TennCare Quarterly Report

January – March 2020

Submitted to the Members of the General Assembly

Status of TennCare Reforms and Improvements

Response to COVID-19 Crisis. On March 12, 2020, Governor Bill Lee declared a state of emergency to help facilitate the state's response to the threat to public health and safety posed by coronavirus disease 2019 (or "COVID-19"). As the agency in Tennessee state government responsible for providing health insurance to more than 1.4 million individuals, the Division of TennCare has developed a multilayered response to the COVID-19 emergency. Working in tandem with partners and stakeholders at the federal and state levels, TennCare designed and deployed a strategy consisting of such elements as—

- Coordinating with the provider community and TennCare's health plans to ensure access to care for TennCare members in need of testing or treatment for COVID-19;
- Assisting providers in offering covered services to TennCare members via telehealth when medically appropriate;
- Increasing care coordination services for members impacted by COVID-19 who are self-isolated so that they can receive additional supports as needed;
- Pausing nearly all terminations of eligibility for TennCare and CoverKids (the state's separate CHIP program) members during the COVID-19 emergency;
- Waiving copays on services related to the testing and treatment of COVID-19 for TennCare and CoverKids members;
- Working with TennCare's health plans to streamline or temporarily lift authorization requirements to ensure services are delivered promptly and claims paid quickly;
- Expediting access to home-based care for former nursing facility patients being discharged from hospitals and electing to transition home;
- Enhancing access to prescription drugs by allowing early refills of prescriptions and by allowing 90-day supplies to be prescribed for most medications;
- Obtaining a Section 1135 waiver from the Centers for Medicare and Medicaid Services (CMS) that provides flexibilities to help ensure that TennCare members receive necessary services;
- Submitting a Section 1115 waiver application seeking CMS authorization to reimburse hospitals, physicians, and medical labs for providing COVID-19 treatment to uninsured individuals; and

- Assisting providers of long-term services and supports in reducing the spread of COVID-19 among individuals who are residents of nursing facilities.

Additional resources concerning TennCare's response to the COVID-19 pandemic are available on the agency's website at https://www.tn.gov/tenncare/information-statistics/tenncare-information-about-coronavirus.html.

Transition to New TennCare Director. On January 17, 2020, Gabe Roberts announced his decision to step down from the role of TennCare Director. Mr. Roberts continued in that role until March 2, 2020, at which point Governor Bill Lee announced that Stephen Smith would succeed Mr. Roberts as TennCare Director.

Mr. Smith had served as TennCare's Deputy Director and Chief of Staff for the preceding year, in which capacity he was instrumental in providing leadership for a number of key TennCare initiatives. Prior to joining TennCare, he had served as Chief of Staff to Governor Bill Haslam, leading initiatives on transportation infrastructure and broadband access. Mr. Smith previously served as Deputy Commissioner for Policy and External Affairs at the Tennessee Department of Education, where he worked on key policy, legislative and legal issues. Mr. Smith is a licensed attorney and formerly worked in private law practice as well as the nonprofit sector, representing clients in both a legal and consulting capacity. He is a graduate of the University of Tennessee, Knoxville, and the Nashville School of Law.

TennCare Connect. TennCare Connect is the name of the system used by the Division of TennCare to process applications and identify persons who are eligible for the TennCare and CoverKids programs. TennCare began piloting the new system in October 2018, and after several months of systems testing, officially launched TennCare Connect on a statewide basis in March 2019. This eligibility and enrollment system has a complex rules engine and many new interfaces that can be used to verify data submitted by applicants and that are used to make eligibility decisions.

The TennCare Connect online application portal has now been in use for more than one year. During that time, approximately 225,000 accounts have been created and more than 84,000 applications have been submitted online. In addition, over 83,000 TennCare Connect mobile apps have been downloaded to use for checking benefits, making address changes, accessing notices, and submitting requested verifications. During the January-March 2020 quarter, TennCare also rolled out enhanced functionality in the TennCare Access portal used by some TennCare providers. This functionality includes the ability to file full applications, submit changes, and complete renewals on behalf of enrollees.

