TennCare Quarterly Report

July – September 2019

Submitted to the Members of the General Assembly

Status of TennCare Reforms and Improvements

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

As of the end of the July-September 2019 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 July-September 2019 quarter, CMS's review of Amendment 36 was ongoing.

Demonstration Amendment 37: Modifications to Employment and Community First CHOICES. On July 2, 2019, CMS approved Demonstration Amendment 37. Amendment 37 primarily concerned modifications 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. Specifically, Amendment 37 added two new sets of services and two new benefit groups in which the services would be available:

- ECF CHOICES Group 7 serves 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 now receive family-centered behavioral health treatment services with family-centered home and community-based services (HCBS).
- ECF CHOICES Group 8 serves 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 now receive short-term intensive community-based behavioral-focused transition and stabilization services and supports.

Other changes to ECF CHOICES contained in Amendment 37 included 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 also revised 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.

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 July-September 2019 quarter, discussions between TennCare and CMS on Amendment 38 were ongoing.

Demonstration Amendment 40: "Katie Beckett" Program. From August 5 through September 6, 2019, TennCare held a public notice and comment period on another amendment to be submitted 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.

During the notice and comment period on Amendment 40, TennCare received dozens of comments, the vast majority of which were supportive of the proposal. TennCare reviewed this feedback carefully and incorporated several suggestions into the final version of the amendment. Amendment 40 was submitted to CMS on September 20, 2019.

Demonstration Amendment 41: Supplemental Hospital Payments. On September 9, 2019, TennCare initiated a public notice and comment period for 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.

As of the end of the July-September 2019 quarter, the public notice and comment period for Amendment 41 was expected to last through October 11, 2019, with submission of the amendment to CMS to follow shortly thereafter.

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 launched a public notice and comment period on Amendment 42 on September 17, 2019. The notice and comment period was to run through October 18, 2019, and was to feature hearings at various sites in each of Tennessee's grand regions.

Update on Episodes of Care. TennCare's episodes of care program is designed 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.

Final results were recently released for the program's 2018 performance period, which includes 27 episode types with financial accountability. Estimated savings achieved in 2018 were approximately $38.3 million. During that time period, quality levels were either improved or maintained for the majority of episode types, and gain-sharing payments to providers exceeded risk-sharing payments by $686,000.

During the July-September 2019 quarter, the episodes program also released a memo outlining changes that would take effect in the 2020 performance period (beginning on January 1, 2020). Using feedback offered by stakeholders over the past year (especially at the Annual Episodes Design Feedback Session meetings held in May 2019), TennCare is in the process of making 41 changes to episode design. Several new quality metrics are being added, including one for morphine equivalent dose per day that complements TennCare's opioid strategy. Another change is the introduction of a list of global clinical exclusions that apply to all episodes. This list will exclude episodes in which patients have rare, high-cost conditions, such as paralysis and coma.

In addition, TennCare's episodes program recently secured designation as an Advanced Alternative Payment Model (APM) by CMS through 2025. This designation not only gives more healthcare providers in Tennessee the ability to join the APM track of Medicare's Quality Payment Program (QPP) by participating in TennCare's Episodes program, but also rewards these providers with the potential to earn additional bonuses from Medicare. TennCare secured this designation to ensure that providers have every opportunity and incentive and drive value in the health care market. Pursuing alignment between TennCare and the larger healthcare market has been a part of TennCare's vision for its delivery system reform initiatives since the inception of the program.

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

[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).

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 July-September 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 (Jul-Sept 2019)	Cumulative Amount Paid to Date[5]
First-year payments	3[6]	$358,292	$180,250,303
Second-year payments	8	$68,000	$59,872,997
Third-year payments	11	$93,500	$37,537,685
Fourth-year payments	2	$17,000	$8,406,515
Fifth-year payments	3	$25,500	$5,377,671
Sixth-year payments	1	$8,500	$2,988,590

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

- Providing daily technical assistance to providers via email and telephone calls;
- Working with TennCare's attestation software vendor to enable submission of 2019 attestations beginning on January 1, 2020;
- 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. As of the end of the July-September 2019 quarter, staff were preparing to advance this strategy by exhibiting at a series of events in October: the

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

[6] First-year payments are usually issued to providers newly enrolled in the EHR program, and enrollment of providers ended in April 2017. The providers to whom first-year payments were issued this quarter had enrolled prior to April 2017 but had submitted attestations requiring corrections. The providers made these corrections in 2019, and their first-year payments were issued during the July-September 2019 quarter.

Tennessee Medical Association Symposiums in Chattanooga, Knoxville, Lebanon, and Memphis, and the 70th Annual Scientific Assembly of the Tennessee Academy of Family Physicians in Gatlinburg.

