TennCare Quarterly Report

July – September 2020

Submitted to the Members of the General Assembly

Status of TennCare Reforms and Improvements

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 1.4 million individuals, the Division of TennCare has developed a multilayered response to the COVID-19 emergency. Working in tandem with partners and stakeholders at the federal and state levels, TennCare designed and deployed a strategy consisting of such elements as—

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

- 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.

Amendments to the TennCare Demonstration. Five proposed amendments to the TennCare Demonstration were in various stages of development during the July-September 2020 quarter.

Demonstration Amendment 35: Substance Use Disorder Services. In May 2018, TennCare submitted Demonstration Amendment 35 to CMS. Amendment 35 would modify the TennCare benefits package to cover residential substance use disorder (SUD) treatment services in facilities with more than 16 beds. The federal government classifies such facilities as "institutions for mental diseases" (IMDs), and federal law prohibits the expenditure of federal Medicaid dollars for services delivered to adults in these facilities. Historically, TennCare's managed care organizations (MCOs) were permitted to cover residential treatment services in IMDs, if the MCO determined that such care was medically appropriate and cost-effective as compared to other treatment options. However, CMS recently issued regulations restricting the ability of MCOs to pay for services in these facilities. Specifically, the new federal regulation limits this option to treatment stays of no more than 15 days per calendar month.[1] TennCare is seeking authority with Amendment 35 to allow enrollees to receive short-term services in IMDs beyond the 15-day limit in federal regulation, up to 30 days per admission.

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

Demonstration Amendment 36: Providers of Family Planning Services. Amendment 36 was submitted to CMS in August 2018. Amendment 36 grew out of Tennessee's 2018 legislative session and, in particular, Public Chapter No. 682, which established that it is the policy of the state of Tennessee to favor childbirth and family planning services that do not include elective abortions within the continuum of care or services, and to avoid the direct or indirect use of state funds to promote or support elective abortions.

Amendment 36 requests authority for TennCare to establish state-specific criteria for providers of family planning services, and to exclude any providers that do not meet these criteria from participation in the

[1] See 42 CFR § 438.6(e).

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 2020 quarter, CMS's review of Amendment 36 was ongoing.

Demonstration Amendment 38: Community Engagement. TennCare submitted Amendment 38 to CMS on December 28, 2018. Demonstration Amendment 38 implements a state law (Public Chapter No. 869) enacted by the Tennessee General Assembly in 2018. This law directed TennCare to seek federal authorization to establish reasonable work and community engagement requirements for non-pregnant, non-elderly, non-disabled adults enrolled in the TennCare program who do not have dependent children under the age of six. The legislation also required TennCare to seek approval from the U.S. Department of Health and Human Services (HHS) to use funds from the state's Temporary Assistance for Needy Families (TANF) program to support implementation of the community engagement program.

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

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

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

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

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

As of the end of the July-September 2020 quarter, TennCare was working with CMS to secure final approval of Amendment 40.

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

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

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

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

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.

Final results were recently released for the program's 2019 performance period. Providers and hospitals continued to improve cost-efficiency while maintaining or improving quality across the majority of episodes. The 2019 results show that costs were $45.2 million less than expected across 45 episodes. Furthermore, of a total of 61 quality metrics tied to gain-sharing, improvements were seen in 15 metrics, with 32 metrics remaining the same and 14 metrics showing negative movement, as defined by at least one percentage point or one point change.

Across the state, gain-sharing payments to providers who met quality metrics and efficiency standards totaled $1.9 million. Because of the COVID-19 emergency, all risk-sharing payments have been waived for the 2019 performance period.

During the July-September 2020 quarter, the episodes program also released a memo outlining changes that would take effect in the 2021 performance period (beginning on January 1, 2021). Using feedback offered by stakeholders over the past year (especially at the Episodes of Care Annual Feedback Session held in May 2020), TennCare is in the process of making 13 changes to episode design. Beginning in January 2021, there are five episode types that will shift to informational-only reporting. The episode types in question are—

- Coronary Artery Bypass Graft;
- Femur/Pelvic Fracture;
- Human Immunodeficiency Virus Infection;
- Non-acute Percutaneous Coronary Intervention; and
- Valve Repair and Replacement.

Although there will be no financial accountability for performance within these episode types, providers will continue to receive quarterly reports on cost and quality. Other notable changes to the program include updating the perinatal and hysterectomy episodes' quality metrics and updating the method of identifying Federally Qualified Health Centers and Rural Health Centers from an episode-level exclusion to a quarterback-level exclusion.

