TennCare Quarterly Report

October – December 2019

Submitted to the Members of the General Assembly

Status of TennCare Reforms and Improvements

Grant to Address Maternal Opioid Misuse. On December 19, 2019, the Centers for Medicare and Medicaid Services (CMS) announced that Tennessee is one of 10 states selected to receive a Maternal Opioid Misuse (MOM) Model grant. The purpose of the grant is to assist states in combating the nation's opioid crisis and address fragmentation in the care of pregnant and postpartum Medicaid beneficiaries with opioid use disorder (OUD).

TennCare will partner with Vanderbilt University Medical Center in 26 rural and urban counties to improve outcomes for women with OUD and their infants. Efforts will focus on the period of time beginning in pregnancy and extending to one year postpartum. The coordination of clinical care and the integration of other services critical for health, well-being, and recovery can improve the quality of care and reduce costs for mothers and infants impacted by opioid use.

Elements of the initiative pursued by TennCare and Vanderbilt will include—

- Engaging women with OUD in treatment before and after pregnancy;
- Maximizing periods of maternal abstinence from illicit substances using evidence-based therapies;
- Optimizing the number of days an infant is with their biological mother by reducing infant hospital stays (birth, readmission, emergency department visits); and
- Ensuring connection to early intervention services for infants.

The grant amount is approximately $5.3 million for a five-year performance period beginning in January 2020. Additional information about the MOM Model is available at https://innovation.cms.gov/initiatives/maternal-opioid-misuse-model/.

Success of TennCare's Delivery System Reform Initiatives Recognized. In November 2019, Tennessee was one of two states recognized by the National Association of Medicaid Directors (NAMD) with the Association's "Spotlight on Innovation" award. NAMD gave Tennessee its Spotlight Award in recognition

of TennCare's national leadership in the area of healthcare delivery system transformation. The award specifically acknowledged TennCare's ongoing efforts to promote value-based payment strategies in the domains of primary care, acute care, and long-term care.

Amendments to the TennCare Demonstration. Six proposed amendments to the TennCare Demonstration were in various stages of development during the October-December 2019 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 October-December 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.

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 October-December 2019 quarter, CMS's review of Amendment 36 was ongoing.

[1] See 42 CFR § 438.6(e).

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 October-December 2019 quarter, discussions between TennCare and CMS on Amendment 38 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.

CMS held a federal public comment period on Amendment 40 from October 2 through November 1, 2019, and negotiations between TennCare and CMS commenced in December 2019. As of the end of the quarter, CMS's review of Amendment 40 was ongoing.

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

matching funds for these GME expenditures, thereby maximizing the resources available to invest in this priority.

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

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

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

TennCare submitted Amendment 41 to CMS on October 24, 2019. The federal public comment period on the amendment followed shortly thereafter, running from October 31 through November 30, 2019. As of the end of the October-December 2019 quarter, CMS's review of Amendment 41 was ongoing.

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

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

Amendment 42 does not rely on reductions to eligibility or benefits in order to achieve savings under the block grant. Instead, it would leverage opportunities to deliver healthcare to TennCare members more

effectively and would permit TennCare to implement new reform strategies that would yield benefits for both the State and the federal government.

TennCare submitted Amendment 42 to CMS on November 20, 2019. The federal comment period on TennCare's proposal lasted from November 27 through December 27, 2019, and yielded more than 6,000 items of public input. CMS's review of Amendment 42 was ongoing as of the end of the October-December 2019 quarter.

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.).

On October 1, 2019, BCBER published a summary of the results of the most recent survey titled "The Impact of TennCare: A Survey of Recipients, 2019". Although the findings of a single survey must be viewed in context of long-term trends, several results from the 2019 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 marked the eleventh straight year in which survey respondents had reported satisfaction levels exceeding ninety percent.
- The uninsured rate in Tennessee increased slightly. The percentage of respondents classifying themselves or their children as uninsured rose from 6.7 percent in 2018 to 6.9 percent in 2019. In longer-term trends, however, the 2019 uninsured rate was relatively low (the fifth lowest level in the last 15 years).
- TennCare families sought care from physicians more frequently than the Tennessee population as a whole. Thirty-three percent of heads of households with TennCare reported seeing a doctor weekly or monthly, and twenty percent reported doing so for their children. By contrast, only fifteen percent of all heads of households reported seeing a doctor weekly or monthly, and only eleven percent reported doing so for their children.

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/tncare19.pdf.

