STATE OF TENNESSEE
The Division of TennCare
REQUEST FOR INFORMATION
FOR
Medicaid Managed Care Re-procurement
RFI # 31865-00702
October 30, 2019

1. **STATEMENT OF PURPOSE:**

   The State of Tennessee, Division of TennCare issues this Request for Information (“RFI”) for the purpose of planning its next statewide Medicaid Managed Care procurement. We appreciate your input and participation in this process.

2. **BACKGROUND:**

   TennCare is the state of Tennessee’s Medicaid program that provides health care for approximately 1.4 million Tennesseans and operates with an annual budget of approximately $12 billion. TennCare members are primarily low-income pregnant women, children, and individuals who are elderly or have a disability. TennCare covers approximately 20 percent of the state’s population, 50 percent of the state’s births, and 50 percent of the state’s children.

   TennCare is one of the oldest Medicaid managed care programs in the country, having begun on January 1, 1994. It is the only program in the nation to enroll the entire state’s Medicaid population in managed care. The TennCare program operates under a Section 1115 waiver from the Centers for Medicare and Medicaid Services (CMS) in the United States Department of Health and Human Services. Unlike traditional fee-for-service Medicaid, TennCare is an integrated, full-risk, managed care program.

   TennCare services are offered through managed care entities. Medical, Behavioral and Long-Term Services and Supports are covered by three statewide “at-risk” Managed Care Organizations (MCOs) and one partial risk MCO for specific populations.

   In addition to the MCOs, there is a Pharmacy Benefits Manager for coverage of prescription drugs and a Dental Benefits Manager for coverage of services to children under age 21.¹

   As a leader in Managed Long-Term Services and Supports (MLTSS), the state successfully implemented TennCare CHOICES in 2010 bringing LTSS into the managed care model. These services are provided in Nursing Facilities (NFs) as well as in homes and communities by Home and Community Based Service (HCBS) providers. In 2016, the Employment and Community First CHOICES program launched providing HCBS for people with intellectual and developmental disabilities targeted to employment and independent community living. TennCare requires its MCOs to also operate a statewide Dual Special Needs Plan (DSNP) in order to serve dual eligible members in the most integrated manner, and we encourage alignment in the same health plan for Medicare and Medicaid, including a passive enrollment process.

¹ The DBM also manages a limited dental benefit for adults with I/DD enrolled in Employment and Community First CHOICES.
Based on legislation passed by the General Assembly and signed by the Governor, Tennessee recently submitted a Medicaid block grant request to CMS. Details on the block grant submission can be found at https://www.tn.gov/content/dam/tn/tenncare/documents2/TennCareAmendment42FAQs.pdf. At this time, TennCare does not anticipate the requested Medicaid block grant impacting the upcoming MCO RFP or the resulting contracts. The Division of TennCare is within the Department of Finance and Administration which is the state agency charged with the responsibility of administering the TennCare program.

TennCare intends to release a new RFP to procure statewide MCOs. The current MCO contract expires on December 31, 2020. Through this RFI, TennCare is interested in soliciting stakeholder feedback on questions grouped in the following topic areas:

- a. Promoting Quality and Innovation in Long Term Services and Supports,
- b. Delivery System Transformation,
- c. Quality and Access to Care,
- d. Improving Clinical Models of Care, with a Focus on Integration,
- e. Addressing the Social Determinants of Health,
- f. Ensuring Efficiency in Pharmacy,
- g. Achieving Administrative Simplification, and
- h. Reducing Fraud, Waste, and Abuse.

3. COMMUNICATIONS:

3.1. Instructions on RFI submission are included within Section 6, Response Format. Please submit your response to:

Matt Brimm, Director of Contracts
Department of Finance Administration
Division of TennCare
310 Great Circle Road
Nashville, TN 37072
615-687-5811
Matt.Brimm@tn.gov

3.2. Please feel free to contact the Department of Finance Administration, Division of TennCare with any questions regarding this RFI. The main point of contact will be:

Matt Brimm, Director of Contracts
Department of Finance Administration
Division of TennCare
310 Great Circle Road
Nashville, TN 37072
615-687-5811
Matt.Brimm@tn.gov

3.3. Please reference RFI # 31865-00702 with all communications to this RFI.

4. RFI SCHEDULE OF EVENTS:

<table>
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<tr>
<th>EVENT</th>
<th>TIME</th>
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<tbody>
<tr>
<td>1. RFI Issued</td>
<td></td>
<td>10/30/2019</td>
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<tr>
<td>2. RFI Response Deadline</td>
<td>4:00 PM</td>
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5. **GENERAL INFORMATION:**

5.1. Please note that responding to this RFI is not a prerequisite for responding to any future solicitations related to this project and a response to this RFI will not create any contract rights. Responses to this RFI will become property of the State.