Incentives for Providers to Use Electronic Health Records. The Electronic Health Records (EHR) Incentive Program is a partnership between federal and state governments that grew out of the Health Information Technology for Economic and Clinical Health (HITECH) Act of 2009. The purpose of the program is to provide financial incentives to Medicaid providers[2] to replace outdated, often paper-based approaches to medical record-keeping with Certified Electronic Health Record Technology (as defined by CMS) that meets rigorous criteria and that can improve health care delivery and quality. The federal government provides 100 percent of the funding for the incentive payments and 90 percent of the funding for administrative costs. Tennessee's EHR program[3] has issued payments for six years to eligible professionals and for three years to eligible hospitals.

EHR payments made by TennCare during the July-September 2020 quarter as compared with payments made throughout the life of the program appear in the table below:

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

[3] In April 2018, CMS announced that its EHR programs would be renamed "Promoting Interoperability (PI) Programs." While Tennessee's EHR initiative falls within the scope of CMS's PI Programs, TennCare continues to refer to its initiative as "EHR Incentive Program" for purposes of clarity and consistency in communications with providers.

Payment Type	Number of Providers Paid During the Quarter	Quarterly Amount Paid (Jul-Sept 2020)	Cumulative Amount Paid to Date[4]
First-year payments	0	$0	$180,176,644
Second-year payments	0	$0	$59,964,655
Third-year payments	0	$0	$37,940,019
Fourth-year payments	0	$0	$8,956,182
Fifth-year payments	0	$0	$6,077,505
Sixth-year payments	1	$8,500	$3,682,748

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

- Processing all remaining corrections to providers' attestations for Program Year 2019;
- Working with the programming contractor to update TennCare's proprietary attestation software for Program Year 2020;
- Increasing 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
- 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 the 2020 program year is to encourage provider participants who remain eligible to continue attesting and complete the program.

***EMCF v. TennCare* Lawsuit.** In September 2018, Emergency Medical Care Facilities, P.C., filed a complaint for declaratory judgment and injunctive relief against TennCare in Davidson County Chancery Court. The suit relates to a $50 cap imposed by TennCare on payment for emergency room physician services determined to be non-emergent. EMCF alleges that TennCare implemented this cap through its contractual relationship with its MCOs and not through the rulemaking process. The parties filed cross-motions for summary judgment, and, on September 1, 2020, the Chancellor granted summary judgment to EMCF on their claim that the $50 cap was void. EMCF then voluntarily dismissed their remaining claims pertaining to the determination of payment for the services in question. TennCare filed a timely appeal of the Chancery Court's ruling on September 29, 2020.

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

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

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 2021 are shown in the table below.

Supplemental Hospital Payments for the Quarter

Hospital Name	County	First Quarter Payments – FY 2021
Methodist Medical Center of Oak Ridge	Anderson County	$740,495
Ridgeview Psychiatric Hospital and Center	Anderson County	$523,142
Tennova Healthcare – Shelbyville	Bedford County	$43,754
Camden General Hospital	Benton County	$194,950
Erlanger Bledsoe Hospital	Bledsoe County	$171,559
Blount Memorial Hospital	Blount County	$474,870
Tennova Healthcare – Cleveland	Bradley County	$270,847
Jellico Community Hospital	Campbell County	$330,946
Tennova Healthcare – LaFollette Medical Center	Campbell County	$140,740
Saint Thomas Stones River Hospital	Cannon County	$63,959
Baptist Memorial Hospital – Carroll County	Carroll County	$130,222
Sycamore Shoals Hospital	Carter County	$196,309
TriStar Ashland City Medical Center	Cheatham County	$213,923
Claiborne Medical Center	Claiborne County	$92,524
Tennova Healthcare – Newport Medical Center	Cocke County	$201,345
Tennova Healthcare – Harton	Coffee County	$157,845
Unity Medical Center	Coffee County	$98,509
Cumberland Medical Center	Cumberland County	$123,001
Ascension Saint Thomas Hospital	Davidson County	$790,525
TriStar Skyline Medical Center	Davidson County	$2,029,225
Nashville General Hospital	Davidson County	$862,042
Ascension Saint Thomas Hospital Midtown	Davidson County	$1,594,341
Select Specialty Hospital – Nashville	Davidson County	$1,907
TriStar Centennial Medical Center	Davidson County	$3,108,517
TriStar Southern Hills Medical Center	Davidson County	$925,784
TriStar Summit Medical Center	Davidson County	$1,144,303
Vanderbilt Stallworth Rehabilitation Hospital	Davidson County	$2,651
Vanderbilt University Medical Center	Davidson County	$11,982,484
Decatur County General Hospital	Decatur County	$17,220
Saint Thomas DeKalb Hospital	DeKalb County	$85,478
TriStar Horizon Medical Center	Dickson County	$1,059,903
West Tennessee Healthcare Dyersburg Hospital	Dyer County	$300,300
Southern Tennessee Regional Health System – Winchester	Franklin County	$251,694
Milan General Hospital	Gibson County	$33,870
Southern Tennessee Regional Health System – Pulaski	Giles County	$166,542

