TennCare Quarterly Report

October – December 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 October-December 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 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. On October 23, 2018, CMS issued a formal approval codifying the details of the new payment system. Since both parties agreed that the issues contained in Amendment 33 had been addressed without amending the TennCare Demonstration, TennCare formally withdrew Amendment 33 from further consideration on November 6, 2018.

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 October-December 2018 quarter, TennCare and CMS continued their discussions concerning Amendment 35. As of the end of the October-December quarter, CMS's review of Amendment 35 was ongoing.

Demonstration Amendment 36: Providers of Family Planning Services. 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.

CMS held a 30-day federal public comment period on Amendment 36 that ran from August 24 through September 23, 2018. As of the end of the October-December 2018 quarter, CMS's review of Amendment 36 was ongoing.

Demonstration Amendment 37: Modifications to Employment and Community First CHOICES. On November 8, 2018, TennCare submitted Amendment 37 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.

[1] See 42 CFR § 438.6(e).

The primary modification to ECF CHOICES contained in Amendment 37 is the addition of two new benefits and two new benefit groups in which the services would be available:

- ECF CHOICES Group 7 would serve 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. These children—who are at significant risk of placement outside the home (e.g., State custody, hospitalization, residential treatment, incarceration)—would receive family-centered behavioral health treatment services with family-centered home and community-based services (HCBS).
- ECF CHOICES Group 8 would serve 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. Individuals in Group 8 would receive short-term intensive community-based behavioral-focused transition and stabilization services and supports.

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.

Apart from the changes to ECF CHOICES, Amendment 37 would also revise the list of populations automatically assigned to the TennCare Select health plan by allowing children receiving Supplemental Security Income to have the same choice of managed care plans as virtually all other TennCare members.

As of the end of the October-December 2018 quarter, CMS's review of Amendment 37 was ongoing.

Demonstration Amendment 38: Community Engagement. TennCare submitted Amendment 38 to CMS on December 28, 2018. Demonstration Amendment 38 implements a state law (Public Chapter No. 869) enacted by the Tennessee General Assembly in 2018. This law directed TennCare to seek federal authorization to establish 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.

TennCare engaged in extensive preparations and public notice activities related to Amendment 38. Among these activities were the following:

- A stakeholder meeting in Nashville in August 2018, in which more than 70 individuals representing advocacy organizations, healthcare providers, managed care organizations, legislators and legislative staff, State agencies, and other interested parties participated;
- A public notice and comment period that ran from September 24 through October 26, 2018, during which time a draft amendment outlining TennCare's proposal was posted and more than 150 sets of written comments were received; and
- Public hearings during October 2018 in each grand region of the state.

Feedback gathered in all of these forums informed the demonstration amendment that was submitted to CMS on December 28. As of the end of the October-December 2018 quarter, CMS was reviewing Amendment 38.

Beneficiary Survey. Every year since 1993, the Boyd Center for Business and Economic Research (BCBER) at the University of Tennessee in Knoxville has conducted a survey of Tennessee citizens—TennCare enrollees, individuals with private insurance, and uninsured individuals alike—to assess their opinions about health care. Respondents provide feedback on a range of topics, including demographics (age, household income, family size, etc.), perceptions of quality of care received, and behavior relevant to health care (the type of provider from whom an individual is most likely to seek initial care, the frequency with which care is sought, etc.).

On October 29, 2018, BCBER published a summary of the results of the most recent survey titled "The Impact of TennCare: A Survey of Recipients, 2018". Although the findings of a single survey must be viewed in context of long-term trends, several results from the 2018 report are noteworthy:

- Satisfaction with TennCare remained high. Ninety-five percent of respondents covered by TennCare expressed satisfaction with the quality of care they had received. This level of satisfaction tied for the highest in the program's history and was the fifth time in eight years—and the second year in a row—that this peak had been attained. In addition, 2018 was the tenth straight year in which survey respondents had reported satisfaction levels exceeding ninety percent.
- The uninsured rate in Tennessee remained relatively low. Although the percentage of respondents classifying themselves as uninsured rose from 6.1 percent in 2017 to 6.7 percent in 2018, the 2018 mark was nonetheless the fourth lowest level in the last 14 years. Furthermore, the percentage of individuals classifying their children as uninsured was 2.3 percent, which was also the fourth lowest level in the last 14 years.
- TennCare families sought care from physicians more frequently than the Tennessee population as a whole. Thirty-one percent of heads of households with TennCare reported seeing a doctor weekly or monthly, and fourteen percent reported doing so for their children. By contrast, only thirteen percent of all heads of households reported seeing a doctor weekly or monthly, and only eight percent reported doing so for their children.

