TennCare Quarterly Report

January – March 2021

Submitted to the Members of the General Assembly

Status of TennCare Reforms and Improvements

Katie Beckett Program. On November 23, 2020, TennCare launched a new "Katie Beckett" program. The Katie Beckett program provides services and supports for children under age 18 with disabilities and/or complex medical needs who are not eligible for traditional Medicaid because of their parents' income or assets. The Katie Beckett program is an outgrowth of legislation (Public Chapter No. 494) passed by the Tennessee General Assembly in the 2019 legislative session. Following enactment of Public Chapter No. 494, TennCare submitted a waiver amendment ("Amendment 40") to the Centers for Medicare and Medicaid Services (CMS) to establish the new program. CMS ultimately approved Amendment 40 on November 2, 2020.

TennCare's Katie Beckett program contains two parts:

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

In addition to Parts A and B, the Katie Beckett program provides 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.

The Katie Beckett program was designed based on the requirements of the law, and with significant input from parents of children with complex medical needs and disabilities, as well as advocates, medical experts, and other stakeholders. This input was gathered across the state through extensive stakeholder processes conducted jointly by TennCare and the Department of Intellectual and Developmental Disabilities (DIDD), both before the amendment was submitted to CMS, and as the State prepared for the program's implementation.

TennCare and DIDD convened a Technical Advisory Group (TAG) to provide guidance regarding the development of medical (or level of care) eligibility criteria for enrollment into the new program and prioritization for enrollment into Part A to comport with the new law. The TAG consisted of the Children's Hospital Alliance of Tennessee, complex care physicians and pediatric experts, parents of children with complex medical needs and disabilities, and advocacy organizations. The medical eligibility rules represent the consensus recommendations of that group to TennCare and DIDD.

Based on the recommendations of the TAG, TennCare originally limited enrollment in Kate Beckett Part A to children who meet the highest level of care standard, referred to as "Tier 1 Institutional," which applies to children at risk of immediate placement in an inpatient (medical or psychiatric) facility unless appropriate in-home supports are available. Children who met the "Tier 2 Institutional" level of care standard—for nursing home level placement—were initially enrolled in the program in Part B, with the possibility of transitioning to Part A. After working through the large volume of initial applications, TennCare and DIDD reconvened the TAG and, based on its recommendations, opened up slots in Part A for children who meet the Tier 2 criteria. Those children are now beginning to transition from Part B to Part A.

The Katie Beckett program began accepting self-referral forms from interested families on November 23, 2020. As of the last day of the January-March 2021 quarter, a total of 606 children were enrolled in the program, with 21 enrolled in Part A and 585 enrolled in Part B.

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.).

During the January-March 2021 quarter, BCBER published a summary of the results of the most recent survey titled "The Impact of TennCare: A Survey of Recipients, 2020". Although the findings of a single survey must be viewed in context of long-term trends, several results from the report are noteworthy:

- Satisfaction with TennCare remained high. Ninety-four percent of respondents covered by TennCare expressed satisfaction with the quality of care they had received. This level of satisfaction tied for the second highest in the program's history and was the fourth time in a row that a satisfaction level of at least 94 percent had been attained. In addition, 2020 was the twelfth straight year in which survey respondents had reported satisfaction levels exceeding 90 percent.
- The uninsured rate in Tennessee rose for adults but remained the same for children. The reported percentage of uninsured adults rose from 8.1 percent in 2019 to 9.9 percent in 2020. This result was not entirely unexpected, as the pandemic was predicted to cause a loss of employment—and therefore health insurance—for a significant number of Tennesseans. Nonetheless, the reported

percentage of uninsured children did not increase in 2020, remaining at the 2019 level of 2.8 percent.

- TennCare members were less likely to use the emergency room for initial medical care. While heads of households with TennCare continued to seek initial medical care for themselves at hospitals six percent of the time, the likelihood of seeking such care for their children fell from six percent in 2019 to three percent in 2020.

In summary, the report notes, "TennCare continues to receive positive feedback from its recipients, with 94 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 https://haslam.utk.edu/sites/default/files/tncare20_0.pdf.

Response to COVID-19 Emergency. 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 1.5 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 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;

- Obtaining federal approval to make supplemental retainer payments to providers of home- and community-based services for individuals with intellectual disabilities, as well as additional flexibilities to support these providers during the public health emergency;
- Assisting providers of long-term services and supports in reducing the spread of COVID-19 among individuals who are residents of nursing facilities; and
- Working with the federal government and healthcare providers in Tennessee to provide enhanced financial support for providers disproportionately affected by the COVID-19 emergency, including primary care providers, nursing facilities, dentists, and community mental health centers and other providers of behavioral health services.