Pharmacy Benefits Administrator (PBA). On January 1, 2020, following months of intensive preparation, TennCare successfully transitioned all pharmacy services (e.g., claims processing, formulary utilization, rebates, call center operations, clinical support services) to its new PBA, OptumRx. By the conclusion of the January-March 2020 quarter, the new pharmacy claims processing system had been fully stabilized, and the PBA was able to help TennCare respond to Tennessee's March tornadoes and the COVID-19 crisis. In addition to ensuring that TennCare members maintained access to vitally important drug therapy,

OptumRx made it easier for members to comply with stay-at-home requirements through such measures as—

- Processing certain maintenance medications (other than opioids and other controlled medications) for up to a 90-day supply;
- Automatically extending prior authorizations that are due to expire on or before June 15, 2020, for medications on TennCare's automatic exemption list and prescriber attestation list; and
- Covering mail or delivery options offered by local pharmacies.

Preliminary reports indicate that this period of transition and stabilization was successful. TennCare monitored the rollout carefully and determined that access to outpatient drug therapy was maintained and that patients continued to receive necessary and appropriate care.

Amendments to the TennCare Demonstration. Eight proposed amendments to the TennCare Demonstration were in various stages of development during the January-March 2020 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.

As of the end of the January-March 2020 quarter, CMS's review of Amendment 35 was ongoing.

Demonstration Amendment 36: Providers of Family Planning Services. Amendment 36 was submitted to CMS in August 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

[1] See 42 CFR § 438.6(e).

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 during the third quarter of Calendar Year 2018. Close to 3,500 comments were received, and CMS subsequently began to review that feedback as well as the amendment itself. As of the end of the January-March 2020 quarter, CMS's review of Amendment 36 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.

As of the end of the January-March 2020 quarter, discussions between TennCare and CMS on Amendment 38, as well as conversations between TennCare and federal TANF officials, were ongoing.

Demonstration Amendment 40: "Katie Beckett" Program. On September 20, 2019, TennCare submitted Amendment 40 to CMS. Amendment 40 implements legislation (Public Chapter No. 494) passed by the Tennessee General Assembly in the 2019 legislative session directing TennCare to seek CMS approval for a new "Katie Beckett" program. The proposal would assist children under age 18 with disabilities and/or complex medical needs who are not eligible for Medicaid because of their parents' income or assets.

The Katie Beckett program proposed in Amendment 40—developed by TennCare in close collaboration with the Tennessee Department of Intellectual and Developmental Disabilities and other stakeholders—would be composed of two parts:

- **Part A** – Individuals in this group would receive the full TennCare benefits package, as well as essential wraparound home and community based services. These individuals would be subject to monthly premiums to be determined on a sliding scale based on the member's household income.
- **Part B** – Individuals in this group would receive a specified package of essential wraparound services and supports, including premium assistance.

In addition to Parts A and B, Amendment 40 provides for continued TennCare eligibility for children already enrolled in TennCare, who subsequently lose TennCare eligibility, and who would qualify for enrollment in Part A but for whom no Part A program slot is available.

As of the end of the January-March 2019 quarter, CMS's review of Amendment 40 was ongoing.

Demonstration Amendment 41: Supplemental Hospital Payments. Amendment 41 is another demonstration amendment growing out of Tennessee's 2019 legislative session. The budget passed by the General Assembly in 2019 provides for an annual increase of $3,750,000 in State funding to support graduate medical education (GME) in Tennessee. One purpose of Amendment 41 is to draw federal matching funds for these GME expenditures, thereby maximizing the resources available to invest in this priority.

Another aim of Amendment 41 is to enhance TennCare's ability to reimburse qualifying Tennessee hospitals for costs realized as a result of Medicaid shortfall and charity care. Currently, the TennCare Demonstration authorizes two funds through which this type of reimbursement may occur:

- The Virtual Disproportionate Share Hospital (DSH) Fund, which provides for total annual payments of up to $463,996,853, and which may be used to pay for Medicaid shortfall and charity care costs; and
- The Uncompensated Care Fund for Charity Care, which provides for total annual payments of up to $252,845,886, and which may be used to pay for charity care costs.