In summary, the report notes, "TennCare continues to receive positive feedback from its recipients, with 95 percent reporting satisfaction with the program. This positive feedback is a strong indication that TennCare is providing satisfactory medical care and meeting the expectations of those it serves." BCBER's report may be viewed in its entirety online at http://cber.haslam.utk.edu/tncare/tncare18.pdf.

Tennessee Eligibility Determination System. The Tennessee Eligibility Determination System (or "TEDS") is the name of the system that will be used by the Division of TennCare to process applications and identify persons who are eligible for the TennCare and CoverKids programs. The first pilot phase of TEDS went live on October 22, 2018. This launch featured a new system for staff use, with a complex rules engine and many new interfaces that can be used to verify data submitted by applicants and to make eligibility decisions. TennCare staff also continued to test the next wave of TEDS functionality that will be released in January 2019, including such elements as a new appeals module and a mechanism by which enrollees may report changes and renew their eligibility for benefits.

In addition, Pilot Wave 1 included a new online self-service portal called "TennCare Connect." TennCare Connect allows applicants and enrollees not only to submit applications and requested verifications, but also to view notices and eligibility periods. For Pilot Wave 1, the portal was made available to residents in three counties, and information gained in this preliminary rollout is being used to improve the system as it becomes more widely available during subsequent phases of the TEDS project.

"TennCare Connect" is also the name of a new mobile application that allows applicants and enrollees to submit requested verifications, view notices and eligibility periods, and make changes to their demographic information via a mobile device (such as a smartphone). The application was released as part of Pilot Wave 1.

Update on Episodes of Care. Episodes of care is a delivery system 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.

The design of the episodes initiative continues to evolve based on program experience and stakeholder feedback. During the October-December 2018 quarter, in response to comments from providers, TennCare developed a policy to address the issue of facility costs within the perinatal episode. The perinatal episode concerns women with low- to medium-risk pregnancies who give birth to a live infant. Providers involved in a perinatal episode had expressed the concern that they could be subject to "risk sharing" penalties for performing deliveries at a high-cost hospital, even when a lower-cost hospital was not available in the same geographical area. According to the new policy, however, TennCare's managed care organizations will automatically adjust payments in a perinatal episode to ensure that eligible providers are not penalized in such circumstances.

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 years to eligible professionals and for three years to eligible hospitals.

EHR payments made by TennCare during the October-December 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 (Oct-Dec 2018)	Cumulative Amount Paid to Date[4]
First-year payments	0	$0	$179,404,230
Second-year payments	20	$161,500	$59,074,761
Third-year payments	2	$651,648	$35,681,002
Fourth-year payments	7	$59,500	$6,924,679
Fifth-year payments	3	$25,500	$4,037,502
Sixth-year payments	2	$17,000	$2,045,099

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;
- Modifying Tennessee's Provider Incentive Payment Program (PIPP) online portal to account for provisions of CMS's 2019 Inpatient Prospective Payment System final rule;

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

[4] Cumulative totals associated with first-year, second-year, and third-year payments reflect recoupments of payments from previous quarters. The need for these recoupments was identified through standard auditing processes.

- Finalizing the software that will allow providers to submit 2018 program year attestations; 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 will continue through the 2021 program year as required by CMS rules. Tennessee's program team continues to work with a variety of provider organizations to maintain the momentum of the program. Current outreach efforts focus on two primary elements: encouraging new attestations from eligible professionals who have yet to earn payments in six separate years, and ensuring that EHR is used by providers to improve clinical decision-making and health outcomes. In support of this outreach strategy, TennCare staff participated in a number of events during the October-December 2018 quarter, including the Tennessee Medical Association Insurance Workshops in Chattanooga, Jackson, Kingsport, Knoxville, Memphis, and Nashville; the 69th Annual Scientific Assembly of the Tennessee Academy of Family Physicians; and the UnitedHealthcare Provider Information Expos in Knoxville, Memphis, and Nashville.

Pharmacy Benefits Management (PBM) Procurement. TennCare contracts with a pharmacy benefits manager, or PBM, to administer its outpatient drug formulary for enrollees with a pharmacy benefit. With just over a year remaining until the contract between TennCare and its current PBM, Magellan Medicaid Administration, Inc., was scheduled to expire, TennCare issued a request for proposals (RFP) for PBM services on September 4, 2018.