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.

Proposed Amendment to the TennCare III Demonstration. As noted in the previous quarterly report to the General Assembly, in January 2021, CMS approved the next iteration of the TennCare demonstration, referred to as "TennCare III." TennCare III is scheduled to run through December 31, 2030.

On February 22, 2021, TennCare provided public notice of its first proposed amendment to the TennCare III demonstration. The amendment (known as "Amendment 1") would introduce the following modifications to the demonstration:

- Integration of services for members with intellectual disabilities into the TennCare managed care program[1];
- Transitioning the care of children receiving Supplemental Security Income (SSI) benefits from the TennCare Select health plan to one of the other health plans that serves TennCare members; and
- Assigning to the TennCare Select health plan certain inmates of public institutions who receive inpatient services in a setting located outside the public institution.

TennCare's public notice and comment period for the proposal lasted from February 22 through March 5, 2021. On March 31, 2021, TennCare submitted Amendment 1 to CMS.

Other Amendments to the TennCare Demonstration. Three other proposed amendments to the TennCare Demonstration were in various stages of development during the January-March 2021 quarter. These amendments were submitted to CMS during the TennCare II demonstration and were numbered accordingly.

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

[1] Specific services to be integrated are intermediate care facility services for individuals with intellectual disabilities (ICF/IID services) and 1915(c) waiver home- and community-based services (HCBS).

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 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.[2] 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 2021 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 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 2021 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 2021 quarter, CMS's review of Amendment 38 was ongoing.

[2] See 42 CFR § 438.6(e).

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.

In March 2021, all providers participating in the episodes of care program were invited to the Delivery System Transformation conference hosted jointly by TennCare and its managed care organizations (MCOs). One of the key elements of the conference was a learning collaborative session entitled *Episodes of Care: Specialists and the Episodes of Care Program* that provided an overview of the program, shared recent program updates, and disseminated information about quality programs currently available to TennCare members. Each MCO has multiple quality programs that specialists can use to support their patients and improve their episodes of care performance. TennCare anticipates that 2021 will continue to be a strong year for provider engagement opportunities.

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[3] 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[4] 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 2021 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 2021)	Cumulative Amount Paid to Date[5]
First-year payments	N/A	N/A	$180,176,644
Second-year payments	2	$17,000	$60,007,155
Third-year payments	1	$8,500	$37,957,019

[3] 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). All hospitals participating in the program have received all payments available to them.

[4] 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.

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

Payment Type	Number of Providers Paid During the Quarter	Quarterly Amount Paid (Jan-Mar 2021)	Cumulative Amount Paid to Date[5]
Fourth-year payments	13	$110,500	$9,109,182
Fifth-year payments	32	$272,000	$6,414,672
Sixth-year payments	47	$399,500	$4,124,748

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

- Conducting reviews of remaining attestation submissions for Program Year 2020;
- Ongoing communications with providers on attestation timelines for Program Years 2020 and 2021;
- Providing daily technical assistance to providers via email and telephone calls;
- Participation in CMS-led calls regarding the EHR Incentive Program; and
- Monthly newsletters and reminders distributed to all registered members of 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, with all remaining payments to be made by the program's conclusion on December 31, 2021. 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 the remainder of the program is to encourage all providers who remain eligible to continue attesting and receive all six payments available.

Dowdy v. Smith **Lawsuit.** On March 12, 2021, TennCare member Shannon Dowdy filed suit in federal court against TennCare to obtain private duty nursing care on a 24-hours-a-day/7-days-a-week basis from his TennCare MCO. This level of services is not currently available to Mr. Dowdy under the TennCare program. The plaintiff had previously been receiving 24/7 nursing care through a combination of programs, with the majority of nursing hours furnished through a 1915(c) waiver program for individuals with intellectual disabilities, and the balance of hours provided by his MCO. Mr. Dowdy's complaint alleges that the services delivered through the 1915(c) waiver were insufficiently staffed, meaning that he was being denied necessary care. The plaintiff initially sought a preliminary injunction, but the parties reached an agreement for the provision of hours during the litigation that mooted the request for an injunction. TennCare is being represented by the Attorney General's office and has until June 1 to respond to the complaint.

Erlanger Health System v. TennCare **Lawsuit.** This declaratory order action was commenced against TennCare regarding the applicability and validity of two TennCare rules that set the reimbursement rates for emergency services provided to TennCare enrollees by non-contract hospitals. The action was later amended to seek invalidation of the related State Plan Amendments approved by CMS. This administrative declaratory order action has been on appeal to the Tennessee Court of Appeals for review of an evidentiary ruling. On March 3, 2021, the Court of Appeals issued an opinion affirming the lower

court's ruling to exclude certain disputed documents. The case was remanded back to the agency for completion of the declaratory order process. A scheduling order has been entered providing for the parties to complete the briefing process by June 24, 2021, with an agency decision to follow within 90 days.

