local health departments, and county clinic sites works to ensure that quality health care services are delivered to those in need. The following are the bureau's major sections:

Patient Care Services. Through outreach, intensive case management, and delivery of direct patient care, Patient Care Services helps ensure all Tennesseans have access to primary health care services.

Communicable and Environmental Disease Services. This section's mission is to detect, prevent, and/or control communicable diseases and their consequences through disease surveillance and investigation; to provide technical assistance, education, and information on the health effects of environmental pollution; and to ensure the delivery of needed services. The section includes the following programs: Immunization, Tuberculosis, Sexually Transmitted Diseases/HIV, Environmental Health Studies and Services, Infectious Diseases, Surveillance, and AIDS Support Services. The Communicable and Environmental Disease Services Program works to protect Tennesseans from infectious diseases through epidemiological investigations of acute communicable diseases, administration of immunizations against vaccine-preventable diseases, and investigation, diagnosis, and treatment of persons with sexually transmitted diseases.

General Environmental Health. Through a system of permits and field inspections, the General Environmental Health section enforces laws and regulations relating to sanitation and safety in hotels, food service establishments, bed and breakfast facilities, organized camps, and public swimming pools.

Regional and Local Health. The Department has seven rural and six metropolitan regional health offices which are responsible for providing overall policy direction, management, and supervision of all health department services. Each of the rural and metropolitan regions has a Regional Health Officer, and each rural county has a Public Health Director responsible for the day-to-day operations of the county's health department.

Regional and Local Health Services offers health services to citizens of the state through a network of regional offices, metropolitan area offices, and county health departments. Grant-in-aid is provided to local health units to ensure that every citizen in the state has access to health care and that each of the county health departments has adequate staff. Grant-in-aid funding supports the following programs:

AIDS	Health Promotion	Tuberculosis Control
AIDS Ryan White Clinical	Home Health (Dyer County)	Women, Infants and Children (WIC Office)
Child Health	Immunizations	WIC Breast Feeding Promotion
Child Health and Development	Men's Health	WIC Education
Dental Clinical	Project Hug	Women's Health
Family Planning	Rape Prevention	
	Sexually Transmitted Diseases	

The following sections also report directly to the State Health Officer:

Health Licensure and Regulations. This office regulates the health care industry through the certification and licensure of health care facilities and emergency medical services and the regulation of certain health professionals.

Policy, Planning, and Assurance. This division includes data collection and systems support, health statistics and information, assessment and analysis, and planning components.

Laboratory Services. This division offers microbiological and environmental laboratory services for intra- and interdepartmental programs. Reference and limited microbiological support is provided to hospitals, private physicians, and private laboratories. The division also provides analytical support to the department's prevention and treatment programs and to environmental regulatory programs. The division has a central laboratory and four branch laboratories in Jackson, Johnson City, Knoxville, and Memphis.

Minority Health. This office's purpose is to improve minorities' access to health care and to improve overall minority health. The office provides state-funded grants to prevention programs that focus on children and youth, develops policy, evaluates strategic plans, develops programs, and disseminates information to assist in advancing minority health issues.

BUREAU OF TENNCARE

To control escalating Medicaid costs, some states have moved some or most of their Medicaid population into a capitated managed-care system. In June 1993, Tennessee applied for, and subsequently received, a waiver from the federal Health Care Financing Administration (HCFA) to implement a five-year managed-care demonstration project under Section 1115 of the Social Security Act. On January 1, 1994, under the terms of the waiver, Tennessee ceased operating a traditional Medicaid program and began TennCare, a system of managed care that made health care available to 800,000 Medicaid-eligible residents and approximately 400,000 previously uninsured Tennessee residents.

TennCare is managed by the Bureau of TennCare, Department of Health, and is financed by pooling federal, state, and local resources for indigent health care. Pooled resources total approximately \$3.6 billion for fiscal year 1998-99—\$2.3 billion for TennCare program services and \$1.3 billion for long-term care (nursing home) services, home and community-based services, Medicare crossovers (enrollees eligible for both Medicare and Medicaid), Medicare premiums, and overall administration. The bureau contracts with nine managed-care organizations (MCOs) to deliver necessary medical care. Through its Partners Program, initiated in July 1996, TennCare contracts with two behavioral health organizations (BHOs) to deliver mental health and substance abuse services to TennCare enrollees. (See the table for a listing of the organizations and the acronyms used to identify them in this report.)

Acronyms

MCO/BHO	Managed-Care Organization/ Behavioral Health Organization
ACC	Tennessee Managed Care Network (Access MedPLUS)
HEA	Health Net, Inc. (Merged with Phoenix Health Care)
HER	Heritage National Health Plan of Tennessee, Inc. (John Deere Health Care)
MEM	Memphis Managed Care Corporation (TLC Family Care Healthplan)
OMNI	Omni-Care Health Plan, Inc.
PHP	Preferred Health Partnership of Tennessee, Inc.
PRE	Premier Behavioral Systems of Tennessee
PRU	Prudential Health Care Plan, Inc. (Prudential Community Care)
TBH	Tennessee Behavioral Health, Inc.
THP	Total Health Partnership, Inc.
VAN	Vanderbilt University Medical Center Health Plan
VSHP	Volunteer State Health Plan (BlueCare—formerly Blue Cross/Blue Shield of Tennessee)
XAN	Xantus Health Plan of Tennessee, Inc. (formerly Phoenix Health Care of Tennessee, Inc.)

TennCare also offers insurance to uninsured and uninsurable persons who were not eligible for Medicaid, regardless of income. To qualify as an uninsured enrollee, a person must not have had access to health insurance on or after March 1, 1993. Under TennCare, enrollees who are not eligible for Medicaid and have incomes above the poverty level would be required to pay monthly premiums based on their income. TennCare limits the total enrollee out-of-pocket expense. TennCare also extended the period of health coverage for many people qualifying under Medicaid. To stay within budget ceilings, the state limited total enrollment to 1.3 million the first year and 1.5 million in succeeding years.

On January 1, 1995, TennCare reached 90% of its target enrollment and closed enrollment in the uninsured category. TennCare reopened enrollment April 1, 1997, in the uninsured category to children under the age of 18 who do not have access to health insurance through a parent or guardian. On May 21, 1997, TennCare enrollment became available for eligible dislocated workers. In an effort to expand coverage to more of Tennessee's uninsured children, the Bureau of TennCare opened enrollment from January 1, 1998, through March 31, 1998, to uninsured Tennesseans under the age of 19 with access to health insurance but whose individual family incomes were below 200% of the poverty level schedule in effect for calculation of TennCare premiums. Effective January 1, 1998, enrollment was opened indefinitely for uninsured children under the age of 19. The Bureau of TennCare eliminated deductibles and limited co-payments for these new eligibility populations and all uninsured children under 18 years of age who had enrolled in TennCare previously. Enrollment remains open to persons who are Medicaid-eligible or are uninsurable as determined by an insurance company's denial (for medical reasons) of health insurance. As of December 12, 1998, enrollment was 1,288,464—833,484 were Medicaid eligibles and 454,980 were in the uninsured/uninsurable categories.

TENNCARE PARTNERS PROGRAM

The TennCare Partners program began July 1, 1996, as the mental health and substance abuse services component of the TennCare program. Partners arose out of the MCOs' inability to provide adequate mental health services.

TennCare opened negotiations with five behavioral health organizations (BHOs) to provide mental health and substance abuse services on a capitated basis to TennCare enrollees and a limited number of others with chronic mental illness. The original five BHOs were combined into two BHOs. Each MCO was required to contract with one of the two BHOs to provide the mental health services covered under the waiver agreement. (Because of its size, Volunteer State Health Plan, formerly Blue Cross/Blue Shield, contracted with both BHOs.) The BHOs provide services through contracted providers, much like the MCOs. Included in the provider network are the community mental health centers and the regional mental health institutes.

Since start-up, the Partners program has had difficulties such as inadequate provider networks, poor monitoring activities, slow claims processing, and poor communication. Under direction from HCFA and the William M. Mercer consulting firm, the TennCare Partners Action Plan (released in May 1997) was established and reflected HCFA's required changes and Mercer's recommended actions, as well as improvements the Bureau of TennCare had initiated.

In March 1998, Governor Sundquist announced an improvement program to be implemented in three phases. Phase I, implemented in May 1998, included a renewed commitment to the principles of the state's Mental Health Master Plan, a pledge to work with the Mental Health Planning Council to update and build on the Mental Health Master Plan, the initiation of an independent actuarial review of the Partners program, and a nationwide search for a nationally recognized mental health expert to lead the program. The state plans to commit \$5.8 million

over five years to match a potential federal grant and to distribute \$7.75 million to the community mental health centers.

Phase II improvements relate to pharmacy services, funding, claims processing, communication, and program design. The goals of Phase II are to improve the quality of care, to broaden opportunities for consumers and family members, to strengthen communication, to increase community-based services, to promote the goals of the Mental Health Master Plan, and to stabilize the provider community.

Phase III improvements are scheduled for implementation after July 1, 1999. This phase intends to vastly improve the way the Partners program determines and monitors eligibility, to extend and expand benefits to recipients, to conduct a true actuarial study, to improve access to care by increasing community-based services, and to better monitor quality. HCFA, however, has denied TennCare's request to proceed with Phase III because of the absence of an actuarial study evaluating BHO capitation rates and the rates paid to providers of mental health services. Two actuarial studies are in progress—the Department of Health has contracted with William M. Mercer, Inc., to evaluate BHO rates, and the Office of the Comptroller of the Treasury has contracted with PricewaterhouseCoopers to evaluate MCO and BHO rates. Both studies will assess capitation payments to the managed-care organizations, as well as those organizations' payments to service providers. Although the Mercer study was expected to be completed in August 1998, an initial draft was not submitted to the Department of Health until December 3, 1998. The PricewaterhouseCoopers study has a legislative due date of March 15, 1999.

REVENUES AND EXPENDITURES

During fiscal year 1998, the Department of Health, excluding TennCare, had expenditures and revenues of nearly \$356 million. The major sources of revenue were the federal government (over \$142 million) and state appropriations (nearly \$136 million). The major types of expenditures included WIC Supplemental Foods (\$86.6 million), Executive Administration (\$65 million), Local Health Services (\$64.8 million), and Alcohol and Drug Services (\$31.7 million).

Revenues and expenditures for TennCare operations were \$3.6 billion in fiscal year 1998. The major sources of revenue were the federal government (\$2.5 billion) and state appropriations (\$1.1 billion).

OBSERVATIONS AND COMMENTS

The issues discussed below did not warrant findings but are included in this report because of their effect or potential effect on the operations of the Department of Health and the health, safety, and welfare of the people of Tennessee.

STATUS OF PUBLIC HEALTH IN TENNESSEE

In 1991, the Public Health Service of the United States Department of Health and Human Services published *Healthy People 2000: National Health Promotion and Disease Prevention Objectives*. That report was intended to assist both health providers and consumers in addressing measurable targets to be achieved by the year 2000. Through the Healthy People 2000 federal initiative, the Department of Health agreed to seek attainment of the 17 targets for various disease incidence rates. Our review of the most recent data available (1994-96) indicates that Tennessee, in most cases, had not yet met the year 2000 objectives (see Exhibit 1); in fact, Tennessee's 1994-96 rates were higher (i.e., worse) than the national rates for 1995 in 14 of the 17 disease categories:

Deaths from all causes	Infant deaths
Coronary heart disease deaths	Adolescent births
Stroke deaths	Low birthweight
Lung cancer deaths	Children below poverty level
Motor vehicle injury deaths	Incidence of tuberculosis
Homicide	Incidence of measles
Suicide	Incidence of syphilis

The status of Tennessee's public health has not substantially changed, in comparison to national disease rates, from the early 1990's data detailed in the February 1998 performance audit. In a May 1998 memorandum, the Assistant Commissioner for Health Services asked Department of Health staff about actions they were taking to meet Healthy People 2000 goals. Based on staff's responses to the memorandum, the various sections of the department are apparently taking steps to meet the goals—for example, training community-based organizations in the prevention of sexually transmitted diseases; providing tobacco-use prevention programs to approximately 26,000 students; providing support to 50 county Adolescent Pregnancy Councils; and screening 5,000 targeted, high-risk persons for high blood-pressure. However, there appears to be no overall department plan to achieve these goals, which the department is supposed to meet in less than two years.

Exhibit 1

Health Status Indicators Comparison of Tennessee, U.S., and Year 2000 Target Rates

<u>Health Status Indicator</u>	<u>Year 2000 Target Rate (a)</u>	<u>1995 U.S. Rate</u>	<u>Tennessee Rate (b)</u>
Deaths from All Causes	(c)	503.9	555.3
Coronary Heart Disease Deaths	100.0	108.0	125.8
Stroke Deaths	20.0	26.7	34.7
Female Breast Cancer Deaths	20.6	21.0	21.0
Lung Cancer Deaths	42.0	38.3	46.8
Motor Vehicle Injury Deaths	14.2	16.3	24.3
Homicide	7.2	9.4	11.1
Suicide	10.5	11.2	12.1
Infant Deaths	7.0	7.6	8.9
Adolescent Births	(c)	5.3	6.5
Low Birthweight	5.0	7.3	8.8
Late or No Prenatal Care	10.0	18.7	16.9
Children Under 18 Below Poverty Level (d)	(c)	22.7	26.0
Incidence of AIDS	43.0	25.7	17.8
Incidence of Tuberculosis	3.5	8.7	9.5
Incidence of Measles	0	0.1	0.2
Incidence of Primary and Secondary Syphilis	4.0	6.3	16.2

Notes: a. Age-adjusted rate/100,000 population. Age-adjusted rates are used so the age distribution of the populations will not affect comparisons. The differences in rates are then a result of other factors.

b. An average of three years of statistics (1994-1996) was used in determining Tennessee's rates to alleviate the problem of yearly fluctuations in rates.

c. No Year 2000 national objective has been determined.

d. 1993 U.S. Census Bureau estimates.

Source: *Tennessee's Healthy People 2000 Update*, June 1998, Department of Health.

One of the diseases that exceed the national rate is syphilis. According to information from the United States Centers for Disease Control and Prevention (CDC), Memphis and Nashville in 1997 had the second and third highest rates among U.S. cities, respectively. The table below indicates the rate and rank for the six highest-ranking cities with 200,000 and more in population.

Rank	City	Rate
1	Baltimore, MD	99.1
2	Memphis, TN	39.5
3	Nashville, TN	37.9
4	Atlanta, GA	28.4
5	New Orleans, LA	27.7
6	Richmond, VA	24.7

Source: Nashville and Davidson County Health Department.

Syphilis, if untreated, could be lethal. According to CDC staff working with the department on the prevention of sexually transmitted diseases, the department is cooperating with the county health departments in Shelby and Davidson Counties to reduce the rates. Assistance includes analyzing the extent of the syphilis problem and getting federal funding for programs to reduce infection rates. The department should continue efforts to reduce rates for all major diseases in all parts of Tennessee.

Department of Health's Comment:

Tennessee's response to Healthy People 2000 included seeking attainment in 17 disease incidence rates. The Department of Health has a role in impacting the disease categories through preventive health programs and some direct treatment and surveillance activities.

The premise of *Healthy People 2000, National Health Promotion and Disease Prevention Objectives* is a coordinated and concerted effort on the part of government, the private providers of health services, and individual citizens to live healthier and prevent disease and injury. Healthy People is not meant to be a strategic plan for public health program activities, but rather a framework in which public health services are provided as a part of attaining the objectives. These are not targets the Department of Health is supposed to meet, rather they are health promotion and disease prevention objectives for Tennessee. The development of the health council infrastructure is an important step in involving communities in addressing health concerns in the respective areas. Information shared with the councils includes data comparing the respective county to the region, state and Year 2000 and 2010 goals for certain health status indicators. Health department activities designed to impact these objectives are detailed in program plans and grant applications of the individual programs.

Unfortunately, Tennessee, like most southeastern states, exceeds the national target objective for primary and secondary syphilis. This should not be construed to indicate that public health in Tennessee is doing an inadequate job of detection, treatment, and surveillance for syphilis. During the five-year period of 1993 through 1997, Tennessee demonstrated dramatic progress in improvement in the rate per 100,000 population for primary and secondary syphilis:

<u>1993</u>	<u>1994</u>	<u>1995</u>	<u>1996</u>	<u>1997</u>
22.7	20.2	17.2	16.0	14.0

Two metropolitan areas, Memphis and Nashville, continue to have syphilis rates that rank them in the top three cities with populations greater than 200,000. Memphis has shown a steady decline and Nashville has shown a steady increase in primary and secondary syphilis rates during the five-year period:

	<u>1993</u>	<u>1994</u>	<u>1995</u>	<u>1996</u>	<u>1997</u>
Memphis	64.7	62.1	55.1	45.8	39.5
Nashville	28.6	19.0	18.3	36.1	37.9

There are a number of factors impacting the rates such as rate of poverty, relationship with drug abuse (especially crack cocaine), urban renewal and spread, health department activities in case finding, surveillance, and contact tracing, relationship with other sexually transmitted diseases such as HIV, and access to medical care.

ACCESS TO HEALTH CARE IN TENNESSEE

Despite legislative and departmental initiatives, residents in some regions of the state still have difficulty accessing some types of health care. Maps (see page 13) from the department's *Health Access Plan Update 1998* identify those counties the commissioner has designated as health resource shortage areas, i.e., areas without the resources to ensure access to primary, obstetrical, or pediatric care for the general population. (See pages 15 and 16 for a discussion of health resource shortage areas for primary care and dental services for the TennCare population.)

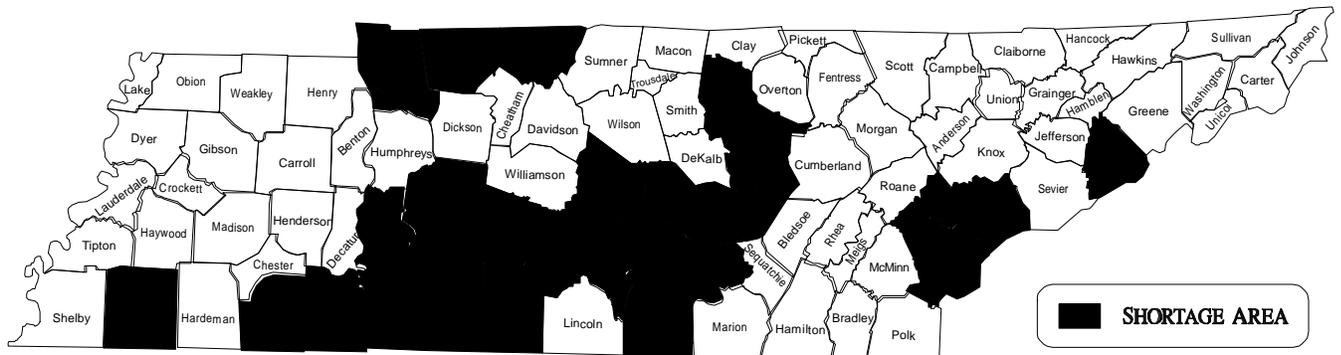
The Health Access Incentive Grant Program was created as part of the Health Access Act of 1989 to give primary care providers financial incentives to practice in medically underserved areas. As of May 1998, the grant program had given \$9.5 million in grants to 180 providers, averaging 20 providers annually and nearly \$53,000 per recipient. Providers have been placed most often in the South Central (35), East (32), and Southwest (27) regions of the state. (See page 14 for program recipients by county of practice.) In 1997, the program expanded its scope by establishing "Community Initiatives," which support innovative projects to improve health care service delivery in areas lacking basic services (e.g., primary, obstetrical, dental). For fiscal year 1999, \$1.6 million is available for the Health Access Incentive Grant Program and the Community Initiative Program (regions can use their allotments for either program)—\$1.25 million has been earmarked for the rural regions, with \$350,000 budgeted for the four urban regions.

Health Resource Shortage Areas for Primary Care, 1998

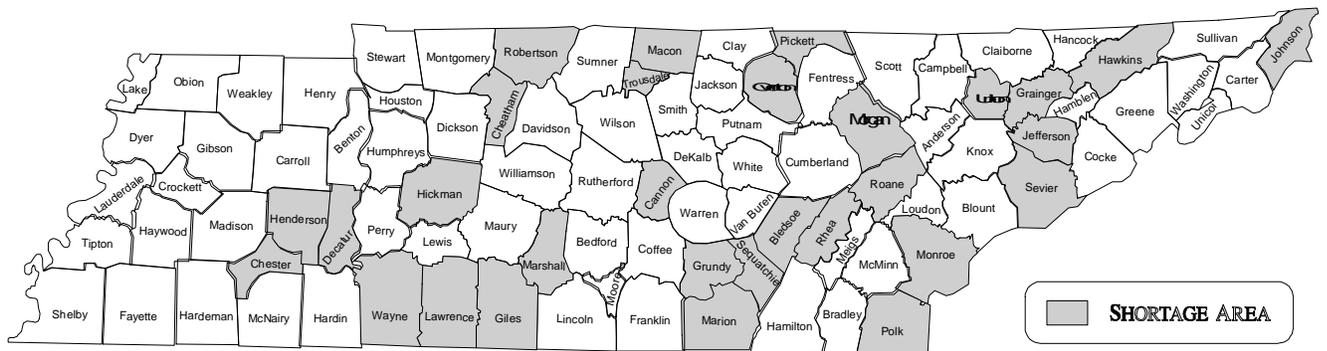


Note: These apply only to family medicine and internal medicine specialties.

Health Resource Shortage Areas for Obstetrics, 1998



Health Resource Shortage Areas for General Pediatrics, 1998



TennCare individuals who are alcohol and drug dependent with intake services, assessment, referral to treatment, and six months of case management upon release from treatment. There are plans to extend the program to the TennCare population in January 1999.

TennCare Primary Care Providers. In those areas where the private sector may be unable to meet the health care needs of TennCare enrollees, the local health departments have stepped in to provide needed services. In October 1998, 19 county health departments were designated as TennCare primary care providers. These “gatekeeper counties” have contracted with the MCOs to act as primary care providers, making their county health departments responsible for providing 24-hour care and for arranging referrals for patients. The remaining 76 counties still provide some basic primary care services, but they do not act as primary care providers, and they do not provide 24-hour coverage. The 19 gatekeeper counties and the number of TennCare patients assigned to the health departments in these counties are listed in the chart below.

Counties Serving as TennCare Primary Care Providers

<i>County Health Departments</i>	<i>Number of Patients Assigned</i>
<i>Upper Cumberland Region</i>	
Clay	23
Cumberland	938
Jackson	30
Macon	36
Putnam	1,038
<i>Mid-Cumberland Region</i>	
Dickson	633
Montgomery	658
Rutherford	504
Stewart	501
Sumner	402
Williamson	1,327
Wilson	267
<i>South Central Region</i>	
Bedford	198
Giles	380
Maury	456
Moore	97
<i>Metro Health Departments</i>	
Hamilton	872
Knox	*2,000
Shelby	22,100

* These are pediatric patients.

Other Primary Care Services Provided by County Health Departments

In addition to the 19 counties that provide primary care, 12 counties operate comprehensive prenatal clinics and 40 counties operate dental clinics. The 12 counties providing comprehensive prenatal care are Bradley, Chester, Crockett, Decatur, Dickson, Fayette, Hamilton, Hardeman, Henderson, Knox, Madison, and Rutherford. The 40 counties that operate dental clinics are responsible for providing basic dental care for indigent children (diagnostic, preventive, and restorative) and emergency dental services (limited to diagnosis and treatment of an acute episode of pain, infection, swelling, hemorrhage, or trauma) for indigent adults. Six additional counties (Gibson, Overton, Rhea, Robertson, Smith, and Warren) have dental facilities with the potential to provide dental care, if the funds needed to recruit dental personnel are available. See the table below for the 40 counties with dental clinics and the number of days per week each clinic operates.

**Counties with Dental Clinics and the
Number of Days Per Week Those Clinics Operate**

1 Day	2 Days	3 Days	4 Days	5 Days
Benton	Bledsoe	Campbell	Anderson	Cumberland
Crockett	Bradley	Grundy	Hardeman	Fayette
Dyer	Carter	Hawkins		Fentress
Jackson	Cocke	Madison		Greene
Macon	DeKalb	McMinn		Hamilton
Obion	Dickson			Knox
Pickett	Johnson			Lauderdale
Van Buren	Marion			Monroe
Weakley	Shelby			Putnam
	Unicoi			Rutherford
	White			Tipton
	Williamson			Washington

Inadequate Level of Dental Care Available. Many of the department's regional directors reported that it has become increasingly difficult to provide adequate levels of dental care since the advent of TennCare. The reason cited is that the reimbursement rate for dentists is much lower under TennCare than it was under Medicaid. As a result, many dentists who took Medicaid eligibles do not take TennCare eligibles. For example, none of the three dentists in Fentress County accept TennCare enrollees, even though 48% of that county's population is enrolled in TennCare. Their refusal to participate has increased the pressure on the regional and county health departments to provide dental care. According to the Department of Health's *Health Access Plan Update 1998*, 21 counties have no TennCare provider for general dentistry. An additional 31 counties had ratios of dentists to TennCare enrollees of 1:6,493 to 1:30,150.

Conclusion

According to Department of Health personnel, the county health departments are to be the focal point for health care across the state, becoming more involved in areas such as TennCare and central intake and assessment for alcohol and drug abuse and mental health

services. It is not clear what effect these additional duties have had or will have on the county health departments, their staffing and other resource requirements, and their ability to provide traditional public health services.

Because of the many additional responsibilities taken on by the county health departments and the apparent continuing need for the public health services historically performed by the departments, it seems particularly important that Department of Health management evaluate the effect of TennCare-related activities on the county health departments to ensure that they have the needed resources and that there are no gaps in needed services. An important tool in such an evaluation would be the encounter data (detailing the number of clients served and services provided) that county health departments routinely submit. The department routinely compiles and analyzes patient encounter information by program, service, reimbursement source, and accounts receivable. Encounters are matched with “relative value units” monthly to reflect relative costs of service for each health department. According to Department of Health staff, management uses these data to make decisions about staff, other resource requirements, and their respective health services to communities and special populations.

The department provided encounter data for the rural county health departments for 1993 (pre-TennCare) and 1997. (See table on page 18.) These data confirmed that patient encounters overall had not decreased since the advent of TennCare. However, certain types of services had decreased dramatically, such as Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services. These services are of particular interest because of the March 1998 consent decree requiring the Departments of Health and Children’s Services to correct deficiencies in providing EPSDT services to TennCare children (see page 31). Information on primary care, tuberculosis, and sexually transmitted disease visits was not available between the two periods noted above (1993-1997) because of data coding discrepancies.

Department of Health management should use the available data on the county health departments’ activities (1) to aid in decisions concerning the county health departments’ budgets, staffing levels, and range of services and (2) to ensure that needed services are provided.

TENNCARE COST SAVINGS

According to projections generated by TennCare, the program has potentially saved the state as much as \$2.7 billion over the five-year period, fiscal year 1994 through 1998. Most agree that shifting from the Medicaid fee-for-service program to a managed-care program has saved the state money, although other information suggests the bureau’s projections may be overstated.

Rural County Health Departments (1)
Patient Encounters
Calendar Years 1993 and 1997

<u>Health Service (2)</u>	<u>1993</u>	<u>1997</u>	<u>Percent Increase/(Decrease)(3)</u>
Childhood Immunization Patients	90,241	71,242	-21%
Childhood Immunizations Given	356,678	234,333	-34%
Children's Special Services Patients	9,546	6,295	-34%
Children's Special Services Visits	20,869	11,160	-46%
Dental Patients	8,992	18,394	+105%
Dental Procedures (4)	51,464	31,214	-39%
Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Patients	60,312	24	-100%
EPSDT Visits	114,459	25	-100%
Family Planning Patients	63,632	52,518	-17%
Family Planning Visits	123,029	115,958	-6%
Head Lice Patients	4,167	10,898	+162%
Head Lice Visits	5,570	17,046	+206%
Women, Infants, and Children (WIC) Program Patients	126,012	148,212	+18%
WIC Visits	347,162	392,762	+13%
Total Patients (5)	411,823	425,192	+3%
Total Visits (5)	1,009,853	1,036,119	+3%

- Notes:
1. Encounter information relating to the six metropolitan counties (Davidson, Hamilton, Knox, Madison, Shelby, and Sullivan) was not available on the central office's computer system until 1996.
 2. The implementation of TennCare was substantially responsible for declines between 1993 and 1997 in patient visits for Family Planning, EPSDT, Children's Special Services, and Childhood Immunizations. Information on primary care, tuberculosis, and sexually transmitted disease visits is not available because of data coding discrepancies.
 3. Rounded to the nearest percentage point.
 4. Number of procedures, not visits, available.
 5. Totals include services not mentioned above, including enrollment of children in TennCare and reverification of TennCare enrollees for eligibility.

Source: Department of Health.

In March 1993, TennCare's Fiscal Division projected the costs for a five-year period (fiscal year 1993-94 through fiscal year 1997-98) if the state had continued administering the Medicaid fee-for-service program. Staff reviewed cost data, growth rates, and inflation rates for the three-year period 1991 through 1993 to arrive at a base year (1993-94) that projected an overall cost of \$3,384,948,700, of which the state's share was \$1,117,874,600. Using the base year numbers, and taking into consideration prior-year growth rates, the bureau projected annual cost increases of 5% for administrative costs and 20% for medical costs.

By comparing these projections to actual TennCare expenditures over the same period, TennCare calculated a cost savings for the state over the five years of \$2,729,751,560. (This calculation was generated in May 1998 and used estimated fiscal year 1998 expenditures.) TennCare used its 1994 annual cost increase projections in calculating these cost savings and has not attempted to assess the accuracy of these projections.

**Comparison of Medicaid Cost Projections to Actual TennCare Expenditures
For Fiscal Years 1993-94 Through 1997-98**

<u>Projected Under Medicaid</u>	<u>Five-Year Cumulative Totals</u>
Non-Federal (State)	\$7,772,531,200
Federal (Title XIX)	<u>\$15,740,572,400</u>
Total	\$23,513,103,600
<u>TennCare Actual</u>	
Non-Federal (State)	\$5,042,779,640
Federal (Title XIX)	<u>\$10,664,851,783</u>
Total	\$15,707,631,423
<u>Savings</u>	
Non-Federal (State)	\$2,729,751,560
Federal (Title XIX)	<u>\$5,075,720,617</u>
Total	\$7,805,472,177

However, actual Medicaid growth rates were substantially less than the bureau's projected growth rates and cast doubt on TennCare's calculations. The Louisiana Legislative Fiscal Office annually surveys the Medicaid costs of the 16 states in the Southern Legislative Conference. The survey results include rates for states like Tennessee that went to a managed-care program as well as those states that elected to stay with a fee-for-service program (see table below.)

**Medicaid Growth Rates 1989 Through 1999
for Southern Legislative Conference States**

Period	Medical Percentage Rate of Growth	Administrative Percentage Rate of Growth
1989 to 1990	25.1%	26.3%
1990 to 1991	34.4%	9.6%
1991 to 1992	35.1%	14.2%
1992 to 1993	12.1%	12.4%

Period	Medical Percentage Rate of Growth	Administrative Percentage Rate of Growth
1993 to 1994	9.3%	13.6%
1994 to 1995	10.5%	10.0%
1995 to 1996	0.5%	5.5%
1996 to 1997	6.1%	8.4%
1997 to 1998*	4.7%	21.4%
1998 to 1999*	5.5%	4.5%

* Projections

Data from these surveys indicate that Medicaid costs were growing at very high rates during the early 1990's—the years prior to the implementation of TennCare and the years on which the bureau based its Medicaid cost projections. However, actual Medicaid costs have moderated since 1992, and the actual rates of increase for medical costs (the vast majority of total costs) are lower than the rate TennCare staff used in their projections. The moderation can be attributed primarily to two factors. First, program enrollment increased significantly during the early 1990's, mainly due to federal mandates that required states to expand coverage to pregnant women and children with family incomes at or above the poverty level. Growth moderated in the years following implementation of these mandates. Second, cost-containment measures instituted by states, including the implementation of selected waivers and the development of managed-care programs, contributed to controlling growth. In the 16 Southern Legislative Conference states, the percentage of the Medicaid population enrolled in managed-care programs increased from 23% in 1994 to over 40% in 1997.

TennCare has undoubtedly saved the state money; however, the exact amount saved is very difficult to accurately calculate because of the many factors that would have to be considered, including the resulting long-term effects on TennCare enrollees and providers.

TENNCARE ENROLLEE SATISFACTION ISSUES

Enrollee satisfaction surveys indicate that the majority of TennCare enrollees are satisfied with the program overall. However, comments by enrollees and providers raise some concerns about the types of program information enrollees receive and the extent to which that information is easily understood.

Since the beginning of the program, TennCare has contracted with the University of Tennessee's Center for Business and Economic Research and Social Science Research Institute to survey enrollees' satisfaction with TennCare. Each annual survey compares findings of previous surveys as well as patient satisfaction reported in 1993, the last year of Medicaid. The

1998 survey results are not yet available, but the Fall 1997 survey results indicated that 81% of recipients surveyed were satisfied with TennCare—nearly equal to the 82% satisfaction rating by Medicaid recipients in 1993. In addition, 66% of those surveyed rated the quality of medical care they received as good or excellent, and 75% rated the quality of medical care their children received as good or excellent. On the other hand, 11% of respondents indicated that they had to wait over three weeks for an appointment to see their primary care physician.

Despite department efforts to inform enrollees about the TennCare program, comments by enrollees, providers, and TennCare staff indicate the need for additional education and outreach efforts. The following percentage of survey respondents indicated they had received TennCare information:

- A grievance form—28%
- Information on filing grievances—31%
- A list of rights and responsibilities—63%
- An enrollment card—70%

To educate enrollees and MCOs about the program, the Division of Contract Compliance distributes information on TennCare policies and procedures. The bureau and the MCOs also distribute welcome letters, quarterly newsletters, and enrollee guidebooks. In addition, TennCare established a hotline to serve as an information center for enrollees and maintains a web site where enrollees can access benefits information and current health outcome studies.

However, some TennCare officials believe enrollees need a better understanding of managed care, and HCFA expressed concerns about the effectiveness of TennCare's education and outreach efforts. In addition, the Tennessee Medical Association questioned the practicality of the web site as a means for enrollee education, considering most enrollees would not have access to the Internet. These concerns were echoed by the providers we surveyed, many of whom commented that enrollees were not aware of TennCare rules and regulations, such as what types of services are covered and how the referral process works. Providers also noted that enrollees do not understand their responsibilities under the program, such as the need to show up for appointments made with their primary care physician or specialists.

Although TennCare has made efforts to adequately educate TennCare enrollees, it appears that additional efforts are needed. TennCare should work with the MCOs/BHOs, providers, and advocacy groups to identify areas where additional information is needed and to determine the most understandable, easily accessible way to present that information.

RESULTS OF A STATE AUDIT INVESTIGATION OF THE BUREAU OF TENNCARE

During 1998, the Division of State Audit reviewed allegations that TennCare Bureau staff had improperly made changes to an external survey report. This review concluded that although the revisions suggested by TennCare Bureau staff gave the appearance of deflecting criticism from the TennCare Bureau, no direct corroborative evidence was found to support the allegations

that these changes were outside the boundaries of the contract, were intentionally deceitful, or were the result of undue influence. However, the special report released February 1, 1999, did raise concerns about the appropriate structure for external reporting, the intended readership and scope of the surveys, and the extent to which surveyors should focus on quality of care.

THE DEPARTMENT OF HEALTH'S ROLE IN FAMILIES FIRST HOME VISITS

Through Families First, Tennessee's welfare reform program, the Department of Health received an additional responsibility. *Tennessee Code Annotated*, Section 71-3-154, states that whenever temporary assistance for a family is terminated for any reason other than the family's successful transition to economic self-sufficiency, the Department of Human Services shall promptly notify the Department of Health. The Department of Health shall then take appropriate actions to monitor and protect the safety and well-being of the children within the family. The statute defines these actions as including, but not limited to, one or more in-home visits with the children within 30 days of the termination of the temporary assistance. The purpose of the in-home visits is twofold: to provide a health check-up for the children and to determine the families' financial circumstances.

After receiving notification from the Department of Human Services that a family's benefits have been terminated, the Department of Health notifies the family that a county health department employee will be making a home visit. The health department professional attempts to arrange a home visit. If initial attempts are unsuccessful, the health professional continues to contact the family by telephone or mail.

Staff making the home visits have home-visiting and family-assessment experience and/or training. They are to determine and report the source and amount of each family's total gross monthly income. (This information is necessary so that Human Services can determine if the family is eligible for temporary emergency assistance.) The health professional is also required to determine the following:

- Current living environment
- Type of housing
- Stability of the family arrangement
- Adequacy of food availability
- Status of the children's immunizations and well-child examinations
- Need for subsequent in-home visits

If a family's utilities have been cut off or an eviction notice has been served, the health professional is required to make an emergency notification to the county Human Services office. Furthermore, any suspicious parental behavior is immediately to be referred to the Department of Children's Services, Division of Child Protective Services. The health professional should provide educational information and/or referrals for any observed needs or safety hazards in the home environment and encourage participation in the Families First Program.

According to documents the Department of Health supplied, a substantial number of home health visits could not be completed. From October 1, 1996, through June 30, 1998, 4,258 of the 11,862 families (36%) referred to local health departments were visited. Staff attempted to visit an additional 5,015 families (42%) who were not at home at the time of their appointment or had moved and could not be located; 203 families (2%) refused the home visit but agreed to be interviewed at the county health department or another site; and 2,386 families (20%) reentered the Families First Program and did not need or refused an in-home health visit. Despite the fairly low percentage of successful visits, Department of Human Services staff expressed satisfaction with the Department of Health's home health visit program, including the timeliness of such visits.

According to Department of Health staff, the number of referrals for home visits decreased dramatically in 1998 because the Department of Human Services was implementing a new central review of all Families First case closures to help ensure individuals were not unfairly removed from the Families First Program. During the review process, fewer families had their temporary assistance terminated. Referrals are currently expected to increase since changes in the central case closure system have been fully implemented.

Information on the referrals the Department of Human Services makes to the Department of Health and the outcomes of the resulting home visits are tracked through a University of Memphis database. From February 1997 through September 1998, 523 auxiliary payments (an average of 26 per month) were issued statewide. These payments were disbursed subsequent to an in-home health visit in which the Department of Health found adequate reason to recommend auxiliary Families First payments by the Department of Human Services. Without such payments, families may have been unable to afford the basic necessities.

TENNCARE

1. Despite TennCare's routine monitoring of the adequacy of provider networks, the MCOs and BHOs continue to have problems providing adequate access to some types of care

Finding

The TennCare Program has experienced access/provider network problems since its inception, and there is no evidence these problems will be solved in the near future. TennCare routinely monitors provider networks and has undertaken numerous activities to increase access; however, our survey of providers (see page 139) indicated a high level of frustration with the managed-care organizations, the low reimbursement rates, and TennCare in general. Because of this frustration, more providers could choose to leave the program or stop accepting new patients.

The contracts between TennCare and the managed-care organizations require that each organization demonstrate the existence of a provider network capable of providing comprehensive health care services to all its TennCare enrollees. The managed-care organizations must make services available and accessible in terms of timeliness, amount, duration, and personnel sufficient to provide the covered services. Emergency medical services must be available 24 hours a day, 7 days a week.

TennCare's Monitoring Activities. The MCOs/BHOs are responsible for ensuring adequate access and provider networks; TennCare monitors the access and networks, notifies the MCOs/BHOs of any deficiencies, and assesses financial penalties if information is not submitted or deficiencies are not corrected within the allotted time. TennCare requires all managed-care organizations to submit monthly updates of their provider networks and verifies this information through telephone surveys of some or all providers listed as participating in each MCO's/BHO's network.

Since TennCare's implementation, bureau staff have monitored three areas of provider access (primary, dental, and inpatient care) monthly to ensure all access standards outlined in the HCFA waiver are met. (See next page.) These three areas are also evaluated quarterly (or more often if problems are identified) through GeoAccess mapping analyses of each organization's enrollee population and provider network. These analyses determine the average distance enrollees in a particular zip code must travel to obtain services. If this distance exceeds the distance limits specified in the contract, the MCO/BHO has 30 days to provide evidence (i.e., signed provider contracts) that this deficiency has been corrected. Otherwise, the bureau will withhold 10% of the organization's monthly capitation payment.

Access Standards Required by Contract

Primary care should be available within 30 miles/30 minutes' travel time (rural) or 20 miles/30 minutes' travel time (urban); patient load of 2,500 or less; appointment within three weeks or 48 hours for urgent care; wait of no longer than 45 minutes at the doctor's office.

Specialty care should be available within 30 days, or 48 hours for urgent care.

Emergency care is to be immediate, at the nearest available facility, regardless of the contract; the wait should not exceed 45 minutes.

Hospital care should be available within 30 minutes' travel time. In rural areas where services may be less readily available, the community standards for accessing care must be followed—such exceptions must be documented and justified to TennCare.

Dental, optometry, pharmacy, lab, and x-ray services should be available within 30 minutes travel time, except in rural areas (see information under hospital care). Appointments for dental and optometry services should be available within three weeks for regular appointments and 48 hours for urgent care; office waits should not exceed 45 minutes.

In addition to routine monitoring activities, TennCare staff may conduct special studies (primarily telephone surveys) to determine the adequacy of specific types of provider “sub-networks,” such as the prenatal, dental, and pediatric networks, or to follow up complaints. (Since Fall 1997, the bureau has received 100 provider/enrollee complaints concerning access.) First Mental Health, Inc., the TennCare contractor that prepares the EQRO (external quality review organization) reports, also monitors the MCOs'/BHOs' compliance with contract requirements during the annual comprehensive survey (with follow-up as needed) of each organization's operations.

Access Deficiencies. Both the MCOs and BHOs continue to have problems meeting access standards. The 1998 EQRO reports cite almost all the MCOs for access/network deficiencies of some type.

Dental services have been a particular problem. (See page 16 for additional information on this deficiency.) TennCare's most recent quarterly GeoAccess mapping analysis determined that all nine MCOs had deficiencies in their dental networks. Five of the MCOs were unable to correct those deficiencies within 30 days and were assessed withholds for November 1998. (The 10% withhold is returned unless the MCO does not correct deficiencies within six months.)

To avoid penalties when they fail to contract with the necessary providers, the MCOs can use nonparticipating providers and pay those providers their standard fee, which is often substantially higher than the reimbursement rates TennCare providers receive. Therefore, according to MCO staff, the MCOs lose money whether they pay penalties because of inadequate networks or address deficiencies by paying providers higher fees than those covered under the capitation payments.

Other common access/network problems identified by providers, the MCOs/BHOs, advocates, regional health departments, and Department of Health staff include insufficient providers of prenatal, pediatric, and orthopedic care and (for the BHOs) inadequate access to case management services and transportation assistance. Concerns were also expressed about additional access-related issues such as (1) inadequate access to some types of medicines (see page 43), (2) inadequate communication of policies and procedures to providers and enrollees, and (3) enrollees who must travel long distances for care or wait too long to get doctors' appointments.

TennCare/Department of Health Activities to Address Access Problems. The department has taken a variety of actions to improve access:

- Operating three information lines—the TennCare and TennCare Partners information lines and the TennCare Advocacy Program—to help educate enrollees about the use of managed-care systems.
- Involving local health departments in education efforts to assist persons in enrolling in TennCare and using managed care effectively.
- Sending enrollees newsletters providing information on available services, etc.
- Developing brochures to help parents understand the range of benefits available to their children through the EPSDT program (see page 31).
- Coordinating a network of clinics and private practices to provide a comprehensive approach to AIDS and HIV treatment.
- Implementing Project Teach, a program in which a public health nurse in each rural region meets with school personnel, families, and providers about occupational, physical, and/or speech therapy opportunities for children.
- Funding a Graduate Medical Education Reimbursement Program in which funds are paid directly to four Tennessee medical schools to provide incentives for those schools to increase primary care residency positions. (At the beginning of 1998, those schools were training 907 residents in primary care, out of 1,564 total residents enrolled.)
- Overseeing the Health Access Incentive Grant Program (see page 12).

Recommendation

TennCare and the MCOs/BHOs need to work together, and with providers, to improve access. TennCare needs to determine providers' and enrollees' concerns, evaluate those concerns, and address those concerns to the extent possible.

Management's Comment

We concur. The most important element for a successful managed-care program is adequate access for the patients. Adequate access is not merely for patient convenience but is a key to cost containment since ready access provides less costly care through early intervention.

At this time, TennCare is in compliance with the requirements of the HCFA waiver. However, mere compliance does not ensure an adequate provider delivery system for a successful managed-care program. TennCare has worked with the MCOs and BHOs to address access issues. We will continue to collect information from enrollees and providers about their concerns and address the identified problems with the MCOs and BHOs.

Even though we are in compliance with the HCFA waiver, the Bureau will expend greater efforts in assisting the MCOs and BHOs in developing a more extensive provider network.

2. The financial condition of some of the managed-care organizations raises concerns

Finding

Based on September 30, 1998 financial filings, two of the eleven managed-care organizations (nine MCOs and two BHOs) in the TennCare Program had not met their net worth requirements. In addition, as of September 30, seven organizations were reporting financial losses in fiscal year 1998. These circumstances raise concerns about the ability of some MCOs and BHOs to remain in the program and continue to support adequate provider networks.

The Department of Commerce and Insurance's TennCare Division is responsible for regulating all health maintenance organizations (HMOs) operating in the state. All MCOs are licensed as HMOs by law and thus are subject to state regulation. Although the BHOs are not licensed HMOs, Commerce and Insurance monitors their activities and performs the same oversight as that for the MCOs. This oversight includes review of the BHOs' and MCOs' quarterly financial reports and, in coordination with the Comptroller's Office's Medicaid/TennCare Division, an annual examination of the financial statements of all MCOs and BHOs.

The Commerce and Insurance/Comptroller examinations focus on whether MCOs and BHOs are financially sound and whether they meet the minimum net worth and minimum deposit requirements. Financial filings by the MCOs and BHOs through September 30, 1998, indicate some entities had profits, others had substantial losses. When Commerce and Insurance identifies financial deficiencies in an MCO, the division can notify TennCare to issue a withhold or assess a liquidated damage. For the BHOs, the division can only recommend that TennCare take disciplinary action.

The net worth requirement, set to ensure the organizations maintain adequate reserves, varies by MCO and BHO and ranges from \$1 million to \$10 million, depending on the amount of premiums paid. MCOs and BHOs are also required by contract (and by statute for the MCOs) to maintain a minimum dollar amount on deposit to ensure they are able to pay claims. The deposit requirement, which is assessed quarterly and changes from year to year, is based on prior-year premiums.

Compliance with Net Worth and Deposit Requirements. Although some MCOs or BHOs were deficient in the past, all currently comply with the deposit requirement. However, based on September 30, 1998, financial filings, two managed-care organizations—Memphis Managed Care and Xantus (formerly Phoenix)—were not in compliance with the net worth requirement. Memphis Managed Care had been deficient for most of 1998; as of its September 30, 1998 quarterly financial filing, it was \$3.9 million deficient and had asked for and received four extensions to correct the deficiency.

On April 8, 1998, Xantus was notified of its net worth deficiency and the requirement that it develop a corrective action plan. According to its financial filings with the Department of Commerce and Insurance, Xantus experienced a net loss of \$13.2 million in 1997 and a \$5.4 million net loss through September 30, 1998.

MCO/BHO Losses. For calendar year 1997, eleven operating MCOs had a net loss of over \$21 million. The losses can primarily be attributed to Phoenix's (now Xantus') \$13 million loss and Health Net's \$16 million loss. Financial filings as of September 30, 1998, show a net loss of \$7.8 million for TennCare HMOs and a net income of \$1.9 million for the BHOs.

According to Department of Commerce and Insurance management, the BHOs' financial situation is more difficult to determine because the program is still relatively new and is still experiencing changes such as the shift in pharmacy services. The first six months of 1998 provided the first real financial data. Another contributing factor is a dispute between regional mental health institutes and the BHOs, which resulted in a settlement of approximately \$1 million per month.

For the last three years, Premier's statements showed a \$10 million loss in 1996, a \$3.7 million loss in 1997, and a profit of \$8.4 million through September 30, 1998. Tennessee Behavioral Health's September 30, 1998, financial filings show a loss of \$6.5 million. According to Commerce and Insurance management, TBH's loss may increase as more claims are submitted, or losses may decline if actuarial estimates are adjusted downward at December 31, 1998.

It is more difficult to determine TBH's losses because the BHO is still settling provider claims resulting from its use of an inappropriate payment method. During the last part of 1996 (when Partners began) and in 1997, TBH executed contracts with the community mental health centers that stated it would pay them whatever was left after TBH took its 10% for administrative fees. HCFA found this practice inequitable. The 1998 financial statement reflects TBH's repayment of the old claims. Commerce and Insurance will not be able to determine TBH's true financial position until the end of 1998 or early 1999.

Because of contractual and statutory requirements for net worth, MCOs and BHOs that continue experiencing losses may not be able to remain in the TennCare program unless additional sources of capital are available. Health Net and Healthsource have dropped out (i.e., sold or transferred their businesses or assets to other MCOs) and Preferred Health Partnership has reduced its service area to East Tennessee for 1999. Another concern is that if losses continue, MCOs and BHOs may have problems paying providers, who in turn may drop out of the program, negatively affecting access to care.