The RFP outlines an array of services that would be required of the new contractor. Among those services are—

- Establishing and managing a pharmacy network;
- Building a claims processing system and loading it with all information (enrollee data, edits specific to TennCare's outpatient formulary, clinical/quantity requirements, etc.) necessary for adjudication of claims;
- Creating a call center and website to assist patients and providers; and
- Managing supplemental rebates.

The deadline for potential bidders to respond to the RFP was December 3, 2019. By December 27, TennCare had completed its evaluation of the bidders' technical responses to the RFP (i.e., their responses to questions concerning finances, experience and qualifications, implementation of the proposed contract, etc.). As of the end of the October-December 2018 quarter, the winning bidder was scheduled to be announced on January 9, 2019. Once the contract goes into effect on or around March 18, 2019, the new PBM will have several months of readiness activities before delivery of pharmacy services to TennCare members would begin on January 1, 2020.

Wilson v. Gordon. *Wilson v. Gordon* is a class action lawsuit filed against the Division of TennCare by the Tennessee Justice Center, the Southern Poverty Law Center, and the National Health Law Program. The suit, which is being heard by the U.S. District Court for the Middle District of Tennessee, alleges federal

noncompliance in the Medicaid application and appeals process TennCare has been using since implementation of the Affordable Care Act.

In October 2018, the *Wilson* case proceeded to trial with Judge William L. Campbell, Jr. presiding. The parties to the case completed post-hearing filings in December 2018. As of the end of the October-December 2018 quarter, Judge Campbell had not ruled on the parties' post-trial motions or issued a final decision in the case.

Shackelford v. Long. This lawsuit (formerly known as *Roan and Shackelford v. Long*) was filed against TennCare in December 2017 by the Tennessee Justice Center and the Legal Aid Society of Middle Tennessee and the Cumberlands. The litigation, which is being heard by the U.S. District Court for the Middle District of Tennessee, concerns limitations placed by TennCare on private duty nursing services for individuals aged 21 and older. The purpose of the limitations—approved by CMS in 2008—is to ensure that private duty nursing expenditures are managed in a medically appropriate yet financially sustainable manner.

When a child enrolled in TennCare receives private duty nursing services in excess of the limits applicable to adult enrollees, the enrollee's MCO works with the child and his family prior to the child's 21st birthday to help transition the individual to a different level of benefits that best meets his needs (and that can include long-term services and supports). In *Shackelford v. Long*, a plaintiff with disabilities who received private duty nursing services as a child challenged TennCare's ability to implement limits on the services he received as an adult. The plaintiff alleged that TennCare's limits violated the Americans with Disabilities Act (ADA) and sought an injunction prohibiting TennCare from reducing the services he was receiving. The State timely filed a response to the Motion for Preliminary Injunction, as well as a Motion to Dismiss and a Notice of Constitutional Question.

The plaintiff's Motion for Preliminary Injunction was heard in November 2018, and Judge Waverly Crenshaw, Jr. subsequently ordered the parties to submit post-hearing filings and to participate in mediation scheduled for January 2019. By the conclusion of the October-December 2018 quarter, Judge Crenshaw had not issued a ruling on the Plaintiff's request for a preliminary injunction.

Supplemental Payments to Tennessee Hospitals. The Division of TennCare makes supplemental payments to qualifying Tennessee hospitals each quarter to help offset the costs these facilities incur in providing uncompensated care. The methodology for distributing these funds is outlined in Attachment H of the TennCare Demonstration Agreement with CMS. The supplemental payments made during the second quarter of State Fiscal Year 2019 are shown in the table below.

