TennCare Quarterly Report

July – September 2018

Submitted to the Members of the General Assembly

Status of TennCare Reforms and Improvements

Amendments to the TennCare Demonstration. Five proposed amendments to the TennCare Demonstration were in various stages of development during the July-September 2018 quarter.

Demonstration Amendment 33: Supplemental Payment Pools for Tennessee Hospitals. In February 2018, TennCare submitted Amendment 33 to the Centers for Medicare and Medicaid Services (CMS). Amendment 33 concerns the supplemental payments that TennCare makes to Tennessee hospitals to help offset the costs these facilities incur in providing uncompensated care. With Amendment 33, TennCare asked that CMS revisit changes imposed on the supplemental payment structure during the most recent renewal of the TennCare Demonstration in 2016.

As submitted, Amendment 33 consisted of three components:

- Restoration of approximately $90 million to the maximum amount TennCare is authorized to pay to hospitals each year for uncompensated care costs;
- Continuation of a special funding pool that supports clinics operated by Meharry Medical College; and
- Extending the implementation period of a new hospital payment structure that was scheduled to take effect on July 1, 2018.

As negotiations proceeded, TennCare and CMS reached an agreement in principle to restore the requested $90 million of uncompensated care funding and clarify TennCare's authority to continue its support of Meharry's indigent care clinics. In addition, CMS agreed to grant Tennessee certain flexibilities that would allow implementation of the new funding system to proceed without the need for a phased approach. During the July-September 2018 quarter, TennCare and CMS continued to finalize the details of the new payment system. Since both parties agreed that the issues contained in Amendment 33 could be addressed without amending the TennCare Demonstration, TennCare expects to formally withdraw Amendment 33 from further consideration during the October-December 2018 quarter.

Demonstration Amendment 35: Substance Use Disorder Services. In May 2018, TennCare submitted Demonstration Amendment 35 to CMS. Amendment 35 would modify the TennCare benefits package to cover residential substance use disorder (SUD) treatment services in facilities with more than 16 beds. The federal government classifies such facilities as "institutions for mental diseases" (IMDs), and federal law prohibits the expenditure of federal Medicaid dollars for services delivered to adults in these facilities. Historically, TennCare's managed care organizations (MCOs) were permitted to cover residential treatment services in IMDs, if the MCO determined that such care was medically appropriate and cost-effective as compared to other treatment options. However, CMS recently issued regulations restricting the ability of MCOs to pay for services in these facilities. Specifically, the new federal regulation limits this option to treatment stays of no more than 15 days per calendar month.[1] TennCare is seeking authority with Amendment 35 to allow enrollees to receive short-term services in IMDs beyond the 15-day limit in federal regulation, up to 30 days per admission.

During the July-September 2018 quarter, TennCare and CMS continued their negotiations concerning Amendment 35. The focus of discussions was the monitoring and evaluation requirements that CMS applies to SUD-related demonstration proposals. As of the end of the quarter, CMS's review of Amendment 35 had not been completed.

Demonstration Amendment 36: Family Planning Providers. Amendment 36 was submitted to CMS on August 10, 2018. Amendment 36 grew out of Tennessee's 2018 legislative session and, in particular, Public Chapter No. 682, which established that it is the policy of the state of Tennessee to favor childbirth and family planning services that do not include elective abortions within the continuum of care or services, and to avoid the direct or indirect use of state funds to promote or support elective abortions.

Amendment 36 requests authority for TennCare to establish state-specific criteria for providers of family planning services, and to exclude any providers that do not meet these criteria from participation in the TennCare program. As specified in Public Chapter No. 682, TennCare is proposing to exclude any entity that performed, or operated or maintained a facility that performed, more than 50 abortions in the previous year, including any affiliate of such an entity.