Amendment 41 would raise the annual limit for payments from these funds by approximately $382 million. Specifically, the limit on reimbursement from the Virtual DSH Fund would be increased to $508,936,029, while the limit on reimbursement from the Uncompensated Care Fund for Charity Care would be increased to $589,886,294. In addition, the amendment would revise the distribution methodologies contained in the TennCare Demonstration for each of the two funds to account for the disbursement of additional monies, and would also create a new sub-pool within the Uncompensated Care Fund to address costs that are not met within the current system.

TennCare submitted Amendment 41 to CMS on October 24, 2019. As of the end of the January-March 2020 quarter, CMS's review of Amendment 41 was ongoing.

Demonstration Amendment 42: Block Grant. Like several other amendments described in this report, Amendment 42 is the result of legislation passed by the Tennessee General Assembly. Amendment 42 implements Public Chapter No. 481 from the 2019 legislative session, which directs TennCare to submit a demonstration amendment to CMS to convert the bulk of TennCare's federal funding to a block grant. The block grant proposed in Amendment 42 is based on TennCare enrollment, using State Fiscal Years 2016, 2017, and 2018 as the base period for calculating the block grant amount. The block grant would be indexed for inflation and for enrollment growth beyond the experience reflected in the base period.

The proposed block grant is intended to cover core medical services delivered to TennCare's core population. Certain TennCare expenses would be excluded from the block grant and continue to be financed through the current Medicaid financing model. These excluded expenditures include services carved out of the existing TennCare demonstration, outpatient prescription drugs, uncompensated care payments to hospitals, services provided to members enrolled in Medicare, and administrative expenses.

Amendment 42 does not rely on reductions to eligibility or benefits in order to achieve savings under the block grant. Instead, it would leverage opportunities to deliver healthcare to TennCare members more effectively and would permit TennCare to implement new reform strategies that would yield benefits for both the State and the federal government.

TennCare submitted Amendment 42 to CMS on November 20, 2019. CMS's review of Amendment 42 was ongoing as of the end of the January-March 2020 quarter.

Demonstration Amendment 43: Extension of Medication Therapy Management Program. Medication therapy management (MTM) is a clinical service provided by licensed pharmacists, the aim of which is to optimize drug therapy and improve therapeutic outcomes for patients. MTM services include medication therapy reviews, pharmacotherapy consults, monitoring efficacy and safety of medication therapy, and other clinical services.

TennCare's MTM benefit was implemented in July 2018 for TennCare members affected by the state's patient-centered medical home (PCMH) program and health home program (known as "Health Link") who met specified clinical risk criteria. TennCare proposed to operate the MTM benefit on a two-year pilot basis in order to evaluate the impact of MTM services on health outcomes, as well as the cost and quality of care for affected members.

In Amendment 43, TennCare proposes to extend its MTM pilot program for an additional 12 months, through the end of June 2021. The purpose of this extension is to allow additional data on the effectiveness of the MTM program to be gathered to inform future decision-making about continuing the program, discontinuing it, and/or expanding it to additional populations.

From February 13 through March 14, 2020, TennCare held a public notice and comment period on Amendment 43. The proposal was then submitted to CMS on March 19, 2020, and, as of the end of the January-March 2020 quarter, CMS's review was ongoing.

Demonstration Amendment 44: Program Modifications. During the January-March 2020 quarter, TennCare issued public notice of another amendment to be submitted to CMS. Amendment 44 outlined program changes that would have been needed if the hospital assessment were not renewed in 2020. These changes have also been proposed in previous years, but were made unnecessary each year by the General Assembly's passage or renewal of a one-year hospital assessment. Changes to the TennCare benefit package for non-exempt adults that would have been necessary if the assessment were not renewed in 2020 were—

- A combined annual limit of eight days per person for inpatient hospital and inpatient psychiatric hospital services;
- An annual limit on non-emergency outpatient hospital visits of eight occasions per person;

- A combined annual limit on health care practitioners' office visits of eight occasions per person;
- An annual limit on lab and X-ray services of eight occasions per person; and
- Elimination of coverage for occupational therapy, speech therapy, and physical therapy.