Recommendation

TennCare, along with the Department of Commerce and Insurance, should continue to monitor the financial conditions of the MCOs and BHOs. TennCare should also evaluate its contracts with the organizations and the results of the actuarial studies currently being performed. If warranted, TennCare should then consider changes in capitation payments and other contract or program changes to help ensure there are a sufficient number of managed-care organizations and adequate provider networks.

Management's Comment

We concur. The Bureau recognizes that the financial health of the MCOs and BHOs is one of several elements critical to the continued success of the program. We rely upon the expertise of the Department of Commerce and Insurance in monitoring the financial viability of these organizations.

The Bureau plans to evaluate its payment levels to the MCOs and BHOs when the actuarial studies are available and to discuss any proposed changes with the Legislature. It is important to note that profits or losses experienced by an MCO or BHO are not the only indicators of the adequacy of the capitation payments.

To assist in monitoring of this area, the TennCare Bureau has established a Financial Technical Advisory Group (TAG) for the Partners Program. Part of this group's responsibility is to establish appropriate benchmarks and financial indicators for evaluating the financial viability of the BHOs.

3. No formal assessment of TennCare rates has been completed since the program's inception

Finding

Without an actuarial study to assess the adequacy of capitation rates paid to managed-care organizations (MCOs and BHOs) or the rates paid to service providers, the bureau has no

assurance these rates are adequate to maintain the provider networks necessary to meet the needs of TennCare enrollees.

TennCare makes monthly capitation payments to the MCOs and BHOs for TennCare enrollees' health services. In turn, the MCOs and BHOs pay service providers, using capitation payments, fee-for-service reimbursements, or a combination.

Capitation rates vary depending on enrollees' sex and age and the type of service provided. TennCare capitation rates were originally developed by Peat Marwick, using 1992 Medicaid cost data as a benchmark, and have not been formally studied since that time. The rates have been increased annually—typically 3% to 5%. The most recent increase, effective July 1, 1998, was 3% across the board with a 5% increase for Medicaid/ Medicare dual enrollees. According to TennCare management, these rate increases are based on the availability of funds, rather than any actuarial assessment.

Two actuarial studies are in progress—the Department of Health has contracted with William M. Mercer, Inc., to evaluate BHO rates, and the Office of the Comptroller of the Treasury has contracted with PricewaterhouseCoopers to evaluate MCO and BHO rates. Both studies will assess capitation payments to the managed-care organizations, as well as those organizations' payments to service providers. The PricewaterhouseCoopers study has a legislative due date of March 15, 1999; William M. Mercer, Inc., sent an initial draft report to the Department of Health on December 3, 1998. According to Mercer staff, the study, which was expected to be completed in August 1998, took longer than expected because of problems obtaining data. The fee-for-service data Mercer hoped to use was not current enough for their needs. As a result, Mercer used encounter data; however, the inpatient data and community mental health center encounter data originally provided was incomplete and inaccurate because of "gross underreporting." Eventually, through working with the department, Mercer was able to obtain acceptable data.

TennCare management stated that without an actuarial study, it is impossible to determine the adequacy or inadequacy of the capitation rates. Our survey of TennCare providers indicates that providers consider low reimbursement rates a serious problem (see page 38). Many providers stated that rates do not meet the overhead costs of treating TennCare enrollees; as a result, some providers are refusing to take additional TennCare enrollees as patients.

Recommendation

Inadequate payments to providers could limit the MCOs' and BHOs' ability to attract providers and build the service networks necessary to ensure quality and consistent care for TennCare enrollees. The bureau should (1) use the results of the forthcoming actuarial studies to adjust rates to the managed-care organizations (or ensure the MCOs and BHOs adjust providers' rates), if needed, and (2) ensure actuarial studies are conducted periodically.

Management's Comment

We concur in part. Although there has been no complete actuarial evaluation of the TennCare programs since their inception, there was a study done prior to implementation in 1994 that reviewed the rate-setting methodology. In addition, reviews have been done on the proportionality of the MCO rates, and there have been two completed reviews of BHO rate methodologies. The Bureau will use the results of the forthcoming actuarial studies as they relate to our capitation rates.

However, for an insurance program the magnitude of TennCare, it is essential that actuarial analyses be used in establishing the capitation rates and that routine actuarial studies be conducted. It is TennCare's responsibility to ensure the capitation rates are adequate. Without an actuarial analysis it is difficult, if not impossible, for the Bureau to comment on the adequacy or inadequacy of the capitation rates based purely on anecdotal input. To raise or not to raise the capitation rates based solely on the availability of funds is not in accordance with good insurance practices. Therefore, the Bureau believes that an actuarial analysis should ideally be conducted periodically.

4. TennCare needs to continue to address the problems identified in the Early and Periodic Screening, Diagnosis, and Treatment Services Consent Decree

Finding

Inadequacies in the state's provision of Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services resulted in a class-action complaint and a March 1998 consent decree requiring the state to take a variety of actions to improve quality of, and access to, care for Tennessee children. Since that time, the bureau (1) has prepared a detailed plan of actions to achieve compliance with the consent decree, (2) has begun implementing the action plan, and (3) has submitted two reports describing the bureau's progress. Despite the progress made, an October 1998 report from an outside review team indicates that the bureau needs to continue to work with the MCOs, the BHOs, and the Department of Children's Services to improve services to children, particularly those in, or at risk of coming into, state custody.

Title XIX of the Social Security Act mandates that TennCare provide Early and Periodic Screening, Diagnosis, and Treatment Services (EPSDT) to Medicaid-eligible individuals under 21 years of age. EPSDT is a separate federally mandated program intended to be the key part in the Medicaid program's provision of care to children. The EPSDT program consists of two components:

- Assuring the availability and accessibility of required health care resources
- Helping Medicaid recipients and their parents or guardians effectively use those resources

These components enable the state to manage a comprehensive child health program of prevention and treatment and to systematically

- seek out eligibles and inform them of the benefits of prevention and the health services and assistance available,
- help children and their families use health resources effectively and efficiently,
- assess the child's health needs through initial and periodic examinations and evaluations, and
- ensure that health problems are diagnosed and treated early before they become more complex.

The Health Care Financing Administration (HCFA) requires five components to be present in a well-child screening:

1. Comprehensive health and developmental history
2. Comprehensive unclothed physical exam
3. Appropriate immunizations
4. Appropriate laboratory tests
5. Health education

EPSDT requires distinct periodic schedules for screening, vision, dental, and hearing services. Additional services must be furnished between the intervals specified in the periodic schedule when medically necessary to identify and treat a suspected illness or condition. Treatment services are covered whenever they are medically necessary to correct or ameliorate defects, physical or mental illnesses, or other conditions discovered (or found to have worsened) through an EPSDT screening. In Tennessee, the managed-care organizations (MCOs) and behavioral health organizations (BHOs) must deliver these services.

EPSDT Class-Action Complaint

A class-action complaint was filed February 25, 1998, in federal district court against the Department of Health's Bureau of TennCare and the Department of Children's Services. The Tennessee Justice Center (TJC) filed the complaint on behalf of the more than one-half million children throughout Tennessee who depend on TennCare for essential medical and mental health services. The complaint sought injunctive relief, and the appointment of a Special Master, to remedy alleged violations of federal and state laws which (according to the complaint) resulted in the widespread denial of essential diagnostic and treatment services. The stated goal of the suit was to prevent state officials from

1. depriving children of early and periodic screening, diagnosis, and treatment (EPSDT) services in violation of Title XIX of the Social Security Act, and
2. depriving TennCare-eligible children who are in state custody, or who are at risk of entering state custody, of needed health and mental services, in violation of the Medicaid Act.

Many of the allegations and injuries focused on medically necessary equipment, such as wheelchairs, or on children not receiving appropriate medical care, such as residential or therapeutic foster care for the mentally disturbed or nursing care for the severely disabled.

EPSDT Consent Decree

The attorneys for the plaintiffs are employed by the Tennessee Justice Center, the Bazedon Mental Health Law Center, the National Health Law Program, and the Southern Poverty Law Center, all nonprofit, charitable organizations. The EPSDT Consent Decree issued by the U.S. District Court for the Middle District of Tennessee at Nashville in March 1998 is the result of negotiations between the two parties. The consent decree attempts to enable TennCare to achieve and maintain compliance with EPSDT obligations and to rectify the problems outlined in the class-action complaint. The consent decree specifically outlines the state's responsibilities under EPSDT:

- Ensure compliance with outreach and screening; diagnosis and treatment; and coordination mandates
- Coordinate and deliver services for children in state custody
- Monitor and enforce MCOs' and Children's Services' compliance
- Report on progress in complying with the decree
- Notify class members about the decree

Reviews of EPSDT

Four reviews of EPSDT were released in 1998.

1. The Division of Health Care Evaluation, Metropolitan Health Department of Nashville and Davidson County, in collaboration with the Bureau of TennCare, conducted a study to determine the use of EPSDT services among TennCare enrollees age 21 and under. This study, released Spring 1998, cited indications that most children have good access to care and that the MCOs are doing a good job with the delivery of preventative health care. However, there was room for improvement in the use of dental services and benefits education to ensure access to care.
2. The Division of Quality Improvement, Bureau of TennCare, conducted a Medical Records Review to determine if the five HCFA-required components of a well-child screening, in addition to vision and hearing screening services, were provided to Medicaid-eligible children. This study, released Summer 1998, indicated that most of the children were receiving age-appropriate immunizations; however, the immunization records were so fragmented it was difficult to follow the schedule. Referrals to specialists, when a problem or condition was noted during a screening, were made promptly and the results were present in the record. Health education and developmental assessment were seldom documented; however, the absence of documentation did not indicate a total absence of services. Vision and hearing examinations did not appear to be performed. Many of the visits were not actual well-child checks. Study

findings indicated a problem with the quality of exams and documentation. The study also found that on average, 3.93 of the seven components per record were documented.

3. The Department of Commerce and Insurance's TennCare Division coordinated a review of all provider contracts executed by the MCOs/BHOs (or their subcontractors) pursuant to Paragraphs 102 and 103 of the EPSDT Consent Decree. Each contract was reviewed to identify provisions that could encourage violations of the EPSDT mandate. Of the 265 contracts reviewed, 162 (61%) contained issues that may encourage violations of the decree. Findings were forwarded to the bureau May 21, 1998, for review, and final findings were forwarded to the MCOs/BHOs for corrective action. The MCOs/BHOs were given 60 days (until September 25, 1998) to formulate a corrective action plan. Some were late with required reports and were assessed liquidated damages. Bureau management indicated that implementation of action plans is an ongoing process.
4. As called for in the EPSDT Consent Decree, the state agreed to create an "expert review process" to assess the adequacy of the present system to address the medical, dental, and behavioral health needs of children in custody and those at risk of coming into Department of Children's Services custody. The Report of the Review Team for the EPSDT Consent Decree, dated September 15, 1998, was released in October 1998. Findings indicated that seven of the 50 children whose cases were reviewed appeared to be making steady progress while in the state's custody. However, the team's record review indicated that children in custody rarely receive well-child care, complete physicals, prescriptions, and certain other services (dental, orthopedic, and behavioral health). Primary care providers and Children's Services case managers rarely had past medical information on children in custody. Providers also indicated that it was difficult to make referrals and that dissatisfaction with the bureau had reduced the number of providers and appeared to be resulting in disruptions in care. The team interviewed providers, foster parents, and Children's Services staff. Findings were unanimous in that managed care had resulted in a drastic reduction in the quantity, quality, and timeliness of behavioral health, medical, and dental services for children in custody and at risk of entering custody. Recommendations from this report encouraged the Department of Health to implement Best Practice Networks for children in custody or at risk of entering custody and for their birth, foster, and adoptive families. This approach focuses on quickly increasing the quantity and quality of services to meet special needs of children in custody. The report recommended simplifying managed care for custody children by having a single MCO directly manage the Best Practice Networks, thus eliminating the need for a BHO for custody children.

In an attempt to address the review team's findings, the various parties involved in the consent decree met to develop a joint remedial plan for compliance. However, the parties were unable to agree on the specific provisions of the plan. Therefore, the Departments of Health and Children's Services submitted their plan to the Court on December 11, 1998, and the plaintiffs submitted their response to the departments' plan on February 17, 1999.

The Department of Health is currently negotiating a contract with East Tennessee State University to perform a medical records review of a sample of TennCare children to determine if they are receiving the required services. The reviewers will note if problems are identified and treated and if children are referred appropriately to specialists.

Recommendation

The bureau should assess its compliance with the consent decree and develop additional action plans as needed to improve compliance. Any additional action plans developed should include specific goals for future performance, clearly identify the various offices involved in providing the services in question, and describe the offices' respective duties, authority, and responsibilities, as well as ways to coordinate their various functions. The plan should be disseminated to all appropriate offices and individuals involved. The bureau should collaborate with the MCOs, the BHOs, and the Department of Children's Services (when appropriate) to ensure that the system facilitates the provision of needed services to children. The bureau may wish to consider the recommendations of studies already performed, including implementing Best Practice Networks and simplifying managed care for custody children by utilizing a single MCO, rather than an MCO and a BHO.

As part of the plan, the bureau may want to consider providing all its constituents additional training and information on EPSDT services and benefits.

The bureau should ensure the corrective action plans of the MCOs and BHOs are adequate, appropriate, and consistent with and supportive of the bureau's plan. The MCOs and BHOs should follow through with necessary corrective action plans of their own and ensure these plans are fully implemented within a reasonable period.

The bureau and the Department of Children's Services need to improve their collaboration through coordination, training, and exchange of information.

Management's Comment

We concur. The Bureau developed a systematic plan for compliance immediately after the EPSDT Consent Decree was entered. This plan identified tasks to be done, units responsible, and timeframes, and has served as a blueprint for action. There has been a great deal of collaboration with other agencies, in particular the Department of Children's Services, in implementing this plan. Some of the activities completed to date include the following:

- Review of all MCO, BHO, and Children's Services provider contracts to determine if there were any items in these contracts that might encourage violation of the EPSDT mandate; identification of these items; and development of plans of correction by the MCOs and BHOs for addressing these items.

- Passage of two rules, one having to do with removing limits on behavioral services for TennCare children and the other having to do with responsibility for EPSDT outreach.
- Expanded reviews of provider networks.
- Organization of a medical advisory committee to draft recommendations for screenings and completion of recommendations for hearing and vision screenings.
- EQRO review of MCO and BHO EPSDT policies.
- Several contract revisions having to do with publication by the MCOs of a list of specialists, transportation, and penalties for BHOs when failure to deliver services results in a child's entering State custody.
- Identification and distribution of a list of statewide services which are appropriate for EPSDT coordination.
- Development of a process for schools to use in communicating with MCOs about children with disabilities.
- Completion of two special studies by outside consultants on EPSDT services for State-custody children.
- Initiation of two more special studies by outside consultants on the availability of diagnosis and treatment under EPSDT.
- Two reviews of appeals.
- Extensive notification of EPSDT to class members and advocacy organizations.
- Publication of handbooks for providers of mental retardation services, special educators, and Children's Services providers.
- Development and presentation to the court of a proposed remedial plan to address problems in the delivery of TennCare services to children in State custody.

These actions, together with other activities aimed at ensuring compliance, are detailed in the two progress reports that have been prepared and filed with the court to date.

The recommendations for implementing Best Practice Networks and a single MCO for custody children have been carefully considered, and the Departments of Health and Children's Services have proposed alternative strategies: (1) the development of Best Practice Standards for treatment of specific disorders that children in State custody are likely to have and (2) greatly expanded training and support of Children's Services workers in appropriate use of the managed-care system. Both of these strategies were included in a proposed remedial plan submitted to the federal court in December 1998.

We believe that these activities demonstrate substantial efforts on the part of the Department of Health to ensure ongoing compliance with the EPSDT Consent Decree.

5. Provider assessments of the TennCare Program are negative

Finding

Provider assessments of the TennCare Program disclose problems with claims processing, reimbursement rates, medical-necessity standards, drug formularies, referral/prior authorization, and other administrative procedures. Because of these problems managed-care networks may have difficulty attracting new providers and retaining existing ones. These problems may also compromise the quality of care TennCare enrollees receive.

Assessments are based on provider satisfaction surveys. We reviewed 1997 and 1998 assessments by three MCOs, one BHO, a professional group, and a consulting firm. The Division of State Audit also conducted a provider survey (see Appendix) and interviewed management of the nine MCOs and the two BHOs and a professional association regarding the most common complaints of their providers. The assessments and interviews revealed similar concerns—slow claims processing, low reimbursement rates, broad medical-necessity standards, restrictive drug formularies, difficulty obtaining referrals and prior authorizations, and cumbersome administrative procedures. Overall evaluation of provider responses to our survey indicates concern for the quality of care provided to TennCare enrollees.

In addition to provider assessments and interviews, we reviewed reports prepared by the TennCare Division of the Tennessee Department of Commerce and Insurance. That division is responsible for examinations of the nine MCOs and the two BHOs to evaluate compliance with statutory and contractual requirements. These reports cited the same concerns found in the provider assessments and interviews. The advocacy groups we interviewed expressed similar concerns. Even TennCare personnel agreed that provider concerns were justified.

Slow Claims Processing

The TennCare MCO and BHO contracts contain timeframes and weekly reporting requirements for claims processing and penalties for noncompliance. BHOs and MCOs must pay or deny 95% of clean claims submitted within 30 calendar days of receipt and the remaining 5% within 40 calendar days of receipt. A “clean claim” is defined in the MCO and BHO contracts as a claim “received by the MCO/BHO for adjudication which requires no further information, adjustment, or alteration by the provider of the services in order to be processed, paid, or appropriately denied by the MCO/BHO.” All claims must be processed within 60 days of receipt. MCOs and BHOs provide weekly status reports to TennCare about the amount and age of claims.

TennCare management stated that withholds are assessed for failure to process claims in a timely manner. We reviewed withholds assessed from November 1997 to November 1998 and determined that only two MCOs were penalized—Xantus in January, February, and March 1998 and Omni-Care in July, August, September, and October 1998.

Timely claims processing is also a concern to HCFA, which had received complaints that MCOs were not making timely payments. TennCare applied to HCFA for a waiver extension on

December 30, 1997. In an April 14, 1998 letter, HCFA requested more information and asked TennCare to describe plans for enforcing timely payments to providers. In response, TennCare officials sent copies of lists of providers who had complained to the Department of Commerce and Insurance about Premier and TBH and submitted the department's November 14, 1997, claims processing report on Premier. TennCare also submitted an Arthur Anderson report on Premier's vendors—Options and GreenSpring—as well as Options' updated claims processing inventory statistics as of February 13, 1998.

Advocacy groups and the media are also aware of claims-processing problems. A representative from the TennCare Partners Advocacy Program said its hotline receives numerous telephone calls from providers who have not received payment for services rendered. The *Knoxville News-Sentinel* printed an article March 1, 1998, describing the BHOs' claims-processing problems. Management in TennCare's Provider Relations Unit recognizes claims-processing problems.

Provider responses to our survey noted the need to streamline the claims process and pay providers more promptly. Several providers noted that MCOs/BHOs failed to process claims within 30 days as stipulated in the plan contracts. Most providers agreed that 30 days was an acceptable length of time. Claims processing was judged slow because of the frequent rejections of initial claims. Failure to submit all the necessary paperwork was the most common reason cited by the MCOs/BHOs for rejection, although providers claimed this basis for rejection was often used on claims that had been appropriately completed. Electronic filing was occasionally noted as a good process, assuming providers could maintain the necessary software. Filing via the Internet was deemed to be too problematic at this time because of the length of time to file each claim.

Low Reimbursement Rates

TennCare sets capitation rates for the MCOs/BHOs; the MCOs/BHOs set rates for the individual providers. Language in the MCO and BHO provider contracts states that a provider agrees to accept TennCare's reimbursement rates for services rendered to TennCare enrollees. However, concern over these rates has led MCOs, BHOs, and providers to request a review of current rates.

In the 1993 waiver application to create TennCare, the state described calculations for capitation rates and said that the rates would be updated annually. However, TennCare has not conducted an actuarial study to assess whether current capitation rates are adequate to cover services. (See finding 3.)

To maintain access/network requirements, some plans compensate for low reimbursement rates by paying providers on a fee-for-service basis rather than using the capitation rate. (One MCO we interviewed suggested a reevaluation of capitation rates because TennCare appears to expect MCOs to provide a higher level of service than that required by the contract or supported by current rates.)

Providers are concerned about reimbursement rates and cited low rates as one reason networks cannot attract new providers. Providers reported numerous examples of reimbursement at 25% to 30% of their overhead. TennCare rates are always less than other insurance companies and frequently less than Medicaid. Providers called for a 50% to 100% increase in rates. Several providers view TennCare as a community service—they willingly provide medical treatment with the full understanding that if received at all, the reimbursement will not cover their cost of providing the service.

Broad Medical-Necessity Standards

Because all medical cases cannot be treated similarly, medical-necessity determinations are difficult to standardize. TennCare's rules and its contracts with MCOs and BHOs define "medical necessity" as "required services or supplies that are consistent with the symptoms, diagnosis and treatment, appropriate for standards of good medical practice, not solely for convenience of an enrollee or provider, and the most appropriate level of services." Other than this definition and its broad criteria, TennCare has not provided any other guidance, leaving the MCOs, BHOs, and the Appeals Unit to establish their own procedures to determine medical necessity.

This lack of guidance has left all parties frustrated. Providers believe the physician treating the patient, not staff at the MCO, should determine medical necessity. Several MCOs and the Appeals Unit claim to use the nationally recognized standards established by Milliman and Robertson (an actuarial and consulting firm that developed Healthcare Management Guidelines) and InterQual (a consulting firm that developed Clinical Decision Support Criteria) for determining medical necessity. Most MCOs, however, believe TennCare's criteria for determining medical necessity differ from theirs. The MCOs also complain that the TennCare Appeals Unit frequently overturns their denials of medical necessity without communicating the reasons. The Appeals Unit states, however, that its physicians communicate the reasons for denial through peer-to-peer reviews with MCO medical directors.

Providers resent the MCOs'/BHOs' denying requests for treatment or referrals. Several stated that if the course of action was not medically necessary, they would not have requested it. Justifications for denials are not always properly communicated to providers. Several noted that denials appear to be made by someone with no medical knowledge working from a predetermined list of responses.

Drug Formularies

Complaints regarding drug formularies and other pharmacy-related issues are numerous. According to quarterly reports to HCFA for the first three quarters of 1998, TennCare's Appeals Unit received 3,257 appeals. Formulary appeals appear to constitute a disproportionate share—1,233 (or 38%) of total appeals.

Providers noted frequent changes in MCO/BHO formularies and stated that the changes were not always communicated to providers. Providers who contract with multiple MCOs/BHOs complained that each plan has its own formulary and that it is difficult to keep up with

which medications are available on which formulary. The same drug denied by an MCO because it is “behavioral” may also be denied by a BHO because it is “medical.” There were also comments regarding pharmacies that would not honor the three-day supply of a prescription while waiting on approval for the medication. The most common complaint of the providers was that the drugs on the formularies are older, less effective drugs that require a longer recovery period. Newer (and usually more expensive) drugs are rarely added to the formularies even when clinical evidence demonstrates that the new drugs are much more effective and recovery is quicker. Providers also questioned having to try formulary drugs to prove they will not work before requesting non-formulary drugs.

Difficulty Obtaining Referrals and Prior Authorizations

The MCO and BHO contracts define “prior authorization” as the authorization of specific services or activities before they occur. However, the contracts do not contain specific guidelines for obtaining prior authorization or referrals. According to MCO representatives, such procedures are at the discretion of each MCO.

Because there are no general guidelines regarding prior authorization or referral, procedures vary by MCO. Advocacy groups believe prior authorization procedures can affect the quality of care by delaying an enrollee’s treatment because of bureaucratic red tape and routine denials. Because providers may belong to more than one network, keeping track of different prior authorization procedures for different plans can become difficult and time-consuming.

Providers complained of delays in approvals for treatment, referrals, and non-formulary drugs. Part of the delay was attributed to difficulty in getting through to an MCO or BHO on the telephone or calls put on hold for excessive lengths of time. Providers fax requests but seldom if ever receive faxed responses. Some providers noted that approvals were eventually forthcoming only if they or their staff were persistent in making repeated calls to check on the status of requests. More often than not the first response is a denial of the request. Some providers believe this “deny-on-first-request” procedure was an MCO/BHO tactic to wear the provider down, hoping that the service would be provided for free.

Cumbersome Administrative Procedures

Each MCO and BHO is responsible for communicating its policies and procedures to its providers. Most plans issue provider handbooks and communicate through provider relations representatives or newsletters. Despite these efforts, many providers stated that they lack knowledge of their plan’s policies and procedures.

Providers cite the difficulty in obtaining up-to-date provider manuals. Providers also complained about the lack of standardized procedures across the MCOs and BHOs. The most common differences were noted in credentialing, referral, and appeals procedures. Currently, providers annually submit information to each MCO or BHO they contract with even if they have been credentialed by that MCO or BHO in the past. Providers recommended that TennCare develop a central credentialing unit to provide information to the MCOs and BHOs. Most

providers complained about the abundance of paperwork required and cited TennCare as worse by far than any insurance company.

Quality of Care

Citing the issues discussed above, providers expressed concern about the quality of care provided to TennCare enrollees. Providers indicated that the TennCare Program is not delivering health care services of the same quality as those under Medicaid. They believed that TennCare's policies or restrictions affected the quality of care. Problems involving the delivery of services to TennCare enrollees include inadequate access to providers (especially specialists), medications, and treatments. Several providers stated that enrollees sometimes had to travel excessive distances (e.g., 100 miles) to see specialists who would treat them. In addition, the process to approve specialized treatments and medications tends to be untimely, and in many cases access to such treatments and medications is denied. The appeals process to address such denials is inadequate in the view of several providers. Enrollees also had long waits for approval of treatment plans. Furthermore, providers stated that some TennCare patients have needs not covered by the program.

Providers complained that enrollees did not have adequate information regarding the program, including their rights and their coverage. They indicated that the Bureau of TennCare is not obtaining sufficient information to monitor the program, does not regularly solicit provider concerns, and does not effectively communicate to them administrative and program requirements. They also complained that MCO and BHO staff many times were not helpful in answering their questions.

For the program to succeed, TennCare needs to maintain adequate provider networks, while offering optimal quality of care. The program already has difficulty attracting dentists, orthopedic surgeons, and other specialists (see finding 1). Ignoring provider concerns may erode current networks further. Providers are integral to the program, and their concerns should be a priority.

Recommendation

TennCare should use the information from provider assessments, complaints, and examination findings to improve its program. Enforcing compliance with contract requirements for claims processing, periodically evaluating reimbursement rates and capitation rates, standardizing procedures for determining medical necessity, reviewing restrictive drug formularies, and streamlining policies and procedures for prior authorization and referrals would increase provider satisfaction. Formal procedures for addressing provider complaints should be instituted and should include establishing a hotline to track and monitor provider complaints and minimize provider frustration. TennCare should periodically assess provider satisfaction to obtain information on areas to improve.

Management's Comment

We concur in part. Managed-care programs, especially HMOs, are under fire across the country. Many of the complaints against TennCare are similar to those lodged against commercial HMOs as well. The movement in the U.S. Congress for a Patient Bill of Rights is a direct result of patient complaints about HMOs.

TennCare receives many of the same complaints as commercial HMOs but has the added dimension of being a governmental program. Complaints are highlighted because of this relationship.

That being said, the TennCare Bureau welcomes the comments from the providers obtained by the Comptroller during the audit. Ample provider input is absolutely essential to correcting deficiencies in the program. If the criticisms are valid, corrective actions must and will be implemented. If the criticisms are erroneous or are incorrect perceptions, they still must and will be addressed since perceptions are reality to the holder.

In the program, sometimes the problems and therefore the criticisms are directed at TennCare when they should be directed toward the MCOs. In such an instance, the Bureau, in partnership with the MCOs, must and will clarify responsibility but also help resolve the real or perceived problems.

Complaints, the number and type, are key indicators of corrective or proactive actions which must be taken. Since the Bureau is ultimately responsible for the entire TennCare Program, from the Governor to the beneficiary, we will treat all complaints as issues to be addressed. We will work with the MCOs, the Department of Commerce and Insurance, and with all necessary agencies to resolve the causes of the complaints. The Bureau will refine existing mechanisms to help address complaints and problems. For problems that are clearly the responsibility of the MCOs, e.g., slow claims processing, the Bureau will obtain the necessary information to assist or direct, in accordance with the law, regulations, and the HCFA waiver, corrective actions by the MCOs. This will be done in a cooperative fashion aimed at correcting deficiencies, not assessing blame.

In the area of complaints about low reimbursement rates, the Bureau cannot intervene in the relationship between providers and the BHOs or MCOs. As to the capitation rates, see the response to Finding 3.

Regarding the Comptroller's report on broad medical-necessity standards and the difficulty in obtaining referrals and prior authorizations, the current procedures will be enhanced when the TennCare Medical Director is in place (we are in the process of interviewing candidates now). Provider input will be welcomed to assist the Medical Director and Quality Improvement Director in correcting deficiencies.

Regarding drug formularies as a source of complaints, see the response to Finding 6.

In the area of cumbersome administrative procedures, the primary responsibility for patient enrollment and education rests with the MCOs and BHOs. However, since an informed beneficiary is a more efficient user of services, the Bureau will assist the BHOs and MCOs where practical in helping to educate the TennCare enrollees since this helps hold costs down, thereby reducing pressure on the capitation rates. The Medical Director will be involved in exploring improvements in credentialing, referral, and appeals procedures.

On quality of care issues, the Medical Director and Quality Improvement Director (also in the process of being recruited) will be responsible for working with the MCOs and BHOs to address all quality issues.

In summary, the Bureau welcomes the input, whether critical or positive, from patients, providers, MCOs, BHOs, legislators, advocates, and anyone else who can contribute to the ongoing improvement of the TennCare Program.

6. Weaknesses in TennCare's formularies are a source of provider dissatisfaction

Finding

The bureau does not adequately monitor the timeliness of authorizations for prior approvals and medical necessity. Providers recently surveyed had the following complaints: the formularies were restrictive, the approval process was slow, and the MCOs were not responsive to their needs.

Managed-care organizations commonly use a formulary, or restricted drug list, to standardize therapy and manage prescription drug cost. Each MCO is responsible for establishing its own formulary, with final authorization from TennCare's Pharmacy and Therapeutics (P&T) Committee. The P&T committee meets quarterly to approve drugs to be added to or deleted from MCO formularies. Until December 31, 1998, six of the nine MCOs contracted with RxCare, which subcontracted with Pro-Mark, to establish a basic core formulary, to supplement this core formulary as needed, and to process prior authorization and medical necessity requests.

HCFA management and professional organizations contacted by auditors (the American Pharmaceutical Association, the Tennessee Pharmacists Association, and the American Society of Health-System Pharmacists) agree that use of multiple formularies for pharmacy services across a managed health plan like TennCare is appropriate as long as there is an adequate mechanism to apply for prior authorization and medical necessity for medications not on the established formulary and an effective appeals process when requests are denied. Multiple formularies allow each managed-care organization the flexibility to tailor a formulary to meet the needs of the market.

The BHOs also were responsible for their own formularies until July 1, 1998, when the Department of Health took over formulary management for behavioral health patients. TennCare management cited two primary reasons for this change: (1) to address the unprecedented increase in behavioral health pharmaceutical costs and (2) to allow the BHOs to focus their attention on case management services (see finding 12).

There are three primary drug categories and methods for obtaining them: drugs on the formulary that can be prescribed without any contact with the MCO, those on the formulary that require prior authorization from the MCO, and those that are not on the formulary and are available only through an override citing medical necessity. Eight of the nine MCOs require prior authorization for some medications and are therefore said to have closed formularies (Omni-Care is currently in the transition to a closed formulary). TennCare policy assumes that if enrollees avail themselves of the mechanisms in place, most drugs are potentially available. However, based on responses from provider surveys summarized below, the bureau does not always process prior authorization and medical necessity approvals in a timely manner.

The MCO/TennCare contract requires that authorization or denial be rendered on the day of the request. If the decision cannot be made the same day, the enrollee can receive a 72-hour supply of the medication in most cases. Exceptions to the same-day rule include medication classified by the Food and Drug Administration as “less than effective,” medication in a noncovered TennCare therapeutic category, and medication whose provision would violate state or federal Controlled Substance laws. Because TennCare does not track how long MCOs take to process prior authorizations or medical-necessity requests, it is limited in its ability to identify problems in processing and to take necessary actions to address the situation.

Surveys of providers and enrollees support concerns about the authorization process. A Division of State Audit survey of TennCare providers indicates strong dissatisfaction with the restrictions associated with the drug formularies. Providers had a number of complaints about the formularies. Below are the most common areas of concern:

- New, more effective drugs were often not included on the formularies.
- The MCOs were not responsive to their questions or needs, often putting them on hold for long periods of time or not returning telephone calls.
- They had to document use of formulary drugs that did not work before requesting nonformulary drugs.
- Changes in formularies were not communicated to them.
- Pharmacy did not provide a three-day supply.
- Each MCO and BHO had a different formulary.

A survey, released in July 1998, of over 300 providers who are members of the Tennessee Chapter of the American College of Physicians–American Society of Internal Medicine reflected the same concerns. Complaints included unacceptable delays while waiting for treatment approval, restrictive access to medications for patients, and unnecessary admin-

istrative complexities. Physicians responded that standardized formularies would improve patient care. Eighty-two percent of respondents had had either major or minor problems with the MCO's covering needed treatment, and 84% reported having to wait for plan approval. According to the survey's author, results indicate that providers "spend an increased proportion of their time dealing with paperwork, phone work, and documentation issues related to MCO administrative demands."

Auditor analysis of service appeals resolved between October 1997 to October 1998 also indicated problems with the pharmacy and formulary appeals process. During that period, 65% of all resolved appeals were overturned, and pharmacy appeals accounted for 43% of that total, suggesting that many requests for prior authorization or medical necessity may be inappropriately denied. (See finding 7.)

TennCare management attributed the high rate of overturns primarily to providers' not including proper documentation or information with the original request. Another factor is the use of formulary services by Medicare crossovers, patients who are eligible for both Medicaid (TennCare) and Medicare. These enrollees can see Medicare doctors who are not in the TennCare network and may not follow appropriate filing guidelines. Although Medicare will pay for the patients to see any doctor, their prescriptions are billed to TennCare.

Soundness of Formularies

As part of the TennCare Drug Formulary Accountability Act, Sections 71-1-401 through 71-1-406, *Tennessee Code Annotated*, TennCare is required to conduct a clinical analysis of the drug formulary of each MCO and BHO to ensure each formulary is therapeutically sound. The *Clinical Analysis of TennCare Formularies*, conducted by the Tennessee Drug Utilization Review Program, the University of Tennessee at Memphis, was released December 9, 1997.

Although researchers commented that there was no generally accepted definition for a therapeutically sound formulary, they considered it to be "one which covers reasonable therapeutic alternatives for major medical conditions and which covers other drugs with unique indications, side effect profiles or properties without unreasonable administrative hurdles." Therefore, researchers reasoned that formularies "can only be therapeutically sound if patients have access to drugs, or therapeutic equivalents, that are needed for their medical conditions."

TennCare has established guidelines for a minimum formulary for outpatient, ambulatory use that generally require every MCO to have at least one drug in each of 80 selected drug categories of the American Hospital Formulary Service. To assess the adequacy of the minimum formulary guidelines, researchers addressed three clinical criteria: unique FDA-approved uses, unique safety profiles, and unique properties that are clinically important for specific patient populations. These criteria were applied to each American Hospital Formulary Service (AHFS) category specified in the TennCare formulary guidelines.

In making assessments, the researchers reviewed electronic files of drugs contained in all MCO/BHO formularies, a written list of drugs that required prior authorization, and clinical criteria for prior authorization. Researchers determined the following for each AHFS category:

compliance with TennCare guidelines, the number of drugs available in the category, and the number of drugs requiring prior authorization.

The study was limited in its assessments because of several factors: performance measurements of formulary processes, patterns of drug usage, disease prevalence, and health care utilization were not available for analysis; patient needs and drug costs, typically considered in selecting drugs for a formulary, were not the focus of the evaluation; and despite internal controls there is always a potential for error in the processing of the electronic formulary data received from the MCOs, BHOs, and database vendors.

Still, the study was able to arrive at some key findings regarding the formularies and minimum formulary guidelines. The study concluded that all the formularies can be generally deemed therapeutically sound overall. However, some were inadequate in certain categories. Although the formularies met most of the minimum TennCare guidelines (compliance levels ranging from 91% to 99% for MCOs and 95% to 100% for long-term care facilities), the guidelines were found inadequate to ensure therapeutic soundness and should not be used as the sole criterion for formulary approval.

Furthermore, some formularies appear inadequate in that they do not include many drugs frequently used as first- or second-line therapies for common conditions. None of the formularies contained all of the agents required by the TennCare minimum formulary guidelines. One formulary had a high percentage of drugs only available through prior authorization, and one had no categories requiring prior authorization.

The study recommended revising the TennCare minimum formulary guidelines to further ensure representation of major therapeutic classes; studying provider and patient experiences with present formularies; evaluating the feasibility of developing electronically available formulary data that the MCOs and BHOs would regularly update; and examining the performance measurements for prior authorization processes to ensure the prior approval policies and procedures the MCOs and BHOs used do not impede quality patient care.

According to TennCare management, the bureau sent letters in December 1997 to the MCOs that were found not to be in compliance. TennCare's follow-up disclosed that most MCOs had come into compliance within two months. The University of Tennessee at Memphis has initiated no formal follow-up of its study to determine if the recommendations were carried out.

Recommendation

TennCare should monitor the authorization process to ensure requests are being decided in a timely manner. Also, the bureau should work with providers to identify and resolve problems associated with the formularies, such as restrictions that could affect quality of care.

TennCare should monitor the formulary process to ensure the guidelines are followed and should evaluate each formulary to ensure enrollees' needs are met.

Management's Comment

We concur in part. Although the TennCare Contractor Risk Agreement requires the MCOs and BHOs to respond to prior authorization requests from providers within 24 hours of receiving the request, many times the provider (prescriber) has faxed (or telephoned) insufficient information to the MCO/BHO or its agent to adequately review the request. In these instances, it may indeed take longer to process the requests as the MCO/BHO or its agent must try to reach the prescriber and seek additional information. The TennCare Bureau has requested updated and current data from the MCOs and BHOs regarding prior approval requests and will analyze that data on an ongoing basis to assure that contractual requirements placed on the MCOs and BHOs (and their subcontractors) are strictly adhered to. In the past, prior approval and medical necessity requests have been responded to within 24 hours 95% of the time (5% inadequate information) and between 70% and 80% of all the requests were approved by the MCOs/BHOs or their agents.

The TennCare drug formularies may seem restrictive to prescribers, but in comparison to the original TennCare formularies they have been vastly improved and expanded. Better than 80% of the enrollees are covered under a single formulary. The TennCare Bureau is formulating an ongoing education program for physician and pharmacy providers that will include written information and face-to-face intervention. The focus of these educational efforts will include informing providers of the formulary development and change process, illustrating the difference among formularies, how to acquire approval for non-formulary drugs, what information to supply the MCOs and BHOs when seeking approval of a non-formulary drug, how to access the different prior approval systems of the TennCare health plans, how to assist enrollees in the appeals process, what the criteria are for different drugs or classes of drugs that require prior approval, how to assure that the 72-hour supply requirements are properly applied, drug utilization data and associated costs, and the mutual benefit of positive interaction between different provider types. In addition, we will be adding the drug formularies and the prior approval criteria to the TennCare web site for quick reference and easy downloading.

Furthermore, the TennCare Bureau intends to implement comprehensive monitoring of the MCO and BHO pharmacy programs. In order to ascertain the effectiveness of the above educational interventions, we will be monitoring prescribing and dispensing habits to determine how well the contractual requirements are being followed. In the event that this educational effort does not address these enrollee issues, the TennCare Bureau will work closely with the out-of-compliance MCOs and BHOs for further improvements. Legal remedies, e.g., liquidated damages, will be only a last resort.

7. Appeals are not adequately monitored

Finding

Enrollees have the right to contest in writing any action taken by the MCO or BHO to deny, reduce, terminate, or suspend a covered service ordered or prescribed by a particular provider. The TennCare Appeals Unit works to resolve these appeals, collects data regarding appeals, and reports monthly to the TennCare Division of Quality Improvement and quarterly to the Health Care Financing Administration (HCFA). Even though the data are available, TennCare does not monitor or assess appeals resolution. Analyses of how, why, and where appeals are resolved and how many decisions are appealed can reveal programmatic deficiencies and areas for improvement.

Total Appeals Enrollees Filed By MCO/BHO October 1997 to October 1998

MCO/BHO	Number Filed	Percent Of Total
Access	449	9.9%
Health Net	69	1.5%
Heritage	41	0.9%
Memphis	67	1.5%
Omni-Care	84	1.8%
PHP	278	6.1%
Prudential	34	0.7%
THP	403	8.9%
Vanderbilt	38	0.8%
VSHP	960	21.1%
Xantus	357	7.8%
Premier	1,181	26.0%
TBH	589	13.0%
Total Number Filed	4,550	100.0%

Standard Operating Procedure (SOP) 033 issued October 25, 1996, clarifies the procedures for processing appeals. According to the SOP, the Appeals Unit is to forward an enrollee's appeal to the MCO or BHO for reassessment. If the MCO or BHO overturns the original decision, the service is provided to the enrollee. However, if the MCO or BHO upholds the original decision, the Appeals Unit reviews the appeal. If the Appeals Unit reverses the MCO's/BHO's decision, services are rendered to the enrollee. If the Appeals Unit upholds the MCO's/BHO's decision, the enrollee may continue the appeal to an administrative law judge or commissioner's designee who hears the case and renders a decision.

Appeals resolution and reporting must be completed in accordance with the Daniels Consent Decree. The consent decree, based on a 1979 Medicaid lawsuit, provides that Medicaid enrollees have a right to due process and timely hearing whenever agencies take actions which adversely affect medical assistance. Although the original consent decree protected Medicaid recipients, the language was modified in 1996 to protect TennCare enrollees from inappropriate denials of health care.

The Daniels Consent Decree also requires that a central registry be established for all enrollee appeals. Each appeal is to be entered into a system for tracking and monitoring and be referred to the appropriate MCO or BHO. Monthly reports are to be compiled indicating the number of appeals by MCO or BHO, the type of care, the number of days for resolution, and the type of resolution (reversal or affirmation after reassessment by MCO or BHO, reversal or affirmation after review by TennCare, or reversal or affirmation after hearing). All appeals and their resolution are to be logged for tracking and statistical purposes.

Although TennCare compiles the data necessary to comply with the Daniels Consent Decree, the bureau does not analyze such data to identify programmatic deficiencies and to improve quality of care. Division of State Audit analysis of appeals data for October 1997 through October 1998 indicates a high number of MCO/BHO decisions were overturned through the appeals process. Most decisions were reversed by the MCO/BHO upon reassessment, and most were formulary related.

Overtured Decisions

The Appeals Unit provided data of all service appeals that were resolved from October 1997 through October 1998. The audit team calculated reversed decisions for that period and found 1,949 of the 3,002 resolved complaints (65%) were reversed. Using raw data, the audit team derived the following tables. Table 1 compares reversed decisions to resolved appeals by each MCO and BHO. The percentage of decisions reversed ranged from a low of 48% for Heritage to a high of 80% for Vanderbilt.

Data indicated that formulary-related decisions were overturned more than any other—43% of all reversed decisions. The next highest category was “mental health–inpatient adult” at 10%. Table 2 shows the categories of service per MCO/BHO for reversed decisions.

**Table 1
Comparison of Reversed Decisions to Resolved Appeals
October 1997 to October 1998**

MCO/BHO	Total Reversed	Total Resolved	Percent Reversed
Heritage	11	23	48%
Access	150	276	54%
Health Net	35	64	55%
Omni-Care	12	21	57%

MCO/BHO	Total Reversed	Total Resolved	Percent Reversed
PHP	115	194	59%
Memphis	31	52	60%
Prudential	7	11	64%
TBH	194	296	66%
VSHP	572	849	67%
Xantus	153	229	67%
THP	213	304	70%
Premier	440	663	66%
Vanderbilt	16	20	80%
Total Percent Reversed	1,949	3,002	65%

Table 2
Percentage of Reversed Decisions
By Category of Service per MCO/BHO
October 1997 to October 1998

Category	Reversals	Percent
Access to services	32	1.6%
Dental	56	2.9%
Durable medical equipment	118	6.1%
Home health	86	4.4%
Mental health inpatient adult	203	10.4%
Mental health inpatient child	63	3.2%
Mental health outpatient child	27	1.4%
Other	51	2.6%
Pharmacy	847	43.5%
Physical therapy	141	7.2%
Physician	165	8.5%
Residential child	76	3.9%
Additional	84	4.3%
Totals	1,949	100.0%

Table 3 shows the levels at which decisions were reversed. Ninety-seven percent of the reversals were made by the MCOs/BHOs upon reassessment; based on information from the Appeals Unit, no reason was given for 77% of these reversals. When a reason was given, medical necessity was cited for 13% of the decisions. In comparison, the Appeals Unit reversed 58 decisions (3% of total reversals); 48% of those were based on medical necessity.

Despite the high reversal rate, TennCare and Department of Health officials are not alarmed and do not suspect invalid or inappropriate claims denial. Management offered several explanations for the high rate: Most claims were denied initially because of provider errors when filing a claim. The additional information available for review during the appeals process may lead to a reversal. The high rate of formulary-related reversals could be attributed to a lack of information on prior authorization procedures, the lack of coordination between claims processing and prior authorization personnel, and a lack of information when filing a claim, particularly for those patients who are eligible for both Medicaid (TennCare) and Medicare. These enrollees can see Medicare doctors who are not in the network and may not follow appropriate filing guidelines.

Another explanation for the high reversal rate lies in possible differing definitions of “medical necessity.” According to representatives from the MCOs, the Appeals Unit uses different medical-necessity criteria from the MCOs. As a result, the MCOs believe they pay for services that are not covered benefits nor medically necessary; they could not, however, provide documentation to support this assertion. According to management in the Appeals Unit, physicians from the Appeals Unit communicate with physicians or the medical director at each MCO to relay and discuss reasons for a reversal based on medical necessity. Furthermore, only an administrative law judge can require an MCO to pay for a noncovered benefit. (The Appeals Unit provided documentation of relevant orders issued by an administrative law judge.)

Regardless of the reasons the bureau and the Department of Health provided for reversal rates, neither analyzes appeals resolution. Therefore, TennCare has no assurance all denials are valid. Without this assurance, quality of care may be significantly affected.

Recommendation

The Bureau of TennCare should increase monitoring of the appeals process and evaluate appeals resolution. If the MCOs and BHOs continue with a high rate of reversals upon reassessment, TennCare should address the reason for the initial claims denial and evaluate the claims denial process.

Table 3
Level at Which Decision Was Reversed
and Reason Given for Resolution
October 1997 to October 1998

Oct. 1997 to Oct. 1988	Reversed at MCO/BHO				Reversed at Appeals Unit			Admin. Reversal*	Total per MCO/BHO
	No reason cited	Medical Necessity	Contract Compliance	Rules Compliance	Medical Necessity	Contract Compliance	Rules Compliance		
Access	108	39		2	1				150
Health Net	25	4	1	4			1		35
Heritage	10	1							11
Memphis	25	5		1					31
Omni-Care	12								12
PHP	86	22	1	1	2			1	113
Prudential	4	2	1						7
THP	177	23		7	6				213
Vanderbilt	12	3		1					16
VSHP	477	62	4	15	7	1	5	1	572
Xantus	118	26		9	1			1	155
Premier	268	41	89	17	8	16	2		441
TBH	137	16	23	9	3	5			193
Total per category	1,459	244	119	66	28	22	8	3	1,949
	<i>Total per MCO/BHO</i> 1,888				<i>Total per Appeals Unit</i> 58			3	1,949

*Either an administrative law judge or the commissioner's designee made this ruling. The records did not provide the reasons for the rulings.

Management's Comment

We concur in part. In September 1997, the Appeals Unit was moved out of the Bureau of TennCare. Although still located organizationally within the Department of Health, there is now a "firewall" between the Appeals Unit and TennCare, with the purpose being to ensure that appeals are handled as objectively as possible. The Appeals Unit makes certain that all appropriate procedures are followed in handling appeals as they occur. They also work to resolve issues in dispute when possible, thereby obviating the need for additional appeals actions. In addition, the Appeals Unit informs the Contract Development and Compliance Unit at TennCare when there are specific problems that may require the levying of liquidated damages. An example of such a problem is the failure of an MCO to deliver a covered service

within 30 days of receiving a directive from the Appeals Unit to do so. It is important to note that the total number of appeals filed (4,550 between October 1997 and October 1998), when compared to the total number of TennCare enrollees during this period (approximately 1.25 million), yields a rate of less than 4 appeals per 1,000 enrollees for the period.