5.2. The information gathered during this RFI is part of an ongoing procurement. In order to prevent an unfair advantage among potential respondents, the RFI responses will not be available until after the completion of evaluation of any responses, proposals, or bids resulting from a Request for Qualifications, Request for Proposals, Invitation to Bid or other procurement method. In the event that the state chooses not to go further in the procurement process and responses are never evaluated, the responses to the procurement including the responses to the RFI, will be considered confidential by the State.

5.3. The State will not pay for any costs associated with responding to this RFI.

5.4. TennCare, at its sole discretion, may issue a related solicitation or may issue multiple solicitations based on the responses to this RFI. Responses to this RFI will not have any bearing on the evaluation and respondent selection resulting from any proposals that may be received in response to any subsequent solicitation.

6. **RESPONSE FORMAT:**

6.1. All responses must include the following information at the top of each page:

   6.1.1. **RESPONDENT LEGAL ENTITY NAME:**

   6.1.2. **RESPONDENT CONTACT PERSON:**
   
   Name, Title:
   
   Address:
   
   Phone Number:
   
   Email:

6.2. All RFI responses must be:

   6.2.1. Correctly identified with the RFI # and submittal deadline;

   6.2.2. Organized in the sequence outlined in “Section 8. RFI Questions” and clearly identify each RFI question on which the responder is commenting. Respondents are not required to respond to every RFI category or every RFI question; Response to this RFI must not exceed fifty (50) pages;

6.2.3. In Arial or Times New Roman font, size 12 for normal text and no less than size 10 for tables or graphs;

6.2.4. Response to this RFI must not include appendices;

6.2.5. Formatted on 8.5 by 11” paper;

6.2.6. Submitted electronically to Matt Brimm, Director of Contracts at TennCare, as identified in “Section 3. Communications.” Responses may not exceed a combined 20 Megabits file size.

7. **DEFINED TERMS AND ACRONYMS**

7.1. Please refer to TennCare’s MCO Statewide Contract for a list of defined terms and abbreviations:

8. RFI QUESTIONS

a. Promoting Quality and Innovation in Long Term Services and Supports

An electronic visit verification (EVV) system has been a part of the CHOICES program since its inception in 2010, and more recently, the Employment and Community First CHOICES program. Under the 21st Century Cures Act, these requirements will be expanded to include home health and private duty nursing as part of this procurement. Importantly, TennCare uses EVV system functionality for more than just program integrity. It is a critical component of our strategy to identify and address gaps in care (e.g., generating real-time alerts when a worker fails to show up as scheduled). Some providers have asked for an “open” system that would be able to interface with their scheduling or other office management systems to allow greater flexibility and streamline their administrative processes. However, open systems would require a significant degree of functionality to meet TennCare quality expectations and requirements. For example, the system would need to be able to accept authorizations and MCO systems or an aggregator would need to be able to interact with all of those systems. In addition, TennCare intends to require real-time access to data, rather than reports.

8.1. What are the advantages and disadvantages of requiring the MCOs to supply an EVV system versus requiring all MCOs to use a single EVV system from the perspective of achieving our goals: To ensure compliance with the 21st Century Cures Act, meet TennCare expectations regarding monitoring of gaps in care, real-time access to data, and program integrity, address providers’ desire for more flexibility and less administrative burden, and ensure MCO capacity to meet contract requirements.

8.2. Are there other ways in which the EVV system could be leveraged—for example, to collect data regarding social determinants of health? To reduce social isolation? To better engage care providers as a member of the care team in providing information to care/support coordinators or primary care providers? For routine health monitoring? Please share innovative strategies that could be integrated into the EVV system to improve member health, outcomes, and independence.

No population faces greater challenges with respect to integration than full benefit dual eligible (FBDE) beneficiaries who must access care across two incredibly complex health insurance programs. Since late in 2012, TennCare has sought to leverage Medicare Part C authority to help increase aligned enrollment of FBDE beneficiaries, having the same MCO for both their Medicare and Medicaid benefits. With the upcoming procurement, we are interested in strategies that will help to further our alignment goals, and improve coordination, quality, and cost-efficiency for this population.