TennCare held its public notice and comment period regarding Amendment 44 from February 13 through March 14, 2020. Shortly thereafter, the General Assembly renewed the hospital assessment, thereby eliminating any funding gap in the TennCare program. As a result, TennCare did not submit Amendment 44 to CMS.

Update on Episodes of Care. TennCare's episodes of care program aims to transform the way specialty and acute healthcare services are delivered by incentivizing high-quality, cost-effective care, promoting evidence-based clinical pathways, encouraging care coordination, and reducing ineffective or inappropriate treatments. Episodes of care is part of TennCare's delivery system transformation initiative, which is changing healthcare delivery in Tennessee by moving from paying for volume to paying for value.

As of January 1, 2020, all 48 of the state's episodes of care are in a performance period. This milestone means that all 48 episodes that were planned for release have accountable providers who are receiving quarterly cost and quality performance reports with financial accountability. TennCare will continue to collaborate with relevant stakeholders to improve upon the program's design.

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 January-March 2020 quarter as compared with payments made throughout the life of the program appear in the table below:

[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.

Payment Type	Number of Providers Paid During the Quarter	Quarterly Amount Paid (Jan-Mar 2020)	Cumulative Amount Paid to Date[4]
First-year payments	N/A	N/A	$180,155,394
Second-year payments	1	$8,500	$59,837,155
Third-year payments	12	$102,000	$37,636,852
Fourth-year payments	16	$133,167	$8,542,515
Fifth-year payments	17	$144,500	$5,519,338
Sixth-year payments	28	$229,501	$3,229,424

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

- Reminding eligible professionals who previously received five payments of the Program Year 2019 submission period and the need to attest for a sixth and final payment;
- Working with TennCare's attestation software vendor to assure that the Program Year 2019 submission process runs smoothly for all participating providers;
- Extending the Program Year 2019 attestation deadline to June 30, 2020, to accommodate providers affected by the March 2020 tornadoes or the coronavirus crisis;
- Providing daily technical assistance to providers via email and telephone calls;
- Participation in CMS-led calls regarding the EHR Incentive Program; 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. The focus of post-enrollment outreach efforts for 2020 is to encourage provider participants who remain eligible to continue attesting and complete the program.

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 third quarter of State Fiscal Year 2020 are shown in the table below.

Supplemental Hospital Payments for the Quarter

Hospital Name	County	Third Quarter Payments – FY 2020
Methodist Medical Center of Oak Ridge	Anderson County	$102,524
Ridgeview Psychiatric Hospital and Center	Anderson County	$119,811

[4] In certain cases, cumulative totals reflect adjustments of payments from previous quarters. The need for these recoupments was identified through standard auditing processes.