Most of the monitoring activity that has been done to date by the Appeals Unit and by TennCare has focused on compliance with procedural issues, such as adequacy of notification, timeliness of response, etc. Monitoring that is more analytical in nature, such as identifying patterns of appeals involving children, is planned for the future. The Bureau of TennCare has developed a process for this activity and will meet with the Appeals Unit in the coming weeks to refine and implement this process. The Bureau is committed to improving the appeals process and resolution.

8. The TennCare management information system is inefficient

Finding

The TennCare Management Information System (TCMIS) is over ten years old and cannot efficiently meet the state's decision-making and reporting needs. Despite numerous modifications, the system remains primarily a claims-processing system designed for Medicaid.

The demands on the system are immense. It is used to generate capitation payments to MCOs (managed-care organizations) and BHOs (behavioral health organizations); to summarize data for management, legislators, and the Health Care Financing Administration (HCFA); and to pay traditional Medicaid (nursing home) claims. The payments to MCOs, BHOs, and nursing homes by necessity must be the focus of the system. Most of the programs and applications are designed to process these payments.

Among the many reports the system routinely generates, a large number were created for Medicaid purposes and are no longer needed. To provide the legislature, HCFA, and others with the information they need, TCMIS staff must, in many cases, write special programs to generate the information requested.

Since TCMIS staff focus on processing payments, these requests for information do not usually receive immediate attention. At weekly status meetings, the Information Services Director sets priorities for the requests outstanding. Projects are sometimes not completed for over a year because the Information Services Director does not deem them a priority.

Further delaying the reports is the difficulty Electronic Data Systems (EDS), the company contracted to operate and maintain TCMIS, has had retaining programmers familiar with TCMIS. Turnover has been at an all-time high, in part because of the demand for programmers resulting from the Year 2000 dilemma. Considering the numerous modifications and changes to the system since the creation of TennCare and the limited documentation

available, programmers unfamiliar with TCMIS may need to make several attempts before they are able to produce a reliable report. These delays frustrate decision makers who need timely information for reasoned, responsive decisions about TennCare.

Some improvement was made in January 1996 with the acquisition of the Pandora subsystem, a very powerful database management program used solely for encounter data. TennCare staff in charge of Pandora have identified the key variables most useful to management and extracted these data elements monthly. According to the bureau's Director of Information Services, the Pandora subsystem has been used in preparing health outcome studies on topics such as infant deaths, prenatal care, and pediatric asthma inpatient admissions and emergency visits. The Director of Information Services believes the bureau would be better able to respond to information requests if all of TCMIS were on a relational database system such as Pandora. The Pandora subsystem, however, is limited in that it contains only a portion of the data in the TCMIS history file and is not updated during the month.

The Department of Health's three-year Information Systems Plan for 1998-2000 contains a project proposal to study replacing the "existing TCMIS with newer technology that will provide more efficient processing." The proposal also states, "Under our present restraints, system changes are cumbersome. Also, ad hoc reporting could be more timely with a relational database."

Recommendation

The Bureau of TennCare should implement its proposal to replace TCMIS. In the meantime, both the state and the contractor should work together to determine methods for coping with the increasing demands for information. The Commissioner should develop guidelines to aid the Director of Information Systems in setting priorities.

Management's Comment

We concur in part. We agree with the finding that the current TennCare Management Information System (TCMIS) should be analyzed to ensure that the TCMIS will continue to be able to support the overall mission and goals of the TennCare Program.

Prior to the implementation of the TennCare Program, the information systems in place were stable. The implementation of TennCare resulted in substantial new business and programming requirements. Furthermore, changes in business requirements and their relative priorities continue to drive new requirements and priorities for information systems support. These changes can be expected to continue until the program becomes more mature and predictable.

The overall information systems design currently has the functional capability to address many of the critical TennCare business needs but may not be adequate for a comprehensive managed-care program. The information systems in several areas of the TCMIS do not support the requirements adequately.

The current TCMIS uses a single-tiered technical architecture consisting of the host computer (IBM-compatible legacy mainframe) MVS/ESA as its operating system, TSO/CICS/Cobol II as the development environment, and VSAM as the file structure. The TCMIS contains well over 200 gigabytes of data and is accessed by numerous TennCare users. This technical architecture is adequate in areas such as maintenance of a large enrollee eligibility database and processing of capitation payments to MCOs and BHOs. However, certain areas of the TCMIS do not adequately support the business environment. Data are maintained on separate large files, and critical information within each file is not consolidated within a single database. In addition, as stated in the finding, access to and quick retrieval of information contained within the TCMIS are cumbersome. Ad hoc reports are slow to execute because they run against large databases which were originally designed for data entry and transaction processing rather than for data access and retrieval.

Again, as stated in the finding, TennCare was able to provide significant improvement in the area of data analysis by acquiring and implementing a decision support system. This system uses the PANDORA software, where data storage is highly structured and the operating system is geared for data access and retrieval. This system is used to analyze encounter data reported by the MCOs and BHOs to TennCare.

Because of the integrated nature of a managed-care information system, there is little opportunity to replace one module of the TCMIS with the "Best in Class" module from any commercially available managed-care information system. We believe that opportunities exist to replace and/or layer additional subsystems on top of the TCMIS base in order to supply more flexible functionality more rapidly. The Department currently has a project proposal to study replacing or adding layers to the existing TCMIS with newer technology. The Commissioner has been meeting with key TennCare staff and key staff from the Department of Finance and Administration to review the overall business goal and objectives of this proposal.

Ensuring that program priorities are being addressed is a major goal of the TennCare Information Services Director and his staff. Their daily activities include formal meetings with the TennCare Facilities Manager Contractor, EDS. Every effort is taken to formally identify resources available for development and system change requests and to produce reports to meet information requests. With the immense demands placed on an old system, pressures can increase for immediate needs. The TennCare Information Services Director is dedicated and committed to rapid response in spite of system limitations.

We concur that the facilities manager has experienced difficulties in retaining staff with TCMIS experience. We also concur that this has affected TennCare's ability to respond to requests for information requiring ad hoc reports. However, every effort continues to be made to ensure that priority requests are responded to timely and that all requests are responded to in a reasonable manner. The TennCare Information Services Director is working with current EDS TennCare account management to identify and implement options for responding to the increasing demands for information. It should be noted that the current Year 2000 project has had and is having an impact on the availability of resources.

9. MCO/BHO coordination efforts do not ensure TennCare enrollees receive appropriate medical and mental health services

Finding

With the implementation of the TennCare Partners Program, the behavioral health organizations (BHOs) became responsible for mental health and substance abuse services, and the managed-care organizations (MCOs) retained responsibility for providing primary health care. Each MCO contracts with a BHO to ensure TennCare enrollees receive appropriate mental health services. Although the state outlined a framework for coordination, the MCOs and BHOs have failed to establish solid working relationships. Poor communication between the MCOs and BHOs and weak monitoring by TennCare hinder possibilities for efficient and effective service delivery. Unless these coordination efforts improve, TennCare cannot ensure enrollees receive all needed physical and mental health services.

At the beginning of the TennCare Partners Program, TennCare assigned each MCO to one of the BHOs—Premier or Tennessee Behavioral Health (TBH). Because Volunteer State Health Plan is by far the largest MCO, it was assigned to both BHOs. (The table below presents MCO/BHO assignment.) Participants were enrolled in the BHO assigned to their managed-care organization. The BHOs in turn had to accept these participants, regardless of their health condition at the time of enrollment.

Premier	Tennessee Behavioral Health
Volunteer State Health Plan	Volunteer State Health Plan
Heritage	Access
Omni-Care	Memphis Managed Care
Vanderbilt	Prudential
Xantus	Preferred Health Partnership

Their TennCare contracts require the MCOs and BHOs to establish and maintain active coordination to ensure continuity and coordination of primary health care and mental health/substance abuse care.

According to the contracts, the BHOs assume responsibility for providing the following services:

- Psychiatric inpatient facility services
- Physician psychiatric inpatient services
- Outpatient mental health services
- Inpatient and outpatient substance abuse treatment services
- Psychiatric pharmacy services and pharmacy-related lab services

- Transportation to covered mental health services
- Mental health case management
- Twenty-four-hour residential treatment
- Housing/residential care
- Specialized outpatient and symptom management
- Specialized crisis services
- Psychiatric rehabilitation services

The contracts further stipulate components of coordination and procedures for resolving disputes. For instance, the coordination of physical and mental health care must include a means for referral which ensures immediate access for emergency care and provisions for treating urgent and routine care in accordance with TennCare guidelines. Coordination must also allow for the transfer of information and maintenance of confidentiality.

Disputes

When disputes arise between the MCO and BHO regarding responsibility for a particular medically necessary covered service, the two organizations must split the cost of the service pending resolution of the dispute to ensure the service will be delivered to the enrollee regardless of who pays. Because the MCO and BHO are jointly responsible for the enrollee, the state will hold each of them accountable for the quality of care the enrollee receives. The contract allows the MCO and BHO to establish, in their coordination agreement, their own procedures for resolving disputes, so long as the enrollee is liable only for applicable co-payments and deductibles and care is not delayed.

If a dispute cannot be resolved, TennCare will decide responsibility after the service has been delivered. The unsuccessful party can appeal the state's decision to a court.

Each MCO and its assigned BHO have established coordination agreements outlining their responsibilities, claims resolution procedures, payment guidelines, etc. Some coordination agreements contain referral guidelines designed to lessen the disruption of services. Under the agreement, the MCO and BHO designate care coordinators to deal with issues as they arise. Care coordinators are to have a list of the other plan's care coordinators and their telephone numbers. In addition, some MCO and BHO agreements established a Claims Coordination Committee composed of representatives from each plan.

In addition to contractual requirements and coordination agreements, TennCare issued a Standard Operating Procedure (SOP) to clarify policy language regarding disputes over responsibility for covered services. SOP 035, issued August 14, 1997, reemphasizes that delivery of medically necessary covered services to TennCare enrollees may not be delayed because of disagreements between the MCO and BHO over responsibility for the service. In addition, an MCO cannot deny a request for prior authorization for a service believed to be the responsibility of the BHO without contacting the BHO, documenting that the BHO agreed to accept responsibility for prior authorization of the service, and linking the requesting provider

with a staff person at the BHO. The same procedure applies to the BHO. Disagreements over responsibility must be documented, and the organization receiving the prior authorization request must assume responsibility for the request and any appeal resulting from denial. The SOP explains that TennCare can assess financial penalties against an MCO or BHO that repeatedly refuses to accept responsibility for services that are later determined to be their responsibility.

Commerce and Insurance Findings

Regardless of efforts to establish and clarify MCO and BHO responsibilities, many MCO and BHO coordination relationships remain problematic. A Department of Commerce and Insurance examination report of Tennessee Behavioral Health (TBH), released July 21, 1997, found that TBH had not implemented a system to coordinate the processing of disputed claims with the MCOs. As a result, many claims with both behavioral health and medical charges were denied by both TBH and its partner MCO, rather than paid to the provider first and settled later. Except for emergency room claims, TBH asserted that it had been paying only for specific mental health diagnostic codes and denying medical charges while the MCOs had been denying the entire claim if both medical and mental health charges were listed.

The report also found problems regarding maximum allowable out-of-pocket expenses to be paid by TennCare enrollees. TBH charged certain participants a co-payment which applied toward that member's maximum annual out-of-pocket expenses, but did not verify the enrollee's accumulated amount with the MCO. Therefore, the out-of-pocket expenses for an enrollee who receives both medical and mental health services could be doubled. According to the report, the MCOs and the BHOs do not have to coordinate these matters.

External Quality Review Organization (EQRO) Findings

The Commerce and Insurance examination report findings are supported by findings of the EQRO 1997 Annual Survey Report for TBH. The External Quality Review Organization, First Mental Health, Inc., reported that TBH's coordination agreements did not address what to do when an enrollee's problems crossed MCO and BHO areas of responsibility. Furthermore, TBH could not provide documentation proving it had evaluated coordination of care between primary care providers and behavioral health providers. First Mental Health based its findings on standards established by the National Committee on Quality Assurance (NCQA).

HCFA Comments

Representatives from the Health Care Financing Administration (HCFA) and the Department of Commerce and Insurance expressed concerns over the effectiveness of MCO/BHO coordination. A HCFA official believed there were problems regarding responsibility for treatment, even though provisions of the waiver require plans to meet periodically to discuss issues. The official asserted that HCFA would look at the issue in the future. Management from the Department of Commerce and Insurance acknowledged that coordination efforts were compounded by contractual difficulties, but that these problems needed to be addressed.

Other Findings

Representatives from MCOs and BHOs made the following points concerning coordination of services. Although some organizations had problems initially, they are now

addressing these problems by either training customer service representatives to refer cases to the appropriate organization or using primary care physicians as the initial point of contact for both medical and mental health services. However, other organizations have not overcome coordination obstacles, such as poor communication and inability to recover funds. One MCO representative expressed concern that enrollees may not be receiving appropriate mental health care follow-up after suicide attempts. Several organizations indicated they do not meet with the BHO regularly.

Regardless of the status of the relationship, most organizations agree that it is difficult to completely “carve out” mental health from medical diagnosis or treatments. Dual-diagnosis drugs seem the biggest problem facing the MCOs and BHOs. Furthermore, MCO representatives stated that TennCare does not provide guidance on how to address these problems outside provisions of the contracts.

Providers in the Tennessee Hospital Association (THA) are affected by MCO/BHO conflicts. According to THA complaints, providers find it difficult to get reimbursed for treating enrollees for overdose, alcohol abuse, or suicide attempts. According to them, the MCO denies the claim because it is the BHO’s responsibility, and the BHO denies the claim because the service was medical. Therefore, the provider does not get paid for reasons of timeliness or lack of prior authorization.

Effect on Quality of Care

MCO/BHO conflicts also affect quality of care. A survey conducted by the Tennessee Alliance for the Mentally Ill (TAMI) attempted to assess the experiences of adult enrollees with serious and persistent mental illness and their relatives. The survey, released June 25, 1997, showed most enrollees were satisfied with the range of services under TennCare but reported trouble getting the MCO to pay for treatment. More important, most respondents had a high rate of physical problems and had difficulty getting medical care for treatment of those problems.

Organizations such as the Urban Institute and the National Committee on Quality Assurance recognize difficulties inherent in coordinating medical and mental health services. In the brief “Questions for States as They Turn to Medicaid Managed Care,” the Urban Institute explains that for states deciding to “carve out” mental health and/or substance abuse services, it is difficult to clearly define a managed-care organization’s contractual obligations and track specific services provided by managed-care organizations. The NCQA asserts that coordination efforts can be strengthened by ensuring that individual practitioners and providers are coordinating a patient’s behavioral and medical care across delivery systems. Also, the state should develop systematic data-sharing processes to facilitate a partnership between a BHO and a MCO on quality initiatives and performance measurement. Furthermore, effective coordination of behavioral and medical care requires both partners to be held at the same level of accountability.

Officials in the Department of Health and the Bureau of TennCare realize coordination could be better and acknowledge it is difficult to separate some diagnoses and treatments. They offered several explanations for the lack of coordination:

- TennCare has not created the best method for ensuring enrollees do not slip through the cracks while the MCO and BHO determine responsibility.

- The coordination agreements are vague.
- MCOs and BHOs do not work closely enough together.
- “Carving out” was a mistake.
- Coordination is monitored through complaints.

The goal of coordinating medical and mental health services is to ensure TennCare enrollees have access to a full range of services. The current state of MCO/BHO coordination cannot ensure such access, however.

Recommendation

The Bureau of TennCare should strengthen its monitoring of MCO/BHO coordination. TennCare should provide guidance and assistance to facilitate effective coordination and communication. TennCare should consider reevaluating the contracts to clarify language and address problems.

Management’s Comment

We concur in part. TennCare has provided structures for the coordination agreements and has also issued several TSOPs on MCO/BHO coordination; however, as the performance audit points out, this has been a difficult area. We expect to see some streamlining of activity now that Premier and TBH have merged and there is essentially one BHO to coordinate with all the MCOs. Because the new combined BHO is following Premier’s policy of not requiring cost sharing on the part of enrollees, the specific issue of coordinating out-of-pocket expenses is now moot, as are other issues cited in this finding which refer specifically to TBH policies and procedures.

TennCare took over the BHO pharmacy program on July 1, 1998. Considerable efforts have been underway since then to work on pharmacy coordination issues between the MCOs and the BHOs.

We intend to improve the MCO/BHO coordination process in the future by strengthening our monitoring efforts and developing additional guidance and assistance activities. We will consider reevaluating our contracts to clarify language and address problems.

10. MCOs and BHOs have not made sufficient effort to detect fraud and abuse

Finding

The MCOs and the BHOs do not have sufficient measures in place to detect and report provider or recipient fraud and abuse. Although the waiver assigns joint responsibility to the MCOs, BHOs, and TennCare for the detection of provider fraud and abuse and their contract requires the MCOs and the BHOs to report fraud to the Tennessee Bureau of Investigation (TBI) and the Program Integrity Unit (PIU) of the Department of Health's Audit and Investigations Division, only four of the 11 MCOs/BHOs have fraud policies and detection units in place.

Failing to detect fraud and abuse could adversely affect the TennCare Program by reducing the funds available for legitimate services. According to figures from the Department of Justice, 10% of all health care costs are potentials for fraud. The TBI estimates that Tennessee's Medicaid Program, now TennCare, has incurred, since the early 1990s, fraud totaling around \$20 million. Twenty-seven provider fraud cases have been opened since January 1, 1994. These incidents of fraud include, but are not limited to, the following:

Provider Fraud

- Submitting fraudulent provider bills to the MCOs/BHOs
- Billing for unnecessary medical services
- Billing for services not rendered
- Using incorrect TennCare marketing techniques
- Enrolling nonexistent patients
- Enrolling ineligible persons (e.g., prison inmates)

One of the more interesting cases involved enrolling Saturn plant employees who were insured by Saturn. The Saturn employees (as well as Saturn officials) were unaware they had been enrolled and simply threw their TennCare cards away thinking that they were mailed to them by mistake.

Recipient Fraud

- Failing to report correct income or access to other types of income
- Selling their prescription drugs
- Receiving TennCare benefits while residing in another state
- Selling their TennCare card to an individual for unauthorized usage

TBI and PIU management strongly believe that fraudulent activities are taking place and that either the MCOs/BHOs have failed to detect and report fraud or they do not have adequate measures in place to detect fraud. The majority of provider fraud referrals come from four organizations that appear to have measures in place to effectively monitor, detect, and report fraudulent activities—Volunteer State Health Plan (VSHP), Preferred Health Partnership (PHP),

Premier, and Tennessee Behavioral Health (TBH). However, as of November 20, 1998, all of the positions in the two BHOs' fraud units were vacant.

Not having a fraud unit in place could by its very absence encourage fraud:

- If providers know an MCO/BHO is not checking for fraud, they may break or bend the rules because there is no apparent deterrent.
- Without further investigation, it is often difficult to distinguish between errors and intentional acts.

There are mechanisms to aid the MCOs and BHOs in setting up and maintaining a fraud unit, but not all organizations have taken advantage of these opportunities. The TBI offers an annual fraud seminar, three annual conferences, quarterly roundtable meetings, and one-on-one assistance. There are guidelines detailing the composition of a fraud unit and performance measures. All that seems lacking is an incentive for the MCOs and BHOs to proceed.

The reference to fraud in the waiver and in the contract reflects the inevitability of fraud in large and complex programs, such as TennCare. Assigning the MCOs and BHOs responsibility for detecting fraud implies the institution of aggressive actions to fulfill that responsibility.

Recommendation

TennCare needs to ensure that the MCOs and BHOs have a means in place to detect and report provider or recipient fraud and abuse to the TBI and the PIU. TennCare should consider amending its contract with the MCOs and BHOs to require the establishment of fraud units.

TennCare may want to consider delegating some of its monitoring and oversight functions to the PIU.

TennCare could provide additional oversight by encouraging designated MCO/BHO management/representatives to regularly attend and participate in TBI's fraud training, seminars, and meetings. TennCare may want to work with the VSHP and/or the Magellan fraud units to develop a model for the other MCOs/BHOs.

Management's Comment

We concur in part, although we have some reservations about the finding. First, the finding makes an assumption that waste at the MCO or BHO level results in higher costs to the State. This is not necessarily true, since the contracts with the MCOs and BHOs are "risk contracts" in which the State's financial liability is a fixed amount per enrollee per month without regard to the amount expended by the MCO and/or BHO for the care of the enrollee. In other words, if the MCO or BHO allows fraud or abuse to take place, the extra expense is the burden of the MCO/BHO since they must maintain contractually and/or statutorily required minimum net worth requirements. However, fraud and abuse at the MCO/BHO level are

certainly undesirable since dollars spent by the MCO/BHO on fraud and abuse could reduce the program dollars they have available to spend on services and could also artificially inflate their operating costs. Also, fraud and abuse can lead to upward pressures on capitation rates, ultimately causing greater cost to the State.

Until we can get some idea of the scope of fraud and abuse, we cannot determine that requiring MCOs and BHOs to establish and fund comprehensive fraud detection and reporting processes is the most efficient way of dealing with this issue. The TBI and the PIU have investigative authority over matters involving fraud and abuse and have access through the TennCare database to essentially the same provider and claims information that the MCOs and BHOs possess. We would suggest that these existing mechanisms be used to detect and report on fraud and abuse, rather than requiring the MCOs/BHOs to establish costly new arrangements which would divert TennCare funds from direct services. However, if it can be documented that a significant fraud and abuse problem exists and such arrangements are required, new funds will be needed for the TennCare Program.

The issue of fraudulent enrollment of persons in TennCare, particularly the employees at Saturn and the prison inmates, should be clarified. This problem occurred at the beginning of the program, with a single MCO plan using independent marketing agents, when the State's eligibility verification system lacked a validation process for social security numbers. As soon as the problem was identified, the TennCare contracts were revised to prohibit the use of independent marketing agents, and the capitation payments made in error to the MCO in question were recovered. This situation illustrates the kind of problem that would not likely have been reported to the Bureau by the MCO involved even if that MCO had had a fraud and abuse detection and investigation unit as recommended by the performance audit.

We agree with the recommendation that TennCare should encourage designated MCO/BHO management/representatives to regularly attend and participate in TBI's fraud training, seminars, and meetings. We will adopt this recommendation.

11. TennCare Partners does not provide a complete continuum of care for enrollees with substance abuse problems

Finding

The TennCare Partners Program is not providing a full-range of alcohol and drug treatment services. Under the state's contract with the BHOs, substance abuse benefits are limited to inpatient hospital and outpatient substance abuse treatment. Residential treatment, such as social-setting detoxification and counseling, is not covered under the contract. However, according to provider groups, only about 10% of substance abusers need medical detoxification—the other 90% benefit more from other services, including those provided by residential treatment facilities.

The BHO contract does state that services in a licensed substance abuse residential treatment facility may be substituted for inpatient substance abuse services “when medically appropriate.” According to Department of Health management, residential treatment may be covered if the BHO determines that service to be a “cost-effective alternative” to inpatient hospital services. However, it is not clear exactly how medical appropriateness or cost-effectiveness is to be determined. According to a late 1997 survey compiled by the Tennessee Alcohol and Drug Association, residential treatment approvals by BHOs had decreased nearly 91% since TennCare Partners began. Provider groups and staff in the department’s Bureau of Alcohol and Drug Abuse Services raised concerns that by focusing on a medical model rather than the clinical model described in the American Society of Addictive Medicine (ASAM) guidelines, the TennCare Partners Program may be ignoring the environmental, emotional, and social conditions that affect addiction.

Under the Phase III improvements to the TennCare Partners Program (scheduled to be implemented after July 1, 1999), adults requiring residential treatment services would receive those services through the block grant program administered by the Department of Health’s Bureau of Alcohol and Drug Abuse Services. This shift of services is intended to fill the void in TennCare’s continuum of care, but it is questionable whether there are enough financial resources in the block grant program to absorb the possible infusion of an estimated 120,000 more people (according to the Director of Quality Development). Bureau of Alcohol and Drug Abuse Services staff expressed concerns about the move to bring more people into a program that is currently having difficulty meeting the needs of its own clientele because of funding and provider network constraints. Also, the absence of a clear channel of communication between TennCare and the block grant program could lead to further disruption in a patient’s continuum of care. Although the intent is to provide for a complete framework of care for substance abuse enrollees, relying on the block grant program may not be the best way to provide these services.

Recommendation

TennCare should determine (and consider requesting) the additional funding necessary to add residential treatment services to the substance abuse benefits covered in the BHOs’ contract. If residential treatment is to be provided by the block grant program, the Department of Health must facilitate improved communication between the Bureau of TennCare and the Bureau of Alcohol and Drug Abuse Services to ensure the continuum of care is not disrupted. The Department of Health must also guarantee that the quality of care available to block grant recipients will not be compromised as a result of the infusion of TennCare participants. The department’s ability to pay for residential treatment for both populations under the block grant program should be confirmed before final implementation.

Management’s Comment

We concur. The TennCare Partners Program was neither intended nor designed to provide a complete continuum of care for enrollees with substance abuse problems.

Residential treatment for substance abuse problems is not identified in the State's contract with the BHOs as a covered service, except when these programs are determined by the BHO to be cost-effective alternatives to inpatient hospital services. The substance abuse benefits included in TennCare Partners are the same benefits that were covered under the Medicaid Program prior to TennCare, although with some differences in limitations. Residential treatment for substance abuse problems was not covered at all under Medicaid prior to TennCare.

The TennCare Partners Program includes only two distinct substance abuse benefits: inpatient hospital substance abuse treatment and outpatient substance abuse treatment. It does not include coverage for the continuum of services that may be desirable between these two benefits. Requiring additional benefits will require additional funding.

12. Case management services have not been offered and provided as required

Finding

The TennCare Partners Program has not ensured that all enrollees suffering from serious mental health problems have access to case management services within seven days of their discharge from care, although the behavioral health organizations (BHOs) are required by their contract to offer this service. For the first eight months of 1998, Tennessee Behavioral Health (TBH) providers discharged 4,219 clients, of whom only 605 (14.3%) received or were offered case management services within seven days of their release. Likewise, providers aligned with Premier released 4,003 clients, of whom 719 (18%) actually received case management services within the seven days. Although the BHOs eventually increased their offering of such services during calendar year 1998, failure to provide comprehensive post-discharge treatment to a highly vulnerable population could result in the return to institutionalized care for persons afflicted with serious mental disorders.

The ultimate goals of case management are to increase service coordination and continuity of care in order to provide more effective treatment and improved outcomes, with a corresponding decrease in the utilization of more restrictive and costly services. To achieve these goals, case managers provide services such as assessment, mental health service planning, daily living assistance, linkage/referral/advocacy, crisis assistance, and independent living supports.

In April 1998, the Bureau of TennCare published a case management survey which showed a wide range in the number of case managers across the community mental health centers (CMHCs), as well as large differences in the number of cases each case manager oversees. The 28 CMHCs employed 503 case managers, ranging from 77 at one center to only one at another center. For children, there were 128 case managers whose average case load ranged from a low of 10 to a high of 104. For both children and adults, the case loads varied significantly across centers. For example, one CMHC had an average case load of 16, while another agency had an average case load of 97. Even allowing for considerable differences in the number of clients the 28 CMHCs serve, such wide variations in the number of case managers

and their average case loads indicate possible weaknesses in case management assignment and monitoring by TennCare and/or the BHOs. According to the BHO contract, the acceptable case load for adults is one to 30 and for children is one to 20.

The contract governing the relationship between the Bureau of TennCare and the two BHOs—Tennessee Behavioral Health (TBH) and Premier—requires that each severely and/or persistently mentally ill or seriously emotionally disturbed (SPMI/SED) patient be offered case management within seven days of release from care. When capitation payments are made to the BHOs each month, 10% is automatically withheld pending the bureau's review of the BHO's compliance with contract provisions. Pursuant to the contract, any amounts withheld for 180 consecutive days are to be permanently withheld. Accordingly, in August 1998, the bureau permanently retained "withholds"—10% of the BHOs' total reimbursable costs for administrative expenses—for January 1998 for failure to attain the case management goals. For TBH, the withhold totaled \$1,113,593 and for Premier, \$1,592,805. In September 1998, when the BHOs had demonstrated no progress, the bureau once again enacted a permanent withhold—this time for February 1998. This second withhold totaled \$1,095,392 for TBH and \$1,612,027 for Premier. (Actually, the BHOs forfeited little or no money because they in turn withheld money from the providers for not providing the required services. This action prompted complaints from the providers who were then, with HCFA's knowledge, reimbursed by TennCare.)

The decision to permanently withhold funds from the BHOs was based on the following events: An external quality review organization study by First Mental Health revealed numerous deficiencies in the provision of case management services. The report, completed in August 1998, sought to assess the quality of mental health services TennCare enrollees received during the first year of the Partners program. First Mental Health based its chief conclusions on a review of the medical records of 248 enrollees hospitalized for mental health disorders between July 1, 1996, and February 1, 1997—the initial eight months of the TennCare Partners program. As a result of this study, the bureau began in January 1998 requiring each BHO to submit a report identifying all enrollees released from inpatient facilities during the previous month. An analysis of these reports revealed that from January to June 1998 less than 20% of clients discharged received case management services in a timely manner. Overall, only 61% of the clients in the EQRO sample of medical records were provided case management services, even though case management was required to be offered to all.

The EQRO report also found that in approximately one-third of the cases reviewed, there was no evidence that the clients' concerns were sought in treatment planning or that a case manager was involved in the planning. The report indicated that a large number of clients already had case managers assigned prior to hospitalization. According to the report, this finding could indicate either that case managers are burdened by large caseloads or that they are not notified when clients are admitted to the hospital. Also, less than half (45%) of the clients in the sample received case management services prior to the inpatient hospitalization, and 61% had to wait until after their discharge. These findings and others convinced the EQRO team that although many of these clients were eligible for case management services upon their discharge, many did not receive it.

Perhaps the most important finding was that coordination of case management services in a community setting apparently increases the likelihood that the recipients of these services will not return to inpatient treatment. Utilization of all types of mental health services decreased when paired with case management subsequent to a patient's release from an institutional setting. The EQRO discovered a dramatic difference between the number of episodes of care before admission as compared to those after discharge. Therefore, the study concluded that decreased service usage following discharge was at least in part a result of intensive case management services.

After the second permanent withhold, the bureau and the BHOs negotiated an agreement in which the BHOs would steadily increase the percentage of their clients receiving case management—50% for September; 65% for October; 80% for November; and 90% for December. If the BHOs met September's target, the bureau would release the March through September withholds. The BHOs met this target, and the bureau released nearly \$19.5 million.

Recommendation

The Bureau of TennCare should require the BHOs to steadily increase the percentage of clients offered case management as set forth in the agreement. If the BHOs do not meet these targets, the bureau should once again permanently withhold funds.

Management's Comment

We concur, although it should be pointed out that TennCare does not require that case management services be offered and provided to all TennCare Partners program participants. We currently require only that these services be offered to persons who have been identified as CRG 1 or 2 or TPG 2 and to persons identified as CRG 3 as clinically indicated.

Delivery of mental health case management services has been an area of significant effort during the past year, as the performance audit documents. We plan to continue our intensive monitoring of this service.

In response to concerns expressed by advocates, consumers, and providers that our mental health case management guidelines are too broad, we organized a Mental Health Case Management Committee last spring which met through the summer and early fall to draw up new and more meaningful guidelines for case management services to adults and to children and adolescents. These new guidelines, which we expect to incorporate in our next BHO contract amendment, will change the requirements regarding delivery of mental health case management services. Identification of who needs mental health case management services will be based much more on the individual's functional impairments and life circumstances. For example, children to be targeted for the service will be those who have been identified as SED and who are in out-of-home placements or at imminent risk of out-of-home placements and/or who are exhibiting multiple needs which require services from more than one agency. We believe that

this refocusing of the guidelines will be helpful in assuring that mental health case management services are delivered to those most in need of them.

13. The TennCare Partners Program lacks a well-defined set of performance measures and a focus on program outcomes

Finding

Without a defined set of performance measures, it is difficult for the external quality review organization (EQRO), advocacy groups, HCFA, and the bureau's quality improvement unit to adequately monitor the outcomes of the TennCare Partners Program and, thus, to determine the program's overall effectiveness.

The waiver extension request the Department of Health submitted to HCFA mentions the utility of performance measures in program monitoring: "These measures should not only assist in focusing the efforts of the BHOs, providers, and state quality improvement staff, but should facilitate the development of meaningful report cards and guide the direction of ongoing quality monitoring activities. These indicators cover areas such as administrative performance, access to care, quality of services, and health outcomes and will serve as the foundation for all quality improvement measures." For each measure, appropriate benchmarks are to be established.

The original contract between TennCare and the BHOs contained more than 130 performance measures the BHOs were to report. Because of concerns that this number of measures was unmanageable, a group consisting of providers, advocates, and staff from the bureau, the Department of Health, the BHOs, and the EQRO created an interim list of 20 key performance measures. However, this list was never finalized, and no standards or benchmarks were developed. (The contract still requires the BHOs to use the original set of performance measures.) During 1998, the department created a technical advisory group that is using the interim list of measures (as well as a list prepared by the Mercer consulting group) to develop a manageable list of measures and benchmarks to monitor BHO and provider performance. The group has also been asked to create measures for areas not previously addressed, such as alcohol and drug issues and children's services.

Both the EQRO and the bureau's quality improvement unit monitor the activities of the BHOs and providers and identify program deficiencies and areas of noncompliance with contracts or industry standards. These monitoring activities include reviews of organizational structure and service-delivery processes, as well as reviews of enrollees' medical records and encounter data detailing services provided. However, although issues that can directly or indirectly affect quality of care are monitored, the effectiveness of the monitoring is limited somewhat by the lack of well-defined performance measures and benchmarks and the failure to measure actual outcomes. Adequate and efficient delivery of care is extremely important, but a program cannot be considered truly effective unless the enrollees' health/mental health improves as a result.

The bureau has taken a first step in assessing program outcomes by contracting with the University of Tennessee for a “cohort” study that will follow a sample of enrollees through treatment. The actual study has not yet begun—participants will be chosen in January or February 1999.

Recommendation

The TennCare Bureau should continue to work with the technical advisory group to develop a comprehensive, but manageable, set of well-defined performance measures and benchmarks. These measures and benchmarks should include health outcome indicators, as well as access, quality of care, and other service delivery indicators. The bureau and the EQRO, as well as other monitoring groups, should then include an assessment of outcome measures as part of their monitoring activities.

Management’s Comment

We concur. Last fall a Quality Management Technical Advisory Group (QM TAG) was appointed, with its initial task being to redefine the performance measures for TennCare Partners and to focus on program outcomes. Members of the TAG include representatives of TennCare and other State agencies, advocates, consumers, and providers. Consultants from William M. Mercer and Company have been working with the QM TAG to develop its recommendations, and a new staff person has been hired at TennCare to facilitate this activity. We expect these steps to be successful in addressing this finding.

14. The management structure of TennCare’s two behavioral health organizations raises questions about a lack of competitiveness and increased vulnerability for the state

Finding

Magellan Behavioral Health Services essentially manages both of the behavioral health organizations (BHOs) that contract with TennCare for mental health services. Magellan owns 50% of one BHO and is in the process of acquiring 100% of the other BHO. This arrangement may limit TennCare’s ability to promote cost savings through competitiveness in provision of services. Also, it could potentially leave the state vulnerable if the company were to drop out of the TennCare program.

The TennCare program, when designed, emphasized multiple MCOs across the state. According to the HCFA waiver application, capitation rates would be developed in a manner that would foster competition among the MCOs. As TennCare was expanded to incorporate mental health services, the TennCare Partners Program was created with the same basic premise of fostering competition among the BHOs.

Initially five BHOs qualified for the TennCare Partners Program, and the original intent was to contract with all of them. Enrollees were to be assigned so that all BHOs would have comparable numbers of enrollees in the different treatment categories. However, the state was concerned that a larger number of BHOs would lead to higher than necessary administrative expenses and confusion in coordinating the working agreements between the MCOs and BHOs. A decision was made to contract with only two BHOs, and the qualifying BHOs were encouraged to form coalitions among themselves. As a result, Premier and Tennessee Behavioral Health (TBH) became the two BHOs operating under the TennCare Partners Program.

The same company, Magellan Behavioral Health Services, essentially manages both BHOs. Magellan owns 50% of Premier in a joint venture with Columbia Behavioral Health. Tennessee Behavioral Health (TBH) is owned by Preferred Health Partnership (PHP), which has an arrangement with Merit Behavioral Care to manage TBH. In 1997, Magellan purchased Merit. Thus, Magellan is managing TBH and Premier. In fact, the same person manages both BHOs.

In July 1998, Magellan formally notified the Department of Commerce and Insurance of its desire to purchase Preferred Health Partnership. According to Department of Health management, Magellan had already received federal antitrust authorization for the purchase. After reviewing the proposal, Commerce and Insurance was prepared to issue approval. However, on December 15, 1998, the department received notice from the state Attorney General's office indicating it had concerns regarding the proposal.

The Attorney General's Antitrust Division was concerned that if the sale were approved, one company would basically be operating the mental health side of TennCare. Such a situation could constitute a monopoly and possibly violate antitrust laws in that it could create an anti-competitive business environment. Attorneys with the division were concerned the purchase could create a situation in which the company would have unfair leverage over the state regarding payments and coverage. As of December 29, 1998, the Attorney General's Office was awaiting documentation from the department's general counsel regarding the financial condition of the companies involved. After learning of the Attorney General's concerns, Commerce and Insurance put a hold on approval until the issues were settled.

Management in the Departments of Health and Commerce and Insurance believe there are advantages (such as consistency in claims administration) in using one company to run all behavioral health services. Both BHOs use the same claim forms and have the same contact persons, thus reducing the administrative problems that would result from multiple procedures and forms. In addition, the Department of Health is confident its contingency plan would adequately address any potential network deficiencies if Magellan were to drop out of the program—the state would administer the program on a fee-for-service basis for an interim period, until another contractor was ready to take over. The BHOs are required by contract to notify the state within six months of the new contract year if they will not be participating in the TennCare program.

Recommendation

The Bureau of TennCare should coordinate an assessment of the current ownership and management relationship of the BHOs to ensure that adequate competition exists and that enrollees would not be adversely affected if Magellan withdrew from the TennCare Partners Program.

Management's Comment

We concur in part. A de facto single provider does put the State in a poor negotiating position and at some degree of risk. Until the kinks are ironed out in the current Partners Program, we are dependent on the single provider.

The State has had a number of organizations that have expressed interest in participating in the TennCare Partners Program as a behavioral health organization. If additional competition is needed, the process could be reopened and a Request for Proposals could be issued.

The State prepared an emergency transition plan almost two years ago when the loss of one of the current BHOs seemed imminent. Therefore, if the State is forced to deal with the current BHO deciding not to participate or with the need to replace the current BHO, the transition to another plan or to the State could be made effectively and without harm to enrollees.

On the other hand, the Partners Program has realized some benefits from the joint management of the two BHOs. Both BHOs now have standardized their claims processing operation and many of their guidelines and practices. This has been a significant improvement from a provider perspective and from a State management view. The ease of working with a single management entity has enabled the State and the BHOs to more readily work through some of the operational issues in the program. Likewise, providers have had to work out their issues with a single entity and devise a single solution for their problems. Also, as noted in the response to Finding 9, coordination between the BHOs and the MCOs has been better as a result of having a single managing entity for the two BHOs.

15. The Fiscal Division does not sufficiently monitor vendor contracts to ensure satisfactory compliance with contract requirements

Finding

TennCare's Fiscal Division is responsible for processing and administering all bureau contracts, except the MCO and BHO contracts that are handled by the Division of Contract Development and Compliance. As of October 19, 1998, the Fiscal Division was administering 34 service contracts totaling over \$400 million—contract amounts for fiscal year 1999 alone totaled \$220 million. Major contracts include those with Children's Services (\$262 million over

two years) for services related to children in state custody, Electronic Data Services (\$46.5 million over five years) for administering TCMIS, and Human Services (\$28 million) for eligibility determination. Most of the other contracts are for studies, such as the surveys conducted by the University of Tennessee and the actuarial study of BHO rates that William M. Mercer, Inc., is performing.

The Fiscal Division has no policies addressing contract monitoring or actions to be taken when vendors fail to comply with contract provisions, although division management stated that some individual contracts are written to include monitoring requirements and penalties for noncompliance. TennCare can choose not to renew the contract of a vendor that does not comply with its contract. However, without adequate monitoring, the division has no basis on which to make such decisions. In fact, management stated that in no instances had contracts administered by the Fiscal Division not been renewed or penalties assessed.

Insufficient monitoring can have negative consequences. According to the Financial and Compliance audit of the Department of Health for the year ended June 30, 1997, TennCare did not adequately monitor the Department of Children's Services' TennCare-related activities. One result of this deficient monitoring was that TennCare inadvertently misused federal funds because it was unaware that Children's Services was billing for the health care costs of incarcerated children who are not eligible for Medicaid (TennCare).

In another example, monitoring has been performed but no action taken when contract noncompliance was cited. The bureau's five-year, \$46.5 million contract with Electronic Data Services (EDS) to operate and maintain the TennCare Management Information System (TCMIS) is monitored by the department's Audit and Investigations Division. This division performs testwork quarterly to determine if EDS is complying with contract terms such as processing applications timely and accurately, providing enrollment changes to MCOs timely, sending TennCare premium statements in accordance with guidelines, and promptly posting premium payments to enrollee accounts. The review of August 1, 1997, through December 31, 1997, revealed discrepancies in each of these areas. Although the contract allows for penalties for noncompliance, no actions were taken against EDS.

TennCare management admitted to weaknesses in the division's monitoring of contracts and stated that the division is developing relevant policies. As of December 1998, these policies had not been formalized or approved; however, management anticipates that a contract monitoring process will be implemented by June 1999.

Recommendation

The Fiscal Division should develop policies and procedures for monitoring vendor contracts and use these policies to ensure vendors comply with all contract terms. Penalties should be assessed, or other actions taken, against vendors who continually fail to comply.

Management's Comment

We concur. The Bureau has taken steps to improve contract monitoring. Invoices and expenditure reports are reviewed. The Bureau has included applicable contracts in the Department of Health's Policy 22 plan. This plan prioritizes contracts to be monitored by risk of noncompliance. This plan will be incorporated into a statewide plan which will be coordinated by the Department of Finance and Administration's Office of Resource Development and Support. Additionally, this Bureau has contracted with the Office of Resource Development and Support to monitor the contract the Bureau has with the Department of Children's Services. With respect to the performance monitoring of EDS, the Bureau reviews the reports and discusses issues noted with EDS and plans to assess penalties when the Bureau feels they are appropriate. The Bureau will develop written monitoring policies and procedures.

16. The submission of encounter data is still problematic

Finding

Despite significant improvements in the timeliness of submission and the quality of encounter data, considerable problems still plague the MCOs' and BHOs' submission of encounter data.

Encounter data detail services provided to managed-care patients and enable TennCare staff and others to evaluate the impact of the program on enrollees. Before the creation of TennCare, a record of all services was generated because each service provided was paid through a claims payment system. Under a managed-care program such as TennCare, however, a capitation payment covers all services provided to the enrollee, and there is no longer an automatic mechanism for generating (at the state level) a record of services provided.

The contracts between TennCare and the managed-care organizations require the MCOs and BHOs to submit encounter data to the bureau. Under the special terms and conditions of the TennCare waiver, the bureau is required to use the data to study clinical and health outcomes. TennCare, in turn, is required to forward the data to the Health Care Financing Administration (HCFA) which uses the encounter data to monitor the program's access and quality of care.

HCFA personnel responsible for monitoring TennCare stated that during the initial months, TennCare submitted no data and that once TennCare began sending data, the submissions were late. HCFA did note that TennCare had taken steps to improve data submission.

As part of the monitoring process, HCFA contracted in September 1994 with Mathematica Policy Research, a public-policy research company, to evaluate the TennCare program. According to the company's vice-president in charge of these evaluations, Tennessee produces more sophisticated data than most other states and is the only one of the five states

Mathematica is evaluating (Hawaii, Maryland, Oklahoma, and Rhode Island) that has encounter data.

Mathematica evaluated the quality of TennCare encounter data to ensure the data was adequate to analyze the program's effects on enrollees. (The evaluation included comparing pre-TennCare Medicaid data and similar data from the TennCare program.) Based on this evaluation, Mathematica concluded that TennCare's 1996 encounter data were adequate overall for their analysis.

Although Mathematica staff were able to obtain needed data from TennCare, they noted that they are Medicaid data experts who know what questions to ask, facilitating the special computer programs that usually have to be written to obtain the desired information from the extremely large data files. (Mathematica's requests may also have been given priority because the company was evaluating TennCare at HCFA's request.) In addition, information requests are often not as simple as they appear. For example, AIDS is often incorrectly diagnosed or reported; therefore, other diagnoses and services must be identified and analyzed to attempt to determine the actual number of AIDS patients.

Although Mathematica reports the ready availability of data, concerns expressed by HCFA and the company contracted to perform actuarial analysis, along with the number of data-related deficiencies cited, indicate continuing problems.

HCFA is concerned with the validity of the encounter data submitted and believes TennCare does not test enough records to reach a satisfactory level of assurance about the accuracy of the data.

TennCare contracted with William M. Mercer, Inc., in January 1998 to analyze the capitation rate payments to BHOs and the subsequent payments to providers. Actuarial consultants who worked on the study indicated problems obtaining quality encounter data. According to the consultants, Mercer initially wanted to look at fee-for-service data. Because this information was dated, the consultants chose instead to review encounter data, specifically inpatient data and community mental health center encounter data, but determined the data to be "unusable because it was incomplete and inaccurate." The consultants concluded there was gross underreporting of encounters. Eventually it took Mercer two months to accumulate the data using Department of Health data, which led to delays in completion of the study.

Despite TennCare management's belief that data submission has improved, records of MCO and BHO withholds indicate otherwise. (See page 66 for explanation of withholds.) For the one-year period November 1997 to October 1998, withholds were taken each month against at least one managed-care organization for deficiencies in the submission of encounter data. Both BHOs were penalized more consistently, primarily for failure to reduce backlogs. TBH was issued a withhold each of the 12 months, and Premier received a withhold in six of the 12 months.

According to TennCare management, annual medical record reviews are the primary source of encounter data testing for the bureau. Perhaps, annual reviews are not frequent enough to provide assurance on the reliability of the data.

Recommendation

TennCare should continue to monitor and enforce the timely submission of encounter data. Also, the bureau should improve the validity testing of data submitted to ensure accuracy by increasing the number of enrollee medical records reviewed.

Management's Comment

We concur in part. A few clarifications to the finding are necessary:

- The Bureau of TennCare provides data routinely not only to Mathematica, but also to Vanderbilt University via a contract with the Vanderbilt Department of Preventive Medicine.
- Although William M. Mercer initially had trouble with BHO encounter data, the inpatient data were used in the actuarial study. It is important to note that the timeframe of these data was comparable to the early years of MCO data, which would indicate that the BHO data is developing more quickly than MCO data.

It is the intent of the Bureau of TennCare to continue all forms of encounter data validity to include matching MCO and BHO self-reported data to reports run against encounters, developing health outcomes reports, and front-end data validation edits and volume checking. Checking medical records against encounters will continue; however, since this is very labor intensive and costly, it will be necessary for an increase in TennCare administrative funding.

17. The bureau does not have a conflict-of-interest policy for persons who make or give advice on decisions concerning drug formularies

Finding

The Bureau of TennCare does not have a conflict-of-interest policy that requires members of various formulary committees and boards to periodically submit statements disclosing potential personal and professional conflicts of interest. The bureau also has not developed procedures describing how and under what situations committee members should recuse themselves from participation in formulary decisions for which they may have a potential conflict of interest.

Pursuant to Title 71, Chapter 1, Part 4 of *Tennessee Code Annotated*, the bureau created the Pharmacy and Therapeutics Committee to make drug formulary decisions and the Pharmaceutical Care Advisory Board to advise the bureau on drug formulary issues and to assist the MCOs and BHOs in developing and managing their formularies. By law, neither committee nor board members may have any business-related conflicts of interest; committee members also cannot be employees of the state, managed-care or behavioral health organizations (MCOs/BHOs), or the pharmacy benefit managers responsible for the current formularies. Board members cannot be government employees.

In addition, the MCOs and BHOs must establish committees to advise their organizations on the development and management of the drug formularies. Through these committees, whose membership TennCare reviews and approves, the MCOs and BHOs retain initial decision-making authority concerning additions to or deletions from the formularies. (TennCare's Pharmacy and Therapeutics Committee makes the final formulary decisions.) Members of these committees may not be owners of MCOs, BHOs, or pharmacy benefit managers.

Conflict-of-interest disclosures are intended to help ensure that the interests of enrollees and the general public are protected and that committee and board members are independent when making drug formulary decisions. No statute requires written disclosure, and nothing came to our attention during this audit to indicate that committee or board members were influenced by personal or professional conflicts of interest. However, without a means of identifying potential conflicts and discussing and resolving them before they have an impact on decisions, committee and board members could be subject to questions concerning their impartiality and independence.

Recommendation

The bureau should develop and implement a formal, written policy on conflicts of interest. The policy should specify the types of situations that would be considered a conflict, the process for documenting such a conflict, and the resulting actions to be taken. Committee and board members for the bureau, the MCOs, and BHOs should be required to update disclosure statements periodically and whenever a change in financial or personal interests occurs.

