TennCare Quarterly Report

January – March 2019

Submitted to the Members of the General Assembly

Status of TennCare Reforms and Improvements

Changes in Executive Leadership. During the January-March 2019 quarter, several individuals assumed new roles within the Division of TennCare.

John G. (Gabe) Roberts was appointed by Governor Bill Lee to succeed Dr. Wendy Long as Deputy Commissioner of Finance and Administration and Director of the Division of TennCare. Mr. Roberts initially joined TennCare in April 2013 as the agency's General Counsel, and subsequently moved into the role of Deputy Director and Chief Operating Officer. During his tenure at TennCare, Mr. Roberts has been instrumental in the design and implementation of many of the agency's key initiatives, including the Tennessee Health Care Innovation Initiative, the Employment and Community First CHOICES program, and the agency's strategy to combat the opioid epidemic in Tennessee. Before joining TennCare, he practiced law at the Nashville law firm of Sherrard, Roe, Voigt & Harbison, where his focus was corporate and business law.

Brooks Daverman is now serving as TennCare's Deputy Director and Chief Operating Officer, a role whose responsibilities include oversight of managed care operations, eligibility, and strategic planning. He previously served as the Director of Strategic Planning at TennCare. Mr. Daverman's duties in that role included working on health care delivery system transformation and integrating the administrative structure of Tennessee's CoverKids program within the overall TennCare organization. Mr. Daverman began working for the State in 2008. He grew up in Nashville and has a master's degree in public policy from Duke University.

Stephen Smith joined TennCare's executive team on January 21, 2019, in the role of Deputy Director and Chief of Staff. Prior to joining TennCare, he had served as Chief of Staff to Governor Bill Haslam, leading key 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.

Jessica Hill, a native Nashvillean, was appointed to serve as TennCare's Director of Strategic Planning & Innovation in January 2019. She is responsible for overseeing the Episodes of Care program, the State Innovation Model (SIM) federal grant, and various other strategic health care transformation efforts for TennCare. Ms. Hill previously served as TennCare's Episodes Strategy Manager for two years, directly managing TennCare's Episodes of Care program. Prior to her time at TennCare, she created and implemented a culture of safety program at Children's Hospital Colorado, which reduced preventable harm to children and transformed the hospital culture. Ms. Hill has also served as a Regional Leader for the Institute for Healthcare Improvement Open School.

Amendments to the TennCare Demonstration. Five proposed amendments to the TennCare Demonstration were in various stages of development during the January-March 2019 quarter.

Demonstration Amendment 35: Substance Use Disorder Services. In May 2018, TennCare submitted Demonstration Amendment 35 to the Centers for Medicare and Medicaid Services (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 January-March 2019 quarter, TennCare and CMS continued their discussions concerning Amendment 35, including the possibility of using authority contained in federal opioid legislation (the SUPPORT Act) in lieu of modifications to the TennCare Demonstration. As of the end of the 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.

[1] See 42 CFR § 438.6(e).

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 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 2019 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.

The primary modification to ECF CHOICES contained in Amendment 37 is the addition of two new sets of services 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.

During the January-March 2019 quarter, CMS continued its review of Amendment 37. Negotiations between TennCare and CMS remained ongoing as of the end of the January-March 2019 quarter.

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.

CMS notified TennCare on January 8, 2019, that the amendment as submitted met the requirements for a complete amendment. A federal public comment period on the proposal was held from January 8 through February 7, 2019. CMS received approximately 1,400 comments on Amendment 38. As of the end of the January-March 2019 quarter, CMS was reviewing Amendment 38.

Demonstration Amendment 39: Program Modifications. During the January-March 2019 quarter, TennCare issued public notice of another amendment to be submitted to CMS. Amendment 39 outlines program changes that would be needed if the hospital assessment is not renewed in 2019. 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 be necessary if the assessment were not renewed in 2019 are as follows:

- 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 opened its public notice and comment period regarding Amendment 39 on March 12, 2019. The comment period was scheduled to run through April 12, 2019.

