TennCare Quarterly Report

October – December 2021

Submitted to the Members of the General Assembly

Status of TennCare Reforms and Improvements

Coverage of Children Adopted from State Custody. The budget approved by the General Assembly for State Fiscal Year 2022 included funding for a number of modifications and enhancements to the TennCare program. One of these enhancements involved expanding TennCare's coverage of children adopted from state custody. TennCare's coverage already included children adopted from state custody for whom a Title IV-E adoption assistance agreement is in effect, as well as children with special needs receiving non-IV-E adoption assistance from the state. However, there are a number of children in foster care in Tennessee each year who do not qualify for either form of adoption assistance (federal or state). Beginning in State Fiscal Year 2022, TennCare covers children adopted from state custody who do not qualify for federal or state adoption assistance. Extending TennCare coverage to this group of children will remove a potential barrier to adoption, as well as promote greater continuity of care for these children as they transition from foster care to permanent homes.

In order to formalize this arrangement within the TennCare Demonstration, TennCare is preparing to submit a demonstration amendment to the Centers for Medicare and Medicaid Services (CMS). On December 7, 2021, TennCare launched a public notice and comment period regarding this proposed demonstration amendment. This amendment is expected to be submitted to CMS in the upcoming quarter at the conclusion of the public notice period. A draft of the proposal is available online at https://www.tn.gov/content/dam/tn/tenncare/documents2/DraftVersionOfAmendment2.pdf. (Note that while TennCare works with CMS to secure approval to add these children to the TennCare Demonstration, TennCare is currently using state funds appropriated by the General Assembly for State Fiscal Year 2022 to ensure that no children lose their TennCare coverage after being adopted.)

Coverage of Chiropractic Services. On January 1, 2022, TennCare began covering medically necessary chiropractic services for adults enrolled in TennCare. Prior to January 1, chiropractic services were covered by TennCare only for children under age 21. Like other TennCare benefits, chiropractic services will be administered by members' managed care organizations (MCOs), which will be responsible for ensuring appropriate utilization of services. The funding for this new benefit was included in the budget passed by the General Assembly for State Fiscal Year 2022.

Maternal Health Enhancements. Another change to the TennCare program contained in the budget for State Fiscal Year 2022 involves enhancements to coverage for pregnant and postpartum women enrolled in TennCare. Specifically, TennCare is planning to extend full coverage for postpartum women from the current duration (60 days) to a full 12 months, and also to provide a dental benefits package for pregnant and postpartum women age 21 and older.

A public notice and comment period on these maternal health enhancements was initiated by TennCare on December 17, 2021, and was expected to conclude on January 20, 2022. Implementation of these maternal health enhancements is scheduled to begin on April 1, 2022.[1]

Enhancements to Home and Community Based Services (HCBS). The American Rescue Plan Act of 2021 provides additional federal funding to enhance, expand, and strengthen Medicaid HCBS programs. In accordance with CMS guidance and after an extensive stakeholder input process, TennCare submitted a proposed HCBS spending plan to CMS on July 12, 2021, outlining how TennCare plans to use the additional federal resources to strengthen TennCare's HCBS programs. The major components of TennCare's plan to enhance and strengthen HCBS are outlined below:

1. **Improving access to HCBS for persons needing supports and family caregivers.** Notably, TennCare intends to reduce by half the number of persons on the referral list for Employment and Community CHOICES by enrolling an additional 2,000 qualifying individuals into the program. In addition, based on significant input from stakeholders, for individuals who are already enrolled in HCBS programs, TennCare has increased, for a limited period of time, access to flexible family caregiver benefits in order to address the additional stresses from impacts of COVID-19, and ensure the sustainability of these supports going forward. TennCare has also made available to persons enrolled in CHOICES a new benefit called Enabling Technology.
2. **Investing in the HCBS Workforce.** TennCare has also used additional federal resources to make targeted provider rate increases for services in CHOICES and in Employment and Community First CHOICES that have a direct care component. In addition, TennCare plans to implement a quality incentive pilot program to incentivize HCBS providers to offer value-based wage increases to their frontline HCBS workers who successfully complete a competency-based training program.
3. **Investing in HCBS Provider Capacity.** TennCare has implemented a referral incentive program for specified types of HCBS to help providers recruit and retain qualified frontline staff.