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 October 2019, TennCare released a series of analytics reports showing success in its delivery system transformation efforts. These reports provide the most complete picture to date of how the State's innovative programs are resulting not only in improved care for TennCare members, but also in significant savings for Tennessee taxpayers. The three programs addressed by the reports are Tennessee Health Link, Patient-Centered Medical Homes, and episodes of care.

The episodes of care report demonstrated that providers made a variety of changes that resulted in improved quality of care. Examples of these changes include—

- **Perinatal episode:** Prenatal group B streptococcus screening rates increased from 88 percent in 2014 to 95 percent in 2018;
- **Asthma acute exacerbation episode:** Acute exacerbations of asthma treated in the inpatient setting declined from six percent in 2014 to three percent in 2018; and
- **Oppositional defiant disorder (ODD) episode:** The percentage of children with non-comorbid ODD who received inappropriate medications fell from 23 percent in 2015 to 4 percent in 2018.

Additional information on all three reports is available on the TennCare website at https://www.tn.gov/tenncare/health-care-innovation.html.

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 October-December 2019 quarter as compared with payments made throughout the life of the program appear in the table below. It should be noted that

[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.

very few payments were issued during the final quarter of the calendar year because all but one of the payments for which providers qualified were able to be completed by September 30, 2019.

Payment Type	Number of Providers Paid During the Quarter	Quarterly Amount Paid (Oct-Dec 2019)	Cumulative Amount Paid to Date[4]
First-year payments	N/A	N/A	$180,186,290
Second-year payments	0	$0	$59,834,589
Third-year payments	0	$0	$37,537,685
Fourth-year payments	0	$0	$8,406,515
Fifth-year payments	0	$0	$5,377,671
Sixth-year payments	1	$8,500	$2,997,090

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 in January 2020;
- Participation in CMS-led calls regarding the EHR Incentive Program;
- Exhibiting at the October 2019 Tennessee Medical Association Symposiums in Knoxville, Memphis, and Nashville; 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. TennCare's next major action in support of this strategy will be a mailing to providers who previously received five EHR incentive payments. The mailing will remind the providers of the period during which attestations for 2019 may be submitted, and will encourage them to attest this year for their sixth and final payment.

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). TennCare's contract with OptumRx required the company to begin processing pharmacy claims for TennCare on January 1, 2020, with readiness activities commencing several months earlier (in March 2019). Priorities during this period of transition include the following:

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

- Establishing and managing the 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 October-December 2019 quarter, preparations focused on testing the claims processing system, training staff on its use, and working to ensure that it complies with all requirements established by TennCare. The systems testing was initiated not only to validate readiness but also to verify that deployment of communication strategies for providers and members had been executed. Other arrangements made during the quarter included formal transfer of communication channels (such as dedicated member and provider phone and fax lines) and prior authorization cases. A number of challenges—such as the difficulties associated with data sharing, automation, and end user experience—have been aggressively tracked by TennCare and resolved promptly to minimize disruptions to members and providers.

Public Forum on the TennCare Demonstration. In compliance with the federal regulation at 42 CFR § 431.420(c) and the Special Terms and Conditions of the TennCare Demonstration, TennCare hosted a public forum in Nashville on December 17, 2019. The purpose of the forum was to provide members of the public an opportunity to comment on the progress of the TennCare Demonstration project, which has delivered Medicaid services to eligible Tennesseans under a managed care model since 1994.

The December 17 open meeting was not the only avenue through which feedback could be offered. Notice of the forum, which appeared on the TennCare website, included an email address and a physical address at which comments would be accepted. Although no comments were received through any of these outlets, additional opportunities to assess the TennCare Demonstration will be available, as the TennCare agency is required to convene a forum on this subject each year for the foreseeable future.

