TennCare Medicaid Advisory Committee (MAC) Meeting

July 21, 2026
1pm CST

Participants:

Attendee	Attendee
Kimberly Howerton (Clinical Provider)	Deborah Murph, Executive Director of Mountain Hope (Clinical Provider)
Jeannie Beauchamp, D.D.S. (Clinical Provider)	Michele Williams, Walker Comprehensive Health Center (Pediatric Clinical Provider)
Julie Joseph, MD, MPH (BlueCare Representative)	Greg Cannella, WellPoint Chief Medical Officer (Medicaid MCO)
Rachelle Ifill, Renaissance Chief Dental Officer	Jesse Samples, Executive Director of Tennessee Health Care Association (Nursing Home Representative)
Leslie Wolf, PharmD (Pharmacist)	Lynette Porter, Council on Developmental Disabilities
Christopher Andershock, United HealthCare	Jon Baese, DDS
Dana Moore, TennCare	Aaron Butler, TennCare
Kena Hahn, TennCare	Jim Guffey, TennCare
Amy Lawrence, TennCare	BAC Member
BAC Member	Reese Devilbiss, Notetaker

Topics:

1.	Welcome and Introduction
2.	Administrative Items
3.	Community Engagement Overview
4.	Provider Services Revalidation Update
6.	Closing Remarks

Meeting Minutes

Welcome

- Dana Moore opened the meeting, welcoming attendees to the first MAC meeting of the second year and thanking the group for their participation.
- Dana introduced Dr. Rachelle Ifill, Chief Dental Officer at Renaissance, the new Dental Benefits Manager (DBM) for TennCare, as a new member of the committee.

Administrative Items

- The committee approved the MAC annual report and the April MAC minutes.
- Dana noted that the annual report will be uploaded to the website by the end of August.
- Dana confirmed she had received all Conflict of Interest (COI) forms and asked members to notify her of any changes as soon as possible.

Community Engagement Overview

- Aaron Butler, the Director of Policy for TennCare, highlighted community engagement requirements being introduced at the national level and emphasized the top-line message: **"TennCare members will not have to do anything new to maintain their TennCare coverage."**
- Aaron explained that the federal 2025 budget reconciliation bill created a new requirement that certain Medicaid members must demonstrate community engagement to receive Medicaid benefits, and reviewed the community engagement requirements:
    - Work at least 80 hours per month
    - Complete at least 80 hours of community service in the month
    - Participate in a work program for at least 80 hours in the month
    - Be enrolled in an educational program at least half-time
    - Engage in any combination of 1,2,3, and 4 for at least 80 hours per month
    - Have a monthly income that is equivalent to the federal minimum wage multiplied by 80 hours
- Aaron noted that while there are exceptions, Medicaid expansion adults are primarily impacted by the new requirement. Non-traditional members receiving benefits under a Medicaid waiver are also subject to the new requirement.
- Aaron clarified that TennCare has not expanded under the ACA, but some individuals enrolled in TennCare, specifically parents and caretaker relatives of dependent children, are eligible for coverage through the TennCare 1115 waiver.
- Aaron explained that TennCare has always covered low-income parents, with income limits dependent on household size.
    - If a parent in Tennessee falls within the Medicaid State Plan coverage, they would be considered a traditional Medicaid enrollee, and the community engagement requirement does not apply to them.
    - In 2024, TennCare expanded income eligibility for parents through the TennCare waiver. For example, under the waiver, coverage of parents in a household of four would extend to up to around $2,750 per month.

- Individuals eligible under the waiver are those parents whose income is too high for the traditional Medicaid category, but who qualify for coverage under the waiver. These are considered non-traditional Medicaid members, and the community engagement requirement applies to them.