Following CMS approval of TennCare's proposed spending plan as well as state budget expansion approval, TennCare began implementing these initiatives during the October-December 2021 quarter.

[1] Note that the U.S. Secretary of Health & Human Services has currently declared a national public health emergency with regard to COVID-19, and that under federal law, states are required to maintain Medicaid eligibility for virtually all beneficiaries for the duration of the public health emergency. So even though TennCare's extension of postpartum coverage formally takes effect on April 1, 2022, as a practical matter, all pregnant women enrolled in TennCare who have given birth during the public health emergency have maintained their TennCare coverage.

Katie Beckett Program. On November 23, 2020, TennCare launched a new "Katie Beckett" program. The Katie Beckett program provides services and supports for children under age 18 with disabilities and/or complex medical needs who are not eligible for traditional Medicaid because of their parents' income or assets. The Katie Beckett program is an outgrowth of legislation (Public Chapter No. 494) passed by the Tennessee General Assembly in the 2019 legislative session. Following enactment of Public Chapter No. 494, TennCare submitted a waiver amendment ("Amendment 40") to the Centers for Medicare and Medicaid Services (CMS) to establish the new program. CMS ultimately approved Amendment 40 on November 2, 2020.

TennCare's Katie Beckett program contains two principal parts:

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

In addition to Parts A and B, the Katie Beckett program provides 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.

The Katie Beckett program began accepting self-referral forms from interested families on November 23, 2020. As of the last day of the October-December 2021 quarter, there were 128 children enrolled in Part A and 979 children enrolled in Part B. Since the end of the October-December quarter, TennCare has continued to enroll qualifying children into the Katie Beckett program. There is no waiting list for enrollment into the Katie Beckett program, including Part A.

Amendment 1 to the TennCare III Demonstration. In January 2021, CMS approved the latest iteration of the TennCare demonstration, referred to as "TennCare III." On February 22, 2021, TennCare provided public notice of its first proposed amendment to the TennCare III demonstration. The amendment (known as "Amendment 1") would introduce the following modifications to the demonstration:

- Integration of services for members with intellectual disabilities into the TennCare managed care program[2];
- Transitioning the care of children receiving Supplemental Security Income (SSI) benefits from the TennCare Select health plan to one of the other health plans that serves TennCare members; and
- Assigning to the TennCare Select health plan certain inmates of public institutions who receive inpatient services in a setting located outside the public institution.

[2] Specific services to be integrated are intermediate care facility services for individuals with intellectual disabilities (ICF/IID services) and 1915(c) waiver home- and community-based services (HCBS).

TennCare submitted Amendment 1 to CMS on March 31, 2021. As of the end of the October-December 2021 quarter, CMS's review of Amendment 1 was ongoing.

Amendment 36 to the TennCare II Demonstration.[3] 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 2021 quarter, CMS's review of Amendment 36 was ongoing.

MCO Procurement. On June 11, 2021, TennCare issued a Request for Proposals (RFP) for three entities to furnish managed care services—including delivery and coordination of physical health services, behavioral health services, and long-term services and supports—to the TennCare population. The due date for proposals was September 1, 2021. On November 8, 2021, TennCare notified bidders that the highest scoring proposals had been submitted by Amerigroup, BlueCare, and UnitedHealthcare.

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 2021, all providers participating in the Episodes of Care program were invited to a collaborative Delivery System Transformation conference hosted jointly by TennCare and its MCOs. Included in the conference was a learning collaborative session entitled "Episodes of Care: Emergency Medicine Groups as Quarterbacks" that discussed how emergency department providers can be successful in the episodes program. The conference was hosted virtually, and providers from across the state attended.