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

Supplemental Hospital Payments for the Quarter

Hospital Name	County	Second Quarter Payments – FY 2020
Methodist Medical Center of Oak Ridge	Anderson County	$107,457
Ridgeview Psychiatric Hospital and Center	Anderson County	$119,811
Tennova Healthcare – Shelbyville	Bedford County	$32,775
Blount Memorial Hospital	Blount County	$133,280
Tennova Healthcare – Cleveland	Bradley County	$107,641
Jellico Community Hospital	Campbell County	$80,973
Tennova Healthcare – LaFollette Medical Center	Campbell County	$55,132
Saint Thomas Stones River Hospital	Cannon County	$19,265
Baptist Memorial Hospital – Carroll County	Carroll County	$28,579
Sycamore Shoals Hospital	Carter County	$84,333
Claiborne Medical Center	Claiborne County	$30,272
Tennova Healthcare – Newport Medical Center	Cocke County	$78,873
Tennova Healthcare – Harton	Coffee County	$61,832
Unity Medical Center	Coffee County	$33,747
TriStar Skyline Medical Center	Davidson County	$373,310
Nashville General Hospital	Davidson County	$396,607
Saint Thomas Midtown Hospital	Davidson County	$234,767
TriStar Centennial Medical Center	Davidson County	$549,244
TriStar Southern Hills Medical Center	Davidson County	$139,438
TriStar Summit Medical Center	Davidson County	$145,020
Vanderbilt Stallworth Rehabilitation Hospital	Davidson County	$363
Vanderbilt University Medical Center	Davidson County	$4,165,489
Decatur County General Hospital	Decatur County	$77,963
Saint Thomas DeKalb Hospital	DeKalb County	$36,073
TriStar Horizon Medical Center	Dickson County	$222,408
West Tennessee Healthcare Dyersburg Hospital	Dyer County	$117,636
Southern Tennessee Regional Health System – Winchester	Franklin County	$69,732
Milan General Hospital	Gibson County	$13,560
Southern Tennessee Regional Health System – Pulaski	Giles County	$65,239
Greeneville Community Hospital	Greene County	$90,735
Morristown – Hamblen Healthcare System	Hamblen County	$152,586
Erlanger Health System	Hamilton County	$3,087,811
Parkridge Medical Center	Hamilton County	$1,188,410
Encompass Health Rehabilitation Hospital of Chattanooga	Hamilton County	$198
Siskin Hospital for Physical Rehabilitation	Hamilton County	$1,283
Hardin Medical Center	Hardin County	$75,741
Henderson County Community Hospital	Henderson County	$16,747
Henry County Medical Center	Henry County	$101,702
Tennova Healthcare – Jefferson Memorial Hospital	Jefferson County	$28,850

Hospital Name	County	Second Quarter Payments – FY 2020
Parkwest Medical Center	Knox County	$338,107
Tennova Healthcare – North Knoxville Medical Center	Knox County	$111,619
East Tennessee Children's Hospital	Knox County	$2,138,762
Fort Sanders Regional Medical Center	Knox County	$262,329
University of Tennessee Medical Center	Knox County	$1,953,135
Southern Tennessee Regional Health System – Lawrenceburg	Lawrence County	$41,536
Lincoln Medical Center	Lincoln County	$173,251
Jackson – Madison County General Hospital	Madison County	$546,104
Pathways of Tennessee	Madison County	$101,373
Starr Regional Medical Center – Athens	McMinn County	$67,659
Sweetwater Hospital Association	Monroe County	$120,990
Tennova Healthcare – Clarksville	Montgomery County	$85,811
Baptist Memorial Hospital – Union City	Obion County	$82,962
Livingston Regional Hospital	Overton County	$26,126
Cookeville Regional Medical Center	Putnam County	$142,403
Ten Broeck Tennessee	Putnam County	$58,215
Roane Medical Center	Roane County	$59,000
NorthCrest Medical Center	Robertson County	$97,971
Saint Thomas Rutherford Hospital	Rutherford County	$234,511
TriStar StoneCrest Medical Center	Rutherford County	$132,803
TrustPoint Hospital	Rutherford County	$34,972
Big South Fork Medical Center	Scott County	$15,330
LeConte Medical Center	Sevier County	$204,784
Baptist Memorial Restorative Care Hospital	Shelby County	$2,417
Baptist Memorial Hospital – Memphis	Shelby County	$690,203
Methodist University Hospital	Shelby County	$1,042,571
Crestwyn Behavioral Health	Shelby County	$91,247
Delta Medical Center	Shelby County	$277,690
Encompass Health Rehabilitation Hospital of North Memphis	Shelby County	$68
Encompass Health Rehabilitation Hospital of Memphis	Shelby County	$838
LeBonheur Children's Hospital	Shelby County	$4,111,238
Regional One Health	Shelby County	$2,515,582
Regional One Health Extended Care Hospital	Shelby County	$252
Saint Francis Hospital	Shelby County	$254,482
Saint Francis Hospital – Bartlett	Shelby County	$78,172
Saint Jude Children's Research Hospital	Shelby County	$742,435
Select Specialty Hospital – Memphis	Shelby County	$512
Bristol Regional Medical Center	Sullivan County	$121,117
Creekside Behavioral Health	Sullivan County	$4,354