8.3. Please share thoughts and ideas that TennCare should consider. Also share ways that MCOs can help demonstrate the value of these aligned arrangements.

MCOs have a long history of coordinating physical and more recently behavioral health services. These are primarily driven from a clinical or medical model. The integration of LTSS into managed care has required a different approach to care coordination—one that is person-centered and takes into account social support as well as physical, health, and LTSS needs. TennCare has launched a system transformation initiative that is intended to align the entire service delivery system around person-centered values, person-centered thinking, and person-centered approaches to planning and providing services and supports. Achieving this transformation at the health plan level is critical to our success.

8.4. How could TennCare, as part of the future procurement, best support or incentivize MCOs in building their capacity and expertise around person-centered planning and in transforming their health plans to become person-centered organizations?

8.5. In order to serve the LTSS population, collaboration amongst the MCOs is often required at the policy making or programmatic level in order to create effective solutions for persons supported through our programs. How can TennCare help encourage and facilitate collaborative processes among MCOs?
At the inception of the CHOICES program, TennCare struggled with whether to establish firm caseload requirements for LTSS. Ultimately, we landed on a weighted caseload approach that in the beginning was recommended, and later became required. Currently, TennCare’s weighted caseload approach utilizes a set methodology to calculate weighted Care Coordinator-to-CHOICES member staffing ratios and Care Coordinator caseloads. Weighting is based on a CHOICES member’s level assessed level of acuity and varies per CHOICES group. Additional information on TennCare’s weighted caseload methodology can be found in 2.9.6.12.9 of TennCare’s MCO Statewide Contract at [https://www.tn.gov/content/dam/tn/tenncare/documents/MCOStatewideContract.pdf](https://www.tn.gov/content/dam/tn/tenncare/documents/MCOStatewideContract.pdf). We have found caseload requirements to be important in terms of ensuring that MCOs maintain sufficient staff to provide high quality care/support coordination.

8.6. What are your thoughts around caseload values and requirements, taking into account both quality and administrative expense?

Shortages in the number of direct support workers have become a challenge across LTSS programs in most states. The shortages are not unique to LTSS programs, but they impact LTSS programs, and health plans bring the opportunity for new partners in addressing these challenges.

8.7. Please share thoughts or recommendations regarding the roles and responsibilities of MCOs versus the state and providers in addressing the sufficiency and quality of the LTSS workforce. What flexibilities or incentives would be helpful to MCOs in partnering with the state and with providers to address these challenges?

In MLTSS, workforce capacity is closely related to network adequacy. Unlike other health care services where network adequacy may be measured by travel time and distance to a site of service, TennCare measures network adequacy for HCBS provided in the home by the ability of a health plan to consistently initiate services within prescribed timeframes and consistently deliver these services without gaps in care. This is monitored through the use of EVV systems, as well as review of appeals data, and reports/audits. In addition, we require choice of HCBS providers. More recently with the implementation of LTSS for individuals with I/DD, we began to specify preferred contracting standards to help MCOs select not just “enough” providers, but providers with the right kind of experience in serving the population and who would be best positioned to deliver program outcomes.

8.8. TennCare is interested in how we can continue to evolve our approach to network adequacy to take into account aspects of the quality of services delivered and the outcomes achieved. Please share thoughts or ideas about how we might approach network adequacy for LTSS under this new procurement. In addition, please share specific thoughts around MCOs’ role in building network capacity to deliver LTSS in rural areas.

LTSS providers (Nursing Facility and HCBS) who have traditionally provided services in a fee-for-service system often struggle to adapt to a managed care approach.

8.9. Do you have particular recommendations for TennCare with respect to how the state and/or MCOs might improve claims processing operations and education for LTSS providers (Nursing facilities as well as HCBS)? What type of support is needed by these providers from MCOs to ensure their success in claims processing under managed care?

8.10. Beyond contracting and claims payment, what are the kinds of supports LTSS providers need from MCO provider services staff (e.g., support in workforce training and development)? How should these requirements and functions look different for LTSS providers?

In CHOICES and in Employment and Community First CHOICES, Consumer Direction is an option for certain HCBS. This allows members to select, employ, and manage their own staff (using the services of a fiscal employer agent or FEA). To date, TennCare has elected to procure a single statewide FEA for Consumer Direction in these programs. This is in part to ensure that Consumer Direction does not look like three separate programs across the state.