Pharmacy Benefits Manager Readiness Activities. In January 2019, TennCare announced that OptumRx, Inc. had been selected through a competitive procurement process to replace Magellan Medicaid Administration as TennCare's Pharmacy Benefits Manager (PBM). Although OptumRx 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, loading it with all information (enrollee data, edits specific to TennCare's outpatient formulary, clinical/quantity requirements, etc.) necessary for adjudication of claims, and performing user acceptance testing of the system;
- Creating a call center and website to assist patients and providers;
- Helping TennCare negotiate and collect supplemental rebates from pharmaceutical manufacturers; and
- Finalizing member and provider communications.

During the July-September 2019 quarter, preparations focused on completing the construction of the claims processing system, training staff on its use, and ensuring that it complies with all requirements established by TennCare. Testing confirmed that the system is able to accept daily TennCare eligibility files and updates, and that deployment of communication strategies for both providers and members has begun. In addition, PBM communication channels (such as dedicated member and provider phone and fax lines) and existing prior authorization approvals are being transferred to OptumRx to ensure that a proper standard of care is maintained during this period of transition. A number of challenges—such as the difficulties involved with transferring provider services and member advocacy communication lines—have been anticipated and addressed with rigorous processes that have been monitored closely in real time.

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 was heard by the U.S. District Court for the Middle District of Tennessee, concerned longstanding limitations placed by TennCare—and approved by CMS—on private duty nursing services for individuals aged 21 and older. The purpose of the limitations 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 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.

In February 2019, the Plaintiff was granted a stay of proceedings in order to attempt to transition to institutional care. On August 22, 2019, Mr. Shackelford filed a motion to voluntarily dismiss his case, and the Court granted the dismissal on August 28, 2019, thus ending this litigation.

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

Supplemental Hospital Payments for the Quarter

Hospital Name	County	First Quarter Payments – FY 2020
Methodist Medical Center of Oak Ridge	Anderson County	$100,919
Ridgeview Psychiatric Hospital and Center	Anderson County	$161,503
Tennova Healthcare – Shelbyville	Bedford County	$30,026
Blount Memorial Hospital	Blount County	$134,881
Tennova Healthcare – Cleveland	Bradley County	$124,487
Jellico Community Hospital	Campbell County	$103,274
Tennova Healthcare – LaFollette Medical Center	Campbell County	$62,845
Saint Thomas Stones River Hospital	Cannon County	$24,129
Sycamore Shoals Hospital	Carter County	$81,365
Claiborne Medical Center	Claiborne County	$24,519
Tennova Healthcare – Newport Medical Center	Cocke County	$67,074
Tennova Healthcare – Harton	Coffee County	$65,280
Unity Medical Center	Coffee County	$46,607
TriStar Skyline Medical Center	Davidson County	$397,701
Nashville General Hospital	Davidson County	$427,043
Saint Thomas Midtown Hospital	Davidson County	$233,090
TriStar Centennial Medical Center	Davidson County	$572,453
TriStar Southern Hills Medical Center	Davidson County	$153,580
TriStar Summit Medical Center	Davidson County	$162,509
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	$185,760
West Tennessee Healthcare Dyersburg Hospital	Dyer County	$157,709

Hospital Name	County	First Quarter Payments – FY 2020
Jamestown Regional Medical Center	Fentress County	$17,990
Southern Tennessee Regional Health System – Winchester	Franklin County	$60,325
Milan General Hospital	Gibson County	$21,195
Southern Tennessee Regional Health System – Pulaski	Giles County	$40,319
Laughlin Memorial Hospital	Greene County	$67,810
Morristown – Hamblen Healthcare System	Hamblen County	$115,838
Erlanger Medical Center	Hamilton County	$2,526,125
Parkridge Medical Center	Hamilton County	$1,205,930
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	$84,679
Tennova Healthcare – Jefferson Memorial Hospital	Jefferson County	$26,103
Parkwest Medical Center	Knox County	$344,435
Tennova Healthcare – North Knoxville Medical Center	Knox County	$105,637
East Tennessee Children's Hospital	Knox County	$2,379,697
Fort Sanders Regional Medical Center	Knox County	$221,187
University of Tennessee Medical Center	Knox County	$1,813,413
Southern Tennessee Regional Health System – Lawrenceburg	Lawrence County	$34,947
Lincoln Medical Center	Lincoln County	$169,663
Jackson – Madison County General Hospital	Madison County	$556,747
Pathways of Tennessee	Madison County	$140,754
Maury Regional Hospital	Maury County	$208,143
Starr Regional Medical Center – Athens	McMinn County	$60,027
Sweetwater Hospital Association	Monroe County	$134,567
Tennova Healthcare – Clarksville	Montgomery County	$121,612
Baptist Memorial Hospital – Union City	Obion County	$65,405
Livingston Regional Hospital	Overton County	$33,470
Cookeville Regional Medical Center	Putnam County	$129,041
Ten Broeck Tennessee	Putnam County	$50,476
Roane Medical Center	Roane County	$46,903
NorthCrest Medical Center	Robertson County	$85,916
Saint Thomas Rutherford Hospital	Rutherford County	$239,011
TriStar StoneCrest Medical Center	Rutherford County	$143,476
TrustPoint Hospital	Rutherford County	$41,267
LeConte Medical Center	Sevier County	$130,833
Baptist Memorial Restorative Care Hospital	Shelby County	$1,280