[3] Because this amendment was submitted to CMS prior to the approval of the TennCare III Demonstration, its numbering reflects the amendments that were in place during the TennCare II Demonstration.

Incentives for Providers to Use Electronic Health Records. The TennCare Electronic Health Records (EHR) Provider Incentive Payment Program distributed more than $300 million in incentives to TennCare providers before sunsetting on Dec. 31, 2021. A partnership between federal and state governments, the program grew out of the Health Information Technology for Economic and Clinical Health (HITECH) Act of 2009. The purpose of the program was to provide financial incentives to Medicaid providers to replace outdated, often paper-based approaches to medical record-keeping with Certified Electronic Health Record Technology (as defined by CMS) that met rigorous criteria and that could improve health care delivery and quality. The federal government provided 100 percent of the funding for the incentive payments and 90 percent of the funding for administrative costs.

CMS operated a version of the EHR program for Medicare, while also providing guidance to states on implementing the program within the context of Medicaid. CMS allowed two types of providers to participate in the Medicaid EHR Incentive programs: 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). TennCare's EHR program allowed eligible hospitals to attest for all incentive payments over a three-year period, while eligible professionals could attest for up to six annual incentive payments. In all, 306 payments totaling $133,412,332 were made to eligible hospitals in the state, while 11,950 payments totaling $167,153,439 were made to eligible professionals.

All payments to providers were completed by December 31, 2021. EHR payments made by TennCare during the October-December 2021 quarter as compared with payments made throughout the life of the program appear in the table below:

Payment Type	Number of Providers Paid During the Quarter	Quarterly Amount Paid (Oct-Dec 2021)	Cumulative Amount Paid to Date[4]
First-year payments	N/A	N/A	$180,309,221
Second-year payments	10	$85,000	$60,307,761
Third-year payments	11	$93,500	$38,288,519
Fourth-year payments	17	$141,667	$9,539,849
Fifth-year payments	19	$161,500	$7,103,172
Sixth-year payments	22	$184,167	$5,017,249

During this final quarter of the program, the EHR Incentive team completed its review of all remaining attestations and either approved them or returned them for correction. In the case of returned attestations, the team communicated with affected providers to facilitate quick adjustment and resubmission of attestations to ensure that providers received payments prior to the conclusion of the EHR program. Other EHR-related activities conducted by TennCare staff during the quarter included 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.

- Providing daily technical assistance to providers via email and telephone calls;
- Participation in CMS-led calls regarding the EHR Incentive Program; and
- Monthly newsletters distributed to all registered members of TennCare's EHR ListServ.

The newsletter will continue to be distributed through March 2022 to provide messages and information of interest to those who participated in the program, and TennCare staff will remain available to address questions or concerns shared by providers. Audits of the EHR program will continue to be performed by TennCare (and funded by CMS) through September 30, 2023.

For 11 years, TennCare has worked with eligible professionals and eligible hospitals to advance EHR technology across Tennessee. Of all attestations submitted by providers, 93 percent met the program requirements, and each provider then received the appropriate EHR Provider Incentive Payment. Furthermore, an annual survey of TennCare enrollees confirmed that improvements had been achieved in each area addressed by the program. Participating providers have improved the quality and coordination of health care by making it more accessible, safe, and patient-centered. As a result, providers are now better able to ensure that each Tennessean and family can be engaged as partners in their care and can benefit from having a newfound portability for their personal health records.

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. 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 an appeal, and, on October 7, 2021, the Court of Appeals ruled in TennCare's favor and reversed the trial court's ruling. The Court of Appeals found that the reimbursement limit fell within the internal management exception of a rule and was not subject to rulemaking requirements. EMCF has filed an application for permission to appeal to the Tennessee Supreme Court, and this application was still pending as of the end of the October-December 2021 quarter.