8.11. What are your thoughts or recommendations about how TennCare should approach FEA services for individuals enrolled in Consumer Direction? Please include a rationale for your recommendations, taking into account the member (as well as health plan) perspective.
Many individuals with I/DD have co-occurring behavioral health conditions or challenging behavior support needs. Yet, behavioral health providers often lack expertise in serving individuals with I/DD. The same is true with respect to physicians and other health care providers as well.

8.12. What are your recommendations for how TennCare can build the capacity and continuum of the health care delivery system, including specifically the behavioral health system, to serve individuals with I/DD. Include proposed delivery models, payment approaches, and other strategies.

b. Delivery System Transformation

For the past five years, TennCare has taken a leadership role in health care delivery system transformation by designing and implementing value-based payment approaches that are aligned across our MCOs. Our strategies (patient centered medical home (PCMH), Tennessee Health Link, episodes of care, and paying for value in LTSS) are described in greater detail at our website: https://www.tn.gov/tenncare/health-care-innovation. We support our PCMH and Tennessee Health Link partners with a care coordination tool and real-time access to admission, discharge, and transfer (ADT) alerts from hospitals statewide. In response to provider stakeholders’ request, there is a remarkable amount of alignment in the design of these strategies across MCOs. Our strategies have been successful. PCMH and Tennessee health link have shown positive results which will be available soon, episodes has saved $38.3 million as of calendar year 2018 while maintaining or improving quality according to most measures. In LTSS, an Enhanced Respiratory Care initiative resulted in a 25% reduction in expenditures in the first year, with significantly higher quality outcomes, including ventilator liberation. Other LTSS initiatives have yielded higher competitive, integrated employment outcomes for people with intellectual and developmental disabilities (I/DD), reduced utilization of emergency department services and inpatient psychiatric care for individuals with I/DD and co-occurring severe behavioral health conditions, and contributed to the 4th largest percent reduction in the country in the use of antipsychotic medications (from 30% to 15%) among long-stay nursing facility residents.2

We plan to continue these successful strategies but are always looking at how they can be improved.

8.13. What suggestion do you have for us on additional strategies that TennCare could require in order to achieve delivery system transformation through the MCO procurement? For example, some payers have partnered with providers on total cost of care arrangements, while large employers such as Walmart have begun to increase quality and efficiency by sending their health plan members to "Centers of Excellence" for certain services. Are these or other strategies ones that we should consider for TennCare, and what are the issues we should be aware of?

8.14. At least for some practices, should TennCare consider moving from its current rewards-only PCMH model to a total cost of care or two-way risk model, or some other form of advanced payment model that incentivizes quality and value, and includes more than nominal financial risk for monetary losses? If so, what are key factors that ensure success for primary care providers in an advance payment model? Would you suggest the advanced payment model (APM) be designed for specific subgroups of the patient population? If so, which ones?

8.15. Are there specific strategies that TennCare should consider related to requiring or encouraging MCOs to implement Value Based Purchasing (VBP) for LTSS, beyond the current Quality Improvement in Long Term Services and Supports (QuILTSS) requirements?

8.16. How much flexibility should TennCare give to MCOs to design unique value-based arrangements with providers versus a coordinated statewide approach? Would this MCO

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2 From baseline (prior to the launch of QuILTSS) through April 2019; see https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Antipsychotic-Medication-Use-Data-Report.pdf.
8.16. How might TennCare encourage MCOs to make effective use of telemedicine or telehealth, and e-visits to improve enrollee access to care while discouraging overuse, fraud, waste, and abuse?

8.21. What types of modifications to its existing reporting and monitoring of MCO provider networks would you recommend for TennCare to better assess the adequacy and timeliness of access to care for Medicaid MCO enrollees?

8.22. For specialties or subspecialties (e.g., pediatric neurologists) where there are shortages of providers, what are better ways to coordinate and triage appointment access for routine, urgent, and emergent referrals? How do you engage specialists in order to ensure timely access relative to routine, urgent, and emergent referrals? How would a Medicaid agency measure the adequacy of the coordination and access?

Ride-share: TennCare as well as other states’ Medicaid agencies, have recently begun working with ride-share providers to supplement our non-emergency transportation benefit.

8.23. What suggestions do you have for how to incorporate ride-sharing in the next MCO procurement? How can ride-sharing be implemented so that our members are able to keep provider appointments while maintaining that ride-sharing services are appropriately used as TennCare recommends?

8.24. How else can TennCare improve access to transportation for its members?

Community Health Workers (CHWs): Some other state Medicaid agencies have placed an emphasis on the use of community health workers by MCOs.