Hospital Name	County	First Quarter Payments – FY 2021
Greeneville Community Hospital	Greene County	$411,771
Morristown – Hamblen Healthcare System	Hamblen County	$654,613
CHI Memorial Hospital – Chattanooga	Hamilton County	$765,360
Erlanger Health System	Hamilton County	$6,711,486
Parkridge Medical Center	Hamilton County	$4,259,905
Encompass Health Rehabilitation Hospital of Chattanooga	Hamilton County	$1,521
Siskin Hospital for Physical Rehabilitation	Hamilton County	$15,425
Hancock County Hospital	Hancock County	$37,619
Bolivar General Hospital	Hardeman County	$259,696
Hardin Medical Center	Hardin County	$262,017
Hawkins County Memorial Hospital	Hawkins County	$90,598
Henderson County Community Hospital	Henderson County	$50,843
Henry County Medical Center	Henry County	$391,107
Saint Thomas Hickman Hospital	Hickman County	$115,230
Houston County Community Hospital	Houston County	$136,419
Three Rivers Hospital	Humphreys County	$53,586
Tennova Healthcare – Jefferson Memorial Hospital	Jefferson County	$73,648
Johnson County Community Hospital	Johnson County	$46,435
Parkwest Medical Center	Knox County	$1,332,223
Tennova Healthcare – North Knoxville Medical Center	Knox County	$280,856
East Tennessee Children's Hospital	Knox County	$2,936,349
Fort Sanders Regional Medical Center	Knox County	$1,547,824
University of Tennessee Medical Center	Knox County	$4,978,608
Lauderdale Community Hospital	Lauderdale County	$275,111
Southern Tennessee Regional Health System – Lawrenceburg	Lawrence County	$192,859
Lincoln Medical Center	Lincoln County	$702,176
Fort Loudoun Medical Center	Loudon County	$101,876
Macon Community Hospital	Macon County	$219,062
Jackson – Madison County General Hospital	Madison County	$2,636,615
Pathways of Tennessee	Madison County	$411,237
Marshall Medical Center	Marshall County	$445,947
Maury Regional Medical Center	Maury County	$826,829
Unity Psychiatric Care – Columbia	Maury County	$650
Starr Regional Medical Center – Athens	McMinn County	$172,719
Sweetwater Hospital Association	Monroe County	$386,961
Tennova Healthcare – Clarksville	Montgomery County	$215,917
Unity Psychiatric Care – Clarksville	Montgomery County	$449
Baptist Memorial Hospital – Union City	Obion County	$394,283
Livingston Regional Hospital	Overton County	$99,009
Perry Community Hospital	Perry County	$13,312