On August 24, 2018, CMS notified TennCare in writing that Amendment 36 met the requirements for a complete amendment and that CMS would publish the proposal for a 30-day federal public comment period. That comment period ran from August 24 through September 23, 2018, and more than 3,500 comments were submitted to CMS. In the remaining days of the July-September 2018 quarter, CMS began its review of the comments received and of the amendment itself.

Demonstration Amendment 37: Modifications to Employment and Community First CHOICES. On August 31, 2018, TennCare launched the public notice and comment period for another demonstration

[1] See 42 CFR § 438.6(e).

amendment to be submitted to CMS. Amendment 37 primarily concerns modifications to be made to Employment and Community First (ECF) CHOICES, TennCare's managed long-term services and supports program that is specifically geared toward promoting and supporting integrated, competitive employment and independent, integrated living as the first and preferred option for people with intellectual and developmental disabilities.

Chief among the modifications to ECF CHOICES in Amendment 37 is the addition of two new benefits and two new benefit groups in which the services would be available. The first is targeted to a small group of children who live with their family and have intellectual and/or developmental disabilities (I/DD) and severe co-occurring behavioral health and/or psychiatric conditions that place the child or others at significant risk of harm and threaten the sustainability of the family living arrangement. These are children at *significant* risk of placement outside the home (e.g., State custody, hospitalization, residential treatment, incarceration). The second will provide short-term intensive community-based behavioral-focused transition and stabilization services and supports to assist adults with I/DD and severe behavioral and/or psychiatric conditions who are transitioning out of a highly structured and supervised environment to achieve and maintain stable, integrated lives in their communities.

Other changes to ECF CHOICES contained in Amendment 37 include modifications to expenditure caps for existing benefit groups within the program, revised eligibility processes to facilitate transitions from institutional settings to community-based settings, and modifications and clarifications to certain ECF CHOICES service definitions. Together with the changes to ECF CHOICES, Amendment 37 would also revise the list of populations automatically assigned to the TennCare Select health plan upon enrollment in TennCare by allowing children receiving Supplemental Security Income to have the same choice of managed care plans as virtually all other TennCare members.

The designated public notice and comment period for Amendment 37 was August 31 through October 1, 2018. TennCare will proceed with submitting Amendment 37 to CMS after all public comments have been reviewed and considered.

Demonstration Amendment 38: Community Engagement. Like Amendment 36, Demonstration Amendment 38 was the result of legislation passed during Tennessee's 2018 legislative session. Specifically, on April 19, 2018, the Tennessee General Assembly enacted Public Chapter No. 869, which directed TennCare to submit a demonstration amendment to authorize the creation of reasonable work and community engagement requirements for non-pregnant, non-elderly, non-disabled adults enrolled in the TennCare program who do not have dependent children under the age of six. The legislation also required TennCare to seek approval from the U.S. Department of Health and Human Services (HHS) to use funds from the state's Temporary Assistance for Needy Families (TANF) program to support implementation of the community engagement program. As a result, TennCare began the process of planning and designing a community engagement initiative in accordance with this State law, including discussions with multiple stakeholders to inform the design process.

On August 20, 2018, TennCare held a stakeholder meeting in Nashville to gather input on this initiative. More than 70 individuals representing advocacy organizations, healthcare providers, managed care organizations, legislators and legislative staff, State agencies, and other interested parties participated in the meeting. During the event, TennCare staff led a series of focused discussions aimed at getting stakeholder input on key policy questions and design issues. Also in attendance at the August 20 stakeholder meeting were HHS representatives, from whom State officials sought guidance on how to secure approval to use TANF funds to implement TennCare's community engagement program.

Using feedback obtained during the August 20 meeting, TennCare subsequently crafted a draft demonstration amendment outlining the agency's community engagement proposal. TennCare posted this draft version of Amendment 38 for public review and comment on September 24, 2018. As of the end of the July-September 2018 quarter, the comment period was scheduled to run through October 26 2018, and was to include a public hearing in each grand region of the state.