8.25. Under what circumstances are community health workers utilized? Which member populations qualify and how are these populations identified? How are these members engaged? Would you recommend standards to create more uniformity in the way that TennCare MCOs utilizes CHWs? Which performance metrics do you use or would you recommend to evaluate CHWs and CHW programs?

d. Improving Clinical Models of Care, with a Focus on Integration

TennCare has integrated physical health, behavioral health (including substance abuse treatment), and LTSS into a single managed care contract since 2009. We regard this integrated approach as critical to treating our members holistically. However, we continue to hear from stakeholders that there is more work to do for MCO and Tennessee’s providers to achieve the vision of fully integrated care for the whole person.
Opportunities to Improve Integration of Healthcare Services

8.26. If you are an MCO responding to this RFI, do you currently have the ability to incorporate behavioral health care management without subcontracting, and if not would you be able to build that capacity in response to this procurement? For all respondents, what do you think the impact of a requirement to integrate behavioral health services would be?

8.27. What other steps could TennCare take through its next MCO RFP to increase integrated whole person care across physical, behavioral and LTSS care? Include consideration of integrated processes, integrated systems, as well as integration of service delivery at the provider level. Please offer suggestions on how TennCare could ensure that successful bidders offer and support improved integration of behavioral health and physical health care delivery for enrollees in this upcoming procurement.

8.28. We continue to see the benefit of maintaining a separate contract for pharmacy benefits management and dental benefits management. Given that we will continue these separate service line contracts, what can TennCare do within this upcoming MCO procurement to increase coordination with pharmacy and dental care?

8.29. Is there an opportunity to educate and encourage providers to perform appropriate behavioral health screens, such as the SBIRT, and to improve processes for timely referral when necessary?

8.30. What specific network development, care delivery and care coordination approaches might TennCare encourage or require MCOs to employ to better meet enrollees’ behavioral health needs?

e. Addressing the Social Determinants of Health

Across the country, Medicaid agencies, health care providers, and many others are looking at the large impact that social risk factors have on people’s health status. Social risk factors that have a strong influence on health include people’s education, housing, social connections, and access to food. Social risk factor mitigation strategies may include: screening for social risk factors to determine their prevalence and impact; analyzing screening data to inform intervention strategies; incorporating social risk factor mitigation within value-based payment; coordinating social risk factor mitigation work across other state agencies, MCOs, and/or community based organizations; or measuring MCO performance on social risk factor mitigation strategies, among other approaches. TennCare has several social risk factor mitigation strategies in place, including a multi-agency collaboration to address child welfare, a program to reduce emergency department utilization by providing air conditioners to high-utilizing Medicaid members, and a requirement that MCOs incorporate social risk factor data into their member’s risk assessments to inform targeted case management.

8.31. What approaches have you found successful in mitigating social risk factors, including but not limited to approaches listed above? Please offer suggestions on key aspects of the social risk factor mitigation strategy where TennCare’s approach should be standardized and suggestions as to where it might work better to allow MCOs and/or providers some flexibility in designing or implementing their own strategies.

8.32. What type of data are you able to collect regarding social risk factors and how do you utilize this data in order to support member needs? What have been the biggest barriers to collecting this type of data?

8.33. TennCare is considering a requirement for screening for social risk factors within primary care. How would you implement this requirement? How could TennCare’s existing use of a care coordination tool support the implementation of screening for social risk factors?

8.34. What are the best mechanisms for supporting MCOs in addressing social risk factors? Sample strategies include incorporating social risk factors into risk adjustment or capitation rates, using withholds tied to SDOH initiatives, and/or implementing a community reinvestment fund.
8.35. How can TennCare collect data about the social risk factors of our members to better inform care coordination and population health programs by both our MCOs and by our primary care providers? What role should MCOs and providers play in the collection and use of this data?

Our LTSS population, and particularly our dual eligible population are groups with disproportionate social risk factors, and this is one area of Medicaid where services such as supported housing (not the actual cost of room and board), as well as employment supports are allowed as federally matched benefits. Our CHOICES and Employment and Community First CHOICES programs, described in more detail at this website, have taken some steps to address social determinants of health.