Hospital Name	County	First Quarter Payments – FY 2021
Cookeville Regional Medical Center	Putnam County	$678,325
Ten Broeck Tennessee	Putnam County	$88,409
Rhea Medical Center	Rhea County	$611,761
Roane Medical Center	Roane County	$231,667
NorthCrest Medical Center	Robertson County	$318,141
Saint Thomas Rutherford Hospital	Rutherford County	$1,680,601
TriStar StoneCrest Medical Center	Rutherford County	$865,784
TrustPoint Hospital	Rutherford County	$54,237
Big South Fork Medical Center	Scott County	$22,988
LeConte Medical Center	Sevier County	$898,592
Baptist Memorial Restorative Care Hospital	Shelby County	$35,403
Baptist Memorial Hospital – Memphis	Shelby County	$2,668,050
Methodist University Hospital	Shelby County	$5,544,471
Crestwyn Behavioral Health	Shelby County	$136,527
Delta Medical Center	Shelby County	$728,373
Encompass Health Rehabilitation Hospital of North Memphis	Shelby County	$520
Encompass Health Rehabilitation Hospital of Memphis	Shelby County	$6,247
Le Bonheur Children's Hospital	Shelby County	$6,238,813
Regional One Health	Shelby County	$5,467,722
Regional One Health Extended Care Hospital	Shelby County	$252
Saint Francis Hospital	Shelby County	$749,564
Saint Francis Hospital – Bartlett	Shelby County	$201,093
Saint Jude Children's Research Hospital	Shelby County	$1,129,733
Select Specialty Hospital – Memphis	Shelby County	$5,861
Unity Psychiatric Care – Memphis	Shelby County	$200
Riverview Regional Medical Center	Smith County	$302,910
Bristol Regional Medical Center	Sullivan County	$923,645
Creekside Behavioral Health	Sullivan County	$11,033
Encompass Health Rehabilitation Hospital of Kingsport	Sullivan County	$6,570
Holston Valley Medical Center	Sullivan County	$1,329,228
Indian Path Community Hospital	Sullivan County	$379,547
Select Specialty Hospital – Tri-Cities	Sullivan County	$48
TriStar Hendersonville Medical Center	Sumner County	$805,160
Sumner Regional Medical Center	Sumner County	$372,655
Baptist Memorial Hospital – Tipton	Tipton County	$474,771
Trousdale Medical Center	Trousdale County	$110,003
Unicoi County Hospital	Unicoi County	$42,195
Saint Thomas River Park Hospital	Warren County	$256,398
Johnson City Medical Center	Washington County	$3,789,727
Franklin Woods Community Hospital	Washington County	$296,468

Hospital Name	County	First Quarter Payments – FY 2021
Quillen Rehabilitation Hospital	Washington County	$3,108
Wayne Medical Center	Wayne County	$37,768
Unity Psychiatric Care – Martin	Weakley County	$302
West Tennessee Healthcare Rehabilitation Hospital Cane Creek	Weakley County	$207
West Tennessee Healthcare Volunteer Hospital	Weakley County	$76,094
Saint Thomas Highlands Hospital	White County	$15,067
Encompass Health Rehabilitation Hospital of Franklin	Williamson County	$50
Williamson Medical Center	Williamson County	$128,228
Vanderbilt Wilson County Hospital	Wilson County	$399,910
TOTAL		**$99,158,303**

Number of Recipients on TennCare and Costs to the State

During the month of September 2020, there were 1,473,026 Medicaid eligibles and 20,502 Demonstration eligibles enrolled in TennCare, for a total of 1,493,528 persons.

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

Spending Category	First Quarter FY 2021*
MCO services**	$2,383,687,000
Dental services	$32,314,700
Pharmacy services	$281,426,800
Medicare "clawback"***	$34,423,000

**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[5] are processed and paid within 14 calendar days of receipt. 99.5% of clean electronically submitted Nursing Facility and applicable Home and Community Based Services claims[6] are processed and paid within 21 calendar days of receipt.	TennCare contract

[5] Excludes Personal Emergency Response Systems (PERS), assistive technology, minor home modifications, and pest control claims. Claims for delivery of these services are handled like general MCO claims.

[6] Ibid.

Entity	Standard	Authority
Dental Benefits Manager (DBM)	90% of clean claims for payment for services delivered to TennCare enrollees are processed, and, if appropriate, paid within 30 calendar days of the receipt of such claims. 99.5% of all provider claims are processed, and, if appropriate, paid within 60 calendar days of receipt.	TennCare contract and in accordance with T.C.A. § 56-32-126(b)
Pharmacy Benefits Manager (PBM)	100% of all clean claims submitted by pharmacy providers are paid within 15 calendar days of receipt.	TennCare contract

The MCOs, the DBM, and the PBM are required to submit monthly claims data files of all TennCare claims processed to the Tennessee Department of Commerce and Insurance (TDCI) for verification of statutory and contractual prompt pay compliance. The plans are required to separate their claims data by claims processor (e.g., MCO, vision benefits manager, etc.). Furthermore, the MCOs are required to identify separately non-emergency transportation (NEMT) claims in the data files. Finally, the MCOs are required to submit separate claims data files representing a subset of electronically submitted Nursing Facility and applicable Home and Community Based Services claims for CHOICES and ECF CHOICES enrollees. TDCI then performs an analysis and reports the results of the prompt pay analyses by NEMT and CHOICES and ECF CHOICES claim types, by claims processor, and by total claims processed for the month.