- Aaron stated that TennCare has shown CMS the income levels that apply to the waiver, the income levels needed to meet the community engagement requirement and has confirmed that anyone subject to the requirement has already met it, deeming them automatically compliant.
- Aaron reiterated the top-line message that TennCare members will not need to do anything new to maintain coverage. There are no new paperwork, reporting, or screening requirements.
- Aaron noted that if members want to keep their coverage, they still need to keep their information updated and engage in the renewal process, as they typically would.
- Aaron noted that information about community engagement is available on the TennCare website and asked whether the group thought TennCare should increase messaging on the topic.
    - A BAC member suggested that social media outreach would be helpful.
- Amy Lawrence asked whether members had heard about work requirements being discussed at the national level, to which the BAC member responded that she had not.
    - Amy noted that TennCare must weigh the value of proactive communication against the potential for creating additional confusion.
- Amy stated that TennCare will send communication to members to whom the requirement applies, and the messaging will make clear that no additional steps are required on their part.
- Jeannie Beauchamp suggested that, as a provider, it would be helpful to receive an email confirming that patients are not impacted, and that TennCare will notify providers if anything changes.
    - Amy acknowledged that sending communications directly to individual providers is a valuable suggestion.
    - Aaron thanked the group for their time.

Provider Services Revalidation Update

- Kena Hahn, Provider Services Director, gave an overview of TennCare's provider revalidation process.
- Kena stated that TennCare follows CMS federal regulations for program integrity for the Medicaid program, which revalidates all providers every five years.
    - TennCare policy exceeds this standard by requiring all providers, regardless of risk category, to revalidate every three years.
    - TennCare also conducts database checks on an ongoing basis to ensure that providers continue to meet the applicable criteria for their provider type.
- Kena noted that over 70,000 providers are enrolled with TennCare to provide services.
- To reduce Medicaid fraud, CMS has mandated all states to perform off-cycle revalidation of high-risk providers.

Risk Categorization

- Kena explained that providers are assigned a risk level (High, Moderate, or Limited) based on several factors to ensure they receive the appropriate level of screening and oversight.

- Providers can be escalated in risk category for any suspicious fraud, waste, and abuse reasons, which would result in additional screenings during initial enrollment or revalidation.

Provider Screening Requirements

- Kena reviewed the screening requirements for each risk level:
    - **Limited Risk:** Verification that the provider meets applicable federal, state, and licensure requirements, along with ongoing database checks to confirm the provider is qualified to deliver the services requested.
    - **Moderate Risk:** All Limited Risk screening requirements, plus unscheduled or unannounced site visits to confirm the physical location, staffing, and legitimacy of the provider.
    - **High Risk:** All Moderate Risk screening requirements, plus a criminal background check and fingerprinting for high-risk providers and any owners with a five percent or greater direct or indirect ownership interest.

Why is TennCare Performing Off-Cycle Revalidation?

- Kena explained that all States received a letter from CMS in April 2026 calling for a swift revalidation of high-risk and non-NPI providers.
- In response, TennCare created a robust two-year strategy to revalidate all registered providers, starting with those at highest risk for fraud, waste, and abuse.

TennCare High-Risk Providers

- Kena reviewed the list of high-risk providers, which includes:
    - Newly enrolling home health agencies, DMEPOS suppliers, Medicare diabetes prevention program (MDPP) suppliers, opioid treatment programs, hospices, and skilled nursing facilities.
    - Pediatric-only home health agencies.
    - Enrolled Opioid Treatment Programs, Durable Medical Equipment suppliers, Home Health Agencies, Medicare Diabetes Prevention Program suppliers, Skilled Nursing Facilities, or hospices submitting a change of ownership application or reporting any new owner.
    - Any provider of any type previously excluded from TennCare or a federal health care program.
- Kena emphasized that newly enrolled providers are reviewed to ensure they are legitimate and appropriately licensed. Pediatric-only providers are reviewed prior to being issued a TennCare Medicaid ID.