Update on Episodes of Care. Episodes of care is a payment reform strategy that focuses on acute or specialist-driven health care delivered during a specified time period to treat physical or behavioral conditions such as an acute diabetes exacerbation or total joint replacement. Each episode has a principal accountable provider who is in the best position to influence the cost and quality of the episode.

In the 2017 performance period for TennCare's episodes of care, doctors and hospitals improved cost efficiency while maintaining or improving quality. The 2017 results show that episode costs were $28.6 million less than expected across the 19 episodes that were in a performance period. Across the state, gain sharing payments to providers who met quality metrics and efficiency standards exceeded risk sharing payments by $206,903, meaning that episode incentive payments had a net positive impact on providers.

The 19 episodes of care in the 2017 performance period were perinatal, acute asthma exacerbation, total joint replacement, colonoscopy, cholecystectomy, chronic obstructive pulmonary disease, acute percutaneous coronary intervention, and non-acute percutaneous coronary intervention, upper GI endoscopy, gastrointestinal hemorrhage, respiratory infection, pneumonia, urinary tract infection – outpatient, urinary tract infection – inpatient, congestive heart failure acute exacerbation, oppositional defiant disorder, coronary artery bypass graft, valve repair and replacement, and bariatric surgery.

Episode design continues to evolve based on stakeholder feedback. The State is making 31 changes to episode design based on stakeholder comments made during this year's Annual Episodes Design Feedback Session. The changes will be implemented for the calendar year 2019 performance period. Some of these changes impact all episode types and address issues that stakeholders have raised for multiple years. One change is a "low-volume" exclusion for principal accountable providers who did not have a minimum number of episodes. Another change is an "overlapping episode" exclusion to hold a principal accountable provider responsible for only one episode if two of their episodes have the same patient and overlapping spend. There will also be a pharmacy spend adjustment for preferred

medications, in order to ensure that the medications that are identified as "preferred" on TennCare's Preferred Drug List are incentivized in episode spend.

Reimbursement Methodology for Nursing Facilities. TennCare's new acuity- and quality-based reimbursement methodology for nursing facilities (NFs) was implemented on August 1, 2018, with an effective date of July 1, 2018. TennCare has worked extensively with the Tennessee Health Care Association, nursing facility providers, residents and their family members, and other stakeholders to design the new reimbursement system. In addition, TennCare has provided numerous trainings and other forms of communication to help NFs prepare for these changes. The new methodology shifts TennCare reimbursement away from cost-based payments and toward a payment approach that takes into consideration the acuity of residents served in facilities, as well as facilities' performance relative to specified quality measures.

Tennessee Eligibility Determination System. The Tennessee Eligibility Determination System (or "TEDS") is the name of the system (currently under development) that will be used by the Division of TennCare to process applications and identify persons who are eligible for the TennCare and CoverKids programs. During the July-September 2018 quarter, readiness activities continued to focus on user acceptance testing. This phase of the project allows staff to test TEDS using scripts and ad hoc scenarios in a simulated environment to ensure that the system is functioning effectively. In addition, TEDS-related Beta testing—a simulation of post-production processes—was completed during the quarter. Approximately 25 caseworkers and contractor partners participated in this four-week activity. The first pilot phase of implementation of the TEDS system is planned for late 2018.

Incentives for Providers to Use Electronic Health Records. The Electronic Health Records (EHR) Incentive Program is a partnership between federal and state governments that grew out of the Health Information Technology for Economic and Clinical Health (HITECH) Act of 2009. The purpose of the program is to provide financial incentives to Medicaid providers[2] to replace outdated, often paper-based approaches to medical record-keeping with Certified Electronic Health Record Technology (as defined by CMS) that meets rigorous criteria and that can improve health care delivery and quality. The federal government provides 100 percent of the funding for the incentive payments and 90 percent of the funding for administrative costs. Tennessee's EHR program[3] has issued payments for six program years to Medicaid providers meeting relevant eligibility requirements.