Amendment 39 was scheduled to be withdrawn from consideration upon the General Assembly's renewal of the hospital assessment. This legislation was still working its way through normal channels as of the end of the January-March 2019 quarter.

Tennessee Eligibility Determination System / TennCare Connect. The Tennessee Eligibility Determination System, along with a companion online consumer portal known as TennCare Connect, is the name of the system that is now 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.

TennCare Connect allows applicants and enrollees to submit online applications and requested verification information to TennCare, as well as view notices and eligibility periods. TennCare Connect also includes 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). TEDS and TennCare Connect have been one of the largest and most complex IT systems launches in the history of state government, and will significantly enhance the consumer experience for TennCare applicants and enrollees. These groups will now be able to apply for coverage and/or manage their accounts 24 hours per day, 7 days a week. Included within this capability are such functions as providing requested verifications, updating demographic information (e.g., income, addresses, household membership, etc.), and completing the annual renewal process. In addition, applicants and enrollees may indicate in the system whether to receive electronic notices or text messages to alert them when TennCare has sent a communication. TennCare Connect is accessible online at https://tenncareconnect.tn.gov/services/HomePage.

Additionally, in January 2019, TennCare began piloting a fourth portal. The "TennCare Access Portal" is designed for use by hospitals and the Tennessee Department of Health in submitting applications for presumptive eligibility, and for long-term care partners to look up information on applicants. All partners in the presumptive eligibility process are now using the TennCare Access Portal statewide.

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.

Of the 48 episodes that have been developed since the program began, 45 currently include financial accountability (i.e., gain sharing and risk sharing) for providers in 2019. TennCare is also implementing over 30 changes to the design of episodes in 2019 based on feedback received from stakeholders. This feedback, which was gathered primarily in the Annual Episodes Design Feedback Session meetings held in May 2018, led to such episode modifications as exempting providers with fewer than five episodes, avoiding duplicative accountability when multiple episodes overlap, and adjusting the reported costs of medications on episode reports. Information about these design changes and other aspects of the

episodes program is available on the TennCare website at https://www.tn.gov/content/dam/tn/tenncare/documents2/Memo2019EpisodesChanges.pdf.

Tennessee continues to lead the nation in transforming the health care delivery system. Humana, a national insurance company, has implemented three episodes using Tennessee's episode designs for maternity, total joint replacement, and spinal fusion. Details of the initiative that Humana modeled on Tennessee's program may be found online at https://www.humana.com/provider/news/value-based-care/payment-models/episode-based-models.

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.[4]

EHR payments made by TennCare during the January-March 2019 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 (Jan-Mar 2019)	Cumulative Amount Paid to Date[5]
First-year payments	N/A	N/A	$180,229,124
Second-year payments	11	$22,667	$59,014,297
Third-year payments	81	$902,292	$36,574,794
Fourth-year payments	99	$705,502	$7,630,181
Fifth-year payments	57	$340,001	$4,377,503
Sixth-year payments	52	$342,834	$2,387,933

[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] At present, all but three participating hospitals have received three years of incentive payments.

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

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 on a daily basis via emails (including targeted emails to eligible professionals attesting to "meaningful use" of EHR technology), technical assistance calls, webinars, and onsite visits;
- Weekly messaging in March 2019 to providers regarding the submission deadline for sixth-year payments;
- Acceptance of Program Year 2018 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;
- Taking steps to ensure that Tennessee's attestation software is fully ready to accept and process 2018 program year submissions from participating providers;
- Participation in quarterly calls with CMS that cover various areas of 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, with particular emphasis on the benefits of electronic health records for patients. The focus of post-enrollment outreach efforts for 2019 is to encourage provider participants who remain eligible to continue attesting and complete the program. In support of this outreach strategy, TennCare staff made preparations during the January-March 2019 quarter to exhibit at the April 2019 provider information expos hosted by Amerigroup Community Care and UnitedHealthcare in Chattanooga, Jackson, Johnson City, Knoxville, Memphis, and Nashville.