Management's Comment

We concur. The TennCare Contractor Risk Agreement addresses issues relating to conflicts of interest, but it may be too broadly applied to fully encompass some concerns specific to drug formularies. We will develop and implement a formal written policy on conflicts of interest.

Long-Term Care

Long-term care was not included in the TennCare waiver. The Medicaid program, however, continues as the primary source for the provision of long-term care in Tennessee. The reimbursed options for long-term care include nursing homes available statewide and home- and community-based services waivers in selected areas. These options are available to enrollees who meet Medicaid medical and financial criteria.

18. Home-based, long-term care for TennCare enrollees is severely limited

Finding

TennCare does not adequately address the needs of Tennessee's elderly and disabled citizens who require assisted-living services. With the exception of Shelby, Davidson, Knox, and Hamilton Counties, TennCare does not pay for assisted-care services in the home for enrollees requiring long-term care. Moreover, services in those counties are limited to a relatively small population—400 in Shelby County and 50 in each of the remaining counties.

Services in these counties are provided under two home- and community-based waiver programs. The Shelby County waiver program offers case management, personal care, homemaker chores, home-delivered meals, personal emergency response systems, and minor home modification services. The second waiver program provides similar services, with the exception of homemaker chores, for Davidson, Knox, and Hamilton Counties.

Enrollees residing outside the four largest counties have the option of entering a nursing home or remaining in the home and applying for non-TennCare assistance, such as homemaker services or meals on wheels. If this assistance is unavailable, cost of care is generally left to the families.

In an apparent effort to limit program population and thus restrict program costs, TennCare did not offer the waiver option to rural counties. Although management cited concerns about finding providers in rural areas to meet service needs and demands, neither TennCare nor the Department of Health has assessed the level of demand in these areas.

TennCare's actions are not contrary to federal regulations. Section 1915 (c) of the Social Security Act, provides that states, with the approval of the Health Care Financing Administration (HCFA), may offer home- and community-based care waivers as an alternative to nursing home care either statewide or to selected segments of the population. States do not have to provide services to the total population. According to HCFA management, this option is intended to provide states flexibility to design a program based on each state's plan and the needs of the clients.

All states offer waivers for alternative care for nursing-home-eligible enrollees under their Medicaid managed-care program. There are currently 460 waivers nationally. Other states

in the region have larger home- and community-based waiver programs than Tennessee's (550 slots and annual program funding of \$3,354,500).

<u>State</u>	<u>Enrollees</u>	<u>Program Cost</u>
Alabama	6,455	\$32,275,700
Arkansas	7,681	\$20,129,200
Georgia	12,810	\$42,433,100
Kentucky	11,500	\$28,911,000
North Carolina	8,700	\$112,744,600
South Carolina	8,754	\$39,616,800
Tennessee	550	\$3,354,500

It would appear that the need in Tennessee for long-term, assisted-care services far exceeds the 550 slots available. According to a General Accounting Office report, approximately 4.6% of the population nationwide is disabled and in need of assisted care. Given that Tennessee's demographics approximate national averages, projections identify the following populations of disabled in Tennessee: 7,191 children under 18; 95,870 of working age; and 136,615 over 65 years of age. For the elderly population, the most common causes for long-term care are arthritis, heart disease, and Alzheimer's disease. According to the department, some form of Alzheimer's may affect five of seven Tennesseans over 65.

Advocacy groups have complained about the lack of options for elderly and disabled Tennesseans. For example, representatives for the American Disabled for Attendant Programs Today (ADAPT) complained that the current home- and community-based waiver program offers care to too few people. TennCare management has been aware that advocates are demanding provision of alternative care services in all areas of the state.

Recognizing the state's existing system of long-term care as "a patchwork of services," the General Assembly in 1998 passed legislation requiring the development of a comprehensive long-term care service plan for elderly and disabled Tennesseans. The legislation created the Tennessee Long-Term Care Services Planning Council, comprised of the Commissioners of Health, Human Services, and Finance and Administration and the executive director of the Tennessee Commission on Aging. In conjunction with the Long-Term Care Services Advisory Council, the planning council was directed to develop the long-term plan to be submitted to the General Assembly by January 1, 1999. A draft proposal was submitted to the legislature on December 17, 1998.

The plan concluded that "significant gaps exist in the availability and funding of home- and community-based long-term care services for the elderly and disabled." Financial considerations often prohibit access to the limited assisted-living services available. As a response, the plan recommends implementation of a statewide home- and community-based waiver program with expanded services. In addition, the plan calls for the development of options for those not meeting the Medicaid medical and financial criteria.

As proposed, the plan will provide multiple services including case management, homemaker services, personal care services, adult day health, adult day care, minor home

modifications, specialized medical equipment and supplies and assistive technology, personal emergency response systems, assisted-care living services (excluding room and board), home-delivered meals, nursing services, and transportation.

The department has yet to determine either the number of enrollees to be served or the amount of state funds available. According to TennCare management, these decisions will be made after the Department of Finance and Administration determines the amount of state funds available and the cost for individual waivers. No determination has been made yet as to how the program will be funded once it receives HCFA approval and thus qualifies for a two-to-one federal-to-state match.

According to TennCare management, the plan is designed to offer the waivers statewide on a first-come, first-served basis. Current discussions focus on a regional waiver program. The state would be divided into 12 or 13 regions, with the number of slots assigned to each depending on the region's over-65 population. The 550 waiver slots in the four counties will be combined into the new program numbers. (Those now receiving waiver services will continue in the program.) This plan is being considered to ensure that residents of the larger counties do not secure the majority of slots and to ensure slots are available for all areas, including smaller, more rural counties.

The Department of Health intends to submit the proposal to HCFA in January 1999. The target date for implementation is July 1, 1999. TennCare management admits that date could be optimistic because details regarding the health and financial assessments have yet to be developed.

Recommendation

The department and TennCare should continue efforts to implement a long-term care plan that provides alternative care waivers to all enrollees in the state. TennCare should continue to work with advocacy groups to address concerns regarding the proposal.

Management's Comment

We concur. We will continue efforts to implement a long-term care plan that provides alternative care options for elderly and disabled Tennesseans, and we will continue to work with the advocacy groups to ensure that the plans meet the needs of elderly and disabled individuals. We are planning to submit a statewide Section 1915(c) Home- and Community-Based Services Waiver once funding and the number of places in the waiver are determined. We anticipate the implementation of this new waiver to be within six months of HCFA approval.

MERGER-RELATED ISSUES

EXTENT OF CONSOLIDATION BETWEEN DEPARTMENTS

The administration proposed to transfer the functions, duties, responsibilities, and authority of the Department of Mental Health and Mental Retardation to the Department of Health, in a bill filed in the General Assembly on February 24, 1997 (Senate Bill 1925, House Bill 1827). After lengthy discussions and testimony from administration officials and numerous advocacy groups, the bill was withdrawn by its sponsors during the legislative session that ended in May 1998. However, in anticipation of the consolidation, management of the affected departments had already begun to coordinate activities and to consolidate staff in several (mostly administrative) areas.

The Departments of Health and Mental Health and Mental Retardation have, to various degrees, consolidated their staff in seven major functional areas: (1) budget and finance, (2) information systems, (3) internal audit, (4) legal services, (5) licensure and regulations, (6) personnel, and (7) policy, planning, and assurance (see exhibit). As of October 1998, staff for each of these functional areas have either been physically located together but as separate department sections (i.e., colocated) or combined. Staff for five functional areas have been colocated; staff for the remaining two areas have been combined.

Six of the seven functional areas (all except information systems) have a single director who supervises the consolidated staff. As of December 1998, four of these directors either reported to the Commissioner of Health or the Commissioner of Mental Health and Mental Retardation, depending on which department was affected by a particular issue. The director over policy, planning, and assurance reported to the State Health Officer. The Department of Health's General Counsel appeared to play only a facilitating role between the legal staff of the two departments, assisting in interagency communications on legal issues that affect both departments. The general counsels of each department reported directly to their respective commissioners.

The Department of Health's Director of Internal Audit uses combined staff not only to perform audit work for his department, but also, under contract, to perform such work for the Department of Mental Health and Mental Retardation in the mental health area, and the Department of Finance and Administration in the mental retardation area. (The Department of Finance and Administration administers the three developmental centers.) The current contracts with both departments are for fiscal year 1999 (i.e., through June 30, 1999). Staff for policy, planning, and assurance are combined, except for the Vital Records Section and the Health Statistics and Information Section that have only Department of Health staff.

The Commissioners of Health and Mental Health and Mental Retardation are located in separate buildings in Nashville. The Commissioner of Health's office is on the third floor of the Cordell Hull Building, while the Commissioner of Mental Health and Mental Retardation's

Exhibit

Consolidation of Functional Areas as of October 1998 Departments of Health and Mental Health and Mental Retardation (a)

<u>Functional Area</u>	<u>Date of Consolidation</u>	<u>Under Single Director?</u>	<u>Director's Agency</u>	<u>Commissioner Director Reports to</u>	<u>Commingled/ Colocated</u>
Budget and Finance	February 1998	Yes	Health	Health/MHMR (b)	Colocated
Information Systems	December 1997	No	Not Applicable	Not Applicable	Colocated
Internal Audit	March 1997	Yes	Health	Health/MHMR (b)	Commingled
Legal Services	January 1997	Yes (c)	(c)	(c)	Colocated
Licensure and Regulations	November 1997	Yes	Health	Health/MHMR (b)	Colocated
Personnel	November 1997	Yes	Health	Health/MHMR (b)	Colocated
Policy, Planning, and Assurance	March 1998	Yes	MHMR	State Health Officer	Commingled (d)

- Notes:
- a. MHMR = Department of Mental Health and Mental Retardation.
 - b. Reports to either the Department of Health or MHMR Commissioner, depending on which department an issue affects.
 - c. The Department of Health General Counsel only facilitates communication between the two departments' legal staffs.
 - d. The Vital Records Section and the Health Statistics and Information Section are not commingled. These sections only have Department of Health staff.

Source: Departments of Health and Mental Health and Mental Retardation.

office is on the eleventh floor of the Andrew Johnson Building. However, the office of Deputy Commissioner for Mental Health Services is located next to the Commissioner of Health's office. The Deputy Commissioner stated that although she reports to the Commissioner of Mental Health and Mental Retardation, her office was placed next to that of the Commissioner of Health to improve communications between the two departments.

Although no documentary evidence was found regarding consolidation of department operations at the commissioner level, the way the two departments are organized gives the appearance of such consolidation. Department of Health directors supervising Department of Mental Health and Mental Retardation functions could potentially come under undue influence by their commissioner or may become biased in favor of their department in cases of disagreement between the two departments.

The structure described above changed somewhat as the result of a February 1999 reorganization. Under the reorganization, the Commissioner of Health, the Acting Commissioner of Mental Health and Mental Retardation, the Director of TennCare, and the Director of Mental Retardation Services report directly to the Commissioner of Finance and Administration. The directors of some consolidated functional areas (internal audit, budget and finance, personnel, and legal) now also report directly to the Commissioner of Finance and Administration. The directors of licensure and regulations and policy, planning, and assurance report to the Commissioner of Health; the directors of information systems for Health and Mental Health and Retardation continue to report to their respective commissioners.

NO WRITTEN MANAGEMENT PLAN TO COORDINATE STATE HEALTH AND MENTAL HEALTH PROGRAMS

Officials from the Departments of Health, Mental Health and Mental Retardation, and Finance and Administration indicated that the Department of Health does not have a written management plan for coordinating the activities of Public Health Services, Alcohol and Drug Abuse Services, Mental Health Services, Developmental Services and Supports, and TennCare. There is, however, some ad hoc coordination of services.

Department personnel reported that despite the absence of a written management plan, the level of coordination and communication among the departments and programs has increased since the merger talks began. For example, department personnel report that representatives from Public Health Services, Alcohol and Drug Abuse Services, Mental Health Services, Developmental Services and Supports, and TennCare meet weekly in executive staff meetings. However, no minutes of these meetings were available for review.

According to department personnel, the meetings are used to identify and discuss issues that affect the various programs and departments, especially those issues that cross departmental lines. For example, the Department of Health and the Department of Mental Health and Mental Retardation are proposing the creation of a registry of children with special needs. This type of registry could allow the departments to better identify overlapping requests for services and enable the departments to better coordinate service delivery across department lines.

According to department personnel, the weekly executive staff meetings have provided a better understanding of the roles each department and program plays. By recognizing these roles and where they overlap, the personnel involved can begin to work together to provide a more coordinated level of service delivery. Department personnel stated that such coordination is in the best interest of all involved, merger or no merger. A written management plan could enhance agency communication and coordination by assigning specific individuals and programs to achieve certain goals and objectives within set time limits.

EFFECT OF PROPOSED CONSOLIDATION

Because of legislative concerns about the effect of the proposed merger and any resulting consolidation activities on the delivery of services to mentally ill and developmentally disabled persons (and on associated lawsuits), we reviewed state and federal monitoring reports and expenditures for mental health and mental retardation services; we also interviewed external monitoring officials, department management, facility superintendents, and representatives of advocacy groups. Based on this audit work, we did not find that the proposed consolidation of the Departments of Health and Mental Health and Mental Retardation has had a detrimental effect on the delivery of services at facilities operated by Mental Health and Mental Retardation. In addition, conditions and services provided within the developmental centers appear to have improved in recent years; most persons interviewed attributed this improvement, at least in part, to the intervention and oversight resulting from the lawsuits (see page 85). However, there has not been comparable progress in developing sufficient community placements for mentally ill and developmentally disabled Tennesseans.

The Tennessee Department of Mental Health and Mental Retardation was created by Chapter 27 of the 1953 Public Acts, codified as Section 4-3-1601 et seq., *Tennessee Code Annotated*, to provide services to persons with mental illness and mental retardation. The department operates five regional mental health institutes. The Department of Finance and Administration (F&A) currently has responsibility for the three developmental centers. The average daily number of residents at all mental health institutes was approximately 880 from January to June 1998. The three developmental centers had 1,057 residents as of July 1998.

Mental Health and Mental Retardation Services Expenditures. Expenditures for both mental health and mental retardation services do not appear to have been adversely affected by the proposed merger. (See page 84.) Fiscal year 1999 budgeted expenditures exceed fiscal year 1996 actual expenditures by 39% for mental health services and by 56% for mental retardation services.

Monitoring of the Regional Mental Health Institutes. A variety of organizations monitor the treatment programs at the institutes. The Department of Mental Health and Mental Retardation's Division of Mental Health Services performs quarterly reviews of services for the mentally ill at four of the five institutes. These reviews attempt to gauge the degree to which the facilities have complied with patient treatment plans, medical care, discharge planning, case management activities, medication rule compliance, incident reporting, environmental conditions, and staffing. The Memphis Mental Health Institute is currently under a federal

Mental Health and Mental Retardation Services Expenditures
Fiscal Years 1996 Through 1999

Mental Health Services

Area	Fiscal Year 1996	Fiscal Year 1997	Fiscal Year 1998	Budgeted Fiscal Year 1999	Percent Increase (Decrease) Fiscal Years 1996 to 1999
TennCare Partners (1)	\$108,385,200	\$328,660,970	\$343,643,752	\$299,097,400	176%
TennCare Partners Pharmacy Program	0	0	5,328,760	105,000,000	Not funded in 1996
Community Mental Health Services (2)	132,903,254	12,167,638	11,858,931	12,552,100	(90%)
Direct Administrative Expense (3)	3,281,455	5,516,298	5,237,112	9,035,700	175%
Mental Health Institutes (2)	<u>108,617,380</u>	<u>36,340,371</u>	<u>58,921,162</u>	<u>64,880,900</u>	(40%)
Total Mental Health Services	<u>\$353,187,289</u>	<u>\$382,685,277</u>	<u>\$424,989,717</u>	<u>\$490,566,100</u>	39%

Mental Retardation Services

Area	Fiscal Year 1996	Fiscal Year 1997	Fiscal Year 1998	Budgeted Fiscal Year 1999	Percent Increase (Decrease) Fiscal Years 1996 to 1999
Mental Retardation Administration (3)	\$1,534,862	\$2,225,801	\$3,202,130	\$4,186,400	173%
Developmental Disabilities Coalition	1,356,881	1,211,583	1,928,867	1,737,200	28%
Community Mental Retardation Services	76,981,916	105,185,533	132,053,688	174,354,600	126%
Community Services Regional Offices (4)	4,173,738	4,757,983	6,057,422	0	(100%)
Developmental Centers	<u>145,757,942</u>	<u>172,960,081</u>	<u>181,760,615</u>	<u>179,083,700</u>	23%
Total Mental Retardation Services	<u>\$229,805,338</u>	<u>\$286,340,981</u>	<u>\$325,002,722</u>	<u>\$359,361,900</u>	56%

- Notes:
1. TennCare Partners began in fiscal year 1997, so figures in fiscal year 1996 represent capitation payments to managed-care organizations for Mental Health Services. The reduction of TennCare Partners expenditures from fiscal years 1998 to 1999 was the result of increased Partners Pharmacy Program expenditures. Specifically, funds were transferred from behavioral health organizations' capitation payments.
 2. The reduction of Community Mental Health Services and Mental Health Institutes expenditures from fiscal years 1996 to 1999 was the result of an increase of TennCare Partners expenditures. Services previously provided by Community Mental Health Services and Mental Health Institutes are now provided by TennCare Partners.
 3. The large increase in Direct Administrative Expense for Mental Health Services was the result of the implementation of TennCare Partners in 1997. The large increase in Mental Retardation Administration expenditures was the result of increased staffing required by the settlement of the U.S. Department of Justice's lawsuit concerning Arlington Developmental Center.
 4. Funding for Regional Offices of Community Services was combined with funding for Developmental Centers in fiscal year 1999.

Source: Department of Health.

settlement agreement and thus is not reviewed by the department. According to department staff, the Memphis facility is monitored separately under federal court supervision.

All five mental health institutes are reviewed for accreditation every three years by the Joint Organization for Accreditation of HealthCare Organizations (JCAHO). The JCAHO renews accreditation on the basis of adherence to industry norms for the care of the mentally ill. These norms include standards pertaining to patient rights, patient care, education, organizational functions, leadership, environment of care, human resources, and information management. Although Tennessee law does not require accreditation for public developmental centers and mental health institutes, those facilities are required by the TennCare managed-care program and the behavioral health organizations to maintain current JCAHO accreditation. All five mental health institutes were accredited, as of the following dates:

- Memphis—January 27, 1998
- Middle Tennessee—November 5, 1996 (compliance with all accreditation recommendations as of January 28, 1997)
- Lakeshore—August 27, 1998
- Western—February 28, 1996 (compliance with all accreditation recommendations as of August 6, 1996)
- Moccasin Bend—September 21, 1998 (as of November 2, 1998, JCAHO had not followed up accreditation recommendations)

Monitoring of the Developmental Centers. The three developmental centers are monitored under the supervision of the federal courts. The U.S. Department of Justice sued the State of Tennessee for violations of the Civil Rights of Institutionalized Persons Act (CRIPA) at the Arlington Developmental Center in January 1992. The facility has been under a U.S. District Court order to correct conditions at the facility since November 1993. A court-appointed remedial monitor oversees the operations of the Arlington Developmental Center. The remedial monitor's staff review treatment programs at Arlington twice a year and also perform quarterly reviews of community services in West Tennessee.

In April 1996, the department entered into a settlement agreement with the advocacy group People First, which had sued the state, charging violations of CRIPA at Clover Bottom and Greene Valley Developmental Centers. (The Department of Justice strongly suggested that the state settle and in December 1996 sued the state to become a party in the settlement negotiations.) The settlement agreement calls for the state to provide adequate community placements for all eligible residents of the two developmental centers. A three-member Quality Review Panel, composed of members representing the Department of Justice, the State of Tennessee, and People First, oversees the operations at Clover Bottom and Greene Valley, as required by the consent decree. The Department of Finance and Administration uses a management information system to collect performance data on the operations of the facilities. This data system represents the state's efforts to address the deficiencies found at both developmental centers and lists outcomes on a variety of measures: assessment, staffing, health care, physical and nutrition management, active treatment, physical environment, protection

from harm, and First Amendment rights. A similar monitoring system is in place for the Arlington Developmental Center.

Like the mental health institutes, the developmental centers are licensed by the newly combined Licensure Division within the Department of Health. The Licensure Division, under contract with the Health Care Financing Administration, also reviews both the institutes and the developmental centers for Medicare and Medicaid certification. In addition, the developmental centers have typically undergone JCAHO accreditation reviews. Currently, however, only Greene Valley is accredited. According to Mental Retardation Services management, JCAHO accreditation, which is typically for more hospital-like facilities, is not currently a priority, given the focus on issues related to the lawsuit.

Comments on the Proposed Consolidation. According to facility superintendents, department officials, the court-appointed remedial monitor, and the chairman of the Quality Review Panel, the proposed consolidation of the Department of Health and the Department of Mental Health and Mental Retardation has had no detrimental effect on the delivery of services at mental health institutes or developmental centers. When the General Assembly was considering the merger, some of the directors of the thirteen regional health departments and the five mental health institutes met to discuss shared operational issues. None of the facility superintendents reported any differences in the administration of the institutions as a result of those meetings.

The remedial monitor and the chairman of the Quality Review Panel did, however, express concerns about a merger, citing as potential problems the loss of accountability and difficulties in managing a large department engaged in the delivery of many different services. In addition, they noted the problems North Carolina and Florida faced in their mergers of public health components.

Community Services. The lack of sufficient community placements was identified by department staff, advocacy groups, and court-appointed monitors as the main impediment to discharging all eligible residents from the developmental centers and mental health institutes. According to the remedial monitor, community services in West Tennessee suffer from an insufficient number of beds and an undersupply of providers capable of offering quality treatments for the developmentally disabled.

The chairman of the Quality Review Panel stated that before Tennessee can move large numbers of developmentally disabled persons into the community, the state must enter into a multitude of contracts and third-party agreements that satisfy the concerns of the court. Until the state can provide clear and convincing evidence that it has made sufficient strides in ensuring community agencies are capable of coordinating the necessary support services, the courts may be reluctant to allow the three developmental centers to operate free of court supervision. In his opinion, East Tennessee lags behind the other two regions of the state in developing adequate community placements.

In addition, although only one of the five regional mental health institutes is currently under court supervision, insufficient community support services were frequently cited by Mental Health Services staff as a barrier to placing more patients in community settings.

FOLLOW-UP
FEBRUARY 1998 AUDIT FINDINGS

We released a performance audit of the Department of Health (excluding TennCare and the Office of Health Licensure and Regulations) in February 1998. In accordance with Section 8-4-109 (b), *Tennessee Code Annotated*, the department submitted a September 1998 report detailing its actions to implement that audit's administrative recommendations. Below we have provided, for each audit finding, the text of the original February 1998 finding and management's comment (in the shaded text), the department's September 1998 follow-up response, and our evaluation of the department's follow-up activities and the current status of those activities.

FEBRUARY 1998 AUDIT FINDING 1

Weaknesses in contracting and service reimbursement in the
Bureau of Alcohol and Drug Abuse Services lessen effectiveness

Several weaknesses in the Bureau of Alcohol and Drug Abuse Services undermine the efficiency and effectiveness of the bureau's efforts. The contracting system for alcohol and drug abuse treatment and prevention services is not uniform, and there is no standard rate of payment for alcohol and drug treatment and prevention services.

The bureau contracts with agencies across the state for a variety of services, e.g., halfway houses, rehabilitation centers, prevention programs. The bureau's estimated expenditures for fiscal year 1997 were over \$33 million; \$24 million of this was funded through a federal alcohol and drug abuse block grant. These federal funds are mixed with state money to provide alcohol and drug abuse services to indigents—80 percent of the funding is spent on treatment and 20 percent on prevention. The state now has two systems providing alcohol and drug abuse services—the public system (funded by the Bureau of Alcohol and Drug Abuse Services) and the managed care system (funded through TennCare, other insurers, etc.).

Contract Award Process

The bureau continues to award contracts to the same service providers year after year. No new treatment providers entered the system in fiscal year 1997. Instead of requesting proposals and asking for bids, the bureau renewed approximately 95 percent of its treatment and prevention contracts.

The department has recognized that there is a need for a uniform contracting system in the Bureau of Alcohol and Drug Abuse Services and stated so in its 1994 and 1995 Financial Integrity Act reports. Additionally, a 1996 Technical Review of the bureau, conducted by an independent contractor on behalf of the federal Center for Substance Abuse Treatment, indicated that the bureau does not have a methodology to allocate grant contracts. Instead, the bureau

bases contracts on “a historical contracting pattern that does not relate to cost utilization, or a specific resource allocation process.”

Bureau staff stated that the bureau used to follow a Request for Proposal (RFP) process for some of the contracts, but mainly contract agencies were “just selected.” The bureau is currently moving towards the submission of bids under the Request for Grant Proposal (RFGP) procedure with the implementation of the Governor’s Prevention Initiative. There does appear to be stability in awarding the same providers money and in providing the same services, especially considering the specialized nature of some of the programs. However, without a uniform contract award process, qualified vendors for a particular service do not have an equal opportunity to bid for state contracts, and there is no guarantee that the most qualified agencies are providing the programs.

Equalization of Rates

The bureau has no formula or procedure in place for adjusting the reimbursement rates after initially awarding a contract. As a result, the rates paid for treatment and prevention services vary widely depending on when the department first funded the beds (or other services). For example, a State Audit review of 1995-96 agency funding indicated that reimbursement per bed for medical detoxification varied from \$18,840 per year to \$71,540 per year. Rates also varied among regions, with reimbursement for residential rehabilitation ranging from \$11,331 to \$20,651 per year, per bed.

The department reported the lack of a standard rate of payment for alcohol and drug treatment services in its 1993, 1994, and 1995 Financial Integrity Act reports. In addition, bureau staff confirmed that some agencies are paid two times what other agencies are paid for the same or similar service.

In its 1995 Financial Integrity Act report, the department stated that moving to a fee-for-service payment system for reimbursing providers of substance abuse treatment services would reduce the discrepancy in reimbursement rates for the same service and bring the rates more in line with the actual cost of providing treatment services. The only program where rates have been equalized thus far are halfway houses. As of July 1, 1996, all halfway houses are using fee-for-service systems for reimbursement.

Recommendation

The Bureau of Alcohol and Drug Abuse Services should award contracts through a process that ensures qualified vendors have an equal opportunity to bid.

The Bureau of Alcohol and Drug Abuse Services should set consistent reimbursement rates between like programs, emphasizing equal reimbursement for similar services.

Management’s Comment

We concur. The bureau began contracting with halfway houses on a fee-for-service basis on July 1, 1996. Beginning January 1998, the bureau was scheduled to implement a standard

reimbursement rate or fee-for-service system for the majority of the remaining treatment services; however, the implementation was postponed because of provider and legislative concerns. Implementation is scheduled to begin July 1, 1998. Contracting agencies will be reimbursed using a standard state-wide rate for providing similar services as defined by criteria published by the American Society of Addiction Medicine. The fee-for-service system will equalize reimbursement rates by this uniform method of fee per unit of service payment.

The bureau is undergoing a thorough review of the availability of treatment services throughout the state. Part of this review process will include evaluation of community needs assessment data that will be available in July 1998. A RFP process is in place to fund additional or expanded A&D services and will be utilized when additional funds become available.

DEPARTMENT'S SIX-MONTH FOLLOW-UP RESPONSE

Contract Award Process. We concur. The Bureau of Alcohol and Drug Abuse Services is undergoing a thorough review of the availability of treatment services throughout the state. Part of this review process will include evaluation of community needs assessment data that will be available in December 1998. Twenty thousand adults will be interviewed, which will represent approximately 210 surveys from each county in the state.

A Request for Proposal (RFP) process is currently in place to fund additional or expanded alcohol and drug services and will be utilized when additional funds become available. Concurrently, a potential provider list is in place. The bureau intends to submit an RFP for fiscal year 2000.

Equalization of Rates. The bureau began contracting for halfway house services on a fee-for-service basis on July 1, 1996. Full implementation of a fee-for-service process began July 1, 1998, for ambulatory services. Contracting agencies will be reimbursed using a standard state-wide rate for providing similar services as defined by criteria published by the American Society of Addiction Medicine. The fee-for-service system will equalize reimbursement rates by this uniform method of fee per unit of service payment. Regional data, TennCare data, agency cost funding data, and provider input were used to establish rates. Fee-for-service transition, including residential services, will be completed by July 1, 1999.

The bureau will receive additional technical assistance in the areas of a fee-for-service process, rate setting and invoicing, effective use of data for planning, enhancing contract development, and other areas applicable to fee-for-service. This helps ensure a smooth transition. The technical assistance is being provided by Johnson, Bassin, and Shaw, Inc. (JBS) and Health Systems Research, Inc. (HSR), under the direction of the Center for Substance Abuse Treatment (CSAT). Bureau staff participated in a conference call with representatives from HSR, JBS, and CSAT on July 23, 1998. A final outline and timeframe is being completed by JBS and bureau staff. The bureau has requested that all technical assistance requested be completed by October 1998. This process will ensure that consistent rates are set and that, in the transition, agencies will remain viable with the development of our invoicing system and "shadow claims" system.

EVALUATION OF DEPARTMENT'S FOLLOW-UP ACTIVITIES

Contract Award Process. The bureau has made some progress toward implementing a request-for-proposal process in awarding contracts for alcohol and drug services. Bureau staff provided evidence that they are communicating with prospective contractors on the process. However, the bureau has not recently funded publicity efforts to make the process known to prospective bidders. The bureau has a list of nine providers that have been informed of the availability of contract opportunities and have expressed interest in the request-for-proposal process, as of November 1998.

According to the staff, the process will be implemented for services as current contracts expire. The staff stated that all such contracts are for one fiscal year. Complete implementation is scheduled for July 1999. This process will apply only to the majority of treatment programs. Federal block grant set-aside treatment programs for women and minority providers will not be contracted for in this manner. In addition, prevention programs will not be contracted through requests for proposal. No contracts yet have been bid through requests for proposal.

According to bureau staff, results from the community needs assessment survey were not available, as of November 1998. The intention of the survey, conducted by the University of Tennessee, is to measure the alcohol and drug abuse patterns of Tennessee adults. The survey is designed to contact 12,000 adults in all 95 counties by telephone.

Equalization of Rates. The bureau is making efforts to equalize rates to contractors through a fee-for-service system. In April 1998, at the bureau's request, the federal Center for Substance Abuse Treatment (CSAT) conducted a technical review focusing on the bureau's ability to transition from a grants-based to a fee-for-service-based payment system. According to the final report, dated November 30, 1998, the bureau has to meet 11 key requirements in order to properly implement a fee-for-service system:

- Determine client eligibility
- Determine provider eligibility
- Define services
- Develop payment rates
- Determine financial incentives
- Develop or modify the management information system
- Conduct service audits, which determine if contractors provide adequate quality of care and appropriate billings
- Provide transition management
- Design and implement contracts
- Purchase organized systems of care
- Establish a quality management system

In September 1998, bureau staff met with staff from Health Systems Research, Inc., a consultant that is working under the direction of the CSAT. The consultant's report on developing a fee-for-service system for alcohol and drug abuse services was due October 1998, but the bureau had not received the report as of mid-November 1998. The bureau could provide no other documentation on the extent of work the consultant or bureau staff had done to implement fee-for-service.

Recommendations. The Department of Health should continue its efforts to implement both the request-for-proposal process and the fee-for-service system. The department should make efforts to have all services, both treatment and prevention, contracted through requests for proposal. The department should take steps to ensure the University of Tennessee provides survey information on community needs assessments in a timely manner. In addition, the department should increase its publicity efforts to inform all prospective providers about the new contracting process. The department should make efforts to ensure all technical assistance on fee-for-service is available in a timely manner. Timely implementation of the request-for-proposal process and the fee-for-service system would help ensure the effective and efficient use of Bureau of Alcohol and Drug Abuse Services financial resources to help Tennesseans with alcohol and/or drug addiction.

Management's Comments. We concur. The Bureau of Alcohol and Drug Abuse Services has implemented a fee-for-service system for the majority of treatment agencies effective January 1, 1999.

The recommendation to have all services, both treatment and prevention, contracted through requests for proposal will be implemented as follows: For new money made available to the bureau, an RFGP will be issued for specific areas of the State and specific gaps of services as identified by the central intake process and other data sources (i.e., community needs assessments). For individual programs (i.e., HIV-AIDS, women's treatment, prevention), an RFGP will be issued on a rotating annual schedule that would allow contracts to be in place for a period up to three years. Federal block grant requirements will have to be evaluated closely regarding this contracting plan so that no compliance issues for funding and program set-asides dictated by the grant will result.

Future contracts for needs assessment will be monitored closely to ensure all reports are submitted per contract guidelines.

The bureau will ensure that any new contracting changes are communicated to potential providers by use of the bureau newsletter, newspaper ads, Department of Health press releases, and other forms of print and electronic media.

The bureau on occasion asks for and receives technical assistance through the Department of Health and Human Services (DHHS), Substance Abuse and Mental Health Services Administration. DHHS and the contractor that provides the technical assistance negotiate dates when final reports are to be submitted to the bureau. The timeliness of submission of these reports is not controlled by the bureau.

FEBRUARY 1998 AUDIT FINDING 2

Weaknesses in monitoring and the ineffective use of data hinder the Bureau of Alcohol and Drug Abuse Services' assessment efforts

Despite a monitoring system that includes periodic on-site reviews of contract agencies and the reporting of a considerable amount of information by those agencies, the Bureau of Alcohol and Drug Abuse Services has limited assurance that the appropriate clients are being seen and that the contracted services are provided and are effective.

Monitoring

The bureau's on-site monitoring focuses on compliance with administrative and procedural requirements, with only limited review of the quality of services or whether those services were provided to the appropriate population. The federal block grant requires that the bureau monitor contract agencies to confirm that the agencies are providing quality services. Currently, service quality is monitored by reviewing files to confirm that the information supports the numbers and results reported by the agencies in their target plans. Program monitors do not routinely review the agencies' utilization numbers (e.g., number of beds filled by TennCare clients, indigents, etc.) to ensure that the appropriate clients are being served. With the advent of TennCare, many of the agencies receiving funds from the bureau are also receiving money from TennCare. Bureau funds are required to be used to treat persons not covered by TennCare (or other insurance) or those who have exceeded their benefit limits. However, Bureau of Alcohol and Drug Abuse staff stated that there is no way for the bureau to know without on-site reviews if the agencies are filling their beds with the appropriate clients because the agencies self-report the number of full beds and do not identify who (TennCare or the bureau) is paying for a particular bed or service. As a result, agencies could possibly be filling their beds with TennCare clients, getting paid by both the bureau and TennCare, and not serving the clients the bureau is supposed to be funding (i.e., those with no insurance).

The bureau's 1995 special review of all 19 adult residential rehabilitation programs indicated that these agencies were indeed mainly treating people with TennCare coverage. The review concluded, among other things, that utilization should be monitored more closely and that utilization penalties outlined in the contract should be applied more consistently. Four agencies had major problems; however, bureau staff did not revisit these four agencies and no monetary penalties or contract sanctions were assessed, although staff agreed penalties/sanctions could have been assessed.

According to bureau management, program monitors usually visit about 80 agencies a year, taking a day or two to review criteria at each site. If deficiencies are found, the agency is required to submit a corrective action plan and complete corrective action within 30 days. Minor corrections are monitored through a desk review of the action plan. If the deficiency is major, the monitor will return to the agency in a couple of months; such follow-ups are conducted on about 10 programs per year. Staff indicated that major problems are rare because most agencies funded by the bureau have been funded for a long time and "know the requirements." According to a State Audit review of contract agencies' files, in some cases, monitors noted several areas where the agencies did not meet performance targets or did not comply with the program

standards; however, very few corrective action plans were required. Such a plan was required for only four of the agencies whose files were reviewed, although 16 of the 20 files noted areas of noncompliance, deficiencies, or lack of support for reported program results.

Performance Measures

Because of difficulties in evaluating program services, performance measures have been used inconsistently in monitoring contract agencies, and agency funding is not tied directly to outcomes. The bureau's fiscal year 1996 contracts were designed to be outcome-based, meaning that each contract agency's performance was to be judged on the basis of successfully treating patients. Agencies presented "target plans" detailing how they intended to measure success. These target plans focused on measuring behavioral changes, not expenses incurred in an individual's treatment. However, according to department staff, the usefulness of the target plans was limited by the bureau's inability to quantify behavioral changes as an accurate gauge of program success. Because of the difficulties in developing an objective standard of performance and a method to connect outcomes with funding, the allocation of money has not actually been tied to outcomes. Instead, grantees have been reimbursed for expenditures. These problems have led to the establishment of fee-for-service contracts, in which the bureau pays a specific rate for a specific service.

In addition to the in-house evaluations, the bureau has contracted since 1988 with the University of Memphis for two programs to develop outcome data for prevention and treatment services provided by bureau grantees. In fiscal year 1996, the bureau spent over \$423,000 for these two programs—TADPOLE (Tennessee Alcohol and Drug Prevention Outcome Longitudinal Evaluation) and TOADS (Tennessee Outcomes for Alcohol and Drugs Services). However, the bureau does not appear to use the resulting outcome data when awarding or funding contracts—contracts are awarded to the same providers, for the same amount, year after year. Staff stated that the outcome data's usefulness is limited because it covers only a small portion of the clients served—those who have volunteered to participate in the evaluation.

Ineffective Use of Data

Because of a backlog in processing the data it collects from contract agencies and a lack of some other types of data, the bureau has difficulty evaluating the agencies' performance. Bureau staff stated that it is difficult to ensure services are actually being provided when there is no data system in place, or the data available are not current. A 1996 Technical Review of the Bureau of Alcohol and Drug Abuse Services prepared for the United States Department of Health and Human Services found that the bureau has inadequate data for meaningful planning, analysis, reporting, and management support. For example, contracts with the agencies specify that they cannot refuse a client because of inability to pay; however, bureau staff do not have the data available to determine, at a given moment, how many indigents an agency is treating.

Although the required data are generally submitted timely by agencies, there is a delay in the Department of Health's entry and compilation of the information. Data from community mental health centers have not been compiled since December 1994, when the Bureau of Alcohol and Drug Abuse Services ceased to use the Department of Mental Health and Mental Retardation's data system. (The bureau was transferred to the Department of Health from the Department of Mental Health and Mental Retardation in July 1991.) The bureau designed a

program for the mental health centers to use in transmitting their data in disk form; however, there have been problems with obtaining the information from the diskettes. For example, because the program is date driven, omission of certain service dates may cause the program to reject the information. To compound the problem, approximately half of the alcohol and drug treatment facilities still use paper forms to submit admission information, which must then be keyed by bureau staff.

Some other types of contract agencies are not tracked by the data section in any manner. Although the bureau funds many early intervention programs with direct services that could be tracked, the agencies are not required to submit program data.

The Bureau of Alcohol and Drug Abuse Services is implementing a new data system in July 1997; however, even after implementation, not every agency will be on-line. Twenty-eight smaller agencies will still be using paper forms to submit data. Thirty-one agencies, mainly mental health centers with their own data systems, will have on-line access to the bureau's system. Six agencies—larger, fairly stable service providers that generate lots of data—will be strictly on-line. Bureau staff stated that the new data system will better ensure that agencies are complying with contract provisions—the agencies will not get paid unless they have entered their data into the system.

Recommendation

When monitoring contract agencies, Bureau of Alcohol and Drug Abuse staff should increase the focus on ensuring that quality services are provided, at the levels reported, to the appropriate clients.

The Bureau of Alcohol and Drug Abuse Services should evaluate the types of data the contract agencies currently submit and require all agencies (including those with early intervention programs) to submit the data needed to adequately monitor the agencies' performance. The bureau should work with the agencies and state information systems staff to resolve the problems with obtaining information from agency diskettes and to facilitate data submissions. The bureau should then process (in a timely manner) the data received and use that data to evaluate and improve agency performance and to make funding decisions.

Bureau of Alcohol and Drug Abuse Services management should reevaluate the contracts for the TADPOLE and TOADS programs, in light of the limited usefulness of the outcome data provided. If the programs cannot be redesigned to provide more useful data, the bureau should consider reallocating these contract dollars for direct provision of prevention and treatment services.

Management's Comment

We concur. The bureau will implement fee-for-service on January 1, 1998. To ensure that all standards are uniform across the state, local health departments will perform A&D client intake and assessment procedures using the Addiction Severity Index and program placement criteria promulgated by the American Society of Addiction Medicine. All clients will be referred to treatment programs appropriate to their treatment needs. On-site monitoring for these

programs will include examination of the data related to admission criteria, intake processing, referral, treatment planning, discharge planning, and outcomes.

In June 1997, the bureau implemented a new A&D data collection system. This system assures collection of pertinent data from agencies; data received from contracting agencies is processed in a timely manner in order to evaluate the quality and effectiveness of A&D programs.

In October 1997, the Division of Community Services developed goals and objectives for all prevention programs. Additionally, prevention programs are submitting quarterly reports to assist the bureau in evaluating each program's effectiveness, and in determining the criteria when developing new programs.

The Bureau of Alcohol and Drug Abuse Services is in the process of updating the contracts for the TADPOLE and TOADS programs to enhance the use of data and to continue to maintain the quality of treatment and prevention programs for all Tennesseans. As a result of the move to fee-for-service, the TOADS project will be revamped to ensure that pertinent outcome data is available to the bureau.

DEPARTMENT'S SIX-MONTH FOLLOW-UP RESPONSE

Monitoring. We concur. On March 1, 1998, the Central Intake process for clients in need of treatment for alcohol and/or drug usage began. The Bureau of Alcohol and Drug Abuse Services and the Bureau of Health Services Administration are collaborating to ensure that Tennessee citizens in need of substance abuse treatment receive appropriate and comprehensive treatment services. Local health department staff are interviewing patients using the Addiction Severity Index (ASI) and placing them according to the American Society of Addiction Medicine (ASAM)–Patient Placement Criteria 2. This method ensures the most appropriate treatment process. Referrals will then be made to one of the treatment agencies that contract with the Bureau of Alcohol and Drug Abuse Services.

The Fiscal Services Section of the Bureau of Alcohol and Drug Abuse Services is currently planning four separate training sessions. The first training session will address fiscal monitoring for contract agencies for fiscal year 1999. This training is scheduled for July 29 and 30, 1998, and will be provided by the Fiscal Services Section to all Program and Compliance staff. Monitoring of the fiscal component will begin August 4, 1998. The second training will provide a dual service. It will consist of training for the Fiscal and Data Section staff relating to the required data and contractual changes due to the implementation of fee-for-service and it will provide for the development of the agenda and materials for the subsequent contract agency training. This training will be held on August 12 and 13, 1998, at Natchez Trace State Park in conjunction with the Bureau of Health Services, Contract Administration Section staff.

The third training session is scheduled for August 17 through 25, 1998. There will be two training sessions offered at each grand division site, which includes Knoxville at the Knox County Health Department, Nashville at the Mid-Cumberland Regional Office, and Memphis at

the Memphis City Board of Education. This training will be provided by the Data Section for contract agency personnel and will specifically target the data changes required for the transition to fee-for-service. The fourth training session is being scheduled for September 1998. Again, there will be two training sessions offered at each grand division site, which will include Knoxville, Nashville, and Memphis. This training will be provided by the Contract Section in conjunction with Bureau of Health Services, Contract Administration Section staff, for contract agency fiscal staff and will specifically target the various contractual and fiscal changes and requirements for fiscal year 1999.

Performance Measures. Results contracting ended for the prevention programs on June 30, 1997, and ended for treatment programs June 30, 1998. This is a change from the 1991-95 partnership with the Department of Finance and Administration and the Rensselaerville Institute of New York for results-oriented programming, which used different performance measures. We have returned to a more traditional process for evaluation of treatment and prevention programs.

In October 1997, the Division of Community Services developed goals and objectives for all prevention programs. Additionally, prevention programs are submitting quarterly reports to assist the bureau in evaluating each program's effectiveness, and in determining the criteria when developing new programs. There is also a performance measure method redesign of bureau strategies incorporating single-state authority performance measures, which include:

Effectiveness—health and economic status, social supports

Efficiency—access to services, treatment retention, cost of services, appropriateness of treatment

Structure—uniform facility data set capabilities

TOADS. The following changes were implemented for fiscal year 1998, in the Tennessee Outcomes for Alcohol and Drug Services (TOADS):

Analysis and reporting—Additional variables were included in the analysis of clients' reported abstinence from alcohol or drugs.

Revision of TOADS instrument—The follow-up survey was revised to be consistent with the ASAM and ASI criteria.

Internal improvements in data management—A new data entry process was developed which will allow TOADS to respond quickly to any questions that can be answered out of current TOADS data.

Revision of TOADS consent form enhanced participation from 1996-97 to 1997-98 by 880 participants.

Use of computer technology—In fiscal year 1996, computer technology replaced the manual completion of bubble survey instruments. The change has increased the number of interviews approximately 50%.

Technical assistance participation and training—Because of the implementation of central intake procedures, TOADS has increased significantly its technical assistance training and services for treatment providers and central intake personnel.

TADPOLE. In July 1998, Community Services staff met again with University of Memphis evaluation staff to recommend changes and improvements to the evaluation process for prevention programs. The target date for full implementation is fiscal year 1999-2000, with some recommendations in progress. The next meeting is scheduled for September 1998, and quarterly thereafter. The goal is to ensure prevention programs are accountable, effective, and efficient in delivering alcohol, tobacco, and other drugs prevention services to all Tennesseans by redefining target populations, developing science-based programs, developing clear definitions of goals and objectives, reviewing the pre- and post-test process, measuring school success, and reviewing the survey instrument.

Ineffective Use of Data. The plan to have the contract agencies on-line has not been realized to date. To address this change in direction, the bureau is in the process of developing short-term and long-range plans to address the data situation. In the short term, the bureau's goals are

- to upgrade four computer systems to enhance speed of data entry;
- to redesign the data flow through the section to more efficiently utilize the available staff;
- to withhold contract agency invoice payments when data is not submitted;
- to provide additional training for current staff; and
- to provide training and technical assistance for contract agencies.

The upgraded equipment, staff cross-training, and redesign of the flow of data will enhance the efficiency and effectiveness of the available staff and will ensure the backlog of data will be input. The withholding of invoice payments will ensure timely submission of data by contract agencies. Additional training will be required so current staff can assist in the PC database development and provide future technical support for the contract agencies as defined below in the long-range plans.

Bureau staff has concentrated on the client registration and admission process. The top priority is registrations and admissions for contract agencies that provide fee-for-service outpatient services. This is necessary to be able to verify fee-for-service invoices submitted to data received. (The data for a majority of these contract agencies is input through March 1998.) The next step will be to focus on the process for agencies with residential services moving to encounter and discharge data processing.

The long-range plans involve how the data is to be submitted in the future and how the data will be used. The contract agencies have various levels of computer sophistication. They range all the way from those with mainframe systems to those that "may" have a PC available. The immediate goals are

- to develop a contract through OIR to develop a stand-alone PC database to assist contract agencies in capturing client data to be submitted on disk;
- to develop guidelines for contract agency main-frame system users to gather data and submit it on disk (some already are);

- to continue to input small contract agency data;
- to provide training and ongoing technical assistance to contract agencies; and
- to develop a contract through OIR to develop a billing system to allow the data received to become the invoice for payment when fee-for-service is fully initiated.

In the future, the goal is to have the data sent via the Internet, rather than by disk.

Once the data backlog is input, reports will be generated and sent to the contract agencies and bureau staff. On an on-going basis, the client data reports will be generated and sent to the contract agencies and bureau staff to be reviewed for accuracy and to be used in the bureau's on-site monitoring process. Reports will also be generated as a type of "shadow-claims" to give the contract agencies a feel of where they will be when fee-for-service is fully implemented in fiscal year 2000.

EVALUATION OF DEPARTMENT'S FOLLOW-UP ACTIVITIES

Monitoring. The Bureau of Alcohol and Drug Abuse Services has implemented a system to evaluate annually the quality of care contract agencies provide. According to bureau staff, the system was implemented in July 1998. The staff evaluate treatment and prevention programs using "review guides" based on the bureau's *Administrative and Program Requirements and Scopes of Services* issued in July 1998. Each type of program has a specific review guide associated with it. In addition, there is a guide used to review contract agency financial operations. These guides appear adequate for evaluating agency operations, including quality of care and record keeping.

As of October 1998, the bureau had completed the review, including report writing, of five contract agencies using the new system. Although this review appears generally adequate, staff did not document the percentage of total client files reviewed. In addition, the staff did not conduct follow-up site visits to determine if problems had been corrected. Instead, the staff reviewed documents submitted by agencies indicating corrective actions.

According to bureau staff, the fiscal year 1999 training for its monitoring staff (mentioned in the department's follow-up response) only pertains to fiscal matters. For example, staff is being trained to evaluate whether contract agencies properly handle the state funds they receive. The training does not focus on operational matters, such as evaluating quality of care.