Supplemental Hospital Payments for the Quarter

Hospital Name	County	Second Quarter Payments – FY 2019
Vanderbilt University Medical Center	Davidson County	$3,955,316
LeBonheur Children's Hospital	Shelby County	$3,870,293
Erlanger Medical Center	Hamilton County	$2,903,636
Regional One Health	Shelby County	$2,605,502
East Tennessee Children's Hospital	Knox County	$2,379,707
University of Tennessee Medical Center	Knox County	$1,813,414
Johnson City Medical Center	Washington County	$1,606,270
Parkridge Medical Center	Hamilton County	$1,188,436
Methodist University Hospital	Shelby County	$1,063,968
Saint Jude Children's Research Hospital	Shelby County	$744,083
Baptist Memorial Hospital – Memphis	Shelby County	$604,035
TriStar Centennial Medical Center	Davidson County	$564,150
Jackson – Madison County General Hospital	Madison County	$548,671
Nashville General Hospital	Davidson County	$490,862
TriStar Skyline Medical Center	Davidson County	$391,939
Parkwest Medical Center	Knox County	$339,437
Tennova Healthcare – Lebanon	Wilson County	$293,465
Saint Francis Hospital	Shelby County	$274,207
Delta Medical Center	Shelby County	$255,463
Saint Thomas Rutherford Hospital	Rutherford County	$235,543
Saint Thomas Midtown Hospital	Davidson County	$229,710
Fort Sanders Regional Medical Center	Knox County	$217,979
Tennova Healthcare – Physicians Regional Medical Center	Knox County	$216,508
Holston Valley Medical Center	Sullivan County	$214,511
Maury Regional Hospital	Maury County	$205,124
Ridgeview Psychiatric Hospital and Center	Anderson County	$186,757
TriStar Horizon Medical Center	Dickson County	$186,325
Lincoln Medical Center	Lincoln County	$169,666
Pathways of Tennessee	Madison County	$162,767
TriStar Summit Medical Center	Davidson County	$160,150
West Tennessee Healthcare Dyersburg Hospital	Dyer County	$158,192
TriStar Southern Hills Medical Center	Davidson County	$151,346
TriStar StoneCrest Medical Center	Rutherford County	$141,399
Sweetwater Hospital Association	Monroe County	$134,973
TriStar Hendersonville Medical Center	Sumner County	$134,280
Blount Memorial Hospital	Blount County	$132,922
LeConte Medical Center	Sevier County	$131,228
Cookeville Regional Medical Center	Putnam County	$127,168
Tennova Healthcare – Cleveland	Bradley County	$122,681
Tennova Healthcare – Clarksville	Montgomery County	$119,848

Hospital Name	County	Second Quarter Payments – FY 2019
Morristown – Hamblen Healthcare System	Hamblen County	$116,190
Bristol Regional Medical Center	Sullivan County	$115,372
Sumner Regional Medical Center	Sumner County	$112,814
Jellico Community Hospital	Campbell County	$103,274
Indian Path Community Hospital	Sullivan County	$102,388
Methodist Medical Center of Oak Ridge	Anderson County	$99,453
Henry County Medical Center	Henry County	$91,230
NorthCrest Medical Center	Robertson County	$86,179
Baptist Memorial Hospital – Tipton	Tipton County	$81,622
Sycamore Shoals Hospital	Carter County	$81,612
Franklin Woods Community Hospital	Washington County	$77,003
Laughlin Memorial Hospital	Greene County	$67,810
Tennova Healthcare – Newport Medical Center	Cocke County	$67,277
Hardin Medical Center	Hardin County	$65,881
Baptist Memorial Hospital – Union City	Obion County	$65,602
Tennova Healthcare – Harton	Coffee County	$65,481
Tennova Healthcare – LaFollette Medical Center	Campbell County	$63,037
Southern Tennessee Regional Health System – Winchester	Franklin County	$60,511
Starr Regional Medical Center – Athens	McMinn County	$60,210
Roane Medical Center	Roane County	$47,050
West Tennessee Healthcare Volunteer Hospital	Weakley County	$46,843
Unity Medical Center	Coffee County	$46,610
TrustPoint Hospital	Rutherford County	$41,269
Southern Tennessee Regional Health System – Pulaski	Giles County	$40,444
Williamson Medical Center	Williamson County	$38,349
Southern Tennessee Regional Health System – Lawrenceburg	Lawrence County	$35,051
Wayne Medical Center	Wayne County	$34,028
Livingston Regional Hospital	Overton County	$33,467
Tennova Healthcare – Shelbyville	Bedford County	$30,119
Tennova Healthcare – Lakeway Regional Hospital	Hamblen County	$28,511
Tennova Healthcare – Jefferson Memorial Hospital	Jefferson County	$26,184
Saint Thomas DeKalb Hospital	DeKalb County	$25,440
Claiborne Medical Center	Claiborne County	$24,517
Saint Thomas Stones River Hospital	Cannon County	$24,132
Crestwyn Behavioral Health	Shelby County	$23,759
Milan General Hospital	Gibson County	$21,195
Jamestown Regional Medical Center	Fentress County	$17,992
Henderson County Community Hospital	Henderson County	$17,529
Rolling Hills Hospital	Williamson County	$1,717
Baptist Memorial Restorative Care Hospital	Shelby County	$1,280