New Pharmacy Benefits Manager. Following a competitive bidding process in which multiple companies submitted proposals, TennCare named Optum Rx., Inc. the program's new Pharmacy Benefits Manager (PBM) on January 9, 2019. Optum will replace Magellan Medicaid Administration, which has held the role since 2013.

Although Optum will not start processing pharmacy claims for TennCare until January 1, 2020, the company began readiness activities in March 2019. Priorities during this period of transition include the following:

- 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
- Helping TennCare negotiate and collect supplemental rebates from pharmaceutical manufacturers.

TennCare's contract with Optum lasts through December 31, 2022, and contains an option for up to four renewals, each lasting as long as one year.

Wilson v. Long. *Wilson v. Long* 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. On January 23, 2019, Judge Campbell issued a decision in favor of TennCare, finding "no evidence of on-going systemic problems in the TennCare application process."[6] The Court further found that TennCare had provided applicants with an opportunity to contest delays in determining eligibility and had codified the appeals process in permanent rules. In addition, he vacated a preliminary injunction imposed on TennCare in September 2014 that required the agency to provide fair hearings on any delayed adjudications of applications for TennCare coverage. The Plaintiffs did not subsequently appeal the decision, meaning that Judge Campbell's findings are final. Although they were unsuccessful in the litigation, the Plaintiffs filed a motion for attorney's fees and costs, which TennCare opposed. A ruling on the Plaintiff's motion remains pending.

Shackelford v. Roberts. 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 longstanding limitations placed by TennCare—and approved by CMS—on private duty nursing services for individuals aged 21 and older. These benefit limits for adults are specifically allowed by federal law. 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, it is the policy of the enrollee's MCO to work with the child and his family prior to the child's 21st birthday to begin planning and supporting the transition to the appropriate level of benefits that best meets his needs (and that can include long-term services and supports). In *Shackelford v. Roberts*, a Plaintiff with disabilities who received private duty nursing services as a child

[6] *Wilson v. Long*. U.S. District Court for the Middle District of Tennessee at Nashville. Findings of Fact and Conclusions of Law, page 18. January 23, 2019. This document is available online at https://www.tn.gov/content/dam/tn/attorneygeneral/documents/pr/2019/pr19-04-wilson.pdf.

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. This mediation took place on January 16, 2019, but was not successful in resolving the case. The Plaintiff subsequently elected to move into a long-term care facility to determine whether it would be a suitable alternative to the private duty nursing services he had been receiving at home. He withdrew the Motion for Preliminary Injunction and moved for a six-month stay of the litigation, which was granted. By August 26, 2019, the Plaintiff must either dismiss the case or move to have the stay of litigation lifted.

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 2019 are shown in the table below.

Supplemental Hospital Payments for the Quarter

Hospital Name	County	Third Quarter Payments – FY 2019
Methodist Medical Center of Oak Ridge	Anderson County	$99,456
Ridgeview Psychiatric Hospital and Center	Anderson County	$186,757
Tennova Healthcare – Shelbyville	Bedford County	$29,166
Blount Memorial Hospital	Blount County	$132,925
Tennova Healthcare – Cleveland	Bradley County	$122,682
Jellico Community Hospital	Campbell County	$103,274
Tennova Healthcare – LaFollette Medical Center	Campbell County	$61,044
Saint Thomas Stones River Hospital	Cannon County	$24,129
Sycamore Shoals Hospital	Carter County	$79,032
Claiborne Medical Center	Claiborne County	$24,519
Tennova Healthcare – Newport Medical Center	Cocke County	$65,151
Tennova Healthcare – Harton	Coffee County	$63,408
Unity Medical Center	Coffee County	$46,607
TriStar Skyline Medical Center	Davidson County	$391,933
Nashville General Hospital	Davidson County	$363,224
Saint Thomas Midtown Hospital	Davidson County	$229,709
TriStar Centennial Medical Center	Davidson County	$564,151
TriStar Southern Hills Medical Center	Davidson County	$151,352