One concern raised in the February 1998 performance audit was that contract agencies might be filling their beds with TennCare patients (instead of patients who have no insurance or have exceeded their benefit limits) and receiving payment from both the Bureau of Alcohol and Drug Abuse Services and TennCare. It appears that the bureau's monitoring staff evaluate this issue during their client record reviews. In addition, the bureau's fiscal director stated that a system was in place to avoid payment for services provided to TennCare patients, and provided related documentation.

Performance Measures. Bureau staff stated that the Division of Community Services' program for evaluating the effectiveness of prevention programs had not been implemented. However, in October 1998, the bureau received technical assistance on program implementation from the federal government.

The bureau does not document the use of data from TADPOLE (Tennessee Alcohol and Drug Prevention Outcome Longitudinal Evaluation) and TOADS (Tennessee Outcomes for Alcohol and Drug Services) to evaluate contract agency client outcomes. The Director of Prevention could not provide documentation on the use of TADPOLE data, and the Director of Quality Development stated that he did not have enough staff to evaluate TOADS data. Although contract agencies receive the results of TADPOLE and TOADS directly from the University of Memphis, they are not required to submit to the bureau reports on what they did with the information to improve program performance.

In addition, the bureau could not provide documentation on efforts to increase client participation in TADPOLE and TOADS. The Assistant Commissioner for Alcohol and Drug Services stated that contract language was changed to facilitate greater participation. However, a review of the TADPOLE and TOADS contracts with the University of Memphis did not indicate changes. The amount of the fiscal year 1999 TADPOLE and TOADS contract with the University of Memphis is \$777,019.

Ineffective Use of Data. According to the bureau's fiscal director, there are still problems with a backlog in processing data the bureau collects. For example, as of November 1998, data on client encounters (e.g., sessions) and discharges were backlogged to June 1997. However, the bureau has contracted with Olsten Staffing Services to provide four temporary data entry staff to deal with the backlog. The bureau's goal is to eliminate the backlog by the end of calendar year 1998.

The bureau is working with two contract programmers to develop a computer data system that will allow agencies to submit data either on diskette or through the Internet, thus eliminating manual data entry. According to the director, work on the system should be completed by November 1998. Using data from the system, the bureau has produced an initial report highlighting duplication of client admissions in intensive focus support group programs.

In addition, the system will facilitate fee-for-service billing, using the number of encounters with clients to pay contract agencies. The bureau's *Program, Report and Data Requirements for Alcohol and Drug Abuse Service Providers*, issued in July 1998, requires that all contract agencies submit data on their financial and operational performance. However, the bureau does not fund contract agencies based on their performance. Bureau staff stated that they were exploring the use of performance-based budgeting as part of the new monitoring system.

Recommendations. The bureau should continue its efforts to review the quality of care that contract agencies provide. The bureau should document the percentage of total client records reviewed and perform follow-up site visits to confirm that the more severe problems have been corrected. The bureau should provide monitoring staff training on how to evaluate agency performance, including quality of care. The bureau should eliminate its data backlog and should

continue its efforts to develop its computer data system and complete modifications in a timely manner.

The bureau should either use the TADPOLE and TOADS data (and document its use) in evaluating client outcomes of contract agencies, or reallocate the TADPOLE and TOADS contract dollars for other uses, such as direct provision of prevention and treatment services. The bureau should use information on client outcomes to develop a method to pay contract agencies whose outcomes are successful and to terminate contracts with those agencies whose outcomes are unsuccessful.

Management's Comments. We concur. Starting in September 1998, the Bureau of Alcohol and Drug Abuse Services has strengthened its program evaluation function by filling two vacant program monitor positions. The new employees have been trained to conduct required treatment and prevention program reviews to determine compliance with established quality of care standards. The additional staff will allow for the more in-depth review of clients' records needed to determine the quality of service provided. This increased record review will better identify problematic agencies as it relates to quality of care provided. Also, for agencies having major quality of care compliance issues, follow-up visits to evaluate implementation of corrective action can be readily adapted in the monitoring schedule.

Agency monitoring reports will identify the number of client records reviewed for a specified month compared to what was reported to the bureau's Management Information System and submitted for payment under the bureau's fee-for-service system.

The Olsten staffing services have been unable to provide four temporary data entry staff requested by the bureau. The two staff provided have kept the registrations and admissions from becoming backlogged. The bureau's new data input system is developed and in place to assist with the entering of client encounters. The department's Bureau of Information Resources is working with a data system vendor to clear up the discharge entry problem. Alcohol and Drug Services' community agency training on the new data input software has been completed. January 1999 data is scheduled to be submitted by each agency on diskette beginning February 10, 1999. This will eliminate the necessity for any new manual data entry and will allow the bureau to continue its effort to have all backlogged data entered.

An Alcohol and Drug Services evaluation and research project is mandated by law (*Tennessee Code Annotated*, Title 68, Chapter 4, Public Acts 1993, Chapter 234), and the Bureau of Alcohol and Drug Abuse Services is therefore required to fund a project of this nature on an ongoing basis. The present TOADS and TADPOLE outcome projects were redesigned for Fiscal Year 1999 to provide updated information that could be used to further the bureau's treatment and prevention program objectives, including using individual agency-reported client outcomes as one measure for continued funding or non-funding. We will be receiving, from both projects, updated client data that is more adaptable for making funding decisions in the present treatment and prevention environment.

We are in the process of revising survey instruments and modifying bureau policies for TOADS and TADPOLE to ensure more individual performance measures per agency. The University of

Memphis is submitting an enhanced plan for TADPOLE. Starting in March 1998, the central intake sites at the local health departments are required to get client consents for participation in the TOADS project. We anticipate that this process will increase client participation.

TADPOLE documentation is available through our annual report of outcomes. Prevention programs use pre- and post-tests to measure attitudes and behaviors toward drug use. The five domains for attitudes include self-esteem, school value, social attitude, non-rebelliousness, and attitudes unfavorable toward drug use and experimentation. The three domains for behaviors include gateway drug use, smokeless tobacco use, and hard drug use. In addition, annual evaluation training is held for prevention programs in the State's three grand divisions.

FEBRUARY 1998 AUDIT FINDING 3

The department should improve its monitoring of AIDS Support Services programs

Several weaknesses exist in the administration of the programs in AIDS Support Services. Monitoring of grantees and subgrantees, as well as monitoring of individual client services, is limited in some cases.

The Tennessee Department of Health has administered federal funds since the inception of the Ryan White CARE (Comprehensive AIDS Resources Emergency) Act in 1990. Until 1994, all funds available to the state were used to provide drug treatments for eligible individuals through the HIV Drug Assistance Program. Beginning in 1994, Tennessee was required to use not less than 50 percent of its total award for the creation and operation of HIV Care Consortia because the state's population of individuals with AIDS equaled one percent or more of all AIDS cases reported to the Centers for Disease Control and Prevention. As of November 1996, five consortia covered all 95 counties.

Consortia

Thus far, formal monitoring of consortia activities has been limited. States use federal funds to establish and operate HIV Care Consortia—associations of one or more public and nonprofit entities that provide medical and support services to HIV-infected individuals and their families. Each regional consortium is similar to a task force and thus is not a legal, incorporated entity with the ability to contract with the state for Ryan White dollars. Therefore, lead agencies (e.g., United Way, community services agencies) are selected to serve as a conduit through which Ryan White funds are disbursed into the individual communities.

Pursuant to the Ryan White CARE Act, each consortium is to provide an on-going assessment of HIV/AIDS service needs for the geographic service area; establish a service delivery plan and priorities for the allocation of Title II funds based on the needs assessment; coordinate the delivery of HIV-related services; monitor and evaluate the services provided by its subgrantees; and evaluate the success and cost-effectiveness of the consortium's response to

identified needs. Each November, a Consortia Guidance and Application packet (containing all state and federal requirements) is sent to each consortium chair and lead agency representative. This packet contains checklists, reports, forms, and other documents that the consortium is required to complete. Department staff use this information to monitor the consortia's activities. However, it appears that development of a more comprehensive auditing or monitoring mechanism by AIDS Support Services would help ensure that funds are used appropriately, only eligible clients are served, and services are delivered effectively. Additional monitoring will be needed because following a change in federal regulation effective April 1997, states are no longer required to give the consortia 50 percent of Ryan White dollars. States may now base consortia funding on performance and must develop parameters for consortia activities, e.g., the use of specific data collection tools, uniform needs assessment surveys, and budgetary caps.

When the Ryan White funds first became available, the federal government provided few guidelines for the administration and use of these funds. Some agencies, according to staff, used these funds to purchase general office equipment and supplies for the consortia, although it is a federal requirement that the funds be used for medical supplies and other programmatic expenses. Concerns about one consortium led not only to a lead agency contract review by AIDS Support Services staff, but also to a 1996 Department of Health Internal Audit. The audit concluded that the Department of Health had allowed administrative expenses (specifically administrative travel and general office supplies) in excess of the 5 percent stipulated in the contract.

Home and Community-Based Care

The Home and Community-Based Care Program does not routinely check whether participants are also enrolled in TennCare (in which case TennCare is responsible for payment). Instead, Department of Health staff rely on providers to advise them whether a program participant has been enrolled in TennCare. The Home and Community-Based Care component of AIDS Support Services is a medical/dental/professional services billing system designed to allow HIV-infected individuals without insurance access to a network of providers. The providers bill the Department of Health for reimbursement, and medical services are paid for the client after the central office approves the claim. Approximately 1,700 services were provided for over 300 clients in the Home and Community-Based Care Program from January through November 1996. If the department pays providers for services covered under TennCare, the state is, in effect, paying the providers twice.

HIV Drug Assistance Program

Program staff's review of participants' eligibility is incomplete. The purpose of the HIV Drug Reimbursement Program is to pay for certain life-sustaining and infection-preventing drugs for low-income HIV patients who have no other method of procuring the drugs. Department rules also limit program eligibility based on an applicant's monthly income and liquid assets. However, the department does no income verification.

Housing Opportunities for People with AIDS (HOPWA)

HOPWA grants, sponsored by the U.S. Department of Housing and Urban Development, are designed to provide states and localities with resources and incentives to devise long-term strategies for meeting the housing needs of people with AIDS or related diseases. Funds, which are awarded to designated project sponsors throughout the state, are used for housing information services, resource identification, and short-term rent, mortgage, and utility payments. A review of the fiscal year 1995 HOPWA files indicated no evidence of on-site monitoring by AIDS Support Services and problems with the service providers' completion of quarterly and annual progress report questionnaires. Some form of assessment and monitoring is necessary to ensure the funding is used appropriately to provide housing for HIV and AIDS patients.

Recommendation

AIDS Support Services should ensure formal monitoring and auditing techniques are in place to determine whether the consortia (through their lead agencies and service providers) are using funds efficiently and effectively and in accordance with state and federal regulations.

The Home and Community-Based Care Program should coordinate with TennCare and should regularly check the TennCare database to determine whether program participants are eligible for TennCare benefits. In addition, the HIV Drug Assistance Program should verify participants' income to ensure eligibility.

To ensure funding is used appropriately, AIDS Support Services staff should conduct periodic on-site monitoring of HOPWA grantees and follow up concerns identified through review of grantees' progress reports.

Management's Comment

We concur with the recommendation.

DEPARTMENT'S SIX-MONTH FOLLOW-UP RESPONSE

The following is a progress report regarding the Total Quality Management approach adopted by AIDS Support Services in response to the performance audit. This report is divided into sections based on the original audit. It is important to note before reviewing each section that a general quality assurance and management process has been implemented, not only in the development of quality assurance monitoring tools, but in an overall way of doing business. Some examples include the following:

- Implementation of a Statewide People with AIDS Advisory Committee
- Quarterly meetings held with lead agency directors and medical care managers
- Job descriptions and orientation training for medical care managers

- On-site technical assistance provided to the individual consortia, health care providers, regional health offices, and community-based organizations upon request (eight on-site technical assistance visits provided in the last six months)
- At least quarterly attendance at regional consortia meetings by AIDS Support Services staff
- Quarterly statewide HIV/AIDS Care Planning Alliance meetings (statewide group developed as a result of the Statewide Coordinated Statement of Need process)
- Collaboration with HIV Prevention Program to provide technical assistance regarding how to write goals and objectives for statewide community-based organizations that are funded with prevention and care dollars
- Computer training for AIDS Support Services staff
- Biweekly AIDS Support Services staff meetings
- Development and dissemination of an AIDS Support Services annual work plan
- Development of a statewide dental policy
- Development of an RFP to implement an Insurance Continuation Program which will include payment of insurance premiums, co-pays, and deductibles for eligible clients
- Development of a fact sheet packet explaining each program funded by AIDS Support Services, disseminated statewide to all case managers and providers

Consortia. A Quality Assurance Monitoring Tool was developed based on the AIDS Support Services Consortia/Lead Agency Guidance document, which outlines the roles and responsibilities of the consortia and lead agencies and a timeline for completion of monitoring. The monitoring tool includes an action plan to be developed by the agency and AIDS Support Services, to ensure resolution to any areas that are not in compliance. Follow-up will be conducted by AIDS Support Services to ensure implementation of the action plan. Failure of the lead agency or consortia to implement corrective action for areas out of compliance may result in loss of funding.

Technical assistance training was held in May 1998 to discuss the monitoring tool and the expectations of AIDS Support Services for lead agencies and consortia. A work plan, which outlines the month in which each agency will be monitored, was developed and disseminated during the training session. [Please note that it is the responsibility of each lead agency to provide quality assurance monitoring of the community-based organizations (CBOs) funded by each regional consortium. A copy of the CBO monitoring tool will be reviewed during the monitoring review of the lead agencies.]

To address the concern that consortia have, in the past, used in excess of the 5% administrative expenses stipulated in the contract, a packet of information entitled "Conditions of Award" was developed by AIDS Support Services and technical assistance training was provided statewide to ensure compliance with this regulation.

Home and Community-Based Care. The issue during the audit was “If the department pays providers for services covered under TennCare, the state is, in effect, paying the providers twice.” Client intake into the Medical Services Program system is completed by a medical care manager (MCM). There is now in place at least one MCM in each public health region. All medical services must first be approved by the MCM and documentation received in the AIDS Support Services office before payment to a provider. The MCM determines whether the client is in receipt of TennCare benefits by requiring a denial letter from TennCare before approving the client for continuing services. As an added measure of quality control, before any invoice is paid by the Medical Services Program, a search is completed using the “TennCare Line,” which provides direct access by AIDS Support Services to the TennCare client records via computer link. Each invoice is approved only after determination that TennCare is not covering the services. Ryan White, Title II, remains the payer of last resort.

HIV Drug Assistance Program (HDAP). The HDAP has implemented income guidelines based on the Federal Poverty Guidelines and income verification through the medical care managers. As with the Medical Services Program, clients must be approved by the MCM prior to receipt of services through the HDAP. In addition, the HDAP now requires recertification every six months to ensure that client income levels have not changed and the client remains eligible for services. (Please note that a routine audit is completed of HDAP client records utilizing the “TennCare Line” to ensure that clients who are enrolled in TennCare are removed from the HDAP active files.)

The implementation of a Mail Order Pharmacy component of the HDAP will assist AIDS Support Services with quality assurance monitoring, drug utilization reports and patient adherence issues. This component is scheduled for implementation in November 1998.

Housing Opportunities for People with AIDS (HOPWA). A Quality Assurance Monitoring Tool has been developed for review of all HOPWA-funded agencies. The tool is currently under review by the Tennessee Housing Development Agency (THDA). The tool is similar to the consortia/lead agency tool, but is specific to HOPWA. (Please note in the work plan that months have already been selected for on-site HOPWA reviews. The review scheduled in July was moved to August as AIDS Support Services awaits approval from THDA.)

Individual meetings with the directors of community-based organizations receiving HOPWA funding through AIDS Support Services have already been conducted. Expectations have been defined and the community-based organizations are aware of the upcoming HOPWA monitoring reviews. AIDS Support Services will be issuing an RFP for disbursement of HOPWA funds for 1999-2000, per the Tennessee Housing Authority Statewide Consolidated Plan.

Summary. AIDS Support Services has implemented, and in some instances exceeded, the recommendations made in the performance audit. For funded agencies, AIDS Support Services now clearly defines the expectations and requirements for receiving Ryan White funds, provides the tools and technical assistance necessary to carry out those expectations, schedules annual monitoring visits, and provides feedback via progress reports and action plans to ensure compliance.

EVALUATION OF DEPARTMENT'S FOLLOW-UP ACTIVITIES

Consortia/Housing Opportunities for People with AIDS (HOPWA). AIDS Support Services is making efforts to implement an on-site monitoring system to evaluate the operations of HIV consortia. The system, which was implemented in April 1998, uses a Lead Agency/Consortia Quality Assurance Monitoring Tool that evaluates various aspects of agency operations, including case management, subcontractor monitoring, communication with AIDS Support Services, and community collaboration. The monitoring tool—a checklist of records, policies, and reports to be reviewed—appeared to address the appropriate operational and fiscal areas. A monitoring tool for the HOPWA program has also been implemented and appears to cover the appropriate items. As of September 1998, AIDS Support Services had performed four agency reviews, including one HOPWA agency review. These reviews were performed on schedule, as required by the AIDS Support Services 1998-1999 Work Plan. All the lead agencies monitored were required to submit action plans to correct any problems uncovered. AIDS Support Services has implemented a tracking system to ensure that problems are corrected on time.

Home and Community-Based Care/HIV Drug Assistance Program. AIDS Support Services has also implemented a system to determine if clients are eligible for Home and Community-Based Care Program services. The system was implemented in April 1998. Medical care managers located in each public health region are responsible for the intake of clients. During intake, the managers determine if clients are eligible for services, including getting documentation from their physicians on their health status and determining whether they are covered by TennCare. Using this information, managers fill out a “Notice of Patient Eligibility” form for each client. Managers also try to enroll patients in programs they are eligible for, including Social Security Disability and TennCare. In addition, medical care managers determine income eligibility for the HIV Drug Assistance Program. The managers contacted confirmed the implementation of the system.

AIDS Support Services staff provided documentation on the implementation of the following initiatives listed in the department's follow-up response: (1) a Statewide People with AIDS Advisory Committee, (2) quarterly meetings with lead agency directors, (3) a medical care manager job description, (4) quarterly meetings with medical care managers, (5) quarterly HIV/AIDS Care Planning Alliance meetings, (6) a fiscal year 1999 work plan, (7) a statewide dental policy, and (8) a fact sheet package explaining AIDS Support Services programs.

Recommendations. AIDS Support Services should continue to monitor HIV Care Consortia, associated lead agencies, and HOPWA providers. AIDS Support Services should also continue determining client eligibility for services, including verification of income for the HIV Drug Assistance Program.

Management's Comments. We concur. AIDS Support Services will continue the process already set in place to monitor the HIV Care Consortia, associated lead agencies, and HOPWA providers. AIDS Support Services will also continue its efforts to determine client eligibility for program services and TennCare enrollment and coverage.

FEBRUARY 1998 AUDIT FINDING 4

Inconsistent reporting by private physicians hinders efforts to track and control communicable diseases

The Department of Health cannot confirm that private physicians consistently report all communicable infectious diseases and therefore cannot provide assurance concerning the accuracy of the data used to track communicable diseases. Since this problem was noted in the March 1990 performance audit of the Department of Health, the department has developed an automated reporting system and has increased contact with physicians' offices in order to facilitate reporting. However, department staff acknowledged that reporting, though improved, is still inconsistent and incomplete.

Tennessee Code Annotated, Section 68-5-102, and Section 1200-14-1.03 of the Department of Health's Rules require physicians to notify public health authorities when any disease classified as "notifiable" or "reportable" is discovered. Communicable diseases and/or those dangerous to the public are considered notifiable (reportable) diseases and are to be reported to the local health officer or local health department by all physicians and other persons knowing of or suspecting a case. All three types of facilities—hospitals, physician's offices, and laboratories—are responsible for supplying the Department of Health with this information each week. The reportable diseases are grouped into four categories:

Urgent Category I	Diseases requiring immediate reporting to the county health department (e.g., measles, encephalitis)
Routine Category II	Diseases for which only morbidity reports are required (e.g., tetanus, malaria, gonorrhea)
Total Count Category III	Diseases such as chicken pox or influenza for which only the total number of cases seen needs to be reported
Special Reporting Category IV	Diseases that require special confidential reporting (i.e., HIV, AIDS)

In January 1996, the paper reporting system was replaced by an automated reporting system, National Electronic Telecommunications System for Surveillance, in all six metropolitan county health departments and three of the seven regional health departments. This system was designed to enable the department to generate communicable and environmental disease data and track those data weekly, monthly, and annually. All 13 regions are capable of receiving compiled disease data from the Department of Health; however, four of the seven regional offices do not yet have the equipment needed to transmit data from their region to the system. According to department staff, the four offices were scheduled to be linked to the system by June 30, 1997.

Although it acknowledges the probability of widespread non-reporting of communicable diseases by private physicians, the Department of Health has taken no enforcement action against

physicians who fail to comply with statutory requirements to report communicable diseases. Possible explanations for the non-reporting include concern for the confidentiality of the doctor-patient relationship (e.g., in the case of sexually transmitted diseases), the low priority given this duty by physicians, and the difficulty in proving non-reporting. The department has, however, heightened its efforts to increase reporting with its own network of field representatives stationed in the county health departments. These representatives maintain weekly contact with physicians' staffs in each county in an attempt to identify communicable disease information not already reported.

Nonreporting of communicable diseases can result in the misdirection of medical resources and personnel to counties or regions not needing these services or in insufficient disease intervention activities, thereby increasing the financial burden on the state's health care system. Also, the time department staff must spend contacting physicians could be better used for disease prevention and control.

Recommendation

The Department of Health should (1) complete the linking of the four regional offices to its automated reporting system and (2) continue to use its field representatives to encourage reporting by physicians and to obtain additional communicable disease information. The department should consider taking enforcement action against those private physicians who continually fail to report communicable diseases.

Management's Comment

We concur in part. The Department of Health CEDS surveillance program completed the linking of the four regional offices to its automated reporting system as of January 17, 1997, giving complete automation of all 13 regional offices. The program continues to use regional CDC nurses/epidemiology personnel (field representatives) in each region to encourage reporting by physicians and to obtain additional communicable disease information. The program believes that taking a positive, practical approach with physicians will result in greater success than a punitive approach. There has been a continuous improvement in reporting throughout Tennessee since all regions are now automated and receiving feedback weekly on all 52 notifiable diseases/conditions. CDC nurses/epidemiology personnel efforts in each region are an invaluable part of the process. They work closely with local physicians to improve reporting. When the new communicable disease reporting form is approved this fall, local/county health department nurses will be encouraged to hand deliver them to any private physicians who fail to report notifiable diseases or are inconsistent in reporting. The program will also begin working with managed care organizations to improve reporting across the state. On the horizon is electronic laboratory reporting which will greatly enhance the surveillance system and represents the best opportunity to improve disease reporting.

DEPARTMENT'S SIX-MONTH FOLLOW-UP RESPONSE

All 13 regional health offices are electronically linked for automated disease reporting. In-service training and conferences for local and regional epidemiology staff are conducted quarterly. Personnel from the Centers for Disease Control and Prevention (CDC) will conduct a formal two-week epidemiology training for local and regional epidemiology staff in May 1999. Local and regional epidemiology staffs have established communication ties with hospital and nursing home infection control practitioners. Articles published in the *Tennessee Medical Association Journal* and the state's *Epi News*, a bimonthly publication distributed to more than 7,000 health professionals across the state, have provided the most current list of notifiable diseases and stressed the importance of complying with requirements to report those diseases and conditions.

Proper disease surveillance is dependent upon timely, accurate, and complete reporting of disease occurrence. Dependence on passive surveillance, i.e., reporting of disease by practitioners, laboratories, etc., is notoriously ineffective throughout all states and territories as noted by the CDC and the Council of State and Territorial Epidemiologists (CSTE). In an effort to improve disease reporting throughout the country, the annual meeting of CSTE always has a workshop addressing notifiable diseases, emerging infections, and surveillance.

Active surveillance is superior to passive surveillance, and in Tennessee, active surveillance programs employing sentinel physicians, hospitals, and laboratories; focused surveillance for specific diseases; and robust case contact tracing have done much to improve disease reporting. Additionally, the Department of Health has received a five-year grant from the CDC to enhance surveillance and electronic laboratory reporting. We have applied for additional funding through a grant to further enhance reporting of new and reemerging infections. When all of these various surveillance initiatives are in place, Tennessee will have one of the best notifiable disease reporting programs in the United States.

Although there is a statutory requirement to report diseases on the notifiable disease list (with failure to do so constituting a Class C misdemeanor, subjecting the offender to not more than 30 days and/or a \$50 fine), the penalties have never been imposed in Tennessee or any other state as far as is known. Imposing penalties for failure to report notifiable diseases is not likely to improve compliance, and it is the consensus of CDC and CSTE representatives that doing so would be counterproductive. Physicians tend to focus more on the individual patient rather than the population and hence often do not think to report diseases to the health department. Rather than penalize physicians for failing to report, we must continue to work with them to emphasize the importance of disease reporting. Every effort will be made to continue improving disease reporting through education and improved networking and collegial association among health department personnel and practitioners, hospitals, clinics, and laboratories.

EVALUATION OF DEPARTMENT'S FOLLOW-UP ACTIVITIES

The department has linked all 13 regional health departments to the National Electronic Telecommunications System for Surveillance to track communicable diseases. However, the

department has not implemented an active surveillance system, except for a system to track flu on a seasonal basis.

Recommendation. The department should pursue implementation of active surveillance programs and should also continue efforts (such as publishing *Epi News*) to educate private physicians on the need to report outbreaks of communicable diseases.

Management's Comment. We concur. The Department of Health continues to pursue active surveillance programs with influenza sentinel physician surveillance. Staff actively participates in electronic laboratory reporting development meetings chaired by the Bureau of Information Resources, and in vaccine preventable diseases surveillance follow-up. A web page was created to communicate notifiable disease data to all health care providers and citizens of Tennessee. Web site information is updated regularly.

Tennessee was recently designated an Emerging Infection Program state. This CDC-funded program based in the department will allow for active surveillance of foodborne illness cases, as well as active surveillance for common bacterial bloodstream infections and cases of encephalitis without a known cause. This program will greatly augment an existing surveillance system.

FEBRUARY 1998 AUDIT FINDING 5

Vital records are not sufficiently safeguarded and are not easily accessed statewide

The Office of Vital Records has no back-up for over 40 percent of the state's vital records, has not adequately developed its existing database resources, and has not updated or fully developed its disaster recovery plan. In addition, access to certain vital records has been a problem in some counties.

Lack of Back-Up

Because of resource constraints, the Office of Vital Records has not backed up on microfilm over 4.5 million of the 11 million records in its files. The documents that have not been backed up consist mainly of marriage and divorce certificates, as well as older death certificates. The following records had not been backed up as of August 1996:

- 158,030 birth certificates
- 39,500 delayed birth certificates (birth certificates not immediately filed)
- 1,194,070 death certificates (primarily death certificates prior to 1969)
- 2,182,979 marriage certificates
- 942,371 divorce certificates

According to department staff, these paper documents are in jeopardy because of the amount of handling and their age. In addition, limitations in the Department of Health's Automated Index Retrieval System (see discussion below) increase the number of documents department staff are forced to handle.

Lack of Development of Existing Resources

The Office of Vital Records uses the Automated Index Retrieval System (AIRS), a series of indexes (abbreviated, alphabetized abstracts which refer to a vital record), to file and organize its data. The office uses AIRS to issue short-form birth certificates (i.e., certified abstracts of the original birth certificates) and to access document file numbers. As of August 1996, several indexes were missing from the AIRS database, including marriage and divorce indexes prior to 1972. Over 87,000 death certificates have to be retrieved manually if needed because the office does not have death indexes for 1946 through 1948. Birth indexes prior to 1922 are not on AIRS; birth indexes from 1922 to 1949 cannot be accessed because of error codes (a lack of sex coding and other information necessary to complete a short-form birth certificate).

In its fiscal year 1995 budget, the Department of Health requested, but did not receive, funds for an image processing system to scan, preserve, and issue vital records. Funding (\$520,000) for such a system is included in the Governor's 1997-98 budget. However, department staff indicated that the Office of Vital Records needs to develop the database resources on the AIRS to a greater extent before acquiring the image processing system because the system can be used more effectively if AIRS indexes are complete. Additionally, documents with error codes need to be corrected before they can be scanned onto the system's magnetic disks.

Limited Access

Residents of some counties have limited access to vital records. Ten rural counties and three regional health departments in Tennessee issue short-form birth certificates; three metropolitan counties (Davidson, Hamilton, and Knox) issue both short-form and long-form birth certificates; and 55 counties accept applications and fees for short-form birth certificates. Because Shelby County is not on AIRS, it can issue only long-form birth certificates (certified photocopies of original certificates). Birth certificates for persons born before 1949, except for those born in Shelby County, have to be obtained from the Department of Health's central office. Marriage and divorce certificates must be obtained through the Department of Health's central office as well. All counties can issue death certificates for deaths that occurred within the last three years in that county; in addition, some counties maintain records for longer periods of time.

Copies of birth certificates are often requested because they are required to enroll children in school, obtain a passport, etc., but obtaining copies is often difficult in those counties not on AIRS. According to department staff, the decision to provide short-form birth certificates is left to the counties. The expense appears minimal (installing a phone line connecting the county to AIRS) considering the convenience local access to the records would provide the residents of the county. Provision of this information at the local levels ensures immediate

access to customers and would appear to decrease the time central office staff spend retrieving the documents.

Disaster Recovery Plan

The Office of Vital Records has not updated its disaster recovery plan since 1992. Because logistics, requirements, and technologies change, it is important that the plan be updated regularly. In addition, there is no assurance staff are aware of the details of the plan since the only copy of the plan is kept at the director's residence. Furthermore, the disaster recovery plan does not appear to contain specific steps necessary to ensure sufficient back-up of records and to reestablish the office in the event of an emergency.

Recommendation

The Office of Vital Records should correct errors in its paper documentation and in its microfilm archives. A timetable should be established for placing all records on microfilm (or magnetic disk if image processing becomes available).

The Office of Vital Records should expand the indexes in the AIRS database to include all the birth, marriage, death, and divorce records currently stored in its archives.

The Department of Health should determine the feasibility of providing on-line access to AIRS to all counties in the state to increase the efficiency of vital record access.

The Office of Vital Records' disaster recovery plan should be updated and the details (i.e., actions to take in the event of a disaster) should be communicated to office staff. The plan should contain provisions for the adequate back-up of records, as well as specific information on procedures, chain of communication, and each person's specific tasks in the event of a disaster.

Management's Comment

We concur. The Vital Records Office has researched various methods of providing security copies of the vital records and other supporting documents that are now stored in the office. An image processing system is considered to be the best solution for providing security of the documents and for improving the efficiency of providing the services for which the office is responsible.

The Department of Health's Office of Vital Records received a budget improvement item of \$520,000 in the fiscal year 1997-1998 budget. This budget improvement was requested as the first of two budget improvements needed in order to implement an image processing system for the Office of Vital Records. The second and final budget improvement in the amount of \$227,000 needed to implement an image processing system will be requested for the fiscal year 1998-1999 budget. If this second request is approved, the office will be able to purchase and implement the image processing system which will fulfill two of the four recommendations contained in the audit. Those recommendations are the ones relating to storing a backup of all records and expanding the indexes in the AIRS database. Implementation of this system will

begin during the current fiscal year; however, it is a long-term project and will require at least four years for all records to be converted to disk storage.

The third recommendation that will not necessarily be implemented as a result of an image processing system concerns on-line access to AIRS in all counties in the state. Such access to the database for the purpose of issuing birth certificates is now available to all counties; however, not all county health departments choose to access the database. These counties often do not have the personnel resources to devote to issuing birth certificates. Only one large county (Shelby) does not provide birth certificates from the state file. Personnel within the Shelby County Health Department are considering the financial feasibility of issuing birth certificates from the state database at the beginning of 1998. Also, the Upper Cumberland Health Department Region has definite plans to begin local issuance in October 1997 in Putnam County, and intends to gradually provide such services in the other counties of that region.

The fourth recommendation concerns the office's disaster recovery plan. The image processing system will provide adequate backup of the records and the indexes. The office considers backup of the records the first and most important step in disaster planning. There are no immediate plans to develop a plan to address, for example, chain of command and each person's specific tasks in case of a disaster. Additional funding and expert assistance would be needed in order to develop such a plan.

DEPARTMENT'S SIX-MONTH FOLLOW-UP RESPONSE

Protection of Vital Records. The department determined that imaging technology would provide a security copy of all the records and related documentation and would improve the efficiency with which the Vital Records Office provides services to its customers. In fiscal years 1998 and 1999, the department was awarded two budget funding improvements to obtain and implement this technology. The Department of Finance and Administration's Office for Information Resources (OIR) Budget Review Committee has approved the image project.

As of July 24, 1998, the project team, which consists of staff from the Department of Health and OIR, are working closely with the integrator (KPMG) that was hired to design and implement the image processing system for the Office of Vital Records. The contractor has recently completed actions under Phase I of the project. Hardware has been ordered. Software needs are being evaluated for selection and purchase or for custom design. The system should be completed, tested, approved, and in use before the end of calendar year 1998. After implementation of the computer system, all new, incoming vital records will be immediately stored as electronic images. Concurrent with the design, development, and implementation of the computer system in 1998, the department will begin the project to convert all existing vital records to an electronic image.

The KPMG consultants were required by contract to provide recommendations for the conversion of the records to image. The State accepted their recommendations on July 22, 1998. The project team is now preparing an RFP for conversion of the existing records to image. The conversion of old records will be done partly by an outside vendor and partly by temporary

personnel hired to perform the task within the Vital Records Office. Although record back-up is planned to begin during calendar year 1998, the entire conversion and back-up process will require about three years, because of the large number of records (13 million) involved.

The conversion process will also link the image of the record to the Automated Index Retrieval System (AIRS). One of the audit issues related to the fact that AIRS is not complete for all years of birth, death, marriage, and divorce records. Within the past year, many additional records have been added to or corrected on the AIRS database in preparation for the image project. As part of the conversion process, these AIRS indexes will be completed. It should be noted that the office has complete indexes of all records in its archives; however, not all indexes are computerized.

Statewide Access to AIRS. In 1988, the state Vital Records Office made the AIRS birth record database available for all county and regional health departments. Local staff have made the decision whether and when to access the database and issue short-form birth certificates. Since the performance audit, additional counties or health department regions have begun to issue short-form birth certificates. As of July 24, 1998, there were 22 sites that accept applications and print the short forms. In addition, 43 other counties accept applications, but the certificates are printed and mailed from the appropriate regional health department office.

The statewide coverage for issuance of short-form birth certificates is considered to be complete except for Shelby County. In some parts of the state, the regional health department offices evaluated population distribution and staff availability and selected strategically located counties to issue certificates daily as opposed to printing at the regional office or having every county issue certificates. The Shelby County Health Department has tentative plans to begin accessing the statewide database for issuance within this calendar year; however, that department already issues the long-form birth certificates for births that occurred in Shelby County. Access to AIRS will permit them to issue short-form certificates for births that occurred in Shelby County and also to issue birth certificates for persons born in other Tennessee counties.

Disaster Recovery Plan. The image processing system will provide adequate back-up of the records and indexes. The Office of Vital Records considers back-up of the records to be the first and most important step in disaster planning. There are no immediate plans to develop a plan to address, for example, chain of command and each person's specific tasks in case of a disaster. Additional funding and expert assistance would be needed in order to develop such a plan.

EVALUATION OF DEPARTMENT'S FOLLOW-UP ACTIVITIES

Lack of Back-Up/Disaster Recovery Plan. According to Vital Records staff, as of November 18, 1998, no records had as yet been converted to electronic image. Image processing should begin in January or February 1999; it is expected to take at least three years to convert all vital records to the system. Staff stated that the office does not have the necessary resources to develop a more comprehensive disaster recovery plan; therefore, the back-up of these records using the imaging system will constitute the department's recovery plan for the foreseeable future. The office does use the state's off-site information depository to store back-up information that has

been put on magnetic cartridges, as part of its participation in the state's Business Resumption Plan. The plan's main purpose is to enable state organizations to survive disasters, either natural or man-made, and reestablish normal business operations.

Lack of Development of Existing Resources. As of November 1998, Automated Index Retrieval System (AIRS) indexes were still incomplete for the periods noted in the February 1998 performance audit.

Access. The department's response describes current access to birth certificates. However, official state marriage and divorce certificates are only available through the central office. Copies of county records (i.e., divorce decrees or marriage certificates) can be obtained from officials of the county where the event occurred. Official state death certificates can be obtained only from the central office or in Davidson, Hamilton, Knox, and Shelby Counties for deaths that occurred in those counties. All other counties can issue their own death certificates for deaths that occurred in that county within the last three years.

Recommendations. The department should convert all vital records to the electronic imaging system as soon as possible. The department should work with the counties to improve citizens' access to marriage, divorce, and death certificates. The department should fully develop and implement an updated disaster recovery plan.

Management's Comments. We concur. Proposals from vendors to handle the backfile conversion of the vital records were evaluated in December 1998. Intent to award a contract was announced on December 15, 1998. On January 4, 1999, one of the unsuccessful bidders filed a protest with Commissioner John Ferguson of the Department of Finance and Administration. Because of the protest, the department is not sure when conversion will begin.

Review of the vendors' proposals indicated that conversion of 10.5 million vital records could be accomplished in less than one year for about \$1.5 million. This conversion would include all birth and death records. The department is pursuing the availability of funds to pay for conversion of marriage and divorce records.

The department is of the opinion that citizens' access to death, marriage, and divorce certificates at the county level is essential in order to provide good customer service. It must be mentioned that, when providing vital records services, the department serves not only persons who live in Tennessee, but also persons who do not reside in Tennessee but need a record of a Tennessee event.

In determining how to improve access, the department has given consideration to the number of marriage, divorce, and death records that are requested and issued from the state office. The general public does not frequently need marriage or divorce records. The state Office of Vital Records issues only 800-900 divorce copies and less than 3,000 marriage copies each year. With the relatively low number of public requests made to the state office, the department does not feel justified in requesting improvement funding to make every marriage and divorce record available from every county without regard to county of occurrence. As stated, records of

marriage and divorce are available locally in the county where the marriage license was issued or from the court where the divorce was granted.

Similarly death records are available, at least for the past three years, from the county health department in the county of death. This availability satisfies the vast majority of needs that families have for a death certificate. Most death certificates are requested and needed within the first few weeks after the death; generally the funeral director obtains the copies on behalf of the family at the time he/she submits the original certificate to the county health department. The state Office of Vital Records issues only about 15,000-20,000 death copies a year. Many of these requests come from out of state; thus, local issuance may not significantly improve public service. Although the department may in the future request funding in order to issue death certificates at the local level using the image processing system, there is no defined time frame for this project.

The department believes that protection of the records by means of conversion to optical disk and storage of a back-up disk offsite is the essential and primary preparation for a disaster recovery for vital records. This process will begin with the award of a contract to a vendor for the backfile conversion.

FEBRUARY 1998 AUDIT FINDING 6

General Environmental Health's inspection time frames are not always met

The department's Division of General Environmental Health inspects several types of entities—food service establishments, hotels and motels, organized camps, bed and breakfast inns, swimming pools, schools, and day care centers—to enforce compliance with laws and regulations concerning sanitation and safety. The department contracts with the governments of Davidson, Hamilton, Knox, Madison, and Shelby Counties to inspect entities in their counties. Neither the department nor the contract counties have always met the required inspection time frames—monthly inspections for swimming pools (while in operation) and inspections every six months for all other entities.

Through its database, the division tracks inspections and critical violations and generates a list of entities that have not been inspected in the six-month period. For the first six months of 1996, division records indicated that 28,067 should have been inspected; 4.4 percent (1,237) were not inspected. Division staff in the field offices failed to inspect only 2 percent (310 of 15,642) of the entities for which they were responsible; the five contract counties failed to inspect 7.5 percent (927 of 12,425).

Using the division's database, we reviewed inspection information for 5 percent of the hotels and motels, organized camps, public swimming pools, bed and breakfast inns, day care centers, and schools required to be inspected by the field offices. This review found that 16 of 383 entities, or 4.2 percent, were not inspected during the first six months of 1996. Swimming

pools and day care centers had the largest percentage of entities not inspected; day care centers, pools, and hotels were most likely to have critical violations (i.e., those violations that present an imminent threat to public health). We also reviewed inspection information for 435 food service establishments in the contract counties—6.7 percent were not inspected during the first six months of 1996.

Even though the division apparently maintains an adequate database to track inspections and violations, some establishments, according to staff, were simply overlooked or could not be inspected as required. Noncompliance with the required inspection time frames could undermine the regulations designed to protect the health and safety of those served by these entities. Our review of inspection files at three county field offices found that some entities had numerous critical violations each time they were inspected. Although the violations were corrected after each inspection, the fact that critical violations kept recurring highlights the need for timely inspections and perhaps more severe sanctions to protect the public.

Recommendation

The Director of the Division of General Environmental Health should work with the department's regional directors to ensure that all permitted entities are inspected in compliance with statutes.

The Division of General Environmental Health should improve its oversight of the five metropolitan counties to help ensure that they comply with the inspection time frames specified in their contracts.

Management's Comment

We concur. Because of staffing shortages, the division was unable to fully comply with its quality assurance program. Quality assurance initiatives are currently being strengthened which will improve or eliminate any deficiencies in this area.

DEPARTMENT'S SIX-MONTH FOLLOW-UP RESPONSE

The performance audit identified two issues relating to sanitation and safety compliance inspections of food service establishments, hotels and motels, organized camps, bed and breakfast facilities, public swimming pools, school plants, and child or day care centers. These issues stated that first, not all establishments received the required number of inspections and second, there was a greater need for quality assurance and metropolitan contract oversight. The audit stipulated that not every establishment, according to the computer database, received a complete inspection for the period January to June 1996. By expanding this to a fiscal year, there were a number of establishments that would not have required two inspections for the year. For the purposes of responding to the audit, this report will use the period July 1, 1997, through June 30, 1998.

A report of establishment inspections is obtained semiannually and reconciled for discrepancies to ensure that the required number of inspections are performed according to rules and departmental policy. As a matter of standard operating procedure, the specifics of the report are verified against the local county health department files, any discrepancies are noted, and further action or corrective measures are provided. The local county health department's files are the "official" records. The data system is a management tool and does not, nor is it intended to, replace or mirror the county files.

There are several reasons the computer database indicated inspections were due, when in fact they were not. The database has not been programmed to differentiate these reasons, and therefore requires management personnel to compare information against the official county records. Most of the establishments do not require or have these inspections for the following major reasons:

1. Establishments are seasonally opened (e.g., many church and girl scout camps operate one to two weeks per year; concession stands at summer operations; college stadiums).
2. Establishments are temporarily out of business and wish to maintain current permits.
3. Not all establishments require an inspection every six months or two inspections per year. For example, school plants no longer have mandatory inspections. Schools are inspected based upon county-specific local board of education requests. The Department of Health does not contract with the counties to perform these inspections. In addition, the Departments of Human Services and Children's Services, as specified in Section 71-3-519, *Tennessee Code Annotated*, are required to inspect childcare centers at least annually. As a courtesy to the Department of Human Services, and based upon contracts and/or letters of agreement, the Department of Health provides annual environmental health and safety inspections of childcare centers. Department of Health contract counties also provide these inspections; however, the services are not contracted. Therefore, the Department of Health does not provide oversight.
4. Establishments opened after July. A second inspection is not required for the reporting period.
5. Establishments are out of business, duplicate accounts, changes of ownership, or other similar administrative matters and remain active on the computer system.

The following is the fiscal year 1998 status of the General Environmental Health's regulatory inspection program. Of the 28,405 regulated establishments, the computer database suggests 1,667 did not have two complete inspections for the period July 1, 1997, through June 30, 1998. An audit of official county files shows that less than 500 or 1.6 % of the establishments did not have the required inspections.

Field Office	Computer Database*	Official County Files*	Percent Inspected**
Northeast	106	4	99.8
East	76	5	99.9
Southeast	46	0	100
Cookeville	47	0	100
Mid-Cumberland	41	0	100
South Central	10	0	100
Northwest	62	0	100
Southwest	147	6	98.4
Field Office	535	25	99.8
Shelby	441	289	93.0
Davidson	226	69	98.1
Knox	225	38	97.3
Hamilton	89	0	100
Jackson	151	44	89.5
Contract Counties	1,132	440	96.3
State	1,667	465	98.4

* Computer database or county files reporting two inspections were not performed.

** Percentage of total permitted or regulated establishments.

The performance audit stated that 4.4% of the establishments lacked an inspection. Similarly, using computer database information only, the above chart reflects that 1,667 or 5.8% of the establishments did not receive the required inspections. However, an audit of official county files showed that the actual percentage is considerably less than the indicated database percentages. It is reiterated that the computer database is a management tool and the official inspection records are maintained at the local county health department. Second, the audit stated that greater emphasis was required in the areas of quality assurance and metropolitan contracts. The division understands that there are problems in this area and personnel were reorganized to resolve this issue. Division personnel currently have a schedule to provide quality program assessments to all field offices and contract counties within fiscal year 1999. The division is expanding emphasis on quality monitoring that will focus on having the required number of inspections per year.

EVALUATION OF DEPARTMENT'S FOLLOW-UP ACTIVITIES

Division of General Environmental Health staff stated that they use county health department information to verify inspections of entities identified as uninspected by the division's computer system, and provided documentation of a verification performed during Summer 1998. However, the division could not provide documentation of past periodic verifications. In addition, the division's quality assessment policies and procedures, which are ten years old, do not mention the need for timely inspections. As of November 1998, only one of three program assessments of county health departments scheduled for the first quarter of fiscal year 1999 (i.e., July 1,

1998–September 30, 1998) had been completed. We reviewed the draft assessment report for Davidson County—the assessment process the division used appeared appropriate and sufficient.

Recommendations. The department should conduct inspection verifications periodically and maintain adequate documentation of those verifications. The department should also update its quality assessment policies and procedures to emphasize the timeliness of inspections.

Management’s Comments. We concur. To verify and maintain documentation of proper frequency of inspections, field office managers and contract county directors shall implement the following:

The field office managers and contract county directors shall submit a plan to the director no later than January 31, 1999, that will assure complete adherence to the requirements of the law and the division’s requirements for minimum inspection frequency. The director will review and approve the plan if it is satisfactory.

Each field office manager and contract county director shall put the following plan into effect:

1. On June 1 and December 1, a computer report showing all establishments not inspected since January 1 and July 1, respectively, shall be available to each field office manager/contract county director for distribution.
2. Each environmentalist shall reply within seven days to the field office manager/contract county director (via his/her supervisor or directly) stating when each establishment will be inspected, why it cannot be inspected, or why it does not need an inspection.

In either case, the field office manager or county contract director shall report to the director before January 31 and July 31, respectively, accounting for 100% of the establishments shown on the report.

General Environmental Services will rectify any perceived problem in quality assessment policies and procedures by placing an emphasis on timeliness of inspections in the Quality Assessment guidelines document and during actual Quality Assessment surveys.

FEBRUARY 1998 AUDIT FINDING 7

Monitoring of some Maternal and Child Health programs is limited

Although the Bureau of Health Services has some monitoring mechanisms in place for programs in the Maternal and Child Health division, monitoring for some programs is limited. The 1994 Division of State Audit financial and compliance audit found that the Department of Health’s monitoring plan for the Maternal and Child Health Services block grant did not ensure each contractor was monitored periodically—four of the five subcontractors tested were not

monitored on-site during the fiscal year. Similar findings were reported in the 1995 and 1996 financial and compliance audits, and a review of files during this performance audit also disclosed little evidence of on-site monitoring. As a result, the department's management controls may not ensure that the Maternal and Child Health funds are being used appropriately and according to state and federal requirements.

Maternal and Child Health administers many programs, providing health services to women of child-bearing age and to children in low-income populations in an effort to reduce maternal and infant mortality and morbidity. The goal of Maternal and Child Health is to have a statewide network of comprehensive community-based health care systems that serve women of reproductive age, infants, children, adolescents, and children with special health care needs. For fiscal year 1997, Maternal and Child Health's budget contained over \$16 million in federal funds and over \$13 million in state matching funds. This funding currently supports newborn and genetic screening, women's health services, home visitation, child fatality surveillance, case management and outreach services, supplies and equipment for children with special health care needs, and Child Health and Development.

Mandated Monitoring

Both federal funding guidelines and the state statutes establishing some programs (e.g., the Resource Mothers program) require the department to monitor the programs it administers. The Maternal and Child Health grant from the U.S. Department of Health and Human Services requires that the Department of Health submit information on annual health status objectives, activities to meet those objectives, and methods to monitor and evaluate the objectives. Monitoring methods listed by the department included the review of monthly and quarterly reports to evaluate and note problem areas, site visits for contract monitoring, internal audits of records, and a comparison of programs in order to recommend changes. Maternal and Child Health management stated that the division tries to monitor as much as possible, usually at least once a year, but acknowledged that the division has had serious problems in the past with not documenting site visits.