8.36. What suggestions do you have to further address social determinants for the LTSS population? What do you think are the most important social determinants for the LTSS population? Do you have thoughts around strategies to help address those as part of the next MCO procurement? What changes would you recommend with respect to care/support coordination, data collection and analysis, benefits, and incentives to address social determinants that most impact LTSS members’ ability to live in the community?

f. Ensuring Efficiency in Pharmacy

340B: The 340B Drug Pricing Program is a federal government program that requires drug manufacturers to provide certain outpatient drugs to eligible health care organizations and Covered Entities (CEs) at a discount. The name of this program refers to the relevant authorizing section of the Public Health Service Act. Within Medicaid, participating drug manufacturers agree to provide outpatient drugs to CEs at significantly reduced prices. More information on 340B can be found at https://www.hrsa.gov/opa/index.html.

The TennCare pharmacy currently requires CEs to submit outpatient pharmacy claims with clarification codes that denote which drugs fall under 340B. MCOs can capture information on which outpatient drugs qualify as 340B through claims submissions but MCOs are not required to report that information.

8.37. What approaches could TennCare use in the next procurement to better align the pharmacy and medical benefits across all plans to improve the outcomes for its members?

8.38. If TennCare were to require that MCOs report which outpatient drugs qualify for 340B, how could such a claims verification process for outpatient drugs be operationalized. What impact would such a requirement have on providers, MCOs, and on pharmacy operations?

Physician Administered Drugs (PAD): TennCare is interested in better aligning the pharmacy and medical benefits across all plans to improve outcomes for its members,

8.39. Describe MCO and clinical best practices to optimize PAD utilization management, coordinate care for members, and rebate collection.

8.40. Please offer specific ideas for achieving aligned VBP strategies amongst Medicaid, Children’s Health Insurance Program (CHIP), and state discount programs. In addition, TennCare is interested in understanding innovative VBP and purchasing options through state multi-agency collaboration including state employee health benefits, Department of Children Services, (DCS), and Department of Correction (DCO).

8.41. What steps could TennCare take to promote improved provider experiences and member care coordination relative to pharmacy/medical coordination of care?

8.42. How can TennCare further reduce the risk of the occurrence of duplicate discounts for 340B drugs administered by physicians?

8.43. Describe how managed care claims systems can be configured to distinctly identify and extract claims relative to physician administered drugs.
g. **Achieving Administrative Simplification**

TennCare is interested in ideas that will ease administrative burden and reduce complexity for MCOs, providers, and enrollees.

8.44. Please offer specific ideas for achieving TennCare’s aim for greater administrative simplification in its Medicaid managed care program by reducing the burden and complexity of the program for enrollees. In addition, TennCare is interested in ideas to make the program less burdensome for providers by reducing paperwork, redundancies, and improving clarity of clinical criteria.

8.45. MCO credentialing processes can be challenging for providers, especially when they must complete three different processes. TennCare plans to implement a Centralized Credentialing Verification Process utilizing a NCQA certified Credentials Verification Organization (CVO). This process will utilize a credentialing committee consisting of representatives from TennCare and each MCC to credential providers upon application for a Medicaid ID number. Each MCO will make its own decision regarding contracting with that provider. This will streamline the time frame it takes for a provider to be fully credentialled across the TennCare Enterprise by eliminating the need for credentialing and recredentialing by multiple entities. Please provide thoughts or recommendations regarding this approach or other options for how MCO credentialing processes could be simplified or streamlined, including ideas regarding how TennCare might support a unified approach to credentialing for some or all providers.

**Claims payment:** Claims payment is a complex process that causes administrative expense for payers and providers. The claims payment process includes initial submissions, claims edits, denials, and appeals.

8.46. What suggestions do you have for ways to simplify this process, reduce administrative costs, or to create more uniformity across different payers? How would the proposed changes impact the ability of payers to control inappropriate or unnecessary care and reduce fraud?

h. **Reducing Fraud, Waste, and Abuse**

Tennessee is required by CMS to prevent, detect, and investigate provider fraud, waste, and/or abuse. This requirement is to ensure regulatory compliance and accountability and protects the financial and health care service integrity of the TennCare program. For more information, please visit TennCare’s Fraud, Waste, and Abuse webpage at [https://www.tn.gov/finance/looking-for/fraudinfo.html](https://www.tn.gov/finance/looking-for/fraudinfo.html).

**Cost avoidance prepay edits:** TennCare has considered requiring prepay edits to known vulnerable health care areas. Prepay edits have been very successful in fighting FWA on the front end with our DBM and PBM entities.

8.47. What issues should we be aware of while we consider this approach? Provide any analysis supporting or rejecting moving in this direction. What health care areas would you suggest for prepay edits?