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

[3] In April 2018, CMS announced that its EHR programs would be renamed "Promoting Interoperability (PI) Programs." While Tennessee's EHR initiative falls within the scope of CMS's PI Programs, TennCare continues to refer to its initiative as "EHR Incentive Program" for purposes of clarity and consistency in communications with providers.

EHR payments made by TennCare during the July-September 2018 quarter as compared with payments made throughout the life of the program appear in the table below:

Payment Type	Number of Providers Paid During the Quarter	Quarterly Amount Paid (Jul-Sept 2018)	Cumulative Amount Paid to Date[4]
First-year payments	0	$0	$179,914,661
Second-year payments	50	$495,674	$58,915,433
Third-year payments	43	$381,650	$35,029,354
Fourth-year payments	66	$555,334	$6,865,179
Fifth-year payments	55	$467,500	$4,012,002
Sixth-year payments	45	$379,667	$2,028,099

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

- Communicating with and assisting providers via emails (including targeted emails to eligible professionals attesting to "meaningful use" of EHR technology), technical assistance calls, webinars, and onsite visits;
- Finalizing Program Year 2017 meaningful use attestations for returning eligible professionals;
- Partnering with the Tennessee Primary Care Association to provide clinical education and outreach to Federally Qualified Health Centers seeking to attest to meaningful use;
- Initiating changes to Tennessee's Provider Incentive Payment Program (PIPP) online portal to account for provisions of CMS's 2019 Inpatient Prospective Payment System final rule;
- Participation throughout the quarter in several Southeast Regional Collaboration for HIT/HIE (SERCH) calls; and
- Newsletters and alerts distributed by TennCare's EHR ListServ.

Although enrollment of new providers concluded on April 30, 2017, TennCare's EHR Incentive Program team continues to work with a variety of provider organizations to maintain the momentum of the program. The focus of post-enrollment outreach efforts is on encouraging new attestations from providers who attested to EHR requirements only once or who have not attested in recent years. TennCare will continue to emphasized this strategy in exhibits at the upcoming Tennessee Medical Association Insurance Workshops; the 69th Annual Scientific Assembly of the Tennessee Academy of Family Physicians; and the Amerigroup Community Care and UnitedHealthcare Provider Information Expos.

Dental Benefits Management Procurement. TennCare contracts with a dental benefits manager (DBM) to administer TennCare's dental benefit for enrollees with dental coverage (primarily children). With just over a year remaining until the contract between TennCare and its current DBM, DentaQuest USA Insurance Company, Inc., was scheduled to expire, TennCare issued a request for proposals (RFP) for

[4] The cumulative total of first-year payments reflects recoupments of payments from previous quarters. The need for these recoupments was identified through standard auditing processes.

DBM services on April 25, 2018. The deadline for potential bidders to respond to the RFP was July 2, 2018, and DentaQuest was the only company to submit a proposal. TennCare determined that the proposal satisfied the criteria outlined in the RFP, and proceeded to award the contract to DentaQuest. The start date for the new contract was September 1, 2019, with an eight-month readiness period to follow. Services delivered under the new contract are scheduled to begin on May 1, 2019.

Essential Access Hospital (EAH) Payments. The Division of TennCare continued to make EAH payments during the July-September 2018 quarter. EAH payments are made from a pool of $100 million ($34,395,000 in State dollars) appropriated by the General Assembly and funded by the hospital assessment fee.

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

The Essential Access Hospital payments made during the first quarter of State Fiscal Year 2019 (for dates of service during the fourth quarter of State Fiscal Year 2018) are shown in the table below.