Family Planning

In calendar year 1995, the Family Planning Program provided 93,055 patients comprehensive family planning services including medical examinations, laboratory tests, education and counseling, and contraceptive supplies. Family Planning services are provided at 142 clinic sites in all 95 counties of the state through local and metropolitan health departments and private non-profit agencies; two Planned Parenthood clinics and the Memphis Health Center are under contract to provide family planning services. In the Fiscal Year 1995 Maternal and Child Health Annual Report, the department reported that all contracts and most county-based programs are visited each year to assess the progress and problems associated with the delivery of family planning services. However, the files contained evidence of a clinical site visit in fiscal year 1996 for only 13 counties and for none of the three private contractors.

Child Health and Development

Child Health and Development services, designed to identify, prevent, and/or correct developmental problems, are administered through health departments in 41 counties. Child Health and Development follows national Social Security block grant guidelines in providing services to children under six years of age at risk of child abuse and neglect or children under six years of age at risk of or with manifested developmental delays, or with a verified handicap. Tennessee's Department of Children's Services contracts with the Department of Health to administer the Child Health and Development program.

The Department of Health does not monitor the program because the Department of Finance and Administration, Resource Development and Support, conducts an annual Child Development audit. The Department of Finance and Administration issues four regional reports, varying the counties visited in the regions every year. As a result, every county's Child Health and Development program is not monitored yearly. Additionally, in 1995, the University of Tennessee College of Social Work evaluated the program using family preservation funds from the Department of Finance and Administration. The audits and the evaluation differ in that the Department of Finance and Administration's primary focus is financial eligibility. The University of Tennessee's evaluation of the program described service provision and the characteristics of participants and identified participant outcomes associated with receiving services. Despite the usefulness of the Department of Finance and Administration's audits, some effort to routinely monitor more than financial eligibility would seem to benefit program administration.

Children's Special Services

Children's Special Services provides evaluation, diagnosis, education, counseling, comprehensive medical care, and case management services for handicapped or chronically ill children ages birth to 21 years. To be eligible for Children's Special Services, the child must be a resident of Tennessee and meet the program's medical eligibility guidelines; once a child is eligible, all services are provided at no cost to the family. Children's Special Services divides the state into seven regions and has established a pediatric health clinic in the main office of each region, as well as clinics in Nashville and Memphis. Roughly half of the children participating in the clinical component are served at the regional clinics; the other half go to private providers whom the state reimburses. Regional staff process the medical claims filed for children who see private providers and attempt to have private insurance or TennCare pay, when applicable. Claims not paid by TennCare or private insurance are then sent to the central office for payment.

Children's Special Services staff conducted on-site evaluations in fiscal years 1994 and 1996. All but one of the regions, staff stated, were visited in fiscal year 1996. As of November 1996 the financial monitoring portions of the 1996 evaluations had been written, but the program portions had not yet been completed. The financial monitoring portions of the six regional evaluations indicated that overall, most claims were appropriately processed. However, in one of the regions the evaluation found (in an overwhelming majority of the claims reviewed) no effort to bill TennCare and no explanation of why no effort was made. (The files showed no evidence of department follow-up of this potential problem.)

Routine monitoring by the central office will become essential since in January 1997 the regional offices assumed responsibility for reimbursement. As a result of this change, the central office will no longer have an opportunity to review claims before they are paid to ensure that Children's Special Services is not reimbursing providers for services that should be paid by TennCare.

Recommendation

Maternal and Child Health management should review current monitoring mechanisms to ensure they meet federal and state requirements and provide adequate assurance that funds are being used appropriately and that programs are effective. Monitoring should include periodic site visits and both a financial and programmatic review.

All monitoring visits by Maternal and Child Health staff should be documented in program files, and the service provider should be promptly notified of any problems and required to take corrective action. The department should follow up problems in a timely manner and take additional action if corrections have not been made.

Management's Comment

We concur. The fiscal years from 1994-1996 were marked with dramatic change in program operations and management functions. Additionally, these years reflected the first years of TennCare implementation when staff were assigned other associated job tasks. Monitoring that was conducted tended to concentrate on those agencies with contracts for specialized services such as genetics screening and counseling, Children's Special Services care coordination, and services for women. Program directors are now submitting annual plans for site monitoring visits to specified contract agencies and are required to file site visit reports with the section director within two weeks of completion of the site visit. This report is also sent to the service provider and, if corrective action is necessary, a timeframe for follow-up is specified in the site visit report.

A task force, designated by the section director, is also developing a uniform monitoring tool for use with Maternal and Child Health programs that is scheduled to be in place in January 1998. This group will also recommend methods for improving the efficiency and effectiveness of site visits including the use of multidisciplinary teams to monitor several programs during one site visit. The department's Patient Tracking Billing Management Information System (PTBMIS) data will serve as an additional tool for assessing program activity. This system is expected to be in place statewide by December 1997.

DEPARTMENT'S SIX-MONTH FOLLOW-UP RESPONSE

During fiscal year 1998, Maternal and Child Health (MCH) Program Directors completed 34 of 51 site visits and filed site visit reports with the MCH Director within two weeks of conducting the site visit. The site visit report is also sent to the service provider/contractor, and if corrective

action is necessary, a timeframe for follow-up is specified in the site visit report. The years 1996-1998 have served as a baseline period in which contract agencies under MCH were visited.

Concurrently, MCH staff developed a detailed plan to formalize the site visit schedule and procedures for MCH contracts. The site visit schedule is based on a risk assessment procedure similar to the procedure established by the department's contract office. The risk assessment sorts out those contract agencies into three-year segments. All agencies will be visited at least once during the three-year period in addition to review of financial and quarterly narrative reports about program activity. MCH staff has also developed standardized site visit monitoring tools, which combine information known by MCH with self-reported information from the agency. These items are combined with the site visit observations and specific program questions for a complete site visit report. This new section procedure was effective July 1998 for contract monitoring during fiscal year 1999. The preliminary site visit schedule for fiscal year 1999 has been established and reflects site visits by program area.

The section is developing a similar schedule for site visiting regional offices, which administer specific MCH programs such as Family Planning services and the Child Health and Development projects. Some counties delivering these services will be visited when the regional site visit occurs. The purpose of these visits will be program monitoring and technical assistance to ensure that services are modeling current best practices. Regions will be reviewed on the following schedule: Year 1—Northeast, East, Southeast; Year 2—Southwest, Northwest, South Central; Year 3—Mid-Cumberland, Upper Cumberland.

EVALUATION OF DEPARTMENT'S FOLLOW-UP ACTIVITIES

The Division of Maternal and Child Health is implementing an on-site monitoring system to evaluate the operations of its contract agencies. The system, implemented in July 1998, evaluates contract agencies involved in all Maternal and Child Health Programs (e.g., Family Planning, Child Health and Development, Children's Special Services) on a three-year cycle.

The division determines priority for agency review by using a risk assessment form. Criteria used in agency risk assessment include amount of funding, type of agency (e.g., private), and past problems. The division then makes an on-site visit using a Contract Monitoring Assessment Tool. The Director of Maternal and Child Health stated that if serious problems are found, a follow-up visit would occur; however, the division does not have formal, written procedures.

As of September 1998, the division had completed the assessment of two abstinence education programs and two family planning programs. Although risk assessment forms were found in the files of only two programs, documentation appeared otherwise complete. All four programs were scheduled for evaluation in fiscal year 1999, as indicated in the division's formal monitoring schedule.

Recommendations. The Division of Maternal and Child Health should continue monitoring its contract agencies. The division should ensure that all evaluation files have complete documentation and should develop and implement formal procedures for follow-up visits.

Management's Comments. We concur. The Maternal and Child Health Section will continue its efforts to monitor its contract agencies and to ensure that all evaluation files have complete documentation. In addition, the section is working on a plan for follow-up visits in order to assure appropriate and timely corrective action. As stated in the report, all four programs were scheduled for evaluation in fiscal year 1999, as indicated in the division's formal monitoring schedule.

In compliance with Finance and Administration Policy 22, the department has prepared and submitted a monitoring plan that includes all applicable contracts for the department.

FEBRUARY 1998 AUDIT FINDING 8

The department should continue improving administration of the WIC Program

The WIC (Women, Infants, and Children) program needs to continue its plans to implement on-site issuance of computer-generated WIC vouchers. The current system of voucher issuance involves the distribution of a large number of manual vouchers (especially in the metropolitan health regions), as well as the distribution of computer-generated vouchers from the central office in Nashville. This dual system is inefficient. Additionally, implementation of a unified reporting system needs to be completed. Currently, three information systems are used to track WIC program participants, creating data integration and flexibility problems. Finally, the department needs to reevaluate the decentralization of its system for monitoring WIC merchants and address potential conflict-of-interest issues.

Congress funded the Special Supplemental Food Program for Women, Infants, and Children in 1974 to help provide nutritious foods to supplement the diets of low-income pregnant and breastfeeding women, infants, and children. The WIC program was established by a grant from the United States Department of Agriculture and is administered through the Department of Health. As of December 1996, approximately 147,000 participants across the state were receiving WIC benefits.

Manual Vouchers

The WIC program issues participants vouchers to purchase certain foods through participating merchants. The WIC program most often issues manual vouchers in two situations: when program participants have immediate nutritional needs that cannot wait until the first of the month (when computer vouchers are issued) and when a WIC program participant has his or her vouchers damaged, destroyed, or stolen. Several large United States banks are responsible for producing and distributing manual vouchers which come in triplicate form, bound in books. Storing the manual vouchers at the clinic sites has historically been a problem since program requirements specify storage of manual vouchers in double-locked boxes or in rooms with double-locked doors.

Unmatched vouchers are those manual vouchers that do not match the program's issuance records (i.e., receipts don't correspond with computer records). According to a review of the vouchers issued by the rural and metropolitan health regions, regions that issue a high percentage of manual vouchers each month also tend to have a higher number of unmatched vouchers each month. For example, the Memphis/Shelby County Health Department had an average monthly issuance of 47% computer vouchers and 53% manual vouchers in fiscal year 1996, with unmatched vouchers averaging 936 per month. The Davidson County Health Department averaged 34% computer vouchers and 66% manual vouchers per month in fiscal year 1996, while generating an average of 475 unmatched vouchers per month. Unmatched vouchers require WIC program staff to spend time tracking records and verifying participant eligibility instead of working with program participants. A 1995 United States Department of Agriculture management review of Tennessee's WIC program noted the high rate of manual voucher issuance statewide. The review cited problems (e.g., lack of flexibility) with the system of voucher issuance as the cause of the high rate and recommended the implementation of a new WIC automated system (on-site issuance).

Computer Vouchers

The Bureau of Information Services in the Department of Health prints, issues, and mails computer-generated WIC program vouchers to the county and metropolitan health departments throughout the state. Computer-generated vouchers are issued in three-month installments unless special circumstances arise; staff stated that the vouchers are sometimes issued monthly or bimonthly to ensure participants come to the health department to receive other services, such as vaccinations. Roughly a third of all vouchers issued from central office have to be voided because the program participant they are designated for fails to pick them up from the clinic. The federal management review stated that a large portion of the manually issued vouchers resulted from the system's lack of flexibility. The review suggested the new system allow for one-, two-, or three-month issuance.

On-Site Issuance

The Department of Health plans to implement on-site issuance of computer-generated WIC program vouchers in early 1997. During the initial transition, manual vouchers will be used as a back-up; however, plans are to discontinue the use of manual vouchers after the transition has been completed. Department staff stated that the proximity of staff to participants during the issuance process will allow for better communication and fewer issuance mistakes. Also, time saved from the move to on-site issuance could be spent on such tasks as developing new forms of community outreach or administering additional nutrition education. Although on-site issuance will eliminate the need for clinics to use inconvenient safety precautions such as double-locked rooms, additional internal controls and monitoring in other areas will be required. For example, limited access to the WIC program's computer network will be necessary. Additionally, controls for the number of vouchers voided and reissued at the clinics will be needed.

Not every county will be able to move to on-site issuance immediately. Madison and Knox Counties do not currently use the department's Patient Tracking Billing Management Information System (PTBMIS) and, therefore, cannot begin on-site voucher issuance. The

counties have agreed to switch to the system at some point in 1997, but a time frame for the move has not been established.

WIC Reporting Systems

The lack of a unified reporting system for tracking WIC program participants has hindered staff's ability to collect program data. Three systems currently track WIC program participants—PTBMIS (Patient Tracking Billing Management Information System), the system used by Memphis/Shelby County and Davidson County, and the data entry forms used by Madison and Knox Counties. The use of three systems has created some problems because the Bureau of Information Resources cannot integrate all the participant information it receives into one system. Additionally, each system provides the WIC program with different information. For example, the data entry forms used by Madison and Knox Counties have not been revised in several years and do not have space for certain facts concerning WIC program participants. The limited information on these forms (no family size, income, etc.) makes it difficult for the Department of Health to supply information requested by the federal auditors. Finally, the computer system Shelby and Davidson Counties use is incompatible with PTBMIS. As a result, WIC program staff cannot read computer records to identify WIC participants who are also participating in the Commodity Supplemental Food Program. According to staff, the department hopes to have all counties on PTBMIS by the end of fiscal year 1997.

Monitoring

WIC program staff at the state and federal level agree that the objectivity of regional WIC directors may be affected by close relationships with WIC vendors (i.e., merchants authorized to sell WIC-approved foods). In some districts, the same person is responsible for authorizing, training, and semiannually monitoring vendors, as well as revalidating and replacing vendors. District staff are also responsible for high-risk identification and targeting of vendors for covert investigations as well as undercover compliance buys. A 1995 federal review stated that Tennessee's unique vendor management decentralization has resulted in close working relationships between regional office representatives and the vendors within their communities. The report indicated that although decentralization and the resulting close contact were good for WIC/vendor relations, there was a potential for a conflict of interest or even fraud. For example, a regional director could choose not to target WIC vendors who are personal acquaintances for compliance buys or other monitoring/investigative activities. The federal review recommended centralization and further automation of high-risk analysis and high-risk targeting and centralization of compliance investigations. Central office staff reported that they are beginning to use risk assessment information to target monitoring actions; however, most monitoring still appears directed from and conducted by staff at the regional level.

Recommendation

The Department of Health should (1) continue its move to on-site issuance of computer-generated WIC vouchers and monitor the performance of the new issuance system to ensure proposed new safeguards are adequate; (2) continue unifying WIC's system for reporting data on program participants through the statewide utilization of the Patient Tracking Billing

Management Information System; and (3) evaluate the current system for monitoring WIC merchants to determine if the system is effective or if conflicts or potential conflicts exist.

Management's Comment

We concur. WIC on-site issuance of computer-generated vouchers has been implemented in all regions except Hamilton and Madison Counties. Hamilton County is now using the department's Patient Tracking Billing Management Information System (PTBMIS) and is scheduled to implement on-site issuance on November 1, 1997. Madison County is scheduled to implement PTBMIS and on-site issuance on December 8, 1997. The new WIC on-site issuance system prints reports each day listing all vouchers issued and voided by each clerk. Controls over who may print and reissue vouchers are in place. The WIC Program will monitor the operation of the new on-site voucher issuance system to assure adequacy of voucher security. Monitoring guidelines for regional and state staff are drafted and are being tested, and results of monitoring will be evaluated to be sure voucher security is effective.

All data on program participants will be reported statewide through PTBMIS in December 1997. All counties will be on the same system. Accuracy and flexibility of reporting program data including participation will be greatly improved.

Because of the potential for a conflict of interest suggested by the 1995 federal review, the Tennessee WIC food delivery staff started developing an alternate system for vendor monitoring/investigative activities. The state program desired to provide separation between the WIC merchants and the regional WIC/vendor staff for monitoring WIC merchants by hiring compliance buyers through state contract to carry out undercover investigative buys from merchants identified as high risk for program abuse. The process put into place establishes a time table of four to five weeks to prepare for and execute three compliance buys in a selected store. Compliance buyers are trained and assigned high risk merchants to investigate by the state food delivery staff. The new monitoring procedure is being initiated on a small scale, and will be evaluated for the most effective operation.

DEPARTMENT'S SIX-MONTH FOLLOW-UP RESPONSE

On-site, on-demand voucher issuance is now operational statewide. Program staff worked closely with the department's Division of Internal Audit to ensure adequate safeguards were built into the new system. New features include system-generated daily receipt reports and void voucher reports that are reconciled against voucher receipts and voided vouchers on file for that day. New monitoring guidelines were developed in conjunction with the new system. Written follow-up is required of any clinic not meeting security standards.

The elimination of manual vouchers has virtually eliminated unmatched vouchers. The few that have been identified have been scanner misreads which were quickly identified and corrected. The new system allows flexibility in the number of vouchers issued, up to a maximum three-month supply. Clinic staff and participants have benefited from the flexibility, which allows vouchers issued to be tailored to individual participant's needs.

All health departments in Tennessee now report WIC participation utilizing the PTBMIS system. All counties using the same software and the same procedures have not only improved the accuracy of the data, but have also increased flexibility of the reporting system. The ease of creating ad hoc reports has improved substantially with the uniform database.

Significant improvements have occurred in WIC vendor monitoring/investigative activities to eliminate potential conflicts of interest. To eliminate the potential for conflict in the close working relationship between vendor monitors and local merchants, the department has entered into a contract with an outside agency for compliance buyers. These buyers carry out undercover investigative buys statewide from merchants who have been identified as having the potential for abuse. This identification is based on objective criteria from information generated by the WIC data system or from a complaint. The compliance buyers do not have any history with the merchant and conduct investigations following specified procedures. This expansion of compliance buys has resulted in increased identification of problem vendors. The standardization of training and procedures has resulted in better investigations. In turn, the program is becoming increasingly successful in removing problem vendors.

Improvements have also been made in the WIC data system, resulting in better vendor information. An assessment of noncompliance risk is now done annually for each local vendor (based on set criteria). This information is entered into a database along with information from system-generated variance reports. The database is used by central office staff to prioritize stores for compliance buys.

EVALUATION OF DEPARTMENT'S FOLLOW-UP ACTIVITIES

Voucher Issuance. The department has implemented on-site issuance of all WIC vouchers through its Patient Tracking Billing Management Information System. The department also appears to have implemented necessary safeguards to prevent improper issuance of such vouchers. These safeguards include requiring a password to access the system's ability to issue vouchers, restricting physical access to the system, and having program participants sign receipts for the vouchers they receive.

Monitoring. The department has taken several steps to help prevent conflicts of interests in its monitoring of WIC-approved vendors. The central office implemented a system in January 1997 using contract staff to carry out undercover investigative buys statewide from merchants who have been identified as having the potential for abuse. The purpose of these "compliance buys" is to determine if participating stores comply with federal and state WIC requirements. (The department contracts with a private nonprofit agency, Tennessee Opportunity Programs, Inc., for the compliance buyers.) In the past, the regional WIC directors determined which vendors would be visited by compliance buyers. Now the central office selects which vendors to monitor using an "assessment of non-compliance risk." The risk assessment involves determining whether a store exceeds its peer group's average redemption of children vouchers (vouchers for children's foods such as baby food, formula, cereal) by one standard deviation. If so, the store becomes a prime candidate for a compliance buy. Children vouchers are used during the

assessment because they allow the purchase of the most common range of products. There are six vendor peer groups ranging from major grocery chains to mom and pop stores.

According to documentation provided by the department, compliance buyers have made buys in all regions of the state since January 1997. The department made 81 buys in calendar year 1997, averaging 6.8 buys per month. From January to September 1998, the department made 102 buys, averaging 11.3 buys per month. Since January 1997, as a result of the compliance buyer program, three vendors have been removed from the program, two vendors are in the process of being removed, and one vendor is currently appealing removal.

Management's Comment. We concur. Department Central Office staff will closely monitor the WIC On-Site Voucher System, PTBMIS reporting, and the "compliance buys" program in order to continually improve the quality of Tennessee's WIC Program.

FEBRUARY 1998 AUDIT FINDING 9

The department's autopsy contract with East Tennessee State University needs to be reevaluated

The Department of Health contracts with East Tennessee State University (ETSU) for the provision of forensic services to nine counties in the Northeast Tennessee Health Region. However, according to a State Audit review of autopsy files maintained by the Department of Health, forensic pathologists working outside the contract with ETSU conducted 13 autopsies for the nine counties in fiscal year 1995 and 46 autopsies in fiscal year 1996 (at \$710 per autopsy). According to one county medical examiner, his county sought forensic services outside the contract because of dissatisfaction with slow service and reporting from ETSU.

The Department of Health signed a contract with the East Tennessee State University College of Medicine in 1984 and has renewed this contract every year since then. The contract stipulates that ETSU is responsible for the provision of forensic services to the nine counties in the Northeast Tennessee Health Region: Hamblen, Hawkins, Carter, Hancock, Johnson, Greene, Sullivan, Unicoi, and Washington. The fiscal year 1996 contract totaled \$165,375, to be paid in quarterly payments of \$41,343.75, after receipt of invoices for services performed. An exhibit to the contract indicated that the contract amount was based on ETSU's performing an estimated 233 autopsies (at \$710 per autopsy) during the course of the fiscal year. (The \$710 per autopsy consists of \$210 for professional services, \$100 for a comprehensive toxicology analysis, and \$400 for facility utilization and associated goods and services—the standard fee schedule for autopsies performed for the state.) According to department staff, under the terms of the contract, ETSU is supposed to provide "comprehensive" forensic services for the nine counties; therefore, if more than 233 autopsies are required, the university is responsible for performing them for no additional fees. On the other hand, if less than 233 autopsies are needed, the state is still required to pay the full \$165,375. Department records indicate ETSU performed 207

autopsies in calendar year 1994 and 233 autopsies in 1995. (The department does not track autopsies by fiscal year.)

The Department of Health's contract with ETSU raises several concerns. It does not seem appropriate for the state to pay ETSU for "comprehensive" forensic services and also to pay other pathologists for autopsies performed for the nine counties. Reimbursing ETSU for autopsies performed (as is the practice elsewhere in the state) may be more cost-effective than contracting with the university for a set amount. Moreover, concerns about ETSU's timeliness and adequacy of autopsy performance need to be investigated before any further action is taken regarding the contract.

Recommendation

The Department of Health needs to reevaluate its contract for autopsy services in the Northeast Tennessee Health Region to ensure the contract terms are appropriate and cost-effective for the state and the services provided are adequate.

Management's Comment

The Department of Health agrees that the grant with ETSU for autopsy services for nine counties reimburses at a higher rate per autopsy than the fee-for-service arrangement with the rest of the state. This was begun in 1984 as the first attempt to create Centers for Excellence for comprehensive forensic services, but funds were never made available to expand to the four other sites. The department is presently evaluating options for strengthening the postmortem evaluation program and review of this grant will occur during that process.

DEPARTMENT'S SIX-MONTH FOLLOW-UP RESPONSE

A grant to ETSU to help create a "Center for Excellence" for postmortem examination services was awarded over 15 years ago as the first step in the state's plan to enhance forensic services of this nature. The \$165,000 grant meant that the state would not provide payment for services (\$210 per completed autopsy report, \$500 for Sudden Infant Death reports, incomplete autopsies, etc.) as it was previously doing—and still provides to other sites.

The funding for the remainder of the "Center for Excellence" concept was never allocated. Therefore, ETSU has been the only site to receive this annual grant which provides a disproportionate share of funds for the autopsies and services performed.

ETSU has been advised that this arrangement cannot continue. However, for the following reasons, the university has requested that the grant be continued for at least one more year:

1. ETSU only had one pathologist and he resigned as of June 30, 1998. They have been trying to recruit a forensic pathologist but no one will accept the 24-hour a day, 365 days a year "on call" job. Therefore, they must recruit two forensic pathologists. In the interim, they are contracting with a pathologist to provide forensic services.

2. Employing two pathologists and upgrading their facility will be a financial burden for ETSU. They do not perform enough autopsies at this time to cover expenses for this cost.
3. The only other forensic pathologist that could handle some of their cases, Dr. Cleland Blake in Morristown, is also retiring. The next closest facility is in Knoxville, and they are building a new facility and have not been serving all the rural counties around them. Dr. Blake has been doing approximately 300 autopsies for counties in the East Tennessee area that could feed into Knoxville's UT forensic center.
4. Therefore, ETSU understands the state must stop our grant to them and pay fee-for-service, but they have asked that we continue the grant until this transition is over and they are stabilized.

The state is required by law to have a postmortem system. However, the state has depended upon county government (i.e., Knox, Hamilton, Davidson, and Shelby) and ETSU to provide the infrastructure for this system because district attorneys and law enforcement officers want this service near home. If ETSU can't provide these forensic services because they are losing too much money, the state will be obligated to find a site for these services. At this time, neither Knox nor Hamilton County can take on this burden. Davidson County no longer does autopsies for surrounding counties, and Shelby County already does autopsies for all of the West Tennessee counties.

The Department of Health believes that ETSU can be fully functional in 12 to 18 months; Knox County will be fully functional in the same period, and the state hopes to build a facility in Nashville as a back-up for all sites. Therefore, in 18 to 24 months this grant can be converted to fee-for-service when the postmortem system is stabilized.

EVALUATION OF DEPARTMENT'S FOLLOW-UP ACTIVITIES

In fiscal year 1998, the department paid ETSU \$165,375 for comprehensive forensic services in the Northeast Health Region. The contract amount was based on estimates that ETSU would perform approximately 233 autopsies at \$710 each. However, ETSU performed only 213 autopsies in fiscal year 1998 and, therefore, was paid an average of \$776 per autopsy. The department, in addition, paid \$9,795 for 49 autopsies performed in the region by non-ETSU pathologists. The vast majority of these autopsies (46), cost only \$210 each. If the department had paid ETSU at the same \$210 rate per autopsy, the total cost for ETSU's services could have been as low as \$44,730, more than \$120,000 less than the contract amount.

Recommendation. The department should replace its contract with ETSU with fee-for-service as soon as possible.

Management's Comment. We concur. The department continues to work with ETSU, and ETSU is continuing to explore options for capital improvements and operation of its postmortem facility. The department has requested a written report from ETSU concerning its progress in

stabilizing the funding for its programs so that the grant can be changed to a fee-for-service reimbursement program.

RECOMMENDATIONS

ADMINISTRATIVE

The following areas should be addressed to improve the efficiency and effectiveness of the Department of Health's operations.

1. Department of Health management should use the available data on the county health departments' activities (1) to aid in decisions concerning the county health departments' budgets, staffing levels, and range of services and (2) to ensure that needed services are provided.
2. TennCare should work with the MCOs/BHOs, providers, and advocacy groups to identify areas where additional information is needed and to determine the most understandable, easily accessible way to present that information.
3. TennCare and the MCOs/BHOs need to work together, and with providers, to improve access. TennCare needs to determine providers' and enrollees' concerns, evaluate those concerns, and address those concerns to the extent possible.
4. TennCare, along with the Department of Commerce and Insurance, should continue to monitor the financial conditions of the MCOs and BHOs. TennCare should also evaluate its contracts with the organizations and the results of the actuarial studies currently being performed. If warranted, TennCare should then consider changes in capitation payments and other contract or program changes to help ensure there are a sufficient number of managed-care organizations and adequate provider networks.
5. Inadequate payments to providers could limit the MCOs' and BHOs' ability to attract providers and build the service networks necessary to ensure quality and consistent care for TennCare enrollees. The Bureau of TennCare should (1) use the results of the forthcoming actuarial studies to adjust rates to the managed-care organizations (or ensure the MCOs and BHOs adjust providers' rates), if needed, and (2) ensure actuarial studies are conducted periodically.
6. The Bureau of TennCare should assess its compliance with the consent decree and develop additional action plans as needed to improve compliance. Any additional action plans developed should include specific goals for future performance, clearly identify the various offices involved in providing the services in question, and describe the offices' respective duties, authority, and responsibilities, as well as ways to coordinate their various functions. The plan should be disseminated to all appropriate offices and individuals involved. The bureau should collaborate with the MCOs, the BHOs, and the Department of Children's Services (when appropriate) to ensure that the system facilitates the provision of needed services to children. The bureau may wish to consider the recommendations of studies already performed, including implementing Best Practice

Networks and simplifying managed care for custody children by utilizing a single MCO, rather than an MCO and a BHO. As part of the plan, the bureau may want to consider providing all its constituents additional training and information on EPSDT services and benefits. The bureau should ensure the corrective action plans of the MCOs and BHOs are adequate, appropriate, and consistent with and supportive of the bureau's plan. The MCOs and BHOs should follow through with necessary corrective action plans of their own and ensure these plans are fully implemented within a reasonable period. The bureau and the Department of Children's Services need to improve their collaboration through coordination, training, and exchange of information.

7. TennCare should use the information from provider assessments, complaints, and examination findings to improve its program. Enforcing compliance with contract requirements for claims processing, periodically evaluating reimbursement rates and capitation rates, standardizing procedures for determining medical necessity, reviewing restrictive drug formularies, and streamlining policies and procedures for prior authorization and referrals would increase provider satisfaction. Formal procedures for addressing provider complaints should be instituted and should include establishing a hotline to track and monitor provider complaints and minimize provider frustration. TennCare should periodically assess provider satisfaction to obtain information on areas to improve.
8. TennCare should monitor the authorization process to ensure requests are being decided in a timely manner. Also, the bureau should work with providers to identify and resolve problems associated with the formularies, such as restrictions that could affect quality of care. TennCare should monitor the formulary process to ensure the guidelines are followed and should evaluate each formulary to ensure enrollees' needs are met.
9. The Bureau of TennCare should increase monitoring of the appeals process and evaluate appeals resolution. If the MCOs and BHOs continue with a high rate of reversals upon reassessment, TennCare should address the reason for the initial claims denial and evaluate the claims denial process.
10. The Bureau of TennCare should implement its proposal to replace TCMIS. In the meantime, both the state and the contractor should work together to determine methods for coping with the increasing demands for information. The Commissioner should develop guidelines to aid the Director of Information Systems in setting priorities.
11. The Bureau of TennCare should strengthen its monitoring of MCO/BHO coordination. TennCare should provide guidance and assistance to facilitate effective coordination and communication. TennCare should consider reevaluating the contracts to clarify language and address problems.
12. TennCare needs to ensure that the MCOs and BHOs have a means in place to detect and report provider or recipient fraud and abuse to the Tennessee Bureau of Investigation (TBI) and the Program Integrity Unit (PIU). TennCare should consider amending its contract with the MCOs and BHOs to require the establishment of fraud units. TennCare

may want to consider delegating some of its monitoring and oversight functions to the PIU. TennCare could provide additional oversight by encouraging designated MCO/BHO management/representatives to regularly attend and participate in TBI's fraud training, seminars, and meetings. TennCare may want to work with the Volunteer State Health Plan and/or the Magellan fraud units to develop a model for the other MCOs/BHOs.

13. TennCare should determine (and consider requesting) the additional funding necessary to add residential treatment services to the substance abuse benefits covered in the BHOs' contract. If residential treatment is to be provided by the block grant program, the Department of Health must facilitate improved communication between the Bureau of TennCare and the Bureau of Alcohol and Drug Abuse Services to ensure the continuum of care is not disrupted. The Department of Health must also guarantee that the quality of care available to block grant recipients will not be compromised as a result of the infusion of TennCare participants. The department's ability to pay for residential treatment for both populations under the block grant program should be confirmed before final implementation.
14. The Bureau of TennCare should require the BHOs to steadily increase the percentage of clients offered case management as set forth in the agreement. If the BHOs do not meet these targets, the bureau should once again permanently withhold funds.
15. The TennCare Bureau should continue to work with the technical advisory group to develop a comprehensive, but manageable, set of well-defined performance measures and benchmarks. These measures and benchmarks should include health outcome indicators, as well as access, quality of care, and other service-delivery indicators. The bureau and the EQRO, as well as other monitoring groups, should then include an assessment of outcome measures as part of their monitoring activities.
16. The Bureau of TennCare should coordinate an assessment of the current ownership and management relationship of the BHOs to ensure that adequate competition exists and that enrollees would not be adversely affected if Magellan withdrew from the TennCare Partners Program.
17. TennCare's Fiscal Division should develop policies and procedures for monitoring vendor contracts and use these policies to ensure vendors comply with all contract terms. Penalties should be assessed, or other actions taken, against vendors who continually fail to comply.
18. TennCare should continue to monitor and enforce the timely submission of encounter data. Also, the bureau should improve the validity testing of data submitted to ensure accuracy by increasing the number of enrollee medical records reviewed.
19. The Bureau of TennCare should develop and implement a formal, written policy on conflicts of interest. The policy should specify the types of situations that would be considered a conflict, the process for documenting such a conflict, and the resulting

actions to be taken. Committee and board members for the bureau, the MCOs, and BHOs should be required to update disclosure statements periodically and whenever a change in financial or personal interests occurs.

20. The department and TennCare should continue efforts to implement a long-term care plan that provides alternative care waivers to all enrollees in the state. TennCare should continue to work with advocacy groups to address concerns regarding the proposal.
21. The Department of Health should continue its efforts to implement both the request-for-proposal process and the fee-for-service system for the Bureau of Alcohol and Drug Abuse Services. The department should make efforts to have all services, both treatment and prevention, contracted through requests for proposal. The department should take steps to ensure the University of Tennessee provides survey information on community needs assessments in a timely manner. In addition, the department should increase its publicity efforts to inform all prospective providers about the new contracting process. The department should make efforts to ensure all technical assistance on fee-for-service is available in a timely manner. Timely implementation of the request-for-proposal process and the fee-for-service system would help ensure the effective and efficient use of Bureau of Alcohol and Drug Abuse Services financial resources to help Tennesseans with alcohol and/or drug addiction.
22. The Bureau of Alcohol and Drug Abuse Services should continue its efforts to review the quality of care contract agencies provide. The bureau should document the percentage of total client records reviewed and perform follow-up site visits to confirm that the more severe problems have been corrected. The bureau should provide monitoring staff training on how to evaluate agency performance, including quality of care. The bureau should eliminate its data backlog and should continue its efforts to develop its computer data system and complete modifications in a timely manner. The bureau should either use the TADPOLE and TOADS data (and document its use) in evaluating client outcomes of contract agencies, or reallocate the TADPOLE and TOADS contract dollars for other uses, such as direct provision of prevention and treatment services. The bureau should use information on client outcomes to develop a method to pay contract agencies whose outcomes are successful and to terminate contracts with those agencies whose outcomes are unsuccessful.
23. AIDS Support Services should continue to monitor HIV Care Consortia, associated lead agencies, and HOPWA providers. AIDS Support Services should also continue determining client eligibility for services, including verification of income for the HIV Drug Assistance Program.
24. The department should pursue implementation of active surveillance programs and should also continue efforts (such as publishing *Epi News*) to educate private physicians on the need to report outbreaks of communicable diseases.
25. The department should convert all vital records to the electronic imaging system as soon as possible. The department should work with the counties to improve citizens' access to

marriage, divorce, and death certificates. The department should fully develop and implement an updated disaster recovery plan.

26. The department should conduct General Environmental Health inspection verifications periodically and maintain adequate documentation of those verifications. The department should also update its quality assessment policies and procedures to emphasize the timeliness of inspections.
27. The Division of Maternal and Child Health should continue monitoring its contract agencies. The division should ensure that all evaluation files have complete documentation and should develop and implement formal procedures for follow-up visits.
28. The department should replace the ETSU contract for autopsy services with a fee-for-service arrangement as soon as possible.

APPENDIX

TENN CARE PROVIDER SURVEYS

Approximately 1,500 surveys were sent to six types of providers to determine their views on the effectiveness and efficiency of TennCare: (1) primary care providers, (2) specialists, (3) obstetricians/gynecologists, (4) dentists, (5) hospitals, and (6) behavioral health providers. We received 675 responses for an overall response rate of 45%. Surveys were completed by 125 primary care providers, 321 specialists, 36 obstetricians/gynecologists, 23 dentists, 4 hospitals, and 166 behavioral health providers. As noted in finding 5, the providers' responses indicated dissatisfaction with the program in several areas: slow claims processing, low reimbursement rates, broad medical-necessity standards, restrictive drug formularies, difficulty obtaining referrals and prior authorizations, and cumbersome administrative procedures. Overall evaluation of provider responses to our survey indicates concern for the quality of care provided to TennCare enrollees.

SURVEY RESULTS

Percentage (calculated by provider type)

1. How would you describe your type of practice?	Primary Care	Specialist	Ob/Gyn	Dentist	Hospital	Behavioral Health
Primary care	89.5	10.2	0.0	72.7	0.0	6.2
Specialty	4.8	85.4	100.0	13.6	100.0	78.9
Other organizations	5.6	4.5	0.0	13.6	0.0	14.9
2. In what setting do you provide services?	Primary Care	Specialist	Ob/Gyn	Dentist	Hospital	Behavioral Health
Group setting	33.1	31.4	25.7	9.5	33.3	14.4
Private practice	47.1	39.2	45.7	71.4	0.0	64.4
Academic practice	6.6	17.5	22.9	4.8	0.0	4.4
Other		12.0		14.3	66.7	16.9
3. Are you a provider in the TennCare program?	Primary Care	Specialist	Ob/Gyn	Dentist	Hospital	Behavioral Health
Yes	98.4	94.2	100.0	100.0	100.0	96.9
No	0.8	5.8	0.0	0.0	0.0	2.5
4. Are you currently accepting <u>new</u> TennCare enrollees? If no, why not?	Primary Care	Specialist	Ob/Gyn	Dentist	Hospital	Behavioral Health
Yes	65.0	90.1	94.1	86.4	100.0	77.3
No	34.1	9.6	2.9	13.6	0.0	21.4

Selected Comments:

Primary Care Providers

Financially and operationally detrimental to practice.

Cannot tolerate the paperwork hassles.

Reimbursement fails to cover the overhead costs.

Major hassle dealing with formularies and referrals.

More than half of our office time is required for less than 30% of patients.

Specialists

Low reimbursement rates.

It is easier to see patients for free than to jump through the hoops necessary for reimbursement.

Ob/Gyns

If not being treated for infertility.

Dentists

Current TennCare load is all we can handle.

Not Phoenix, because it does not keep records straight and does not work out problems with providers.

Behavioral Health Providers

We are considering not taking any new fee-for-service clients due to inadequate rates.

TBH, not Premier. Premier doesn't pay enough to keep my office open and sometimes doesn't pay at all.

Difficulty encountered in getting paid.

Rates are low.

Flooded with referrals beyond our capacity.

Payments are erratic and require telephone calls that are costly, lengthy, and ineffective.

Administrative tangles make further involvement undesirable.

TennCare staff are making treatment decisions.

5. Please estimate what percentage of your total patient caseload is TennCare enrollees.	Primary	Specialist	Ob/Gyn	Dentist	Hospital	Behavioral
	Care					Health
Less than 25%	40.0	54.0	27.8	40.9	100.0	49.7
25-50%	34.2	33.0	27.8	31.8	0.0	27.0
50-75%	17.5	10.0	19.4	18.2	0.0	10.1
Greater than 75%	8.3	3.1	25.0	9.1	0.0	13.2

6. Do you believe accepting TennCare enrollees has increased your patient caseload excessively?

Yes	30.3	23.1	32.4	50.0	0.0	20.7
No	68.9	76.9	67.6	50.0	100.0	78.7

If yes, please describe what effect your patient caseload has on the delivery of quality care to enrollees.

Selected Comments:

Primary Care Providers

The amount of paperwork is excessive.

Change is unrelated to caseload, but to the restrictions placed on physicians by TennCare.

5% of patients are TennCare, but they account for 25% of workload. They come more often, are more demanding, and have to have everything certified.

Increased workload decreases time spent with patients.

Specialists

Excessive number of TennCare patients seen in ER for non-emergency problems.

Delays in patient care due to referral process.

Ties up front office/nursing time.

Ob/Gyns

Less time available for patient education.

Dentists

Patients often break appointments that could be scheduled to see those who need treatment.

Spending more time on “non-profit” patients makes the paying customers go elsewhere. Income has decreased.

Behavioral Health Providers

Cannot see patients as often as they need to be seen.

Amount of paperwork excludes me from adding additional clients.

Providing the same quality of care is not profitable.

Quality of care will not change to my patients.

Bureaucracy takes time away from direct care.

If we continue to accept new TennCare patients, it will be difficult to provide quality care to all.

Waiting lists are always long, which can’t be good for enrollees.

We sometimes can’t get enough visits approved; therefore we have to discharge prematurely; then because they don’t finish the program properly, they relapse and are back.

7. Do you believe TennCare enrollees are provided adequate information regarding the program, including their rights and their coverage?

	<u>Primary Care</u>	<u>Specialist</u>	<u>Ob/Gyn</u>	<u>Dentist</u>	<u>Hospital</u>	<u>Behavioral Health</u>
Yes	44.8	37.2	37.5	45.0	0.0	55.6
No	55.2	62.8	62.5	55.0	100.0	44.4

If no, please describe what effects the lack of information may have on enrollees’ ability to obtain quality care.

Selected Comments:

Primary Care Providers

They lack a knowledge of referral protocols and ER (emergency room) protocols.

They have no idea to what they are entitled.

Patients don’t understand primary care vs. ER care.

They have a poor understanding of what a PCP is and who theirs is.

They expect referrals without office visits.

Specialists

Confusion over who the assigned primary care provider is.

Difficulty getting appointments.

Even if the TennCare enrollees receive adequate information, socioeconomic and other factors prevent them from making informed choices about their medical care and they become overly dependent on the good graces of their physicians to ensure that they receive adequate care.

Few know about pre-certification requirements.

Most believe they can go anywhere and get care, see any doctor anytime, and get any medicine they want.

No TennCare patient we have spoken to realizes that TennCare is not a supplement to Medicare or commercial insurance.

They are not aware of the ability to file grievances for denied care.

They do not understand that specialist accessibility is very limited or nonexistent in some MCOs.

They seem to rely solely on the provider for interpretation of information.

Ob/Gyns

Patients with co-pays have no idea they must pay and also do not understand referrals.

We routinely have to describe and discuss care with our patients. They have no idea how their care is given.

Dentists

Enrollees don't seem to know if they are covered or not and don't seem to be aware of their benefits. Patients do not seem to be aware of age restrictions or treatment restrictions.

Behavioral Health Providers

Some feel they have unlimited benefits and do not understand concept of medical necessity. Many thought they could only go to the Mental Health Center on their card. Enrollees do not understand pre-certification, grievances, etc. It is getting better with patient advocacy groups. Most do not understand the difference between BHOs and MCOs. No booklet explaining covered services. No info on transportation. Overutilization of ER. They have no idea that services need to be preauthorized. What difference does it make if they do (have adequate information)? They have no power to get the care, the bottom line controls this.

8. Overall, how would you describe the quality of care TennCare enrollees receive?	Primary	Specialist	Ob/Gyn	Dentist	Hospital	Behavioral
	<u>Care</u>	<u>Specialist</u>	<u>Ob/Gyn</u>	<u>Dentist</u>	<u>Hospital</u>	<u>Health</u>
Excellent	17.6	31.1	47.1	59.1	66.7	23.3
Good	53.8	34.3	26.5	36.4	0.0	30.0
Fair	27.2	27.3	20.6	4.5	33.3	32.0
Poor	0.8	7.3	5.9	0.0	0.0	14.7

9. Do you believe enrollees are receiving a higher quality of care under the TennCare program than they were under Medicaid?	Primary	Specialist	Ob/Gyn	Dentist	Hospital	Behavioral
	<u>Care</u>	<u>Specialist</u>	<u>Ob/Gyn</u>	<u>Dentist</u>	<u>Hospital</u>	<u>Health</u>
Yes	31.6	21.5	33.3	47.1	66.7	25.2
No	68.4	78.5	66.7	52.9	33.3	74.8

Selected Comments:

Primary Care Providers

More benefits.
 Better access.
 Quality of care is the same.
 TennCare stresses preventative medicine and physical exams which are good for patients.
 Certainly not better.
 More and easier access to care.
 More paperwork and less time with the patient.
 More people are enrolled under TennCare, which is good.
 Less able to abuse TennCare than Medicaid.
 Drug formulary is much more restrictive.
 Scheduling tests such as CAT scans, MRI, etc., is a problem. Each HMO requires different labs.
 In the past we made a preliminary diagnosis and were able to speak directly to the specialist/physician who agreed to see the patient and work up and follow through on care. Now we have to get permission to treat from individuals who question every stage of the primary doctor's workup.

Specialists

About the same.

Better access.

Speech/language therapy is now available under TennCare.

Impediments to diagnostic services; medications and treatments frequently delay care.

It was poor then and worse now.

Different policies for different TennCare plans lead to poorer care.

Patients with complex medical problems have been lost to the various MCOs where these problems are inadequately addressed.

Some restrictions may prevent earlier detection of diseases.

TennCare has created barriers to care for children and families. The PCP concept is sound; however, when the PCP refers the child for further services, the MCO or BHO denies coverage all too often. What is the value of a PCP if his/her recommendation is ignored?

Patient on Medicaid could be seen. Now in primary care offices, the appointments are so booked, the really sick people have a difficult time being treated.

Ob/Gyns

It was easier to give time and attention to what really mattered—the patient. No paperwork and telephone calls.

Dentists

About the same.

Not as many doctors accepting TennCare.

Dental services for adults are too limited.

Behavioral Health Providers

A middle level of management never improves service delivery.

BHOs have focused on saving money, not quality care.

More difficulty finding doctors, and some provide poor care.

Rapid change in BHO structure leaves patients/providers confused.

Medicaid was more uniform.

TennCare has put several good local MHCs out of business and chronic patients have less choice in getting care.

Medicaid care was controlled by doctors; now it is controlled by businessmen.

10. Does the current TennCare system provide adequate access to: (If no, please explain your response.)

quality care?	Yes	Primary Care					Behavioral Health
		Specialist	Ob/Gyn	Dentist	Hospital		
	Yes	65.5	59.6	62.9	84.2	100.0	41.6
	No	34.5	40.4	37.1	15.8	0.0	58.4

Selected Comments:

Primary Care Providers

Basic primary care is ok.

If lucky enough to get a good doctor.

Limited medicine selection, difficult to find specialists in rural areas.

Not enough specialists.

Orthopedics sadly lacking; also, plans reluctant to allow rehab. PT almost impossible.

Specialists

A lot of times, when we try to refer patients and are given names of providers, we have to call 6-8 providers before we can locate one. HMO provider lists are not up to date. The average referral takes about 3 hours to locate provider, get appointment, and get approval. Then many times, the patients cancel and reschedule and we have to go through the process again.

Not enough orthopedics signed up for TennCare. Care is often delayed because a patient cannot go through their PCP for a referral. Care is also delayed when the PCP does not send the referral as they promised when they called and made the appointment.

Can't get orthopedic referrals or neurosurgery.

Drug formulary too limited.

It just takes a lot more effort.

Limited on hospital choice.

Limited providers in Phoenix and Access MedPlus.

Many good physicians don't accept TennCare.

Access MedPlus refuses to pay and authorize specialty visits.

Patients have adequate access to specialists only because we have compassion for patients and are willing to care for them under reimbursement rates that are lower than our overhead.

Providers are rushed; don't take time to see and discuss issues, plans, follow-up with patients.

TennCare doesn't understand the needs of the hearing impaired.

Best providers will always avoid the TennCare system because of the hassles and low reimbursement.

Ob/Gyns

Difficult to refer to another specialist.

Lots of trouble finding doctors on the plans.

TennCare has managed to drive good MDs away.

Dentists

If the provider cares about his patient, he will give quality care even if he's not fully reimbursed.

Limited services.

Not enough providers in my area.

You cannot find orthodontist to accept TennCare patients.

Behavioral Health Providers

Access depends on availability of providers and that has been drastically reduced due to TennCare.

Because of such poor payment fees to the providers, they don't want to participate.

Care system is still not "provider friendly."

It seems that clients aren't always put first.

Excessive paperwork and minimal reimbursement.

Many MDs have opted out of TennCare due to administrative delays in pre-cert and claims payment.

Needed inpatient care is too limited. Newer psychotropic medications too slowly approved.

Not for medical or chiropractic and not for mental health due to reductions in number of providers and in CMHC services.

Services needed are denied.

Several levels of care are not available.

Too many decisions made by nonclinicians.

Transportation to appointments is problematic on a regular basis.

		<u>Primary</u>					<u>Behavioral</u>
		<u>Care</u>	<u>Specialist</u>	<u>Ob/Gyn</u>	<u>Dentist</u>	<u>Hospital</u>	<u>Health</u>
specialty care?	Yes	41.2	53.2	58.1	50.0	100.0	31.0
	No	58.8	46.8	41.9	50.0	0.0	69.0

Selected Comments:

Primary Care Providers

Delay in orthopedic referrals due to lack of providers.

Dermatology and neurology a problem.

Lack of specialists accepting TennCare.

Most of the time have to call specialists, cannot go by lists.

No specialist available in our area for orthopedics, urology, endocrinology, rheumatology.

Orthopedics and dental seem to be problem areas.