Hospital Name	County	First Quarter Payments – FY 2020
Baptist Memorial Hospital – Memphis	Shelby County	$612,921
Methodist University Hospital	Shelby County	$1,079,627
Crestwyn Behavioral Health	Shelby County	$20,549
Delta Medical Center	Shelby County	$254,676
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	$3,046,832
Regional One Health Extended Care Hospital	Shelby County	$103
Saint Francis Hospital	Shelby County	$278,239
Saint Jude Children's Research Hospital	Shelby County	$744,083
Bristol Regional Medical Center	Sullivan County	$117,065
HealthSouth Rehabilitation Hospital – Kingsport	Sullivan County	$985
Holston Valley Medical Center	Sullivan County	$217,669
Indian Path Community Hospital	Sullivan County	$102,080
TriStar Hendersonville Medical Center	Sumner County	$136,255
Sumner Regional Medical Center	Sumner County	$114,474
Baptist Memorial Hospital – Tipton	Tipton County	$81,376
Saint Thomas River Park Hospital	Warren County	$42,098
Johnson City Medical Center	Washington County	$1,606,271
Franklin Woods Community Hospital	Washington County	$76,767
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	$46,698
HealthSouth Rehabilitation Hospital – Franklin	Williamson County	$5
Rolling Hills Hospital	Williamson County	$1,718
Williamson Medical Center	Williamson County	$38,911
Tennova Healthcare – Lebanon	Wilson County	$292,574
TOTAL		**$31,625,000**

Number of Recipients on TennCare and Costs to the State

During the month of September 2019, there were 1,410,919 Medicaid eligibles and 20,055 Demonstration eligibles enrolled in TennCare, for a total of 1,430,974 persons.

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

Spending Category	First Quarter FY 2020*
MCO services**	$1,699,723,900
Dental services	$37,414,100
Pharmacy services	$261,753,400
Medicare "clawback"***	$37,170,700

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

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

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

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

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

Entity	Standard	Authority
MCOs (services other than CHOICES and ECF CHOICES)	90% of clean claims for payment for services delivered to TennCare enrollees are processed and, if appropriate, paid within 30 calendar days of the receipt of such claims. 99.5% of all provider claims are processed, and, if appropriate, paid within 60 calendar days of receipt.	TennCare contract and in accordance with T.C.A. § 56-32-126(b)
MCOs (CHOICES and ECF CHOICES services)	90% of clean electronically submitted Nursing Facility and applicable Home and Community Based Services claims[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 July-September 2019 quarter, the MCOs submitted their NAIC Second Quarter 2019 Financial Statements. As of June 30, 2019, TennCare MCOs reported net worth as indicated in the table below.[9]

MCO	Net Worth Requirement	Reported Net Worth	Excess/ (Deficiency)
Amerigroup Tennessee	$32,303,660	$176,483,930	$144,180,270

[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)
UnitedHealthcare Plan of the River Valley (UnitedHealthcare Community Plan)	$98,223,126	$449,022,171	$350,799,045
Volunteer State Health Plan (BlueCare & TennCare Select)	$53,841,080	$406,642,855	$352,801,775

During the July-September 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 June 30, 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 first quarter of Fiscal Year 2020 furnished for this report by the OIG are as follows:

Fraud and Abuse Allegations	First Quarter FY 2020
Fraud Allegations	724
Abuse Allegations*	706
Arrest/Conviction/Judicial Diversion Totals	**First Quarter FY 2020**
Arrests	15
Convictions	11
Judicial Diversions	4

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

Criminal Court Fines and Costs Imposed	First Quarter FY 2020
Court Costs & Taxes	$2,909
Fines	$1,400
Drug Funds/Forfeitures	$80
Criminal Restitution Ordered	$298,793
Criminal Restitution Received[10]	$13,778
Civil Restitution/Civil Court Judgments	**First Quarter FY 2020**
Civil Restitution Ordered[11]	$0
Civil Restitution Received[12]	$4,213

Recommendations for Review	First Quarter FY 2020
Recommended TennCare Terminations[13]	73
Potential Savings[14]	$296,447

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	$5,314,604
Restitution to TennCare MCOs	$90,768
Restitution to Law Enforcement	$18,996
Food Stamps	$81,337
Fines	$1,374,706
Court Costs	$381,310
Drug Funds	$477,865944
Civil Restitution	$3,098,281

[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 $4,060.92).