Hospital Name	County	Second Quarter Payments – FY 2019
Siskin Hospital for Physical Rehabilitation	Hamilton County	$1,274
HealthSouth Rehabilitation Hospital – Kingsport	Sullivan County	$985
Quillen Rehabilitation Hospital	Washington County	$552
HealthSouth Rehabilitation Hospital – Chattanooga	Hamilton County	$481
HealthSouth Rehabilitation Hospital – Memphis	Shelby County	$453
HealthSouth Rehabilitation Hospital – North Memphis	Shelby County	$396
Kindred Hospital – Chattanooga	Hamilton County	$308
Regional One Health Extended Care Hospital	Shelby County	$103
Spire Cane Creek Rehabilitation Hospital	Weakley County	$67
Vanderbilt Stallworth Rehabilitation Hospital	Davidson County	$13
HealthSouth Rehabilitation Hospital – Franklin	Williamson County	$5
TOTAL		**$31,625,000**

Number of Recipients on TennCare and Costs to the State

During the month of December 2018, there were 1,330,909 Medicaid eligibles and 16,727 Demonstration eligibles enrolled in TennCare, for a total of 1,347,636 persons.

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

Spending Category	Second Quarter FY 2019*
MCO services**	$1,662,451,400
Dental services	$41,565,700
Pharmacy services	$284,323,100
Medicare "clawback"***	$53,747,000

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

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

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

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

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

Entity	Standard	Authority
MCOs (services other than CHOICES and ECF CHOICES)	90% of clean claims for payment for services delivered to TennCare enrollees are processed and, if appropriate, paid within 30 calendar days of the receipt of such claims. 99.5% of all provider claims are processed, and, if appropriate, paid within 60 calendar days of receipt.	TennCare contract and in accordance with T.C.A. § 56-32-126(b)
MCOs (CHOICES and ECF CHOICES services)	90% of clean electronically submitted Nursing Facility and applicable Home and Community Based Services claims[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 October-December 2018 quarter, the MCOs submitted their NAIC Third Quarter 2018 Financial Statements. As of September 30, 2018, TennCare MCOs reported net worth as indicated in the table below.[7]

[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)
Amerigroup Tennessee	$30,058,528	$174,899,598	$144,841,070
UnitedHealthcare Plan of the River Valley (UnitedHealthcare Community Plan)	$65,141,772	$413,591,867	$348,450,095
Volunteer State Health Plan (BlueCare & TennCare Select)	$47,825,838	$443,749,728	$395,923,890

During the October-December 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 September 30, 2018:

MCO	Company Action Level	Reported Net Worth	Excess/ (Deficiency)
Amerigroup Tennessee	$110,985,558	$174,899,598	$63,914,040
UnitedHealthcare Plan of the River Valley (UnitedHealthcare Community Plan)	$221,464,280	$413,591,867	$192,127,587
Volunteer State Health Plan (BlueCare & TennCare Select)	$160,340,902	$443,749,728	$283,408,826

All TennCare MCOs met their minimum net worth requirements and Company Action Level requirements as of September 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 second quarter of Fiscal Year 2019 are as follows:

Fraud and Abuse Allegations	Second Quarter FY 2019
Fraud Allegations	663
Abuse Allegations*	515
Arrest/Conviction/Judicial Diversion Totals	**Second Quarter FY 2019**
Arrests	23
Convictions	23
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	Second Quarter FY 2019
Court Costs & Taxes	$4,045
Fines	$8,250
Drug Funds/Forfeitures	$133
Criminal Restitution Ordered	$70,112
Criminal Restitution Received[8]	$122,169
Civil Restitution/Civil Court Judgments	**Second Quarter FY 2019**
Civil Restitution Ordered[9]	$0
Civil Restitution Received[10]	$5,752
Civil – Administrative Fee	$1,074

Recommendations for Review	Second Quarter FY 2019
Recommended TennCare Terminations[11]	59
Potential Savings[12]	$239,679

Program Totals

The following table identifies monies ordered by the courts as a direct result of TennCare fraud investigations conducted by the OIG since its inception in 2004. Some of these forms of restitution relate to types of fraud (e.g., food stamps) that do not relate directly to the TennCare program but that were discovered and prosecuted by OIG during the course of a TennCare fraud investigation.

[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).

Type of Court-Ordered Payment	Grand Total for Period of 2004-2018
Restitution to Division of TennCare	$4,925,572
Restitution to TennCare MCOs	$88,774
Restitution to Law Enforcement	$9,936
Food Stamps	$83,937
Fines	$1,323,536
Court Costs	$370,291
Drug Funds	$476,233