Essential Access Hospital Payments for the Quarter

Hospital Name	County	EAH First Quarter FY 2019
Vanderbilt University Hospital	Davidson County	$3,652,292
Regional One Health	Shelby County	$3,216,140
Erlanger Medical Center	Hamilton County	$2,258,399
University of Tennessee Memorial Hospital	Knox County	$1,666,652
Johnson City Medical Center (with Woodridge)	Washington County	$1,151,981
Parkridge Medical Center (with Parkridge Valley)	Hamilton County	$864,997
LeBonheur Children's Medical Center	Shelby County	$770,710
Metro Nashville General Hospital	Davidson County	$554,536
Jackson – Madison County General Hospital	Madison County	$525,180
East Tennessee Children's Hospital	Knox County	$479,290
TriStar Skyline Medical Center (with Madison Campus)	Davidson County	$473,961
Saint Jude Children's Research Hospital	Shelby County	$409,472
Methodist Healthcare – Memphis Hospitals	Shelby County	$408,893

Hospital Name	County	EAH First Quarter FY 2019
TriStar Centennial Medical Center	Davidson County	$367,639
Parkridge East Hospital	Hamilton County	$357,795
Methodist Healthcare – South	Shelby County	$345,033
Delta Medical Center	Shelby County	$306,238
Parkwest Medical Center (with Peninsula)	Knox County	$286,797
Baptist Memorial Hospital for Women	Shelby County	$266,102
Saint Thomas Midtown Hospital	Davidson County	$257,058
Methodist Healthcare – North	Shelby County	$251,979
Saint Francis Hospital	Shelby County	$231,026
University Medical Center (with McFarland)	Wilson County	$226,838
Saint Thomas Rutherford Hospital	Rutherford County	$210,289
Baptist Memorial Hospital – Memphis	Shelby County	$197,002
Fort Sanders Regional Medical Center	Knox County	$193,449
Wellmont – Holston Valley Medical Center	Sullivan County	$186,927
Erlanger North Hospital	Hamilton County	$185,902
Pathways of Tennessee	Madison County	$185,668
Ridgeview Psychiatric Hospital and Center	Anderson County	$180,838
Maury Regional Hospital	Maury County	$168,830
TriStar StoneCrest Medical Center	Rutherford County	$158,600
Methodist Le Bonheur Germantown Hospital	Shelby County	$157,629
TriStar Horizon Medical Center	Dickson County	$151,915
Tennova Healthcare	Knox County	$149,111
Wellmont – Bristol Regional Medical Center	Sullivan County	$140,210
TriStar Summit Medical Center	Davidson County	$138,487
Cookeville Regional Medical Center	Putnam County	$136,499
Rolling Hills Hospital	Williamson County	$133,494
Blount Memorial Hospital	Blount County	$130,221
Gateway Medical Center	Montgomery County	$125,027
TriStar Southern Hills Medical Center	Davidson County	$122,543
Dyersburg Regional Medical Center	Dyer County	$112,776
Lincoln Medical Center	Lincoln County	$110,047
Morristown – Hamblen Healthcare System	Hamblen County	$106,829
Skyridge Medical Center	Bradley County	$105,970
LeConte Medical Center	Sevier County	$96,650
Sumner Regional Medical Center	Sumner County	$95,962
Methodist Medical Center of Oak Ridge	Anderson County	$87,506
Takoma Regional Hospital	Greene County	$84,687
TriStar Hendersonville Medical Center	Sumner County	$82,775
Tennova Healthcare – Newport Medical Center	Cocke County	$78,212
Saint Francis Hospital – Bartlett	Shelby County	$75,410
Jellico Community Hospital	Campbell County	$70,720
Tennova Healthcare – Harton Regional Medical Center	Coffee County	$69,339
Indian Path Medical Center	Sullivan County	$68,505