Specialists

*Hearing impaired children’s needs aren’t understood.
Inadequate number of orthopedists and other specialists like urologists.
MDs are attempting to treat everything.
Must be seen first by PCP before seeking specialty care.
Poor formulary, poor social and psychiatric services.
Regarding our specialty (eyes), we feel that no referral should be necessary for medical treatment.
Requiring unnecessary trips to primary care MD.
Specialist penalized if primary forgets to send referral paperwork.
Surgical care for children is unsatisfactory.*

Ob/Gyns

*Not enough specialists enrolled in the TennCare program.
Patients often unable to see specialists they prefer.
We never do surgery unless it is absolutely necessary. How can an insurance company make the decision?*

Dentists

*Not enough dental specialists signed up.
Limited services.*

Behavioral Health Providers

*Case management too strict.
Difficult to access specialty MDs, psychiatry limited to CMHCs.
Difficulties with accessing appropriate MH services in problem cases.
Often the PCP does not refer to a specialist and attempts to provide treatment themselves with limited knowledge.
Psychological testing is underpaid, not efficiently authorized.
Several areas of care are not available like detox and partial hospitalization.*

		<u>Primary</u>					<u>Behavioral</u>
		<u>Care</u>	<u>Specialist</u>	<u>Ob/Gyn</u>	<u>Dentist</u>	<u>Hospital</u>	<u>Health</u>
medical treatment?	Yes	80.5	71.6	63.6	100.0	100.0	50.9
	No	19.5	28.4	36.4	0.0	0.0	49.1

Selected Comments:

Primary Care Providers

*Access is very limited.
Medication problems.
Medicines for proper treatment are non-formulary.
Not enough quality physician providers.*

Specialists

*Big problem with Access MedPlus.
Doesn’t cover important new drugs.
I think patients on the whole get adequate treatment.
It is often slow and much more prolonged than it should be.
Many services are declined or ineffective substitutes are encouraged.
Many PCPs are poor clinicians for children and don’t recognize disease.
Sometimes treatment is delayed when referred to other specialists.
Those who do receive care, receive adequate to good care because of the tenacity of their physicians and office staff to have appropriate “approval” delivered by the “Health Care Provider” rendering decisions at a computer terminal far away.
Have had patients whose PCP was located 100+ miles away who they had never seen.*

Ob/Gyns

Medications given to patients are not approved by MCO and they are given some other medicine, but it is not adequate.

Surgeries and treatment requested are too often denied.

There are times it prolongs services such as D&C and then hysterectomy.

Behavioral Health Providers

4 visits a year is inappropriate.

Depends on the type of TennCare. Access MedPlus is very difficult.

Difficult with appropriate psychiatric admissions.

I have a client who had a broken ankle and sat at home 3 weeks unable to find an MD who would even see her for cash.

Psychiatry is a particular need.

Services recommended were not approved, unnecessary delays.

It is difficult to find a psychiatrist who will deal with TennCare.

necessary medication?		Primary	Specialist	Ob/Gyn	Dentist	Hospital	Behavioral
		Care					Health
Yes		46.6	42.4	54.5	100.0	100.0	35.2
No		53.4	57.6	45.5	0.0	0.0	64.8

Selected Comments:

Primary Care Providers

As long as it is a formulary with their particular MCO.

Formularies are too restrictive.

Following formulary is like practicing in a third world country.

Formulary many times 5-10 years behind current good medical care.

Difficult to get approval for some medicines.

Often covered meds are not the most effective. May require higher doses which lowers compliance.

Difficult to keep up with the different formularies.

Specialists

90% of the time it is okay

A lot of prescriptions for ophthalmic meds are not covered.

Have to use drugs with which I have no experience.

Each MCO is unique in their formulary.

Many of the most useful meds are denied.

No funding, in my case, for chemotherapy in the majority of MCOs.

Newer medications are limited.

Poor antibiotic choices with lots of resistance. Poor medication in general with more side effects than other better medications available.

Restrictive formulary will provide coverage for the cheapest but not the best drug for treatment.

Some eye medications do not transfer well to generic.

Appeals are very time consuming.

The limitations placed on the formulary interfere with delivery of good care and in several of my cases, denial of appropriate medication has led to unnecessary hospitalization and surgery that could have been prevented.

Ob/Gyn

Cannot get diaphragms for women who cannot take oral contraceptives.

Patient was denied treatment with a low dose contraceptive because it was not on the formulary.

Very inconvenient formulary for patient care.

Behavioral Health Providers

Just because they are on TennCare shouldn't keep them from having access to the best medicines.

*No treatment for nicotine dependence.
 Not state of the art or most appropriate treatment.
 Frequent difficulty getting approval for effective, safe meds.
 Limited and constantly changing list of approved medications.
 Many brand name meds are excluded.
 Many new psychiatric meds must be approved only after failure of older meds.
 Medication list is a serious limitation in mental health.
 New psychotropic drugs that are far superior are too slowly approved.
 Pleasantly surprised that most medications are okayed.*

timely treatment?		Primary				Behavioral	
		Care	Specialist	Ob/Gyn	Dentist	Hospital	Health
Yes		73.3	64.1	53.3	94.1	100.0	48.5
No		26.7	35.9	46.7	5.9	0.0	51.5

Selected Comments:

Primary Care Providers

*Appointment to specialist may be delayed if TennCare MCO only has a set number of providers in a specialty.
 Difficult for some referrals in timely fashion.
 Forced to use treatments that don't work to prove they don't work to obtain permission to use treatments that do work.
 Particularly psychiatric care is much worse.
 Sometimes takes 2-3 days or more to obtain approval for meds.
 Specialists appointments for many plans take up to 4-6 months for an initial evaluation.*

Specialists

*Appointments often rescheduled, no referral obtained.
 Patients often have to return to the ER because they are unable to see their PCP or appropriate specialist in follow-up.
 Delay to get approval for drugs and surgery.
 Delays due to extreme difficulty obtaining authorization.
 Delays due to increased administrative time needed for pre-certification.
 For many TennCare patients, the ER is the only access to timely treatment, even for non-emergency problems.
 Home health coverage can take weeks after many appeals to get 1-2 visits approved.
 I currently have a patient who has plastic rods sticking out of his eyelids and he is still waiting for surgery approval.
 In emergency situations, perhaps. I have known patients to wait in ERs for up to 12 hours before a disposition is made.
 It is getting better. Not such a long wait in the last 6 months.
 Not if the patient needs a specialist. We have to wait for primary care referral and precertification.
 Pain management is penalized, many carriers (PHP) require review from medical director.
 Patients show up in ER for office visits because of excessive wait times for PCPs.*

Ob/Gyns

*Most TennCare enrollees have to wait months to be seen.
 Need for a referral when the patient may not have even seen the PCP.
 Too much paperwork for referrals, especially for patients who "walk in" and are sick.*

Dentists

Not enough providers.

Behavioral Health Providers

Admission to facility is timely.

Average.

Because of a lack of providers, there are longer waits for care.

BHOs don't ever notify providers like the contract requires.

Delays in finding qualified providers.

Delays in receiving responses lead to delays in care, lack of callbacks.

Great lapse in time for getting authorizations.

Limited providers add to longer waits.

Once the patient gets seen by MD, treatments are timely; however, inpatient lengths of stay are sometimes too short to stabilize at-risk patients.

PCP has to be changed when child enters one of our programs.

		<u>Primary Care</u>	<u>Specialist</u>	<u>Ob/Gyn</u>	<u>Dentist</u>	<u>Hospital</u>	<u>Behavioral Health</u>
appropriate screening and diagnostic services, particularly for children?	Yes	88.8	80.0	78.3	94.1	100.0	41.0
	No	11.2	20.0	21.7	5.9	0.0	59.0

Selected Comments:

Primary care

For obese patients, there is no way to get them into a weight loss program.

I have had diagnostic services turned down when the patient needed a test done.

These kids are screened, screened, and rescreened. Much of the screening is pointless. It should follow pediatric guidelines, not be yearly.

Specialist

I have seen few screening services provided.

Even when the diagnosis services are covered by the PCP, the BHO and MCO will deny or severely limit services.

This is one area where TennCare works.

Some cases may fall out of the guidelines established for precerts.

Yes for children; other patients aren't screened well before going to specialist.

Ob/Gyns

Can't find doctor for newborn care at Access MedPlus.

Not all covered without prior authorization.

Often basic screening tests require authorization. Too much time on the phone.

Several PCPs in our area do not do EPSDT screenings or well baby checkups.

Behavioral Health Providers

No longer able to send children for learning disability testing by Ph.D. Must be done by school system which does not have adequate funding for this.

Doesn't cover enough.

How much training have the Health Department Staff had in EPSDT training?

Experience suggests that children's services are extremely limited.

It is harder to get approval for evaluation than for counseling.

Most are simply referred to the overloaded community mental health system.

Need coverage for psychological testing!

Screener asks for too much confidential information.

The system of TennCare fails the children.

Waiting list is long for mental health services.

11. Do you know of instances in which enrollees have to travel excessive distances to receive medical treatment? If yes, please explain your response.

	<u>Primary Care</u>	<u>Specialist</u>	<u>Ob/Gyn</u>	<u>Dentist</u>	<u>Hospital</u>	<u>Behavioral Health</u>
Yes	69.4	46.1	48.4	50.0	25.0	41.5
No	30.6	53.9	51.6	50.0	75.0	58.5

Selected Comments:

Primary Care Providers

All of our TennCare patients who need referral to specialists travel at least 100 miles for treatment. This is not only due to patients living in rural area.

Assigned PCP 50 miles away, specialists even farther.

Dermatology 2 hours away.

For orthopedics and psychiatric referrals patients often travel 30-50 miles.

I can't find a rheumatologist less than 80 miles from Greeneville, nor a urologist.

I have to send people 50-100 miles for specialty care.

In my area, a 60-120 minute drive for dermatology or neurology.

Many travel over 50 miles to see specialists when local ones won't accept TennCare.

No doctor in Roane County was accepting new patients or not accepting their MCO; thus, patients have to travel up to 50 miles for a PCP.

No GYN specialty close by for Access MedPlus. Nearest orthopedic care for Phoenix TennCare 75 miles away. No ophthalmology for Access MedPlus patients.

No one has actually done it because unable to afford the travel.

Orthopedic specialists few and far between who accept TennCare.

Was a bigger problem in earlier part of the program.

Specialists

Northeast Tennessee to Chattanooga for heart disease.

Chattanooga to Nashville for orthopedics/neurosurgery, back problems.

70 miles to see PCP.

Approximately 50-75% of my patients are from counties greater than 50 miles away.

Children travel statewide for acute psychiatric services.

Complex pediatric cases must come to Vanderbilt, at times from hours away.

In this area, all patients who need a specialist must travel 50-100 miles. We were told by one HMO that some of their employees drive 40 miles to work and these patients should not mind driving that far. Most of our patients are on disability or minimum wage.

No urology, orthopedics specialist in our area. Patients go to Knoxville.

Non-metropolitan areas have minimal to no specialist care.

One of my patients who lives in Knoxville had four children enrolled in TennCare. Two were assigned to a pediatrician in Oak Ridge (40 miles from her home) and two assigned to a physician in Clarksville (200 miles from her home). I have also received referrals for patients who have traveled from Chattanooga, Johnson City, Crossville, Cookeville and other towns 75-150 miles from my office because there were no local providers.

Orthopedics, travel Chattanooga to Tullahoma or Nashville.

Patients travel 100-150 miles. No provider in their area.

Several patients from Chattanooga because no urologist on panel. Travel over 100 miles one way.

Ob/Gyns

For example, no provider in local area for high risk OB.

Just try to find a specialist on Access MedPlus.

There are not enough providers in Clarksville, Ardmore, and Pulaski. Therefore, enrollees must travel to Nashville.

We have patients who travel over 2 hours for appointments.

Dentist

Access MedPlus has limited pediatric dental providers.

In order to refer to a periodontist or orthodontist, our patients must drive at least 1 hour.

We are receiving new families from counties 50 miles away and over.

Behavioral Health Providers

100s of miles for psychiatrists, psychotherapists.

Poor clients can ill afford the gas money, often lack vehicles to travel to Nashville to see certain providers.

Expected in rural areas.

Most TennCare patients have no personal transportation, but get assigned to PCPs clear across the county.

My clients report that they have to travel over 50 miles for dental care as well as specialists' care.

Patients have described situations when they had to travel 1-2 hours to receive medical tests which could have been done locally.

Some of my clients drive 45 minutes or more; cannot get into closer mental health center.

We are a rural county and a lot of the time the specialists are 50 to 75 miles away.

When more comprehensive psychiatric treatment is needed, members then travel to Nashville area (60-80 miles) from area such as Cookeville and Crossville.

Without a car or access to transportation, 2 miles can be excessive.

12. Do you believe there are enough providers (either primary care physicians or specialists) in your geographic region of the state? If no, what locations and what types of providers?

	<u>Primary Care</u>	<u>Specialist</u>	<u>Ob/Gyn</u>	<u>Dentist</u>	<u>Hospital</u>	<u>Behavioral Health</u>
Yes	43.5	54.9	55.2	55.6	33.3	36.6
No	56.5	45.1	44.8	44.4	66.7	63.4

Selected Comments:

Primary Care Providers

Because the system is so fragmented by the subspecialist to general doctor ratio of 4:1. The definition of "primary care" has been gerrymandered to hide the problem.

Cannot get orthopedists, neurologists, rheumatologist to see patients even in hospital.

Cumberland County, all procedures.

Dermatologist, orthopedists, rheumatologist, endocrinology, ophthalmologists.

East Tennessee - Ophthalmology, GYN, orthopedics, rheumatology, dermatology.

Knoxville specialists especially pediatric specialists.

Lafollette - Lacks all forms of specialists. We must refer to Knoxville or Oak Ridge, Tennessee.

Lawrence County PCPs and specialists, Maury County, the same. Very few in this county accept TennCare at all!

Memphis - orthopedics.

Neurologists, cardiologists, primary care.

Neurology (pediatric), Cardiology (pediatric) in Jackson.

No rheumatologists, dermatologists, in Jackson.

Northwest Tennessee - Dermatology, urology, orthopedics, neurology.

NW Tennessee needs more specialists.

Obion Co. Specialists.

Orthopedics, dermatologists in Chattanooga area.

PCP's, especially in rural areas, but in Nashville as well.

Pediatric specialists.

Shelby County - Neurologists.

Specialists - especially rheumatologists. Access MedPlus has NONE in the state of Tennessee.

Surgery - Tullahoma.

Specialists

Chattanooga urologists.

Clinical psychologists are needed in increased numbers in Middle TN.

General lack of neurosurgeons, orthopedic surgeons, general surgeons.
 General Practitioners. But the problem is not just availability, it is patient choice. I am repeatedly told by patients they prefer to come to the ER because they will be seen that day rather than waiting for an appointment.
 Hamilton County – Neurologists.
 McMinnville - Primary Care.
 Mid State - ear, nose and throat specialists.
 Not enough PCPs in Sumner County/Gallatin.
 Patients need timely access to their assigned PCPs. They have the name of a PCP on their TennCare card, but can't get an appointment.
 Primary care providers in Warren County.
 Primary care providers, Middle TN.
 Primary care, East Nashville.
 Primary care, general surgery, colorectal surgery, vascular surgery.
 Southeast – psychiatrists.
 Southeast – specialists
 Urology in Southern Middle TN.
 West Tennessee, Dermatologists.

Ob/Gyn

There are never enough primary care providers.
 There are not enough Omni-Care providers in Middle TN.

Dentists

Need more specialists, particularly orthodontists and oral surgeons.
 Not enough dentists or specialty dentists in a 90 mile radius of our Crossville location.

Behavioral Health Providers

All of the above - but Nashville is in better shape than outlying centers.
 Blount and Knox, psychiatrists.
 Clinical psychologists.
 Even Jackson patients cannot get psychiatric care. Pathways told my patient they did not have a psychiatrist available.
 Group homes, outpatient rehabilitation.
 Johnson City, psychiatric.
 Mental Health Southeast TN.
 MH providers.
 Mid Tennessee Psychiatrists.
 Middle TN, no one covers Access MedPlus.
 Patients can't get medical care because MDs in the provider manual aren't accepting new TennCare patients. Mental Health Services have been decreased for chronics (e.g., DTP). Many private mental health providers have been forced out of business due to poor pay.
 Psychiatrist in Tri-Cities area.
 Psychiatrists Maryville/Blount/Loudon/Sevier/Monroe counties.
 There are no inpatient programs.
 You will find that the BHO's have a provider panel that is sufficient from the perspective of size, but they will not accept clients. Proof could be documented by looking at encounter data from the BHOs.

13. Do you believe the process to approve specialized treatment and medication is timely? If no, please explain your response.

	<u>Primary Care</u>	<u>Specialist</u>	<u>Ob/Gyn</u>	<u>Dentist</u>	<u>Hospital</u>	<u>Behavioral Health</u>
Yes	45.3	39.2	31.4	70.6	0.0	40.5
No	53.8	60.8	68.6	29.4	0.0	59.5

Selected Comments:

Primary Care Providers

80% of the time.

At times, 2 days, other times must totally resubmit.

Difficult to get through on telephone. Prior approval process is slow.

Difficulty reaching MCO or Promark. Frequently MCO personnel do not know answer to questions and do not return calls.

Keep my personnel on the phone holding for 30-60 minutes sometimes.

Medication approvals are very S-L-O-W and others require repeated requests.

Often times things take longer than 48 - 72 hours.

Often we wait for weeks for new drugs to be added to the formulary.

Paperwork is enormous and time spent on the phone is ungodly!!!

Promark—72 hrs to get approval. 50% of time they never fax us. We have to return call - I guess they save money that way.

Responses are not necessarily received within 72 hours.

Sometimes takes days for off-formulary meds to either be approved or rejected.

Takes too long. Best example - my nurse held for 45 minutes on Friday afternoon. Phone clicked and she was cut off. Called back, got recording that they close at 5:00, call back Monday.

Three days is a long time when you are sick. Patients lost because of difficulty contacting them (no phones, calling neighbors who may or may not give message).

Timely, yes. Getting an educated response, no.

Usually days to weeks for non-formulary medication.

We have had to hire 2 extra personnel to handle this process.

Specialists

6 months or more at times.

Again, pain management is penalized by having to go before med director for some TennCare products and many of the new medications are not formulary.

Antibiotic approval hard to get.

Argumentative process.

Contacting MCOs for approval of treatment is delayed due to excessive phone time wait and uneducated resources with regard to the plan rules.

Excessive time and delay to approve drugs may take more than 2 weeks for a patient that needs drug immediately.

Frequently on weekends, you cannot get in touch with the TennCare office to get prior approval. This can significantly delay treatment, and can destroy reimbursement.

Having to hold for 15-30 minutes to leave voice mail and then no reply for 48 hours or none at all is inadequate. Very time consuming to reach to get referrals or pre-cert.

Medications are needed quicker. Not all pharmacies will give 3-day supply.

Not always, difficulty getting approval for physical therapy.

Occasionally, patients seen at night or on weekend at ER need non-formulary medications. It is impossible to get these OK'd at these times.

Only works if you are very persistent.

Pain management takes weeks and months to get authorization.

Physician review not quick enough and usually results in denial. Too many med requests require "2nd request" before getting answered.

Treatment yes, medication no.

We have to submit requests to Phoenix several times to get an approval or denial.

Ob/Gyn

Omni-Care and Phoenix TennCare are not timely.

Sometimes takes too long (esp. during a clinic) talking to someone with minimal knowledge of the disease process trying to explain reasons for specialized treatment.

Too long, have to wait on phone. Often person for approval not even there.

Dentists

Sometimes takes 6+ weeks delaying much needed care which necessitates increased prescriptions; 2-3 weeks should be mandatory.

Behavioral Health Providers

Approval rejections don't get faxed back.

At times we have had to go through the process 2-3 times because paperwork was lost or misplaced by TennCare.

Emergency precerts for inpatient treatment sometimes takes seven hours.

I hear of people being told drug has been approved, but drug store computer doesn't show it.

It took me 4 weeks to get a client who was actively suicidal on medication.

I've had excellent response time.

Most of the time.

Our nurses routinely have to fax prior approvals for psychotropic meds 2-4 times before they receive any response.

Patients with acute needs do not need to wait two weeks, so often our patients become inpatients as they wait.

Psychological testing is too slowly authorized (by mail) and there are too many restrictions.

14. Do policies or restrictions associated with the TennCare program affect the quality of care? If yes, please explain your response.

	<u>Primary Care</u>	<u>Specialist</u>	<u>Ob/Gyn</u>	<u>Dentist</u>	<u>Hospital</u>	<u>Behavioral Health</u>
Yes	74.8	71.8	76.5	50.0	50.0	81.2
No	25.2	28.2	23.5	50.0	50.0	18.8

Selected Comments:

Primary Care Providers

23-hour observation policies for certain severe disorders are very disruptive because most of the time these are not resolved significantly within the period of time. Then the entire hospitalization is denied by the carrier.

All MCOs need to follow the same protocols.

Difficulty with health promotion, especially for smoking cessation.

Formularies are restrictive, testing can be delayed waiting for approval.

I can't get authorization for meds or diagnostic studies at times. Suggestion: allow physicians to make choices first, then collect your data on overutilizers, then select those providers for review. This would reduce hassle factor for the 90% of us who know how to practice medicine.

Restrictions can affect quality by requiring more steps in process. Waiting days instead of hours for medicines to start patient on road to recovery.

The primary care doctor should have the authority to refer a patient without waiting 1-2 hrs on the phone for approval or several days after getting things faxed.

There are times when patient needs to be in hospital but TennCare refuses admission. Doesn't agree with doctor.

Unavailability of certain drugs and consultations results in hospital admissions and unnecessary surgery.

Specialists

Allowable drugs are not always best.

Any time a doctor or provider has to consider whether they will be paid adequately, they will make some decisions that are not in the best medical interest of a patient.

Delayed approval for tests or treatment allows problems to compound.

Each program has its own requirements. It would be better for enrollee and provider if requirements were more uniform.

For the most part the HMOs decide the care. E.g., patient needing hysterectomy, most of the time requires D&C first. 95% of the time, doesn't solve problem, TennCare ends up paying more.

Formulary restrictions make appropriate medications excessively difficult to give. Often we must start with drugs we know won't work (i.e., for cholesterol) before we can use the drugs that will.

In some instances may delay care because frequent surgical patient has to be referred back to PCP to initiate further drug test prior to operation.

Limitations on chemotherapy treatment.

Not with us. Everyone is treated equally and with the best of care.

Of course, our inability to obtain x-rays and lab work to evaluate patients with lupus and inflammatory arthritis delays care. We are often forced to wing it.

One place is the ridiculous insistence on sticking with outmoded treatment for depression. Prozac should be more available.

Patients often get frustrated with all the TennCare rules and forego treatment.

Sometimes "things" need to be done the day the patient is seen and can't find primary physician to get approval.

The hassles are so great some days that I just don't want to fight the system and prescribe a less effective medication. Also, many denials affect the quality of care.

The process to receive coverage is not timely. Many times the patient is only allowed the least amount of care possible (especially with home health) or the family is forced to learn to do a skill that only an RN in the hospital is qualified to do.

Too much red tape! Delayed payments and denied claims make doctors reluctant to see the patients.

Too restrictive; emphasis seems to be denial of treatment by TennCare.

Ob/Gyn

I was refused an induction of labor that I felt was necessary and TennCare said it did not meet their criteria.

OB/GYN should be considered primary care; we have to get referrals for sterilization, D&C for miscarriages, amniocentesis, colds/flu during pregnancy, etc.

Obtaining referrals is difficult if the patient refuses to see their PCP. Phoenix has just changed their policy and now requires referral for well woman exam. Access/BlueCare does not.

Dentists

Prior approval process. Some patients won't wait for approval; electing instead to extract teeth vs. restore. Sometimes what treatment is best for the patient, isn't covered by TennCare.

Too restrictive for dental treatment on adults. Some TennCare programs will pay for removal of teeth, but not replacement.

Behavioral Health Providers

As a mental health provider the services for which I receive compensation are limited. The chronically mentally ill have lost day treatment services, suicidal patients have been turned away from psychiatric hospital.

Certain medications are not approved by TennCare; residential treatment is difficult to access.

Difficult to get testing or family therapy approved. Phone reviews and paper reviews are useless.

Reviewers never see clients.

Has become very difficult to hospitalize acute patients who are suicidal or severely depressed. It is inappropriate for them to have to sit and wait for several hours to be evaluated by mobile crisis.

I have had patients who were imminently suicidal who were denied in-patient care.

In MH situations persons who would appropriately be sent for inpatient treatment are kept out of inpatient treatment because they are not absolutely suicidal.

Paper work still takes a lot of time and is inconsistent. One month, it must be done one way, 2nd month-different, 3rd month go back to old way. This is confusing.

Patient not responsible for fees if they do not show for appointments as others are with regular insurance.

Rate of reimbursement. My fee was lowered 10% which was already 60% below my UCR.

The credentialing process is so slow and limiting it directly affects clients who are waiting.

Yes - one gets what one pays for. Minimal reimbursement must affect quality of care - even if unconsciously.

15. Has your MCO/BHO ever denied your request for treatment or services you believed were medically necessary? If yes, with what frequency does this occur?

	Primary Care	Specialist	Ob/Gyn	Dentist	Hospital	Behavioral Health
Yes	67.8	67.1	75.0	70.0	100.0	50.3
No	32.2	32.9	25.0	30.0	0.0	49.7

Selected Comments:

Primary Care Providers

~ 50% of the time.
 ~ once a month.
 < 5%.
 1%.
 1 time in 6 months. Referral for orthopedic.
 10%.
 I have discharged patients too soon against my will.
 For psychiatric care it occurs 9 of 10 times. Refusal can be indirect, such as (1) appointments for depression 6 weeks away, (2) poor treatment when patient finally gets to psychiatrists.
 Infrequently.
 Not frequent, but a lot of hassle.
 Not that I remember.
 Not too often.
 Only few times. Usually they delay for several months and require several calls to get things approved.
 Rarely.
 Too frequently. Meds - 75-80% denial. Referrals – 50% denial.
 Usually drugs like Prilosec for reflux and Zoloft for depression.
 Usually weekly.
 Very frequently.

Specialist

4 times/year. We have learned not to ask.
 About 20-30% of services provided by this specialty clinic.
 About 60% of our TennCare patients.
 All the time, especially for pain medicines.
 Almost daily.
 Not often.
 Often.
 Rarely.
 Routinely deny certain tests which are needed.
 Several times each week.
 Too often.

Ob/Gyns

1/5.
 10%.
 10%.
 10-20% of time.
 75% of time on GYN surgeries.
 Not often, but any time it happens it is an inconvenience.

Dentists

Occasionally.
 Often.

Behavioral Health Providers

1 time.

10%.

100%.

1-2 times per year.

9 of 10 evaluation requests.

Enough to be of concern, since it is usually the most crucial (i.e., emergency hospitalization).

Every nicotine dependent case.

Infrequently.

Often when hospitalization is necessary.

Psychological testing, often.

Rarely.

Regularly.

Seldom.

16. When requests for treatment/services are denied, are the reasons clearly communicated? If no, please elaborate.

	<u>Primary Care</u>	<u>Specialist</u>	<u>Ob/Gyn</u>	<u>Dentist</u>	<u>Hospital</u>	<u>Behavioral Health</u>
Yes	60.0	50.3	46.2	76.5	0.0	65.6
No	40.0	49.7	53.8	23.5	100.0	34.4

Selected Comments:

Primary Care Providers

"Not covered" and "Not a formulary drug" is what is communicated.

Fax responses are generic.

I am usually told, "Does not fit criteria for services requested."

It never comes out and says "this is too expensive."

Medication denial without personally speaking with me even though specifically asked to discuss this with me if med is denied.

No specific justification given.

Person on phone apparently has criteria list and NO medical knowledge.

The pharmacy service states refused due to "guidelines" but we don't have recent updated copies of "guidelines."

They make no sense.

Usually all we get is a faxed note with photocopied policy.

We receive letters much later but do not get told directly unless we go after the physician to get an answer.

Specialists

"Doesn't meet criteria" is about all we get.

"We just don't do that" is the usual explanation.

All they will say is not medically necessary.

Communication clear, reasons obscure.

Denial explanations vague.

Different answers from different persons without qualified people to make decisions.

Just denied.

Many times the only response is a denial for payment with no explanation.

Patients presenting symptoms are simply assessed as non-urgent or the visit denied.

Seldom, just cookie cutter responses.

We are providers of anesthesia services and are frequently denied for need of medical records which we have no access to.

Ob/Gyn

An explanation may be given but may show clearly that the approver had no idea about the clinical scenario.

Example: denial of diaphragm for contraceptive use.

*Sometimes they tell me criteria has changed but won't communicate new criteria.
Usually only a generalized statement is given.*

Behavioral Health Providers

I was just told no.

Not the real reasons. Not even the pretend one. Just "NO"!

The reasons given were frequently arbitrary and discounted our professional judgment in favor of a reviewer who had never seen the patient.

Usually say procedure is not necessary without knowing details.

17. What were the primary reasons given for denial of treatment and service requests?

Selected Comments:

Primary Care Providers

"It's not on formulary."

"Not a covered service."

"Not medically necessary" or "needs referral to specialist."

Felt services could have been obtained on outpatient basis.

Got to try something else first.

Let specialists request tests, not PCP.

Patient needed other tests prior to MRI tests.

Pre-established protocol wasn't tried first.

Specialists

"I think he (she)'s just trying to manipulate the system." Commonest: "He (she) doesn't meet our criteria."

"Treatment not indicated." "Admission not indicated."

Called procedures cosmetic when they were medically necessary.

Mostly arbitrary decision to delay care in the hope patient would go away or doctor would do service anyway for free.

Need for medical records which we have no access to and therefore cannot provide.

No authorization on file, even though one was sent with claim.

Not an emergency.

Not medically necessary.

Prozac, etc., too expensive.

Service provided before authorization gotten.

Services should be provided by schools; not medically necessary.

Ob/Gyn

Denied hysterectomies, not needed (or less treatment needed).

MCO's demand lengthy trials of drugs and/or other minor surgery prior to approving surgery requested.

Conservative treatment not tried long enough.

Not needed, other options available. Suggested patient go to family planning clinic, which means she is without contraception until and if she goes to another clinic.

Dentists

Failure to pay for antibiotic injections for severely abscessed teeth.

Just not going to cover it.

Not severe enough.

Behavioral Health Providers

"Let the schools test." "That's not a medical necessity."

"No prior treatment on medication." "Are you sure they're suicidal?"

"Oh I'm sorry, someone made an error.... We're just really busy" or "I'm sorry, that does not meet our necessary criteria."

Forms not filled out correctly.
 Lower level of care was felt appropriate on review.
 The client had run out of visits (maxed their insurance plan).
 Person's problems were not deemed severe enough.
 It's "not done by others in system."
 They did not meet medical necessity. We as providers would not be calling if we did not believe it was medically necessary.

18. Does the TennCare program have an adequate appeals process to address denials? If no, please describe the deficiencies in the process.

	Primary Care	Specialist	Ob/Gyn	Dentist	Hospital	Behavioral Health
Yes	58.9	52.8	30.4	75.0	50.0	61.2
No	41.1	47.2	69.6	25.0	50.0	38.8

Selected Comments:

Primary Care Providers

Appeals are a waste of time.
 Don't have time to go through various appeals processes on top of time already spent.
 I have sent letters of appeal on a variety of cases for which I never receive any feedback or acknowledgement. I usually just receive another denial note back without explanation or acknowledgement of receipt of my letter.
 Too much difficulty. Too many forms and phone calls.
 Too much waiting on phone lines, not enough people to guide you as to necessary documentation.

Specialists

For Access Med Plus, we have to furnish doctor notes/records in the appeals process. Being a specialist, we do not have access to patient files.
 Adequate but time consuming.
 Can be totally frustrating.
 Difficult or no access to medically trained reviewer.
 Few responses, generic form letters.
 If a service is denied, a TennCare MD should be required to discuss the denial with the requesting MD.
 When you send a written appeal in, you just get a note from them saying they have denied your appeal with no explanation.
 Only a bureaucrat would like the process.
 The appeal process has been improved since the publication of the 1998 (March) provider manual.
 The Bureau of TennCare states it is unable to adjudicate appeals or negotiations between providers and MCO/BHO.
 The companies have almost none. We are trying out the state appeals system.
 They put you through a process that eventually leads to an untimely filing limit.
 Upper levels (e.g., director) will not return phone calls or reply to letters.
 We correspond with the MCOs regarding denials, and the results are always unfavorable to us.
 We have to fight for almost every dollar. People we must talk to are not knowledgeable about the surgical procedures.
 Would be helpful to have process in writing.

Ob/Gyns

Adequate but not timely.
 Always denied regardless of reason for appeal.
 Too time consuming. Provider should be making decisions in some of these cases.

Behavioral Health Providers

Appeals process does not result in benefits being paid for services already rendered.
 Cumbersome, pointless to appeal, denials usually rubber stamped.

*It's a joke - takes several months and then usually has to be re-done/re-filed.
 It's different with each MCO.
 Phone calls are lengthy, costly and ineffective. Follow-through is poor.
 Too intimidating for clients.
 When you send in a grievance form, it takes weeks to hear back from them. By that time the client is either gone or receiving "free" services.*

19. Have you frequently experienced delays awaiting approval of patient plans?	Primary					Behavioral
	Care	Specialist	Ob/Gyn	Dentist	Hospital	Health
Yes	65.3	59.4	75.8	47.4	100.0	45.7
No	34.7	40.6	24.2	52.6	0.0	54.3

If yes, do you believe this delay has affected the quality of care? Please explain your response.

Yes	79.2	70.7	86.4	37.5	0.0	61.6
No	20.8	29.3	13.6	62.5	100.0	38.4

Selected Comments:

Primary Care Providers

*Patient had delay in approval of follow-up orthopedic visits, was in wheel chair longer. Patient never did get good, adequate wheelchair or cushion and now has sores on buttocks.
 Antibiotic therapy needs to be initiated immediately - unsafe to wait 2-3 days.
 Treatment delayed is treatment denied.
 They believe rightly or wrongly that these delays will force us to give up!! If we are on the phone 2-3 hours for one patient, it detracts from care for other patients.
 We have waited for up to 6 weeks to get approval for cardiology consult.
 When a patient is denied appropriate diabetes medicine even for a month or so, the high blood sugar does damage that is unnecessary.*

Specialists

*Cancer grows while waiting. Eardrums rupture. Reflux gets worse because can't get necessary drugs approved.
 Delays allow medical problems to worsen.
 Generally we fight for our plans rather than allowing a delay to affect our patient care.
 If you've got an infection and need high quality antibiotics, you get sicker waiting for approval.
 In some cases but not always. We usually just go ahead and give the necessary care, knowing that we won't be paid.
 Lifesaving medicines have required 72 hours for approval. Pharmacies occasionally will not supply for 3 days.
 Once again, the weekends are almost impossible to get in touch with any official of TennCare.
 Radiation therapy has been delayed after surgical removal of tumors, and tumors have enlarged waiting for surgery to be approved.
 Somewhat but not normally. Patients are treated or given equipment anyway with an understanding that this insurance may or may not pay for services.
 Time is always important in quality of care.
 We are now seeing children referred a year ago.*

Ob/Gyns

*Every time I try to get an antifungal medicine that will work for persistent yeast vaginitis.
 Obviously the longer a patient waits, the quality goes down.
 Patient is bleeding and in pain; we have to wait.*

Dentists

For our patients to receive crown approval, we wait up to 4 weeks—that’s a long time to go with a broken front tooth.

Behavioral Health Providers

This often happens with children in state custody. It takes several weeks for treatment plans to be processed to continue members’ care.

Especially involving physical therapy treatment.

No, because I will continue to see my clients because I feel they should not have to suffer. However, other providers do not feel the same way.

Of course it affects it; if the physician refers a hospitalized (medical) patient to me, he wants that patient seen now, today, not 2 weeks from now after discharge.

People sitting in waiting rooms of hospitals until BHOs call back is a denial of care.

Visits are delayed waiting for authorization.

Waiting 1½-2 hours for pre-authorization of hospital and medication when patient is in crisis delays care and that affects quality.

20. Do you believe that restrictions associated with the drug formularies affect quality of care? Please explain your response.

	<u>Primary Care</u>	<u>Specialist</u>	<u>Ob/Gyn</u>	<u>Dentist</u>	<u>Hospital</u>	<u>Behavioral Health</u>
Yes	86.0	78.2	78.8	13.3	100.0	90.9
No	14.0	21.8	21.2	86.7	0.0	9.1

Selected Comments:

Primary Care Providers

Adequate migraine treatment is not available.

Because the archaic drugs that are often first choice are laden with side effects and inconvenient dosing schedules - both of which severely affect compliance.

Constant changing in the formularies leads to confusion.

Doctors are sometimes unable to order the medications that they feel the patient really needs because they are not on the formulary.

Limited choices for treatment of hypertension, diabetes, asthma and cardiac conditions.

Many allergy medications not covered.

Medications on the formulary change everyday. It is hard to keep up with what is covered and what is not.

Medications that work with patients are non-formulary. Have to try formulary medications first (must be recent trial even if they have been tried and have failed before), even if trying formulary medications puts patient at increased health risk.

Need non-narcotic alternatives for pain management. Recommend non-narcotic cough and cold medicines.

Only the cheapest medications are on formulary, not what is best for the patients.

Patient has to change medications because their medications aren't on formulary.

Pharmacists rarely if ever provide a 72-hour supply of medicine while awaiting approval.

There are so many instances of using generic medications with such poor results.

Use of clearly inferior products results in many return visits to clinic and sometimes hospitalization.

Specialists

Cannot use drug of choice. TennCare formularies very limited when treating glaucoma. It is rare for a patient to be treatable using TennCare approved drugs.

Formularies remain outdated and emphasize cost of medication as opposed to effectiveness.

In children with complex medical needs, greater flexibility may mean better treatment outcomes. It is ridiculous to go through a course of drugs that the MD knows won't work, just to prove it hasn't worked! Valuable time has been lost before the patient receives the appropriate medication.

It has recently improved.

Ophthalmic formulary is quite limited. Nearly one-half of standard ocular medications are not on the formulary.

Ob/Gyns

Limited, 1960's antibiotics.

Limited oral contraceptives are available. Some, which have specific therapeutic uses or which work well in certain situations, are not covered.

Behavioral Health Providers

Absolutely! Patients require longer and more intensive treatment with more complications because they do not have access to newer psychotropic medication such as Prozac.

Addicted person can get a narcotic quicker than they can get a non-narcotic.

Approved medicines usually are older, less effective, have more side effects and patients tend to not comply with treatment due to less effective medicine.

Clients are having to use medicines which take longer to stabilize depression/anxiety and they are experiencing more side effects.

For some medications, we must demonstrate "x" number of failures first. This is unkind to clients.

21. Do your TennCare patients have medical needs that are not covered by the program? If yes, please elaborate.

	<u>Primary Care</u>	<u>Specialist</u>	<u>Ob/Gyn</u>	<u>Dentist</u>	<u>Hospital</u>	<u>Behavioral Health</u>
Yes	59.0	50.5	55.2	80.0	50.0	53.5
No	41.0	49.5	44.8	20.0	50.0	46.5

Selected Comments:

Primary Care Providers

Adult dental and vision services.

Alcohol and drug programs.

Breast reductions for teenage girls who are embarrassed and uncomfortable. Same for older women.

Cosmetic - acne, plastic surgery, etc. Psychiatric care.

Dermatology, rheumatology.

Diabetic education.

Long-term home health nursing and long-term nursing home care.

Medications.

Obesity management, outpatient antibiotics.

One problem is lack of help to stop smoking.

Specialists

Acne topical meds.

Children with disabilities.

Cough suppressants in lung cancer patients.

Hearing aids, don't provide allergy coverage.

Home care (particularly nursing care), physical therapy are among the worst. Can't keep patient in hospital, but can't get all care necessary at home.

Impotence, infertility, insomnia, headache.

Limited mental health and alcohol and drug services.

Many of our new chemotherapy drugs and some antibiotics are not covered.

Nerve blocks for post-op pain management.

Not aware of any.

Pain management.

Some requested tests are not in line with guidelines (e.g., mammograms for younger patients).

TMJ treatment and over-21 dental surgical treatment.

Transplants.

Weight reduction programs, vocational skills, home care.

Ob/Gyn

Circumcision, post-partum tubal ligation.

Infertility, routine pap smears.

*IUDs, Norplants.
Need to pay better for birth control and sterilization.
Some MCOs do not cover home monitoring.*

Dentists

Full crowns (porcelain to metal), fixed bridge; interceptive orthodontics, fixed or removable crossbite appliances.

Many children need early (interceptive) orthodontics and/or special appliances, etc.

Over age 21: Partials or dentures to help restore function of mastication (chewing) to assist in food digestion and for proper nutrition.

Behavioral Health Providers

Chiropractic.

Inpatient and residential treatment of adolescents with chemical dependency.

MRI, CAT Scans, any preventive tests. Blood screens for venereal disease.

Orthopedic needs, periodontists, oral surgeons, orthodontists.

Psych testing for adolescents and children.

22. On average, how long do your TennCare patients have to wait when scheduling appointments?

Selected Comments:

Primary Care Providers

1 day (50 responses).

2 days (23 responses).

3 days (6 responses).

Within 7 days (13 responses).

2 weeks (12 responses).

Within one month (12 responses).

Longer than one month (3 responses).

Same as our other patients.

Depending on problem and specialty.

If emergency, seen immediately, if office is open, or next day.

Acute care - same day. New child (EPSDT) within 4 weeks.

Established patients 1-3 days. New patients 3 days - 1 week.

Specialists

1 day (38 responses).

2 days (18 responses).

3 days (7 responses).

Within 7 days (40 responses).

2 weeks (33 responses).

Within one month (13 responses).

Longer than one month (16 responses).

Immediately.

In my experience patients have told me they could not get appointment for 2 or more weeks.

Ob/Gyn

1 day (7 responses).

2 days (2 responses).

Within 7 days (10 responses).

2 weeks (5 responses).

Within one month.

Depending on nature of visit, can accommodate same day appointments.

Dentists

1 day (4 responses).
3 days.
Within 7 days (5 responses).
2 weeks (5 responses).
Within one month (6 responses).
Longer than one month.

Behavioral Health Providers

1 day (19 responses).
2 days (10 responses).
3 days (8 responses).
Within 7 days (67 responses).
2 weeks (19 responses).
Within one month (17 responses).
Longer than one month (3 responses).
10 days because it is mandatory.

23. If you serve as a provider for more than one MCO/BHO, do they have: (If no, please elaborate.)

		<u>Primary Care</u>	<u>Specialist</u>	<u>Ob/Gyn</u>	<u>Dentist</u>	<u>Hospital</u>	<u>Behavioral Health</u>
standard procedures?	Yes	71.0	67.8	89.7	94.1	50.0	67.8
	No	29.0	32.2	10.3	5.9	50.0	32.2

Selected Comments:

Primary Care Providers

All forms (referral) look different. Network providers are different. Formularies are different. Different labs. Credentialing by each MCO is time-consuming and stupid. Different requirements for different recipients.
Not among themselves. You know that TennCare was not to simplify but make more complicated. When we had one program we knew standards. But now each MCO is doing differently.
They only provide a contract and a few standards for a medical condition but they always get conflicting information from people on the phone. These things are written but we can't look it up in our contract and then recite it to the minimum wage employee and get any results.

Specialists

All have different requirements and therefore unduly burden providers.
Different billing procedures for each MCO.
Different filing limits, different provider numbers on claims.
Each MCO has individual procedures, paperwork, percentage of reimbursement...very confusing.
Procedures for admissions and discharge vary.

Ob/Gyn

Some need referrals for me to do annual gynecological exam, some don't, some won't let me do annual exam even if the woman has been my client previously.
Too much deviation among various plans.

Behavioral Health Providers

Different forms for each agency.
Different formularies, different criteria.
I can't even keep up with what lists I'm on because companies change names or go by several names. I keep forgetting what are the MCOs and what are the BHOs.
Most of their procedures are confusing and different.

standard credentialing processes?		Primary					Behavioral
		Care	Specialist	Ob/Gyn	Dentist	Hospital	Health
Yes		78.3	71.5	82.8	100.0	0.0	80.0
No		21.7	28.5	17.2	0.0	100.0	20.0

Selected Comments:

Primary Care Providers

Credentialing individually for each MCO is a pain. Why can't providers credential with TennCare only and MCOs check with TennCare?

Credentialing criteria vary, forms vary and some deny nurse practitioner participation.

Why must we be credentialed repeatedly by each MCO?

Specialists

All credentialing packages and procedures are different.

Everybody's form is different, information same.

One application should serve all.

Recredentialing process varies from MCO to MCO.

There should be only one credentialing process for TennCare. This would eliminate paperwork and time spent on it. If it was done only once for all MCO/BHOs, it would save the MD time. It would save TennCare money.

Behavioral Health Providers

It takes an extraordinarily long time to become credentialed.

standard paperwork requirements?		Primary					Behavioral
		Care	Specialist	Ob/Gyn	Dentist	Hospital	Health
Yes		69.9	65.0	78.6	100.0	0.0	60.7
No		30.1	35.0	21.4	0.0	100.0	39.3

Selected Comments:

Primary Care Providers

All different, just adds to confusion.

All have similar referral form.

Different formularies.

Different labs.

Each MCO has a different form, asks for different items. Sometimes you have to submit the same paperwork to several people at the MCO.

Similar, not standard.

Specialists

Each MCO has its own.

My office manager/insurance person has 3 notebooks with the various forms needed.

Standard within MCO but varies from MCO to MCO.

Behavioral Health Providers

Different forms/deadlines.

Inadequate notification of changes.

Some new form all the time, if a request is made for all the forms a provider needs, the BHO couldn't produce them.

standard approval processes?		Primary					Behavioral
		<u>Care</u>	<u>Specialist</u>	<u>Ob/Gyn</u>	<u>Dentist</u>	<u>Hospital</u>	<u>Health</u>
	Yes	71.4	70.3	66.7	88.9	0.0	61.1
	No	28.6	29.7	33.3	11.1	100.0	38.9

Selected Comments:

Primary Care Providers

Different MCOs require different prior authorizations.

Each MCO has a different time limit for approvals for new providers. The MCO's credentialing committee meets differently.

Specialists

Which procedures require precertification/referrals varies from MCO to MCO.

Behavioral Health Providers

All have different processes and forms.

Arbitrary and secretive.

standard coverage for treatment?		Primary					Behavioral
		<u>Care</u>	<u>Specialist</u>	<u>Ob/Gyn</u>	<u>Dentist</u>	<u>Hospital</u>	<u>Health</u>
	Yes	71.9	65.5	80.0	88.9	0.0	64.3
	No	28.1	34.5	20.0	11.1	100.0	35.7

Selected Comments:

Primary Care Providers

But we hear that a tacit approval written on the back of the form or given over the phone does not guarantee payment.

Some pay for screening; some don't. Some pay for flu and pneumonia; some don't.

Specialists

Approved and denied inconsistently.

Different plans cover different things.

Different referral and authorization requirements.

Access Med Plus insists all eye exams be done by an optometrist! This is absurd for evaluation of strabismus! They don't do surgery!

Phoenix requires authorization for numerous radiology exams even when performed as outpatient. Other MCOs do not.

Some limit care to 1-3 visits and others give you a case manager.

Some pay for chemotherapy; most don't.

Ob/Gyns

Certified nurse midwives must be covered by all MCOs.

Dentists

Different MCOs provide different coverage for same procedures.

standard coverage for medications?		Primary					Behavioral
		<u>Care</u>	<u>Specialist</u>	<u>Ob/Gyn</u>	<u>Dentist</u>	<u>Hospital</u>	<u>Health</u>
	Yes	62.0	71.6	76.9	100.0	0.0	73.8
	No	38.0	28.4	23.1	0.0	100.0	26.3

Selected Comments:

Primary Care Providers

2 standards under Promark.

Different formularies.

Different meds covered under different plans.

Except the formulary keeps changing without notice.

Very confusing for providers to try and keep up with the different formularies. No standard format, each MCO different.

Specialists

According to our nurses, "It stinks." We do not get up-to-date formularies and "even the pharmacies" don't know.

Some plans pay for some OTC meds while others don't; meds much better than other processes above.

Ob/Gyns

John Deere only covers Ortho oral contraceptives. Others only cover others. Difficult to keep all straight.

Behavioral Health Providers

Separate policies for medication approval.

24. Do you believe the TennCare program is adequately monitoring the MCOs/BHOs? If no, please explain your response.

	<u>Primary Care</u>	<u>Specialist</u>	<u>Ob/Gyn</u>	<u>Dentist</u>	<u>Hospital</u>	<u>Behavioral Health</u>
Yes	41.7	32.3	41.7	69.2	0.0	38.5
No	58.3	67.7	58.3	30.8	100.0	61.5

Selected Comments:

Primary Care Providers

Better control needed.

Doctors not getting paid by certain MCOs.

I can't tell there is any monitoring at all - especially mental health problems.

I understand the TennCare Oversight Committee has been disbanded.

If they were, they would require better service from MCOs.

Over-assignment of patients to certain "preferred" PCCMs by some MCOs. No accountability for delayed responses to special requests for services. No accountability for outrageous bookkeeping by MCOs.

Increased payments to MCOs are not passed along to PCCMs.

TennCare Bureau refuses to enforce the contract with MCOs, especially with issue of prompt payment for claims.

TennCare has no idea what is going on at MCO level.

The patients are being arbitrarily dropped from the BHO.

Specialists

Absolutely not.

Corrective action plans do not appear to be acted upon either timely or with deliberateness.

Suspect that TennCare is unaware of the multitude of different requirements for each MCO.

I am not certain that anyone is truly looking out for the interests of the TennCare enrollees.

If Phoenix is adequately monitored, I doubt they would be in business.

If they are monitored, it must be from the Caribbean.