TennCare Moderate-Risk Providers

- Kena reviewed the list of moderate-risk providers, which includes:
    - Ambulance service suppliers, community mental health centers, comprehensive outpatient rehabilitation facilities, hospice organizations, independent clinical laboratories, independent diagnostic testing facilities, physical therapists, portable x-ray suppliers, revalidating home health agencies, and revalidating DMEPOS suppliers. These providers go through initial screening and receive a site visit.

TennCare Limited-Risk Providers

- Kena reviewed the list of limited-risk providers, which includes:
  - Physicians, ambulatory surgical centers, end-stage renal disease facilities, FQHCs, RHCs, hospitals, HCBS providers, Indian Health Service facilities, ICFs/IID, mammography screening centers, mass immunization roster billers, NEMT providers, organ procurement organizations, pharmacies newly enrolling or revalidating via the CMS-855B application, radiation therapy centers, religious nonmedical health care institutions, and skilled nursing facilities.
- Kena noted that providers can be individuals, groups, or entities.

Off-Cycle Revalidation Timelines

- Kena reviewed the revalidation timeline table:
  - **High-Risk Providers** not revalidated in the last 365 days: By February 2027.
  - **Other Prioritized Categories** (ABA, pediatric-only home health, NEMT, adult day care, personal care services, home delivered meals, home modifications, in-home supportive care, and non-NPI providers) not revalidated in the last 365 days: By June 2027.
  - **All Other Providers:** By June 2028.
- Kena noted that all TennCare providers must have a National Provider Identifier (NPI).

Communications for Off Cycle Revalidation

- Kena explained that TennCare is partnering with the internal Provider Data Management System (PDMS) to display banners identifying which providers are due for revalidation.
- Additional communication channels include:
  - Monthly provider bulletin articles
  - MCO newsletters
  - A website banner.
  - Provider webinar education sessions.
  - MCO expo materials.
- Kena noted that in normal communications, providers will receive revalidation information through CAQH (where providers update demographic information) or within the provider portal, making it essential that providers keep their information up to date.
- Kena confirmed that specific alerts will be sent in advance. For example, August alerts for providers that are due in February.
- Kena added that there is a call center where providers can call for information and support.

Off-Cycle Revalidation Tracking and Reporting

- Kena stated that reporting will be conducted annually on the revalidation webpage, including reporting requirements and progress against submitted timelines.

BAC Update

- Dana provided an update on the recent BAC meeting, where the group discussed the Pathway to Independence program.
- Pathway to Independence discussion points included:

- Members expressed hesitancy about pursuing higher-paid employment due to potential loss of TennCare coverage.
- Other members felt that initial support during the transition off TennCare would make the change less difficult.

- Members expressed preferences for clear and concise communication via email, QR codes, and text messages, and commended TennCare for reducing duplicate communications.
- Members suggested additional topics for future meetings.

Closing Remarks

- Dana inquired whether there were any topics or agenda items members would like to discuss in future meetings.
  - Jeannie Beauchamp shared that in the dental world, providers are concerned about limited access to operating room (OR) time at hospitals and surgery centers. She noted that meetings have been held with Renaissance, who were reportedly evaluating reimbursement rates for 2027.
    - Jeannie explained that a significant portion of dental care for young children and individuals with special needs occurs in surgery centers, and while some anesthesiologists come to dental offices, low reimbursement rates discourage providers from booking at surgery centers.
  - A BAC member requested a future discussion on private duty nursing coverage with TennCare.
- Leslie Wolfe noted that overall, things are going well in pharmacy. The only concern she raised was the lack of new patient coverage for chronic pain management, aside from grandfathered cases.
  - Unless new patients present with conditions such as sickle cell disease or burns, coverage opportunities are limited.
- Dana thanked the group for their suggestions and requested that members send any additional future topics via email for consideration in upcoming MAC meetings.
- Dana confirmed that the next MAC meeting is open to the public and is scheduled for **October 20, 2026, at 1:00 p.m. CT**.
- The meeting was adjourned and attendees left the call.