Hospital Name	County	Third Quarter Payments – FY 2020
Tennova Healthcare – Shelbyville	Bedford County	$32,775
Blount Memorial Hospital	Blount County	$127,161
Tennova Healthcare – Cleveland	Bradley County	$102,699
Jellico Community Hospital	Campbell County	$80,973
Tennova Healthcare – LaFollette Medical Center	Campbell County	$55,132
Saint Thomas Stones River Hospital	Cannon County	$19,265
Baptist Memorial Hospital – Carroll County	Carroll County	$28,579
Sycamore Shoals Hospital	Carter County	$84,333
Claiborne Medical Center	Claiborne County	$30,272
Tennova Healthcare – Newport Medical Center	Cocke County	$78,873
Tennova Healthcare – Harton	Coffee County	$61,832
Unity Medical Center	Coffee County	$33,747
TriStar Skyline Medical Center	Davidson County	$356,173
Nashville General Hospital	Davidson County	$396,607
Saint Thomas Midtown Hospital	Davidson County	$223,990
TriStar Centennial Medical Center	Davidson County	$524,030
TriStar Southern Hills Medical Center	Davidson County	$133,037
TriStar Summit Medical Center	Davidson County	$138,363
Vanderbilt Stallworth Rehabilitation Hospital	Davidson County	$363
Vanderbilt University Medical Center	Davidson County	$4,165,489
Decatur County General Hospital	Decatur County	$77,963
Saint Thomas DeKalb Hospital	DeKalb County	$36,073
TriStar Horizon Medical Center	Dickson County	$222,408
West Tennessee Healthcare Dyersburg Hospital	Dyer County	$117,636
Southern Tennessee Regional Health System – Winchester	Franklin County	$69,732
Milan General Hospital	Gibson County	$13,560
Southern Tennessee Regional Health System – Pulaski	Giles County	$65,239
Greeneville Community Hospital	Greene County	$86,570
Morristown – Hamblen Healthcare System	Hamblen County	$152,586
Erlanger Health System	Hamilton County	$3,087,811
Parkridge Medical Center	Hamilton County	$1,133,857
Encompass Health Rehabilitation Hospital of Chattanooga	Hamilton County	$198
Siskin Hospital for Physical Rehabilitation	Hamilton County	$1,283
Hardin Medical Center	Hardin County	$75,741
Henderson County Community Hospital	Henderson County	$16,747
Henry County Medical Center	Henry County	$101,702
Tennova Healthcare – Jefferson Memorial Hospital	Jefferson County	$28,850
Parkwest Medical Center	Knox County	$322,585
Tennova Healthcare – North Knoxville Medical Center	Knox County	$106,495

Hospital Name	County	Third Quarter Payments – FY 2020
East Tennessee Children's Hospital	Knox County	$2,138,762
Fort Sanders Regional Medical Center	Knox County	$250,286
University of Tennessee Medical Center	Knox County	$1,953,135
Southern Tennessee Regional Health System – Lawrenceburg	Lawrence County	$41,536
Lincoln Medical Center	Lincoln County	$173,251
Jackson – Madison County General Hospital	Madison County	$521,034
Pathways of Tennessee	Madison County	$101,373
Maury Regional Medical Center	Maury County	$355,776
Starr Regional Medical Center – Athens	McMinn County	$67,659
Sweetwater Hospital Association	Monroe County	$120,990
Tennova Healthcare – Clarksville	Montgomery County	$81,871
Baptist Memorial Hospital – Union City	Obion County	$82,962
Livingston Regional Hospital	Overton County	$26,126
Cookeville Regional Medical Center	Putnam County	$135,866
Ten Broeck Tennessee	Putnam County	$58,215
Roane Medical Center	Roane County	$59,000
NorthCrest Medical Center	Robertson County	$97,971
Saint Thomas Rutherford Hospital	Rutherford County	$223,745
TriStar StoneCrest Medical Center	Rutherford County	$126,706
TrustPoint Hospital	Rutherford County	$34,972
Big South Fork Medical Center	Scott County	$15,330
LeConte Medical Center	Sevier County	$204,784
Baptist Memorial Restorative Care Hospital	Shelby County	$2,417
Baptist Memorial Hospital – Memphis	Shelby County	$658,517
Methodist University Hospital	Shelby County	$994,709
Crestwyn Behavioral Health	Shelby County	$91,247
Delta Medical Center	Shelby County	$277,690
Encompass Health Rehabilitation Hospital of North Memphis	Shelby County	$68
Encompass Health Rehabilitation Hospital of Memphis	Shelby County	$838
LeBonheur Children's Hospital	Shelby County	$4,111,238
Regional One Health	Shelby County	$2,515,582
Regional One Health Extended Care Hospital	Shelby County	$252
Saint Francis Hospital	Shelby County	$242,800
Saint Francis Hospital – Bartlett	Shelby County	$74,584
Saint Jude Children's Research Hospital	Shelby County	$742,435
Select Specialty Hospital – Memphis	Shelby County	$512
Bristol Regional Medical Center	Sullivan County	$115,557
Creekside Behavioral Health	Sullivan County	$4,354
Encompass Health Rehabilitation Hospital of Kingsport	Sullivan County	$1,149