Hospital Name	County	Second Quarter Payments – FY 2020
Encompass Health Rehabilitation Hospital of Kingsport	Sullivan County	$1,149
Holston Valley Medical Center	Sullivan County	$198,847
Indian Path Community Hospital	Sullivan County	$101,535
Select Specialty Hospital – Tri-Cities	Sullivan County	$48
TriStar Hendersonville Medical Center	Sumner County	$139,480
Sumner Regional Medical Center	Sumner County	$102,791
Baptist Memorial Hospital – Tipton	Tipton County	$104,291
Unicoi County Hospital	Unicoi County	$24,544
Saint Thomas River Park Hospital	Warren County	$77,547
Johnson City Medical Center	Washington County	$1,256,376
Franklin Woods Community Hospital	Washington County	$87,388
Quillen Rehabilitation Hospital	Washington County	$404
Wayne Medical Center	Wayne County	$13,598
West Tennessee Healthcare Rehabilitation Hospital Cane Creek	Weakley County	$27
West Tennessee Healthcare Volunteer Hospital	Weakley County	$29,808
Encompass Health Rehabilitation Hospital of Franklin	Williamson County	$6
Williamson Medical Center	Williamson County	$40,414
Vanderbilt Wilson County Hospital	Wilson County	$158,934
TOTAL		**$31,625,000**

Number of Recipients on TennCare and Costs to the State

During the month of December 2019, there were 1,390,818 Medicaid eligibles and 22,339 Demonstration eligibles enrolled in TennCare, for a total of 1,413,157 persons.

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

Spending Category	Second Quarter FY 2020*
MCO services**	$1,715,289,100
Dental services	$41,239,500
Pharmacy services	$290,124,900
Medicare "clawback"***	$57,271,100

**These figures are cash basis as of December 31 and are unaudited.*

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

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

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

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

Entity	Standard	Authority
MCOs (services other than CHOICES and ECF CHOICES)	90% of clean claims for payment for services delivered to TennCare enrollees are processed and, if appropriate, paid within 30 calendar days of the receipt of such claims. 99.5% of all provider claims are processed, and, if appropriate, paid within 60 calendar days of receipt.	TennCare contract and in accordance with T.C.A. § 56-32-126(b)
MCOs (CHOICES and ECF CHOICES services)	90% of clean electronically submitted Nursing Facility and applicable Home and Community Based Services claims[5] are processed and paid within 14 calendar days of receipt. 99.5% of clean electronically submitted Nursing Facility and applicable Home and Community Based Services claims[6] are processed and paid within 21 calendar days of receipt.	TennCare contract

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

[6] Ibid.

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

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

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

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

During the October-December 2019 quarter, the MCOs submitted their NAIC Third Quarter 2019 Financial Statements. As of September 30, 2019, TennCare MCOs reported net worth as indicated in the table below.[7]

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

MCO	Net Worth Requirement	Reported Net Worth	Excess/ (Deficiency)
Amerigroup Tennessee	$32,303,660	$170,712,416	$138,408,756
UnitedHealthcare Plan of the River Valley (UnitedHealthcare Community Plan)	$98,223,126	$517,406,985	$419,183,859
Volunteer State Health Plan (BlueCare & TennCare Select)	$53,841,080	$417,935,796	$364,094,716

During the October-December 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 September 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 second quarter of Fiscal Year 2020 furnished for this report by the OIG are as follows:

Fraud and Abuse Allegations	Second Quarter FY 2020
Fraud Allegations	429
Abuse Allegations*	447
Arrest/Conviction/Judicial Diversion Totals	**Second Quarter FY 2020**
Arrests	15
Convictions	9
Judicial Diversions	1

***** *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	Second Quarter FY 2020
Court Costs & Taxes	$0
Fines	$0
Drug Funds/Forfeitures	$0
Criminal Restitution Ordered	$25,098
Criminal Restitution Received[8]	$10,246
Civil Restitution/Civil Court Judgments	**Second Quarter FY 2020**
Civil Restitution Ordered[9]	$0
Civil Restitution Received[10]	$16,535

Recommendations for Review	Second Quarter FY 2020
Recommended TennCare Terminations[11]	93
Potential Savings[12]	$377,666

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	$5,339,702
Restitution to TennCare MCOs	$90,768
Restitution to Law Enforcement	$19,171
Food Stamps	$81,337
Fines	$1,374,706
Court Costs	$385,560
Drug Funds	$477,944
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 $4,060.92).