Hospital Name	County	EAH First Quarter FY 2019
Starr Regional Medical Center – Athens	McMinn County	$67,485
Tennova Healthcare – LaFollette Medical Center	Campbell County	$63,631
NorthCrest Medical Center	Robertson County	$61,899
Parkridge West Hospital	Marion County	$60,869
Henry County Medical Center	Henry County	$58,304
Southern Tennessee Regional Health System – Winchester	Franklin County	$53,465
Regional Hospital of Jackson	Madison County	$52,727
Wellmont Hawkins County Memorial Hospital	Hawkins County	$52,520
Roane Medical Center	Roane County	$46,046
Sycamore Shoals Hospital	Carter County	$45,530
Saint Thomas River Park Hospital	Warren County	$43,101
Southern Tennessee Regional Health System – Lawrenceburg	Lawrence County	$41,834
Heritage Medical Center	Bedford County	$40,545
Skyridge Medical Center – Westside	Bradley County	$39,467
Hardin Medical Center	Hardin County	$38,710
Bolivar General Hospital	Hardeman County	$37,424
Baptist Memorial Hospital – Union City	Obion County	$36,063
Erlanger Health System – East Campus	Hamilton County	$35,990
McKenzie Regional Hospital	Carroll County	$35,895
Lakeway Regional Hospital	Hamblen County	$35,793
Hillside Hospital	Giles County	$34,780
Starr Regional Medical Center – Etowah	McMinn County	$34,149
Livingston Regional Hospital	Overton County	$34,074
TrustPoint Hospital	Rutherford County	$30,931
United Regional Medical Center	Coffee County	$28,494
Tennova Healthcare – Jefferson Memorial Hospital	Jefferson County	$28,380
Volunteer Community Hospital	Weakley County	$28,026
Claiborne County Hospital	Claiborne County	$27,770
Saint Thomas DeKalb Hospital	DeKalb County	$23,856
Saint Thomas Stones River Hospital	Cannon County	$23,237
Henderson County Community Hospital	Henderson County	$23,155
Jamestown Regional Medical Center	Fentress County	$21,823
Milan General Hospital	Gibson County	$21,013
Wayne Medical Center	Wayne County	$17,854
Decatur County General Hospital	Decatur County	$13,709
Kindred Hospital – Chattanooga	Hamilton County	$12,854
Southern Tennessee Regional Health System – Sewanee	Franklin County	$11,391
Houston County Community Hospital	Houston County	$10,169
TOTAL		**$25,000,000**

Number of Recipients on TennCare and Costs to the State

During the month of September 2018, there were 1,323,071 Medicaid eligibles and 15,934 Demonstration eligibles enrolled in TennCare, for a total of 1,339,005 persons.

Estimates of TennCare spending for the first quarter of State Fiscal Year 2019 are summarized in the table below.

Spending Category	First Quarter FY 2019*
MCO services**	$1,320,526,500
Dental services	$36,016,700
Pharmacy services	$222,268,000
Medicare "clawback"***	$36,345,600

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

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

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

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

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

Entity	Standard	Authority
MCOs (services other than CHOICES and ECF CHOICES)	90% of clean claims for payment for services delivered to TennCare enrollees are processed and, if appropriate, paid within 30 calendar days of the receipt of such claims. 99.5% of all provider claims are processed, and, if appropriate, paid within 60 calendar days of receipt.	TennCare contract and in accordance with T.C.A. § 56-32-126(b)
MCOs (CHOICES and ECF CHOICES services)	90% of clean electronically submitted Nursing Facility and applicable Home and Community Based Services claims[5] are processed and paid within 14 calendar days of receipt. 99.5% of clean electronically submitted Nursing Facility and applicable Home and Community Based Services claims[6] are processed and paid within 21 calendar days of receipt.	TennCare contract

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

[6] Ibid.