Hospital Name	County	Third Quarter Payments – FY 2019
TriStar Summit Medical Center	Davidson County	$160,152
Vanderbilt Stallworth Rehabilitation Hospital	Davidson County	$13
Vanderbilt University Medical Center	Davidson County	$3,955,316
Saint Thomas DeKalb Hospital	DeKalb County	$25,442
TriStar Horizon Medical Center	Dickson County	$180,435
West Tennessee Healthcare Dyersburg Hospital	Dyer County	$153,187
Jamestown Regional Medical Center	Fentress County	$17,990
Southern Tennessee Regional Health System – Winchester	Franklin County	$58,596
Milan General Hospital	Gibson County	$21,195
Southern Tennessee Regional Health System – Pulaski	Giles County	$39,163
Laughlin Memorial Hospital	Greene County	$67,809
Morristown – Hamblen Healthcare System	Hamblen County	$112,517
Tennova Healthcare – Lakeway Regional Hospital	Hamblen County	$27,611
Erlanger Medical Center	Hamilton County	$2,148,613
Parkridge Medical Center	Hamilton County	$1,188,439
HealthSouth Rehabilitation Hospital – Chattanooga	Hamilton County	$481
Kindred Hospital – Chattanooga	Hamilton County	$308
Siskin Hospital for Physical Rehabilitation	Hamilton County	$1,274
Hardin Medical Center	Hardin County	$65,881
Henderson County Community Hospital	Henderson County	$17,529
Henry County Medical Center	Henry County	$82,144
Tennova Healthcare – Jefferson Memorial Hospital	Jefferson County	$25,353
Parkwest Medical Center	Knox County	$339,440
Tennova Healthcare – Physicians Regional Medical Center	Knox County	$216,508
East Tennessee Children's Hospital	Knox County	$2,379,697
Fort Sanders Regional Medical Center	Knox County	$217,979
University of Tennessee Medical Center	Knox County	$1,813,413
Southern Tennessee Regional Health System – Lawrenceburg	Lawrence County	$33,945
Lincoln Medical Center	Lincoln County	$169,663
Jackson – Madison County General Hospital	Madison County	$548,672
Pathways of Tennessee	Madison County	$162,763
Maury Regional Hospital	Maury County	$205,124
Starr Regional Medical Center – Athens	McMinn County	$58,307
Sweetwater Hospital Association	Monroe County	$130,709
Tennova Healthcare – Clarksville	Montgomery County	$119,848
Baptist Memorial Hospital – Union City	Obion County	$63,530
Livingston Regional Hospital	Overton County	$33,470
Cookeville Regional Medical Center	Putnam County	$127,170
Roane Medical Center	Roane County	$45,557