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 supplemental payments made during the third quarter of State Fiscal Year 2021 are shown in the table below.

Supplemental Hospital Payments for the Quarter

Hospital Name	County	Third Quarter Payments – FY 2021
Methodist Medical Center of Oak Ridge	Anderson County	$124,695
Ridgeview Psychiatric Hospital and Center	Anderson County	$101,551
Tennova Healthcare – Shelbyville	Bedford County	$37,024
Blount Memorial Hospital	Blount County	$173,726
Tennova Healthcare – Cleveland	Bradley County	$145,058
Jellico Medical Center	Campbell County	$107,212
Tennova Healthcare – LaFollette Medical Center	Campbell County	$66,115
Saint Thomas Stones River Hospital	Cannon County	$34,880
Sycamore Shoals Hospital	Carter County	$95,122
Claiborne Medical Center	Claiborne County	$58,708
Tennova Healthcare – Newport Medical Center	Cocke County	$71,662
Tennova Healthcare – Harton	Coffee County	$71,755
Unity Medical Center	Coffee County	$65,245
Ascension Saint Thomas Hospital	Davidson County	$427,132
TriStar Skyline Medical Center	Davidson County	$569,441
Nashville General Hospital	Davidson County	$290,479
Select Specialty Hospital – Nashville	Davidson County	$203
TriStar Centennial Medical Center	Davidson County	$943,495
TriStar Southern Hills Medical Center	Davidson County	$182,500
TriStar Summit Medical Center	Davidson County	$184,835
Vanderbilt Stallworth Rehabilitation Hospital	Davidson County	$124
Vanderbilt University Medical Center	Davidson County	$5,504,621
Saint Thomas DeKalb Hospital	DeKalb County	$37,889
TriStar Horizon Medical Center	Dickson County	$298,788
West Tennessee Healthcare Dyersburg Hospital	Dyer County	$107,258
Southern Tennessee Regional Health System – Winchester	Franklin County	$94,476
West Tennessee Healthcare Milan Hospital	Gibson County	$28,810
Southern Tennessee Regional Health System – Pulaski	Giles County	$83,067

Hospital Name	County	Third Quarter Payments – FY 2021
Greeneville Community Hospital	Greene County	$152,727
Morristown – Hamblen Healthcare System	Hamblen County	$215,543
Erlanger Behavioral Health Hospital	Hamilton County	$142,117
Erlanger Health System	Hamilton County	$2,919,854
Parkridge Medical Center	Hamilton County	$1,532,049
Encompass Health Rehabilitation Hospital of Chattanooga	Hamilton County	$321
Siskin Hospital for Physical Rehabilitation	Hamilton County	$422
Hardin Medical Center	Hardin County	$114,581
Henderson County Community Hospital	Henderson County	$29,570
Henry County Medical Center	Henry County	$146,637
Tennova Healthcare – Jefferson Memorial Hospital	Jefferson County	$40,778
Parkwest Medical Center	Knox County	$449,774
Tennova Healthcare – North Knoxville Medical Center	Knox County	$143,458
East Tennessee Children's Hospital	Knox County	$2,422,790
Fort Sanders Regional Medical Center	Knox County	$350,909
University of Tennessee Medical Center	Knox County	$1,751,974
Southern Tennessee Regional Health System – Lawrenceburg	Lawrence County	$53,284
Lincoln Medical Center	Lincoln County	$309,719
Jackson – Madison County General Hospital	Madison County	$709,352
Pathways of Tennessee	Madison County	$92,409
Perimeter Behavioral Hospital of Jackson	Madison County	$28,954
West Tennessee Healthcare Rehabilitation Hospital Jackson	Madison County	$414
Maury Regional Medical Center	Maury County	$237,371
Sweetwater Hospital Association	Monroe County	$147,818
Tennova Healthcare – Clarksville	Montgomery County	$149,354
Baptist Memorial Hospital – Union City	Obion County	$99,264
Livingston Regional Hospital	Overton County	$44,808
Cookeville Regional Medical Center	Putnam County	$249,328
Roane Medical Center	Roane County	$82,987
NorthCrest Medical Center	Robertson County	$119,586
Saint Thomas Rutherford Hospital	Rutherford County	$295,922
TriStar StoneCrest Medical Center	Rutherford County	$240,270
LeConte Medical Center	Sevier County	$248,205
Baptist Memorial Restorative Care Hospital	Shelby County	$1,397
Baptist Memorial Hospital – Memphis	Shelby County	$992,986
Methodist University Hospital	Shelby County	$1,432,029
Crestwyn Behavioral Health	Shelby County	$103,157
Delta Specialty Hospital	Shelby County	$318,544