Hospital Name	County	Third Quarter Payments – FY 2020
Holston Valley Medical Center	Sullivan County	$189,718
Indian Path Community Hospital	Sullivan County	$101,535
Select Specialty Hospital – Tri-Cities	Sullivan County	$48
TriStar Hendersonville Medical Center	Sumner County	$133,078
Sumner Regional Medical Center	Sumner County	$98,072
Baptist Memorial Hospital – Tipton	Tipton County	$104,291
Unicoi County Hospital	Unicoi County	$24,544
Saint Thomas River Park Hospital	Warren County	$77,547
Johnson City Medical Center	Washington County	$1,256,376
Franklin Woods Community Hospital	Washington County	$87,388
Quillen Rehabilitation Hospital	Washington County	$404
Wayne Medical Center	Wayne County	$13,598
West Tennessee Healthcare Rehabilitation Hospital Cane Creek	Weakley County	$27
West Tennessee Healthcare Volunteer Hospital	Weakley County	$29,808
Encompass Health Rehabilitation Hospital of Franklin	Williamson County	$6
Williamson Medical Center	Williamson County	$38,559
Vanderbilt Wilson County Hospital	Wilson County	$151,637
TOTAL		**$31,625,000**

Number of Recipients on TennCare and Costs to the State

During the month of March 2020, there were 1,399,625 Medicaid eligibles and 23,525 Demonstration eligibles enrolled in TennCare, for a total of 1,423,150 persons.

Estimates of TennCare spending for the third quarter of State Fiscal Year 2020 are summarized in the table below.

Spending Category	Third Quarter FY 2020*
MCO services**	$2,161,140,300
Dental services	$36,927,700
Pharmacy services	$326,770,500
Medicare "clawback"***	$60,822,700

**These figures are cash basis as of March 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 January-March 2020 quarter, the MCOs submitted their 2019 NAIC Annual Financial Statements. As of December 31, 2019, 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	$33,562,799	$231,587,192	$198,024,393
UnitedHealthcare Plan of the River Valley (UnitedHealthcare Community Plan)	$77,500,193	$615,878,537	$538,378,344
Volunteer State Health Plan (BlueCare & TennCare Select)	$56,256,150	$489,759,698	$433,503,548

During the January-March 2020 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.

All TennCare MCOs met their minimum net worth requirements and Company Action Level requirements as of December 31, 2019.

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 third quarter of Fiscal Year 2020 furnished for this report by the OIG are as follows:

Fraud and Abuse Allegations	Third Quarter FY 2020
Fraud Allegations	339
Abuse Allegations*	115
Arrest/Conviction/Judicial Diversion Totals	**Third Quarter FY 2020**
Arrests	16
Convictions	3
Judicial Diversions	2

***** *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	Third Quarter FY 2020
Court Costs & Taxes	$0
Fines	$250
Drug Funds/Forfeitures	$500
Criminal Restitution Ordered	$38,511
Criminal Restitution Received[8]	$28,890
Civil Restitution/Civil Court Judgments	**Third Quarter FY 2020**
Civil Restitution Ordered[9]	$0
Civil Restitution Received[10]	$2,540

Recommendations for Review	Third Quarter FY 2020
Recommended TennCare Terminations[11]	24
Potential Savings[12]	$97,497

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.

Type of Court-Ordered Payment	Grand Total for Period of 2004-2020
Restitution to Division of TennCare	$5,378,213
Restitution to TennCare MCOs	$90,768
Restitution to Law Enforcement	$19,171
Food Stamps	$81,337
Fines	$1,374,956
Court Costs	$385,560
Drug Funds	$478,444
Civil Restitution	$3,129,725

[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).