Hospital Name	County	Third Quarter Payments – FY 2019
NorthCrest Medical Center	Robertson County	$83,453
Saint Thomas Rutherford Hospital	Rutherford County	$235,544
TriStar StoneCrest Medical Center	Rutherford County	$141,395
TrustPoint Hospital	Rutherford County	$41,267
LeConte Medical Center	Sevier County	$127,082
Baptist Memorial Restorative Care Hospital	Shelby County	$1,280
Baptist Memorial Hospital – Memphis	Shelby County	$604,031
Methodist University Hospital	Shelby County	$1,063,969
Crestwyn Behavioral Health	Shelby County	$23,762
Delta Medical Center	Shelby County	$247,374
HealthSouth Rehabilitation Hospital – North Memphis	Shelby County	$396
HealthSouth Rehabilitation Hospital – Memphis	Shelby County	$453
LeBonheur Children's Hospital	Shelby County	$3,870,303
Regional One Health	Shelby County	$3,488,163
Regional One Health Extended Care Hospital	Shelby County	$103
Saint Francis Hospital	Shelby County	$274,203
Saint Jude Children's Research Hospital	Shelby County	$744,083
Bristol Regional Medical Center	Sullivan County	$115,367
HealthSouth Rehabilitation Hospital – Kingsport	Sullivan County	$985
Holston Valley Medical Center	Sullivan County	$214,512
Indian Path Community Hospital	Sullivan County	$99,154
TriStar Hendersonville Medical Center	Sumner County	$134,279
Sumner Regional Medical Center	Sumner County	$112,814
Baptist Memorial Hospital – Tipton	Tipton County	$79,043
Saint Thomas River Park Hospital	Warren County	$83,119
Johnson City Medical Center	Washington County	$1,606,271
Franklin Woods Community Hospital	Washington County	$74,567
Quillen Rehabilitation Hospital	Washington County	$552
Wayne Medical Center	Wayne County	$34,034
Spire Cane Creek Rehabilitation Hospital	Weakley County	$67
West Tennessee Healthcare Volunteer Hospital	Weakley County	$45,359
HealthSouth Rehabilitation Hospital – Franklin	Williamson County	$5
Rolling Hills Hospital	Williamson County	$1,718
Williamson Medical Center	Williamson County	$38,346
Tennova Healthcare – Lebanon	Wilson County	$284,187
TOTAL		**$31,625,000**

Number of Recipients on TennCare and Costs to the State

During the month of March 2019, there were 1,375,264 Medicaid eligibles and 18,652 Demonstration eligibles enrolled in TennCare, for a total of 1,393,916 persons.

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

Spending Category	Third Quarter FY 2019*
MCO services**	$2,084,079,400
Dental services	$40,107,300
Pharmacy services	$306,822,600
Medicare "clawback"***	$53,589,800

**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[7] 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[8] are processed and paid within 21 calendar days of receipt.	TennCare contract

[7] 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.

[8] 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 2019 quarter, the MCOs submitted their 2018 NAIC Annual Financial Statements. As of December 31, 2018, TennCare MCOs reported net worth as indicated in the table below.[9]

[9] 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	$32,303,660	$187,159,719	$154,856,059
UnitedHealthcare Plan of the River Valley (UnitedHealthcare Community Plan)	$98,223,126	$462,998,137	$364,775,011
Volunteer State Health Plan (BlueCare & TennCare Select)	$53,841,080	$410,918,440	$357,077,360

During the January-March 2019 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, 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 third quarter of Fiscal Year 2019 are as follows:

Fraud and Abuse Allegations	Third Quarter FY 2019
Fraud Allegations	1,513
Abuse Allegations*	1,289
Arrest/Conviction/Judicial Diversion Totals	**Third Quarter FY 2019**
Arrests	12
Convictions	10
Judicial Diversions	9

***** *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 2019
Court Costs & Taxes	$1,407
Fines	$35,650
Drug Funds/Forfeitures	$27
Criminal Restitution Ordered	$87,679
Criminal Restitution Received[10]	$40,379
Civil Restitution/Civil Court Judgments	**Third Quarter FY 2019**
Civil Restitution Ordered[11]	$0
Civil Restitution Received[12]	$5,336
Civil – Administrative Fee	$0

Recommendations for Review	Third Quarter FY 2019
Recommended TennCare Terminations[13]	82
Potential Savings[14]	$333,114

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 2004-2019
Restitution to Division of TennCare	$5,187,431
Restitution to TennCare MCOs	$91,801
Restitution to Law Enforcement	$17,809
Food Stamps	$83,937
Fines	$1,368,556
Court Costs	$384,460
Drug Funds	$481,306

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

[11] 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.

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

[13] 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.

[14] 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).