Hospital Name	County	Third Quarter Payments – FY 2021
Encompass Health Rehabilitation Hospital of North Memphis	Shelby County	$579
Encompass Health Rehabilitation Hospital of Memphis	Shelby County	$522
Le Bonheur Children's Hospital	Shelby County	$4,727,210
Regional One Health	Shelby County	$2,789,667
Regional One Health Extended Care Hospital	Shelby County	$55
Saint Francis Hospital	Shelby County	$319,610
Saint Francis Hospital – Bartlett	Shelby County	$109,718
Saint Jude Children's Research Hospital	Shelby County	$744,864
Bristol Regional Medical Center	Sullivan County	$176,052
Creekside Behavioral Health	Sullivan County	$75,098
Encompass Health Rehabilitation Hospital of Kingsport	Sullivan County	$685
Holston Valley Medical Center	Sullivan County	$303,154
Indian Path Community Hospital	Sullivan County	$124,824
TriStar Hendersonville Medical Center	Sumner County	$200,616
Sumner Regional Medical Center	Sumner County	$137,298
Baptist Memorial Hospital – Tipton	Tipton County	$144,650
Unicoi County Hospital	Unicoi County	$21,992
Saint Thomas River Park Hospital	Warren County	$130,329
Johnson City Medical Center	Washington County	$1,568,405
Franklin Woods Community Hospital	Washington County	$115,768
Quillen Rehabilitation Hospital	Washington County	$329
Wayne Medical Center	Wayne County	$22,688
West Tennessee Healthcare Rehabilitation Hospital Cane Creek	Weakley County	$68
West Tennessee Healthcare Volunteer Hospital	Weakley County	$35,471
Saint Thomas Highlands Hospital	White County	$75,979
Encompass Health Rehabilitation Hospital of Franklin	Williamson County	$17
Williamson Medical Center	Williamson County	$67,141
Vanderbilt Wilson County Hospital	Wilson County	$273,964
TOTAL		**$38,443,286**

Number of Recipients on TennCare and Costs to the State

During the month of March 2021, there were 1,539,848 Medicaid eligibles and 19,890 Demonstration eligibles enrolled in TennCare, for a total of 1,559,738 persons.

Estimates of TennCare spending for the third quarter of State Fiscal Year 2021 are summarized in the table below.

Spending Category	Third Quarter FY 2021*
MCO services**	$2,066,536,200
Dental services	$36,852,300
Pharmacy services	$325,753,200
Medicare "clawback"***	$51,848,400

**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[6] 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[7] are processed and paid within 21 calendar days of receipt.	TennCare contract

[6] 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.

[7] 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 2021 quarter, the MCOs submitted their 2020 NAIC Annual Financial Statements. As of December 31, 2020, TennCare MCOs reported net worth as indicated in the table below.[8]

[8] 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	$38,720,932	$293,535,089	$254,814,157
UnitedHealthcare Plan of the River Valley (UnitedHealthcare Community Plan)	$58,718,194	$647,575,808	$588,857,614
Volunteer State Health Plan (BlueCare & TennCare Select)	$59,296,934	$515,271,610	$455,974,676

During the January-March 2021 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, 2020.

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 2021 furnished for this report by the OIG are as follows:

Fraud and Abuse Allegations	Third Quarter FY 2021
Fraud Allegations	252
Abuse Allegations*	560
Arrest/Conviction/Judicial Diversion Totals	**Third Quarter FY 2021**
Arrests	9
Convictions	1
Judicial Diversions	3

***** *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 2021
Criminal Restitution Ordered	$8,104
Criminal Restitution Received[9]	$39,461
Civil Restitution/Civil Court Judgments	**Third Quarter FY 2021**
Civil Restitution Ordered[10]	$0
Civil Restitution Received[11]	$615

Recommendations for Review	Third Quarter FY 2021
Recommended TennCare Terminations[12]	560
Potential Savings[13]	$2,496,346

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. Although food stamps are not part of the TennCare program, OIG occasionally discovers evidence of fraud in this area during the course of a TennCare fraud investigation.

Type of Court-Ordered Payment	Grand Total for Period of 2004-2021
Restitution to Division of TennCare	$5,828,966
Restitution to TennCare MCOs	$90,768
Food Stamps	$81,337
Civil Restitution	$3,129,725

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

[10] 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.

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

[12] 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.

[13] 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 $4,457.76).