If an MCO does not comply with the prompt pay requirements based on the total claims processed in a month, TDCI has the statutory authority to levy an administrative penalty of $10,000 for each month of non-compliance after the first instance of non-compliance was reported to the plan. The Division of TennCare may also assess liquidated damages pursuant to the terms of the TennCare Contract. If the DBM and PBM do not meet their contractual prompt pay requirements, only TennCare may assess applicable liquidated damages against these entities.

Net worth and company action level requirements. According to Tennessee's "Health Maintenance Organization Act of 1986" statute (T.C.A. § 56-32-101 *et seq.*), the minimum net worth requirement for each TennCare MCO is calculated based on premium revenue reported on the National Association of Insurance Commissioners (NAIC) Annual Financial Statement for the most recent calendar year, as well as any TennCare payments made to the MCO that are not reported as premium revenue.

During the July-September 2020 quarter, the MCOs submitted their NAIC Second Quarter 2020 Financial Statements. As of June 30, 2020, TennCare MCOs reported net worth as indicated in the table below.[7]

MCO	Net Worth Requirement	Reported Net Worth	Excess/ (Deficiency)
Amerigroup Tennessee	$33,562,799	$265,691,719	$232,128,920

[7] The "Net Worth Requirement" and "Reported Net Worth" figures in the table are based on the MCOs' company-wide operations, not merely their TennCare operations.

MCO	Net Worth Requirement	Reported Net Worth	Excess/ (Deficiency)
UnitedHealthcare Plan of the River Valley (UnitedHealthcare Community Plan)	$77,500,193	$652,877,948	$575,377,755
Volunteer State Health Plan (BlueCare & TennCare Select)	$56,256,150	$536,908,904	$480,652,754

During the July-September 2020 quarter, the MCOs were also required to comply with Tennessee's "Risk-Based Capital for Health Organizations" statute (T.C.A. § 56-46-201 *et seq.*). Risk-based capital (RBC) involves a method of calculating the minimum amount of capital necessary for a health entity to support its overall business operations depending on its size and risk profile. A health entity with a higher amount of risk is required to hold a higher amount of capital. The RBC statute gives TDCI the authority and mandate to use preventive and corrective measures that vary depending on the amount of capital deficiency indicated by the RBC calculations. A "Company Action Level" deficiency (defined at T.C.A. § 56-46-203(a)) would require the submission of a plan to correct the entity's capital deficiency.

All TennCare MCOs met their minimum net worth requirements and Company Action Level requirements as of June 30, 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 first quarter of Fiscal Year 2021 furnished for this report by the OIG are as follows:

Fraud and Abuse Allegations	First Quarter FY 2021
Fraud Allegations	947
Abuse Allegations*	63
Arrest/Conviction/Judicial Diversion Totals	**First Quarter FY 2021**
Arrests	23
Convictions	3
Judicial Diversions	2

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

Criminal Court Fines and Costs Imposed	First Quarter FY 2021
Court Costs & Taxes	$1,084
Fines	$3,000
Drug Funds/Forfeitures	$3,000
Criminal Restitution Ordered	$120,908
Criminal Restitution Received[8]	$25,695
Civil Restitution/Civil Court Judgments	**First Quarter FY 2021**
Civil Restitution Ordered[9]	$0
Civil Restitution Received[10]	$2,215

Recommendations for Review	First Quarter FY 2021
Recommended TennCare Terminations[11]	63
Potential Savings[12]	$255,929

Program Totals

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

Type of Court-Ordered Payment	Grand Total for Period of 2004-2020
Restitution to Division of TennCare	$5,523,511
Restitution to TennCare MCOs	$90,768
Restitution to Law Enforcement	$19,356
Food Stamps	$81,337
Fines	$1,378,206
Court Costs	$386,644
Drug Funds	$481,444
Civil Restitution	$3,129,725

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

[9] This total reflects dollars identified for recoupment by the OIG in such non-criminal contexts as civil cases, administrative hearings, and voluntary reimbursements to TennCare.

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

[11] Recommendations that enrollees' TennCare coverage should be terminated are sent to the Division of TennCare for review and determination of appropriate action. These recommendations are based on information received and reviewed by the OIG. TennCare determines whether these referrals meet the criteria for termination. Reviews of these recommendations must factor in some limitations, such as the inability to disenroll individuals in certain federally protected categories.

[12] Potential savings are determined by multiplying the number of enrollees whose coverage would be terminated, assuming all of the State's criteria for termination are met, by the average annual cost per enrollee for MCO, pharmacy, and dental services (currently estimated by TennCare to be $4,062.36).