Entity	Standard	Authority
Dental Benefits Manager (DBM)	90% of clean claims for payment for services delivered to TennCare enrollees are processed, and, if appropriate, paid within 30 calendar days of the receipt of such claims. 99.5% of all provider claims are processed, and, if appropriate, paid within 60 calendar days of receipt.	TennCare contract and in accordance with T.C.A. § 56-32-126(b)
Pharmacy Benefits Manager (PBM)	100% of all clean claims submitted by pharmacy providers are paid within 15 calendar days of receipt.	TennCare contract

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

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

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

During the July-September 2018 quarter, the MCOs submitted their NAIC Second Quarter 2018 Financial Statements. As of June 30, 2018, TennCare MCOs reported net worth as indicated in the table below.[7]

MCO	Net Worth Requirement	Reported Net Worth	Excess/ (Deficiency)
Amerigroup Tennessee	$30,058,528	$187,686,741	$157,628,213

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

MCO	Net Worth Requirement	Reported Net Worth	Excess/ (Deficiency)
UnitedHealthcare Plan of the River Valley (UnitedHealthcare Community Plan)	$65,141,772	$371,769,813	$306,628,041
Volunteer State Health Plan (BlueCare & TennCare Select)	$47,825,838	$511,857,768	$464,031,930

During the July-September 2018 quarter, the MCOs were also required to comply with Tennessee's "Risk-Based Capital for Health Organizations" statute (T.C.A. § 56-46-201 *et seq.*). Risk-based capital (RBC) involves a method of calculating the minimum amount of capital necessary for a health entity to support its overall business operations depending on its size and risk profile. A health entity with a higher amount of risk is required to hold a higher amount of capital. The RBC statute gives TDCI the authority and mandate to use preventive and corrective measures that vary depending on the amount of capital deficiency indicated by the RBC calculations. A "Company Action Level" deficiency (defined at T.C.A. § 56-46-203(a)) would require the submission of a plan to correct the entity's capital deficiency.

The following table compares the MCOs' net worth to the Company Action Level requirements as of June 30, 2018:

MCO	Company Action Level	Reported Net Worth	Excess/ (Deficiency)
Amerigroup Tennessee	$110,985,558	$187,686,741	$76,701,183
UnitedHealthcare Plan of the River Valley (UnitedHealthcare Community Plan)	$221,464,280	$371,769,813	$150,305,533
Volunteer State Health Plan (BlueCare & TennCare Select)	$160,340,902	$511,857,768	$351,516,866

All TennCare MCOs met their minimum net worth requirements and Company Action Level requirements as of June 30, 2018.

Success of Fraud Detection and Prevention

The mission of the Tennessee Office of Inspector General (OIG) is to identify, investigate, prosecute, and arrest persons who commit fraud or abuse against the TennCare program and to recoup money owed to the State of Tennessee. The OIG receives case information from a variety of sources, including local law enforcement, the Division of TennCare, Health Related Boards, the Department of Human Services (DHS), other State agencies, health care providers, MCCs, and the general public via the OIG website, fax, written correspondence, and phone calls to the OIG hotline. Cases adjudicated during a particular fiscal year may have no relationship to dates of arrest during the same year. Selected statistics for the first quarter of Fiscal Year 2019 are as follows:

Fraud and Abuse Allegations	First Quarter FY 2019
Fraud Allegations	1,084
Abuse Allegations*	823
Arrest/Conviction/Judicial Diversion Totals	**First Quarter FY 2019**
Arrests	28
Convictions	25
Judicial Diversions	4

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

Criminal Court Fines and Costs Imposed	First Quarter FY 2019
Court Costs & Taxes	$783
Fines	$11,250
Drug Funds/Forfeitures	$27
Criminal Restitution Ordered	$68,351
Criminal Restitution Received[8]	$43,722
Civil Restitution/Civil Court Judgments	**First Quarter FY 2019**
Civil Restitution Ordered[9]	$0
Civil Restitution Received[10]	$3,191

Recommendations for Review	First Quarter FY 2019
Recommended TennCare Terminations[11]	42
Potential Savings[12]	$170,619

Statewide Communication

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

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

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

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

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

[12] Potential savings are determined by multiplying the number of enrollees whose coverage would be terminated, assuming all of the State's criteria for termination are met, by the average annual cost per enrollee for MCO, pharmacy, and dental services (currently estimated by TennCare to be $4,062.36).