I have seen no outcome studies since TennCare was introduced.

MCOs business practices are grossly unethical.

Monitoring should include standardization of all processes.

Not responsive to patient/provider needs/complaints. Reimbursements and timing of reimbursements not overseen.

Payment and claims processing are full of errors.

Payments to providers are arbitrarily denied and unjustifiably delayed. The TennCare Bureau should do something about it.
Phoenix has not paid claims in months. Blue Cross is denying claims on technicalities.
TennCare needs to monitor adequacy of networks, process necessary to receive approval to treat, and timely and adequate claims payment.
The system is too big for adequate monitoring.
They are spending time monitoring the care but not the timeliness of reimbursement to physicians who are paying taxes to support TennCare and working at charity rates—a double hit.
They don't look at internal denials! This must be done to get a true picture of the difficulties families experience in obtaining care.
They wouldn't let Phoenix withhold treatment and payment as long as they do.

Dentists

Need audit for payment accuracy/delay tactics. Consistency in payments-fees-procedures. Rates very depressed; no regular increases. Keep doing more for less!!

Behavioral Health Providers

BHOs are notoriously late in re-certification, updating enrollee data bases, and providing reimbursement. Historically payment has been slow and unpredictable.
I believe the MCOs' and BHOs' middle and executive management are getting fat off decreased patient care and poor reimbursement rates for providers. Many of us have been forced out of the system due to poor pay.
I believe the BHOs need to be more closely monitored, especially since the group that owned Premier now owns TBH as well. It seems a bit odd and troublesome.
It seems the state wants to micromanage the day to day aspects of the program and turn its head on the systematic problems.
There are too many problems with the whole set-up; example: EQRO isn't monitoring anything; they're not making sure TennCare is following through.
Too many administrators with high salaries - much higher than individuals with same degree and experience who provide direct care.
We as providers do not know because we are not given adequate information about changes and what is expected.

25. Are there clearly defined requirements for the MCOs and BHOs to report to the TennCare bureau?

	<u>Primary Care</u>	<u>Specialist</u>	<u>Ob/Gyn</u>	<u>Dentist</u>	<u>Hospital</u>	<u>Behavioral Health</u>
Yes	65.8	47.4	53.3	75.0	100.0	68.6
No	34.2	52.6	46.7	25.0	0.0	31.4

Selected Comments:

Primary Care Providers

Don't know.
Reporting to a bureau in no way equates with oversight by the bureau.

Specialists

But no one follows them. The information submitted is falsified.
Don't know.
Not that we are aware of. We have reported the MCOs' claims processing to TennCare for auditing.
State does not require MCOs to honor contract as TennCare MCO except in token cases.
State doesn't know what to do with the data.

Behavioral Health Providers

Don't know.
There must not be since the MCOs and BHOs are in disarray and in financial trouble.
I have no idea what is going on; could someone let us know!

26. Are you required to submit encounter data?	Primary					Behavioral
	Care	Specialist	Ob/Gyn	Dentist	Hospital	Health
Yes	40.2	28.6	39.1	43.8	100.0	55.8
No	59.8	71.4	60.9	56.3	0.0	44.2

Selected Comments:

Primary Care Providers

All encounters are filed even if capitated.

At times during a review.

Chart review.

Encounter-based claims data is submitted through PTBMIS.

I fill out an encounter form on each patient evaluated.

Not to my knowledge.

On billing claim.

To whom?

Used to be.

Specialists

Copies of test and documentation must be sent with each claim.

Don't know of any.

Don't send anything but claim form.

If requested.

Not formally. Always believed this was tracked based on claims filed.

Ob/Gyn

Via claims.

Dentists

Encounter data comes from routine patient billings.

When audited.

Behavioral Health Providers

Electronically, on a routine basis.

For some MCOs.

I don't have time to collect data for the BHO which has a large staff.

Only way to provide services.

The requirement is no longer necessary.

We were in the beginning.

27. Do you receive any feedback regarding the encounter data you submit?	Primary					Behavioral
	Care	Specialist	Ob/Gyn	Dentist	Hospital	Health
Yes	37.1	16.4	21.4	36.4	100.0	31.6
No	62.9	83.6	78.6	63.6	0.0	68.4

Selected Comments:

Primary Care Providers

From some MCOs.

I get a performance sheet on records, etc.

Just payment or denial.

Just that they want us to do more.

Occasional request for more specific diagnosis.

Specialists

Rarely.

Some helpful feedback has been given. However, most feedback is frankly critical without helpful suggestions.

Usually negative.

Behavioral Health Providers

Not in a timely manner.

28. What suggestions could you give to improve the state's monitoring efforts?

Selected Comments:

Primary Care Providers

Do central credentialing at TennCare to let providers spend their time with patients.

Be more involved and interested in provider issues with the MCO.

Ensure children don't lose their TennCare as a result of parents who don't follow through with the reapplication process.

Evaluating suffocated provider network - both physician and hospital.

Have doctors participate in monitoring effort. Limit amount of money insurance companies clip off top for "administrative fees."

Review at least quarterly the turn-around time from claim submission to claim payment.

Standard guidelines for MCOs would ensure consistent care and quality of services and help with monitoring.

Talk to providers.

To view this realistically. Dumping hundreds of millions of dollars into these MCOs means that often no one can track dollars as going for specific purposes. Often MCOs send us a lump sum with no documentation of what specific services it is for. This amounts to an attempt to silence complaining providers by appeasing them with money. There needs to be some accounting for every dollar of my tax money going to an MCO. I don't know if my money is well spent or if it is paying for extremely inefficient administrative staffers, advertising, perks for MCO executives, etc.

Specialists

Monitor promptness and accuracy of payments to providers.

Monitor adequacy of provider base compared to number of covered lives and geographic coverage.

Require active BHO involvement in oversight, rather than requiring the provider (inpatient) to manage network problems.

Require BHO to utilize their information system to resolve their reporting requirements, rather than passing this task to providers in forms and paperwork.

Be sure specialists' requests are reviewed by that specialty; not pediatrics by orthopedics.

Make sure quantity doesn't dilute quality.

A very powerful oversight and review panel and someone to work with and listen to the providers and carry out some of the providers' ideas.

Begin by enforcing state's contract with MCOs, to the letter of the law.

Communicate the regulations to all providers. Standardize the way the MCOs operate.

I didn't know they were monitored at all.

Employ persons with medical experience to perform monitoring.

Assess outcomes following denial.

Physician and provider surveys. Patient surveys. Review claims payment systems and practices of MCOs.

Publish some standards comparing the MCOs, etc.

Reduce number of MCOs.

Stay in touch with office management personnel.

The monitoring program should have been established far in advance of the program. The amount of personnel is probably inadequate for the job.

Ob/Gyn

All programs need to have the same criteria for coverage of benefits.
Standardize, improve process time.

Dentists

Need to have standards across the board for all TennCare plans.

Behavioral Health Providers

Decrease some of the politics.
Develop tool of BHO requirements, NCQA requirements, CAHO requirements then audit unannounced.
Improve monitoring, give a copy of monitoring guidelines to each physician.
Increase monitoring of how administrative money is spent and timeliness of reimbursement.
It appears the state makes no attempt to monitor and does not adequately fund the program. Too much emphasis on denying/restricting claims.
Make it simple and get out of the way.
Quarterly financials made public and MCOs made to show their income/expenses/net income.
TennCare to follow the EQRO report would be a start.
What does the state do to monitor? We saw changes made only after HCFA was brought in.

29. Are MCO/BHO staff helpful in answering questions? If no, please explain your response.

	<u>Primary Care</u>	<u>Specialist</u>	<u>Ob/Gyn</u>	<u>Dentist</u>	<u>Hospital</u>	<u>Behavioral Health</u>
Yes	69.0	52.8	57.1	94.1	50.0	69.2
No	31.0	47.2	42.9	5.9	50.0	30.8

Selected Comments:

Primary Care Providers

Not in the past. Maybe they are better trained now.
Cannot trust what they say.
Depends on MCO. Constant turnover in staff.
You can get 2 different answers from 2 different people.
I prefer to avoid speaking with them.
Information will differ from what office is told and patient is told.
My staff have been on the phone as much as 6 hours with one patient's MCO and may be transferred to as many as 6-7 persons.
Rude, generally not helpful.
Sometimes but rarely on the first contact.
They are very courteous, but nothing ever gets resolved. Problems just go on and on.
You usually get someone who is undereducated making health care decisions based on an algorithm they don't understand and have no idea what is clinically important.

Specialists

BHOs are the least helpful.
Not available at off hours.
Only voice mail.
Depends on the plan.
Don't return phone calls.
Generally the first person you talk with is ill-informed. It may take a while to find someone to answer questions.
Many persons contacted are inept, ignorant, or rude to MDs or RNs.
Most of the time.
Often seem to be giving scripted answers to questions, exhibit no flexibility.
Precert staff are always great, just overworked.
Some have no clue, some want to be helpful but have no power, and one MCO contact person is down right rude.

Some members of staff are very helpful.
 Staff are too bound to their computer's database to make any medical decision that requires knowledge of the TennCare enrollees' problems and insight into what is necessary to render quality care. Medical directors are too difficult to locate.
 They are not trained adequately.
 They are overwhelmed.
 They have a list of yes and no and after that we get no further answer.
 Usually.
 Usually the office credentialing person has to leave multiple voice mail messages over two and sometimes three weeks to get answers.

Ob/Gyns

Double talk - kick up to next level - catch 22.
 Most support staff seem to be lacking necessary knowledge.
 Once you reach them.
 Staff rude.
 They don't always give correct answers.
 Too hard to get through, sometimes 20-30 minutes to 1 hour holding on phone.

Behavioral Health Providers

I certainly get misinformation from Medicare, TennCare, and all other insurance companies.
 When I get one, they're great.
 They are defensive and make it clear they hold total power; we become almost beggars to attempt to get just a few sessions more.
 They are rude, inconsiderate, and not knowledgeable.
 They give inaccurate information.
 Those I have talked with are most cordial and helpful.

30. Has TennCare or your MCO/BHO solicited your concerns?	Primary					Behavioral
	Care	Specialist	Ob/Gyn	Dentist	Hospital	Health
Yes	37.3	16.7	26.7	38.9	33.3	24.8
No	62.7	83.3	73.3	61.1	66.7	75.2

If yes, please describe actions taken in response to your concerns.

Selected Comments:

Primary Care Providers

Yes, from one MCO did receive letter saying will improve but the same problem remains.
 None.
 PHP great to work with and has addressed all our issues.
 Have told problems with specialist and referrals to representatives and provided services - no changes.
 When we went out of our way to talk to them, we got a polite hearing and no action.
 The state Department of Commerce and Insurance helped us with reimbursement issues recently after a letter we sent.
 They do not contact us. We contact them with questions.
 No feedback.
 Most have representatives who visit.

Specialists

Only one, OmniCare, and that's because we had complained to the TennCare Bureau about their not paying timely.
 Phoenix case manager made a point of visiting us to ensure things were going smoothly.
 Phoenix, by supplying names in their organizations to call regarding different areas.

*Surveys, no summary of responses.
Access Med Plus routinely has a representative drop by to address concerns.
They have never asked me my concerns. The provider reps have not been by to meet us. When we had issues, we have had to call them.*

Ob/Gyns

Some send surveys to be filled out, but no action is taken.

Dentists

*Always receive answer to concerns.
They took necessary actions.*

Behavioral Health Providers

*I've written letters and even volunteered to do a presentation to the medical board to no avail!
Much correspondence in past, little response.
None reported.
Not that I'm aware of but they do listen and react to concerns expressed over phone.
Premier had me complete 1 survey (4 questions) over the telephone.
Premier meeting addressed several questions (area-wide meeting).
Somewhat, we did have a representative from TennCare come to our facility to explain some issues.
However it took a lot of "putting the pressure on" with TennCare to get that. And there are still concerns we haven't gotten answers for.
TennCare - not BHOs.
We complained about a reviewer whom we had consistent conflict with and he was removed from reviewing us.*

If no, please explain.

Selected Comments:

Primary Care Providers

*I just don't remember their soliciting them.
Never had request for concerns.
They have not asked, called or written.
We are never contacted regarding any aspect or operation of the TennCare system.
We have never been asked about problems we have, with exception of one MCO.*

Specialists

*Have never been contacted.
Has never been done.
No one asks why we do not like TennCare.
No previous communications.
Typical answer, we'll check into it (HaHaHaHa).
We asked for meetings and were referred to our county liaison. We were denied meetings.
We faxed several denied services to BlueCare MCO and Premier BHO and those were never paid because neither could decide who was responsible.
We have had to complain to the legislature to get something done.*

Ob/Gyn

No one listens to concerns.

Dentists

*TennCare called me several weeks ago.
They send letters telling us what they have done, but there is no request for our input.*

Behavioral Health Providers

My concerns have not been solicited.

Meetings but no formal feedback.

I have suggested or complained on several occasions only to be told that someone will get back to me, which never occurs.

They have yet to ask me and I'm reluctant to give negative feedback because they can drop me from the panel.

31. Does the TennCare program have excessive administrative requirements? If yes, please explain your response.

	<u>Primary Care</u>	<u>Specialist</u>	<u>Ob/Gyn</u>	<u>Dentist</u>	<u>Hospital</u>	<u>Behavioral Health</u>
Yes	64.6	63.6	72.0	25.0	66.7	72.1
No	35.4	36.4	28.0	75.0	33.3	27.9

Selected Comments:

Primary Care Providers

Requires a referral written for everything.

Charts are set up differently for each MCO. Patients change MCOs and charts have to be changed.

Phone calls, delays.

Prior authorization process for meds.

The increased time for "paperwork" will destroy these attempts to provide managed care.

MCOs demand that medical charts are put in an order (different from all other patients).

Specialists

Credentialing/services and billing not standardized.

Too many audits.

No electronic claims processing.

Participating in TennCare increases overhead for the practice because of the time spent getting referrals, precerts, and approvals for procedures usually denied.

Referral process is ludicrous. There needs to be a published list of specialists accessible to providers and patients.

Each MCO has its own administrative structure. Medicaid had one.

Some plans require paperwork which takes 15-30 minutes per patient.

Too much time on phone to obtain approval, argue for services, argue for reimbursement.

Too much red tape and bureaucracy. It costs me, literally, twice as much to provide care to TennCare patients as to my private MCO patients.

You have to call, fill out form and double check eligibility because they (patients) have dropped/added/changed PCP and carry multiple cards!

Ob/Gyns

Sometimes we must refile claims 8-10 times to get paid.

I can't wipe a nose without a referral.

Dentist

Prior authorization process needs to be streamlined.

Too much paperwork on credentials since information is sent yearly. I feel completed form from previous year should be reviewed for any changes and resubmitted.

Behavioral Health Providers

Significant amount of time is spent with paperwork rather than patient care.

Questions I must respond to often concern demographic data not treatment.

Paperwork is 3 times the amount required for commercial insurance precertifications.

Ridiculously long treatment plans, having to call after every 7-12 sessions.

Takes too long to get credentialed.

Rigid requirements about presentation of information rather than working with us to use what we're already doing.

32. Are administrative and program requirements effectively communicated to providers? If no, please explain your response.

	<u>Primary Care</u>	<u>Specialist</u>	<u>Ob/Gyn</u>	<u>Dentist</u>	<u>Hospital</u>	<u>Behavioral Health</u>
Yes	60.7	53.4	34.6	75.0	0.0	51.5
No	39.3	46.6	65.4	25.0	100.0	48.5

Selected Comments:

Primary Care Providers

*If we had updateable provider manuals, that would be helpful.
 But mostly larger and more time consuming than commercial carriers.
 Communications are in thick memos and complicated. No one has the time to read them.
 It has taken 9 months to get a manual.
 So much information, sometimes hard to keep up with.
 Things change from month to month, especially formularies without the providers being notified.
 We find out what some requirements are after the fact.
 We have shelves full of binders from each MCO.*

Specialists

*Providers sometimes are not notified in a timely manner when changes occur.
 I received a set of guidelines in 1996. No updates; I get word of mouth communications from colleagues.
 Need more communication.
 Never hear from reps.
 Not to specialist, manuals are geared for PCPs.
 Often times contradictory and ever changing.
 Some MCOs have not even supplied provider manuals.
 The communication of the requirements is effective.
 The reasons for implementation of these requirements are not readily evident.
 Too detailed and constantly changing. Need to be simple outlines/guidelines and remain in place for a year.
 We have been asking for information for months.*

Ob/Gyns

*Usually through newsletters, often after the fact or after policies change and we are not informed.
 Only when you specifically call and ask about particular problems.
 They send us provider manuals. We still have phone calls to verify that the info has not changed.*

Dentists

Would like some sort of newsletter.

Behavioral Health Providers

*After new regulations are in force, with abrupt deadlines and numerous duplication of data requirements.
 Communication with providers is poor and usually several weeks after a change has gone into effect.
 Standards of care are not defined.
 No clear communication on credentialing process or status.
 Often I get letters long after they're dated. Often end up having to miss the training or whatever is offered because of lack of notice.
 Provider manual requested 3/98, received 7/98.
 Sometimes get notice of provider meetings after they have taken place.
 They send out one thing on paper and will tell you something different on the phone.
 Too many and they change daily.*

33. On average, how long does it take to process TennCare claims?

Selected Comments:

Primary Care Providers

1-2 weeks (4 responses).

3-4 weeks (8 responses).

4-6 weeks (4 responses).

1-2 months (23 responses).

3-4 months (2 responses).

1 month for PHP, 2 weeks for BC/BS.

14-18 days - electronically, 30-60 days – manually.

15-20 minutes to process claim BUT months to receive payment of claim.

30 days to forever.

3-5 minutes to place in the computer.

Electronically 6-8 weeks. Paper 6 weeks to 6 months.

For us - minutes. For TENNCARE - weeks.

Specialists

1-2 weeks (6 responses).

3-4 weeks (14 responses).

1-2 months (71 responses).

3-4 months (28 responses).

6 months (7 responses).

2 months - often 1+ years.

45 days hardcopy, electronic is a nightmare!

Ob/Gyn

1-2 months (6 responses).

2-3 months (8 responses).

over 3 months (2 responses).

From 3 weeks to 1 year to never.

Months on tubal ligations and hysterectomies.

Too long.

Dentists

1-2 weeks.

2-4 weeks (7 responses).

1-2 months (7 responses).

Over 3 months.

Minutes for us to fill out/weeks to get reimbursed.

Behavioral Health Providers

Under 1 month (11 responses).

1-2 months (50 responses).

2-3 months (12 responses).

Over 3 months (11 responses).

6 months on average, often 1-2 years!

From 1 month to 6 months to never.

Most never paid.

There are some not responded to since July '96.

Too long.

34. Do you believe it takes too long to process claims?

	<u>Primary Care</u>	<u>Specialist</u>	<u>Ob/Gyn</u>	<u>Dentist</u>	<u>Hospital</u>	<u>Behavioral Health</u>
Yes	57.5	75.1	88.5	60.0	100.0	67.4
No	42.5	24.9	11.5	40.0	0.0	32.6

If yes, what would be an acceptable processing time.

Selected Comments:

Primary Care Providers

- 1 week (4 responses).
- 10 days (3 responses).
- 14 days (4 responses).
- 2-3 weeks.
- 3 weeks.
- 30 days (6 responses).
- 30 days as required by the MCO contract.
- 30 to 45 days (3 responses).
- 2 months.

Specialists

- 24 hours (2 responses).
- 1 week (2 responses).
- 1-2 weeks (17 responses).
- 2-4 weeks (12 responses).
- 1 month (38 responses).
- 1-2 months (22 responses).
- 4-6 months.
- "clean" electronic claims should be paid in 14 days.
- 30 days, as contracts state.
- At least 30 days (paper), 2 weeks (electronically).
- Medicare does it in 21.
- Phoenix should process claims in 30 days just like the other MCOs.
- Phoenix takes forever if at all. BlueCare is second. Access Med Plus most timely.

Ob/Gyn

- 2 weeks.
- 2-3 weeks electronically.
- No more than 3 weeks.
- 30 days (7 responses).
- 30-45 days (2 responses).

Dentists

- 2 weeks (3 responses).
- 2-3 weeks (Phoenix is 6-8 weeks).
- 2-4 weeks.
- 30 days.

Behavioral Health Providers

- 2-3 days.
- 10 days.
- 2 weeks (26 responses).
- 3 weeks (11 responses).
- 1 month (26 responses).
- 45 days (8 responses).

2 months (5 responses).
 3 months.
 Should be able to bill electronically, fewer mistakes, faster, less paper!
 90 days is industry standard.
 Most insurance companies—less than 45 days.
 Regulations says a response should be received within 30 days.

35. Are the reimbursement rates for providers adequate? Please explain your response.	Primary	Specialist	Ob/Gyn	Dentist	Hospital	Behavioral
	Care					Health
Yes	19.0	11.2	3.3	17.6	0.0	6.0
No	81.0	88.8	96.7	82.4	100.0	94.0

Selected Comments:

Primary Care Providers

Should be increased 100%.
 No payment on labs. We must do labs on patients in office to make adequate diagnosis. It is not safe to send off labs and wait one week for results!
 Almost always less than 50% of what was charged.
 Does not cover overhead of a 15 minute office visit or lab.
 Don't match other insurance reimbursements.
 How can the system justify paying a physician \$1.74 for an injection that cost \$3.25 per shot?
 Frequently it is significantly less than Medicare.
 It covers between 21%-35% of our cost.
 Payments should be mandated by TennCare Bureau. All MCOs have different schedules.
 Rates are approximately 35% less than other insurance companies.
 Rates have not increased since Medicaid (January 1994).
 For time, effort, and excessive paperwork, the fee is not even close.
 Some plans pay as little as \$12.00 per office visit regardless of what length of time and procedures are done to the patient. Practice loses money.
 You cannot provide service to a patient for \$6.50 a month!

Specialists

35% reimbursement.
 80 % of Medicare rates.
 About 30% of usual and customary rates.
 Getting 20% of billing is not enough to sustain and care for ill patients.
 Have not received rate increase since inception of program even though the MCOs have received multiple increases.
 Rates are unreasonably low, especially in light of carriers' profits.
 If they were, more doctors would accept it.
 It is extremely inadequate for the care that the patients are receiving.
 Rates need to have better inflationary adjustments to keep us from losing money caring for TennCare enrollees.
 The surgical reimbursement rate is abysmal and not worth the risks of subjecting the patient to anesthesia.
 Too low for care and back-up staffing to take care of paperwork.

Ob/Gyn

Payments for some procedures won't even pay the malpractice premium and certainly aren't worth the risk of a possible complaint.
 Much lower on some plans than others.
 Surgical procedure payment too low; \$112 for a tubal ligation.

Dentists

Providers (dental) should be reimbursed more than current amounts due to our quality of care, time with patients, and expert opinions of dental health.

Rates run about 40% of our usual and customary rates.
 Some rates are adequate/some are ridiculous.
 They are much better than earlier in program - our orthodontic fee is reimbursed at about 50%.

Behavioral Health Providers

\$30 for a severely mentally ill patient, with numerous problems? Come on!
 1/2 my normal fee.
 Below community standard/below Medicare.
 Constantly being reduced. In 5 years has been reduced from \$70 to \$44.
 Cost per hour to run office is \$30; pay is \$30.18. \$0.18 is basically pro bono work.
 I receive 1/4 the fee for TennCare clients than I receive for others.
 Insulting and infuriating.
 Lately I think it is better.
 My retail rate is \$180 per 3-hour intensive outpatient session and TennCare pays \$49.50.

36. Do you believe community-based services (e.g., transportation, housing) are adequate to meet enrollees' needs? If no, please explain your response.

	<u>Primary Care</u>	<u>Specialist</u>	<u>Ob/Gyn</u>	<u>Dentist</u>	<u>Hospital</u>	<u>Behavioral Health</u>
Yes	57.1	58.9	54.5	60.0	0.0	27.9
No	42.9	41.1	45.5	40.0	0.0	72.1

Selected Comments:

Primary Care Providers

Bus to transport patients to office visit has left patients standing outside in snow prior to 8 a.m. when the office opens. Some patients sit for 3-4 hours waiting to be picked up. The driver has been verbally abusive to the patients.
 Patients experiencing difficulty with transportation to appointments.
 Transportation services seem adequate.
 Unable to get transportation expeditiously.

Specialists

Frequently, patients need urgent appointments and only option is ambulance transportation.
 More than enough.
 Never enough.
 Requirement for 5-day advance notification to arrange transportation is not adequate or realistic.
 TennCare transportation is not always reliable and people don't know how to get it.
 We have a 20% no-show rate for our TennCare patients due to errors with TennCare transportation.

Ob/Gyns

My staff often has to stay through lunch or after hours since transportation takes so long to arrive after multiple calls.

Behavioral Health Providers

Clients have had long waits for transportation. Clients have had incidents in which they were mistreated by transportation workers.
 A very large number of session hours have not been provided to patients with appointments because transportation failed to get them here.
 Transportation glitches are common; some drivers are discourteous.
 Transportation is an absolute nightmare. It doesn't work for scheduled appointments.
 Transportation very unreliable, shows up late, or not at all. Rude.

37. Do you believe that BHOs provide adequate support for case management? If no, please explain your response.

	<u>Primary Care</u>	<u>Specialist</u>	<u>Ob/Gyn</u>	<u>Dentist</u>	<u>Hospital</u>	<u>Behavioral Health</u>
Yes	47.4	54.5	50.0	100.0	0.0	49.5
No	52.6	45.5	50.0	0.0	100.0	50.5

Selected Comments:

Primary Care Providers

*BHO services are difficult to access and obtain appropriate services.
I can't tell there is any case management at all.
I have a mentally ill child and case management has never been offered. I can't even get her into treatment.*

Specialists

*There needs to be more case management for children's needs.
They only deal with crises. They don't do prevention.*

Behavioral Health Providers

*2 to 4 case managers for 10,000 covered lives.
People who require case management have to be dropped to pick up people who actually don't need it due to uninformed decisions by the insurance providers.
Didn't know there was case management.
Its difficult to contact case managers to coordinate treatment.
Turn over rates are extremely high—one case can have many case managers in a 3-5 month period.
Most of our TennCare patients supposedly have case managers through a community MH center, yet the case managers are not greatly involved or are not involved at all.*

38. Do you believe transferring the management of pharmaceutical services from the BHOs to TennCare will affect the quality of care? Please explain your response.

	<u>Primary Care</u>	<u>Specialist</u>	<u>Ob/Gyn</u>	<u>Dentist</u>	<u>Hospital</u>	<u>Behavioral Health</u>
Yes	34.3	53.2	20.0	100.0	100.0	69.4
No	65.6	46.8	80.0	0.0	0.0	30.6

Selected Comments:

Primary Care Providers

*It will help the situation.
It's already better, with appeals easier.
Pharmaceutical services are generally a problem.
No, unless it results in more open formulary.
Will be better, less fragmentation.*

Specialists

*Afraid many non-generic drugs will be dropped from formulary.
At least it will be standardized in one place.
Couldn't be worse! Might be better, probably the same.
If this adds another layer of bureaucracy, may further or delay treatment.
It may improve.
It will all be about money—they will not deny medicine for patients properly.
Probably will worsen it.*

Behavioral Health Providers

All changes have been difficult especially during the transition, and changes usually mean clients are negatively affected.

Hopefully for the better, the former arrangement was very difficult, slowed approval time.

I do not. It seems unlikely.

I have little faith that the TennCare program can operate so that consumers' needs are adequately met.

If TennCare can be more concerned for care vs. profit only.

It may improve access to more effective psychotropic drugs.

It's better already.

More centralized. More responsive to public need.

Only if the formulary is broad and scientifically accurate and if the approval process by statutory guardian is revised.

The BHOs are more familiar with the needs of the enrollees.

39. Please describe particular areas of strengths and weaknesses in the TennCare program.

Strengths

Selected Comments:

Primary Care Providers

More people have access to affordable care. Being assigned to a PCP provides for adequate monitoring. A good tracking system to prevent patients from seeing multiple health care providers and getting multiple medications for the same medical condition.

Care for children, especially the well visits, so that appropriate immunizations, assessment of developmental delays, and anticipatory guidance can be done.

Cost cutting efforts utilized. Children are primary concern. Pay for transportation for those who need it.

Emphasis on preventive services. Earlier entry of care for Prenatal. Premiums based on income.

Has stopped some abuse of the ER and overuse of multiple pharmacies.

It is a managed plan whereby patients cannot choose on their own to see 4 different physicians in one week without being referred. I think that this is a positive thing so as to try and hold down health care costs.

Organized effort to limit abuse by patients.

Patients get a sense of choice in choosing a health plan.

Providing a "gate-keeper" concept does reduce the cost of medical care.

Specialists

Children are now receiving services they were ineligible to receive when we were under Medicaid. More early intervention can now take place.

Has increased access to primary care outside of ER setting.

Having the PCP to manage patient's case is a plus.

TennCare covers many uninsured patients who might not obtain appropriate care in other states.

It helps the legislature budget health care expenditures.

Successful reduction of enormous expense under Medicaid.

The PCP concept is great for children.

The only strength is that some patients do receive medication that they otherwise would not.

Ob/Gyn

Comprehensive access to health care for Tennessee residents.

It enrolls the working poor (\$10,000/year) and gets them into the medical system better and easier.

It generally covers pregnant women.

Dentists

Creates competition which usually means better services.

It provides care for many needy children and some adults. I am proud to participate in this program.

Provider access to dental care for many people who were previously not eligible.

Since the client is required to go thru a PCP - duplication of services is avoided.

Behavioral Health Providers

*Always approve requested services when treatment plan is clear. Friendly, helpful staff.
Good level of health care to people who need it. Everyone I've ever spoken with in the TennCare System and in the BHOs seem to really care about providing good service.
Affords clients more options for service providers, requires accountability/quality requirements.
Allows patients with very limited finances to get mental health treatment.
Availability of case managers, good outcomes defined.
Easy access for most patients.
Nice people working the phones - wait time has improved.
Provides adequate medical insurance for the working poor.*

Weaknesses

Selected Comments:

Primary Care Providers

*Blanket disapproval of many medications. The incredible time required to get hold of the BHOs, the MCOs, etc.
Not apparently well monitored from patient use standpoint to identify overuse or inappropriate use of services.
TennCare appears not to be enforcing the gatekeeper system. Some patients continue to see multiple primary care providers.
No dental care on many plans.
Limited drug formulary.
Not keeping providers notified of formulary change.
Fragmentation between MH and physical health services.
Education of the patient (by TennCare) and on requirements and limitations of the various plans.
Multiple MCOs to deal with vs. 1 Medicaid.
Many physicians do not want to participate in the TennCare program and this makes it extremely difficult to obtain appointments with physicians who are located near the patients. Physicians also are very frustrated that they cannot always prescribe their choice of medication for a patient.
Needs a better political footing. Urban hospitals and subspecialty dominated physicians keep demanding "the best care" for all. Without tort reform or rewards for physicians who truly manage the care, it is a temporary Band-Aid on a larger set of problems.
No specialists locally available.
Phone waiting time. Precertification personnel are not well trained.
Physician provider directories are full of errors - doctors listed under wrong specialty, for example.
Lack of crisis intervention teams for psychological problems.
Plethora of plans. No uniformity to make it easier for providers.
Preventive medicine should be more available; that would in turn reduce the need for more expensive and prolonged medical care.
Refusing direct access to Ob/Gyn.
Slow payment. Low payment.
Credentialing process too long.*

Specialists

*No set standards all MCO must use.
Fees too low, over time most MDs will drop out, cannot do business at a loss.
Inadequate emergency psychiatric services. Poor and delayed reimbursement to providers.
Little or no accountability by MCOs to state. State has not required MCOs to have providers.
Not enough phone support. Rejected claims that were totally clean claims with valid referrals—feel this is a stalling technique or feel they hope you will finally just give up and write off claim.
Many persons covered who are fully capable of purchasing general insurance or who are able to manage patient pay.
Poor communication of program to enrollees.
Approval process is slow and cumbersome. Formulary restrictions can prevent optimal care and reimbursement often doesn't cover costs.*

Communications with plans are very time consuming and the information received is many times inaccurate or conflicting with previous information received.
Too many people enrolled that could afford other types of ins. but have managed to get TennCare or get and keep after circumstances change.
Does not make quality care, follow-up care, medications, home health care accessible sometimes to those who need it because of "criteria" guidelines. Every case should be treated on individual needs assessment.
Failure of the system to honor the recommendations of the PCP. Why bother to assign a PCP if the PCP is going to be overruled!
HMO model as a care-denying measure; plus, no funding for catastrophic illnesses such as cancer.
Excessive cost to continually modify electronics claims submission software.
Many patients still come to the emergency room for care which should be given by their PCP.
Adversarial relationship that often develops between MCO and physician. Medical directors making decisions in areas in which they have no experience.
MCOs do not manage systems in place to process claims nor do they have interested, trained personnel to address problems.
Not enough support for telephone lines when trying to receive authorizations.
Not far-reaching enough for older Tennesseans.
The administrative cost, the money off the top for the MCO, is way too high.
The implementation of behavioral health services leads to a disincentive for physicians to see these patients.
Unable to get home visits by nurses for patients, but we are urged to send them home fast.
Unnecessary denials made by mistake.
Unreasonable guidelines for hospital length stays making MDs and hospital personnel waste time trying to justify needed care.

Ob/Gyns

No standardization, reimbursement too low, too many administrative requirements.
Patients believe that all care is provided. They are upset with us when we inform them that they cannot see any doctor at any time and certain tests may not be covered.
There is no interest on part of MCOs to ensure that providers are satisfied with their services and so are willing to stay TennCare providers.
Too much micromanagement.
MD concerns are never addressed.

Dentists

Inadequate reimbursement for services. Inadequate coverage for adults.
Not enough dental specialists particularly in orthodontics and oral surgery. Very slow paying the providers.
Enrollees not aware of coverage.
Some patients take advantage of the program.
Too many MCOs to have to deal with and their individual regulations.

Behavioral Health Providers

Grossly underfunded for the Benefit Package offered. State still wants to deal in process rather than outcome.
TennCare refuses to tell BHOs how to do their business unless grievances are filed. I don't trust the BHOs' accountability.
Not able to keep providers.
No mental health "preventative" services such as counseling for marital problems, job/employment skills.
No funding for day treatment. Lack of A&D services.
Poor communication of changes to providers and consumers.
Months and months go by with no paid claims.
Implementation is administratively cumbersome and wasteful. The state would do better to ally with providers than with business people who are doing this only for money.
It is difficult to get an appointment.

*Judging by the number of MHCs going out of business and the number of providers refusing to participate, it should be fairly obvious that the money needs to go to patient care – not administrative costs.
Low reimbursement, slow uncertain payment, too many administrative rules and frequent changes.
Managed care is an inadequate model for understanding and providing mental health care. There is no competition with one company even if it were a good model. Remember, the managed care concept was initiated to provide competition and reduce cost. It never presumed quality care!
Medication formulary is too restricted; too few psychiatrists.
Payment of providers is quite delayed and inadequate. It drives better providers out of TennCare.
Authorization process is too time consuming.
Process to become a provider is demanding.
The BHO issues are a mess. There needs to be one set of standard rules with regard to access to treatment.
They have few competent choices since the pricing excludes experienced and qualified providers.
Too much emphasis on paperwork rather than on identifying patients' needs and providing quality care.
1/2 of initial appointments don't show up.*

40. Please describe the type of difficulties experienced in providing quality care to TennCare enrollees.

Selected Comments:

Primary Care Providers

*Referral forms keep changing. Meds go off and on the formulary. Need easier access to specialists.
Difficult to motivate many TennCare patients to follow through with health care plans. Excessive and inappropriate use of services. Failure to keep appointments with specialists and for diagnostic tests.
No specialist available.
Excessive time required of physicians and staff to get approvals, appeal denials of medications and services.
Frequent no-shows. Frequent "urgent" visits to PCP for trivial problems (no disincentives - i.e., No co-pay.)
It takes me at least twice as long per visit to see TennCare patients (due to bureaucratic hassles) for one-third to one-half the reimbursement of commercial carriers. That's why I lose money every time I see them.
Most frustrating is not being able to use quality, up-to-date medications appropriate for patients' needs.
Patients get changed on MCO then have to change PCP/specialist. Take a survey, see how many different PCPs a typical TennCare patient has per year. This program has created less consistent doctor-patient relationships. As OB/GYN, I cannot follow my patients without referrals - delaying therapy.
TennCare patients often have numerous problems, are complex, take more time to evaluate and treat, also require more referrals than other patients. They often have other social and economic problems besides medical problems.*

Specialists

*After-hour decisions when TennCare/MCO not available to approve care not reimbursed.
Patients with serious complex medical problems should not be funneled into primary care clinics. They should see only specialists who are allowed to make referrals.
Access to specialists (ortho, etc.) access to drugs that work (high quality stuff).
Administrative demands are excessive. These demands take professionals away from seeing patients and require massive amounts of time to be spent filling out forms.
Difficulty with prescribing what I believe is the most effective medication, which in the long run will be most cost-effective.
Need to educate enrollee and PCP to avoid using ER for nonemergencies, etc. Need to keep appointments.
Excessive "no-show" rates for appointments.
I give quality care to all of my patients even though I am reimbursed very poorly.
Insufficient money to provider/hospital. Lack of coordinated care.
Limited formulary, constantly changing formulary, excessive precert. process, inadequate compensation.
Low reimbursement will eventually affect quality and quantity of care.
Over-utilization. Lack of judgement in being prudent consumer of resources.*

*TennCare is probably trying to do the best it can, with inadequate support and funding!
They don't know how to keep asking for services they need, and TennCare will not pay for good case management and psychological services.*

Ob/Gyn

*Enrollment, transportation, availability of site location to see patients.
I really don't mind to do it; I have always seen poor people, but the hassle with the federal and state management just wears you down, and you become sort of numb to the process, and some of the fun and good feeling goes out of the practice and art of medicine.*

Dentists

*Need to educate patients.
I'm getting very frustrated with not having adequate dental specialists in our area. Most patients have to drive 100 miles one way to see one. There are not enough specialists because of the very poor reimbursement levels.*

Behavioral Health Providers

*Excessive paperwork. Very hard to speak with representatives. Constant changing of insurance administrators.
A lack of adequate reimbursement will eventually affect the quality of care. Also, limiting what laboratories a recipient must use affects their quality of care.
Financial problems, transportation problems, formulary problems, inadequate referral services, delay in payments.
Finding quality providers willing to work for TennCare rates is impossible.
Helping them find adequate medical and psychiatric care. No one seems to take new patients.
In mental health, emergency care and hospital care are a travesty.
Inadequate reimbursement, inadequate access to case management. Long waits to see psychiatrists.
It was a grand mistake (which is becoming more apparent over time).
It's not any more challenging than any other managed care companies - just pays poorer than most!!
Providers have the responsibility and concern for patients; MCOs and BHOs are in it only for money.
Reimbursement rate laughable (Premier), too many hurdles, too stingy case managers, arrogant companies.*

41. What is your overall impression of the TennCare program?

Selected Comments:

Primary Care Providers

*It is the best thing available to those who cannot afford private insurance.
Abuse by patients is curtailed (especially ER visits) and doctor shopping minimized.
More working people who are currently not eligible should be enrolled under TennCare as many cannot afford private insurance or afford self-pay.
It requires standard of care at below standard of reimbursement.
It hinders cash flow of physicians due to delay in reimbursement.
Restricts needed psychological care for pediatric patients.
A help to needy patients. A disaster to physicians. Adds unneeded bureaucracy.
A necessary evil that is better than no coverage for the medically indigent. I understand why many providers do not participate, not because they don't want to help the underserved, but because the process is so cumbersome. It is very easy to lose money delivering care through this system.
Good. TennCare has opened access to medical services to people who had little or no access previously.
Has grown and improved daily. Is now comparable to insurance through private sector.
I am very annoyed when I receive new policies that attempt to shift more hurdles to my office from the MCOs. I do not like being told that a patient is not supposed to wait over 45 minutes to be examined when I am talking to the MCO, or being put on hold on the telephone, making all of my patients wait while we*

wait for the MCO's permission to refer to give any meds, etc. to the previous patient(s). The MCOs make people wait with all of their rules.

I had a better impression of the previous Medicaid program.

It is inadequate. Medical care equal in quality to private insurance cannot be provided with the low reimbursement and excessive time requirements.

Not favorable at this point. Patient's needs are not being met.

Quality of care for patients has dropped considerably. We now have angry doctors taking care of hostile demanding patients who have no financial investment in their care.

Services for children are excellent. For most healthy adults, the program is good. Patients with complex problems are less likely to have health care needs adequately treated.

Specialists

Very frustrating for patients and providers.

Reimbursement poor and if it gets much worse, I suspect more doctors will drop out, at least those that are not susceptible to extortion by the larger insurance companies.

MCOs seem to operate on the concept that the more difficult it is to get treatments approved, the less will be done without regard to medical appropriateness.

Perception that state took an observer position once MCOs were up and running.

Little or no change in quality of care for patients over Medicaid. Change only in method of reimbursement and increased paperwork.

A major disappointment. Essentially designed to shift the state's financial burden of providing medical care onto the backs of hospitals and providers while the state washes its hands of responsibility.

Adequate. Has potential to be very good.

Offers services to a more extensive group of patients.

An unfortunate necessity. Probably no worse than other Medicaid-type programs.

Better than no care.

Could be a very effective program if patients were better educated and MCOs were held more accountable.

Presently there is an incentive for MCOs not to be available to OK admissions or drugs. If they are not available, they can't give approval and therefore don't have to pay/reimburse.

Good concept, disastrous implementation, poor oversight, improving administration.

I feel that physicians are actually seeing more patients but for free because of all the standard rules for precert, authorization, forms, etc., and patients.

I hate it. We were better off under Medicaid when at least a non-participating provider or facility could treat a patient and be paid something. I am very seriously considering dropping all TennCare patients.

I have worked with TennCare since the program began. You would think you would have all the "bugs" out by now. I feel that the enrollees still do not have a grasp on how the system works and probably never will.

I am not sure if anyone truly understands the "system."

Needs a lot of work to achieve its full potential. MCOs need to be more accountable to providers and TennCare Bureau.

Needs uniform standard procedures for all MCOs and someone with Bureau of TennCare to make sure this is carried out.

Seems to work more efficiently than Medicaid.

There is no monitoring of the system. Provider complaints are not answered timely. Providers end up having to spend money on legal fees to take MCOs and BHOs to court to get paid for services rendered.

Ob/Gyns

A good try but way too much administration, as with any MCO.

It serves a vital need.

It's a necessary evil. I believe insurance coverage should be available to the poor. It just shouldn't be such a major hassle to give good care to these folks.

Overall TennCare is an excellent program. TennCare has opened doors for individuals who were unable to receive insurance through their jobs. TennCare is much better than the Medicaid program.

Dentist

Average.

Pitiful. I feel a person has a moral obligation to help those in need - that is the only reason I am seeing TennCare patients. When Doral notified me that they are having a bad year and will pay only 35% of the already low TennCare reimbursement rate, I feel cheated! At that pitifully low rate I am now consistently losing money by serving TennCare patients. Luckily, the rest of my practice makes up for lost income in the TennCare portion of my practice so I continue to see them. But if policies like those Doral has just implemented continue, I will be forced to stop seeing all TennCare patients.

TennCare needs more dentists. In order to do this, the reimbursement rates are going to have to be increased and paperwork cut down to a minimum.

Wonderful idea to serve children who often need our care badly.

Behavioral Health Providers

Mostly I get good response from case managers for authorization of services.

Reaching the case manager is easy because I do not have to go through multiple automated telephone prompts.

It has improved since its implementation and we are now not required to complete voluminous paper work on scan forms.

Physical health is working; Mental health is improving. More people have TennCare coverage.

Adequate.

While I still supposedly am affiliated with BC/BS and Premier, I really have discontinued the practice of even trying to get cooperation from them. I no longer take TennCare patients, and the one I have I simply see pro bono. The program has been a debacle. I no longer work in the public sector, but the mental health centers have been crippled by the program. It has, in effect, proven to be nothing more than a complicated set of obstacles whose purpose is to make care unavailable to those "covered" by it, and to make reimbursement to the professionals whose purpose is to actually help those people very unlikely.

Dismantle it and start over.

I have had to quit being a psychiatrist in major part because of the abuses of TennCare because I cared too much for my patients and couldn't justify putting them under one label of treatment for too short a treatment period and not having more say in their treatment and not being paid for the work that I had done. In some ways I can see it getting better, but in some ways it is worse since I stopped practicing. In some areas I have benefited from being on TennCare and in some areas I have been worse. I am glad that I am no longer a provider.

It's a wonderful dream.

It's been an emotional, financial, and physical killer for patients, providers, and associated business.

Needs major overhaul so it doesn't look like a managed cost system looking for excuses to deny claims.

Pleased with physical health services; mental health very poorly administered.

42. What are your suggestions for improving the TennCare program?

Selected Comments:

Primary Care Providers

Reassess reimbursement rates and payment procedures. Become more patient-friendly and realize children need psychological care just like they need immunizations. Increase accessibility of program for questions and answers by phone and through mailings. Improve patient education of what TennCare pays, its requirements, and how to access assistance from the TennCare program.

TennCare Bureau enforce existing contracts with MCOs. Pediatricians and children's hospitals are not getting paid. Work to improve reimbursement which in turn will increase access to care. Access to care is a real problem. Remember that simply having an insurance card DOES NOT equal access to care!

Increase the number of local subspecialists. Streamline the recertification process. Why not have a universal application? Make authorization and precert processes user friendly - answer the phone! Make a touch-tone system for provider changes and some arrangement for contracted physicians who are not PCPs to be paid for seeing patients.

Open drug formulary. Same forms and standards for each MCO.

*Uniform fee schedule. Convert as much paperwork as possible to electronics.
Better reimbursement to providers, especially the specialists who assist us.
Eliminate the MCOs.*

Get rid of Partner's program - put it back with MCOs.

Give the program adequate funding.

It is impossible to put the health of vulnerable people in the hands of for-profit or not-for profit organizations and expect that their needs will be the first consideration. Medicaid should (could) hire three very good managed care executives for decent salaries (no bonuses or stock options) and run the program centrally, avoid unnecessary duplication (and the additional expense of having 12 administrators). All the rules, regulations and changes could have been instituted by one entity.

Oversight, accountability for all money sent to MCOs.

Tennessee does better than other states.

Specialists

Offer equitable rates. Provide incentive for community providers to participate. Require BHOs to assume responsibility for data management.

Eliminate MCOs. Create one plan and hire TPA to administer claims. Require all physicians licensed in state to take their share of TennCare patients (i.e., total members in area divided by total PCPs = members/PCP). Require all hospitals to participate. Require ER physicians to perform separate screening for emergency treatment; pay for screening only if condition is not an emergency. Fund the program so that adequate reimbursement can be obtained. Improve the formulary choices. Decrease the time and hassle involved in the approval process.

Probably the best suggestion came from one of my patients who said "All legislators and state executives as well as MCO executives should be required to have TennCare for their families and themselves. Then they would straighten this out!"

Higher level of staff processing claims. Consistent rules and regulations related to coverage issues and billing requirements. Have qualified provider representatives who are more accessible.

All providers should accept TennCare and this could only be accomplished by better reimbursement.

Decrease scope or increase funding.

Fund it properly!

Hold the patients more accountable.

Stricter guidelines for enrollment.

Ob/Gyns

As mentioned earlier, the reimbursement rates to the provider should reflect the time and effort involved in caring for the patients. Lack of any relationship between the TennCare reimbursement rate and the "fair market value" of the services rendered is, in my view, the single most important problem that needs to be addressed.

Decrease paperwork, improve payment for services.

Require standardization of all MCOs, require enough full-time personnel so we can reach them and not be on hold an hour at a time.

Dentists

Let the practicing dentist treat the patient the same as non-TennCare patients and not have people who know nothing about patient care or needs making the decision. Pay the dentist the usual and customary fee for service.

Cut red tape. Pay fees that are at least 70% of the going rate. Stop asking for proof of insurance, DEA, license every year!

Fee for broken appointments.

Behavioral Health Providers

Allow funding for day treatment for chronic individual. Provide funding for increased service for case managers so they can make a difference. Increase payment to cover cost.

Establish a reasonable cost for the benefit package offered. If the cost is more than the state can afford, change the benefits. Seriously look at the \$36 million spent for the BHOs and determine if that money could be better utilized. The state either needs to run the program and eliminate BHOs or get out of the

way and let them do it. Have the state take a share of the financial risk so the decisions they make will be seen in the financial impact.

Be realistic: TennCare is low dollar business, so either pay promptly and don't hassle providers so we feel it is worthwhile to participate, or pay a much higher rate to make it worth the hassle. If providers are going to work for low pay, make it user-friendly, easy, simple, quick so we are eager to participate.

Go back to Medicaid or at least have reimbursement equivalent to Medicaid.

More checks and balances.

Provide adequate funds and allow mental health providers to manage them. We know what is needed by our clients. The needs vary by urban/rural etc. One size doesn't fit all.

Providing adequate transportation.

Unfortunately those who continue to accept TennCare Partners are (for the most part) the providers of the least quality of services to patients; TennCare has become the ghetto of health care services due to funneling vast amounts of money into setting-up and administering TennCare. This is a bad experiment. Please end it soon.