Erlanger Health System v. TennCare **Lawsuit.** This declaratory order action was commenced against TennCare regarding the applicability and validity of two TennCare rules that set the reimbursement rates for emergency services provided to TennCare enrollees by non-contract hospitals. TennCare's Commissioner's Designee issued a declaratory order upholding the rules being challenged by Erlanger, and on November 12, 2021, Erlanger filed a Petition for Judicial Review of the declaratory order in Chancery Court.

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 supplemental payments made during the second quarter of State Fiscal Year 2022 are shown in the table below.

Supplemental Hospital Payments for the Quarter

Hospital Name	County	Second Quarter Payments – FY 2022
Methodist Medical Center of Oak Ridge	Anderson County	$119,616
Ridgeview Psychiatric Hospital and Center	Anderson County	$172,132
Behavioral Health of Rocky Top	Anderson County	$2,070
Vanderbilt Bedford Hospital	Bedford County	$49,933
Blount Memorial Hospital	Blount County	$142,870
Tennova Healthcare – Cleveland	Bradley County	$143,698
Tennova Healthcare – LaFollette Medical Center	Campbell County	$108,901
Ascension Saint Thomas Stones River Hospital	Cannon County	$43,421
Sycamore Shoals Hospital	Carter County	$126,549
Claiborne Medical Center	Claiborne County	$40,141
Tennova Healthcare – Newport Medical Center	Cocke County	$151,163
Vanderbilt Tullahoma-Harton Hospital	Coffee County	$81,114
Unity Medical Center	Coffee County	$108,537
Ascension Saint Thomas Hospital	Davidson County	$449,338
TriStar Skyline Medical Center	Davidson County	$487,867
Nashville General Hospital	Davidson County	$352,474
TriStar Centennial Medical Center	Davidson County	$916,898
TriStar Southern Hills Medical Center	Davidson County	$177,161
TriStar Summit Medical Center	Davidson County	$224,121
Vanderbilt Stallworth Rehabilitation Hospital	Davidson County	$29
Vanderbilt University Medical Center	Davidson County	$5,369,867
Ascension Saint Thomas DeKalb Hospital	DeKalb County	$26,728
TriStar Horizon Medical Center	Dickson County	$192,334
Southern Tennessee Regional Health System – Winchester	Franklin County	$122,949
West Tennessee Healthcare Milan Hospital	Gibson County	$23,085
Southern Tennessee Regional Health System – Pulaski	Giles County	$99,289
Morristown – Hamblen Healthcare System	Hamblen County	$294,526
Erlanger Behavioral Health Hospital	Hamilton County	$110,580
Erlanger Medical Center – Baroness Hospital	Hamilton County	$2,872,818
Parkridge Medical Center	Hamilton County	$1,371,479
Encompass Health Rehabilitation Hospital of Chattanooga	Hamilton County	$277
Siskin Hospital for Physical Rehabilitation	Hamilton County	$544
Hardin Medical Center	Hardin County	$108,369
Henderson County Community Hospital	Henderson County	$17,661
Henry County Medical Center	Henry County	$207,849

Hospital Name	County	Second Quarter Payments – FY 2022
Tennova Healthcare – Jefferson Memorial Hospital	Jefferson County	$80,074
Parkwest Medical Center	Knox County	$407,921
Tennova Healthcare – North Knoxville Medical Center	Knox County	$168,065
East Tennessee Children's Hospital	Knox County	$2,405,081
Fort Sanders Regional Medical Center	Knox County	$370,922
University of Tennessee Medical Center	Knox County	$1,509,219
Southern Tennessee Regional Health System – Lawrenceburg	Lawrence County	$74,168
Lincoln Medical Center	Lincoln County	$212,363
Jackson – Madison County General Hospital	Madison County	$637,612
Pathways of Tennessee	Madison County	$16,225
West Tennessee Healthcare Rehabilitation Hospital Jackson	Madison County	$343
Maury Regional Medical Center	Maury County	$237,986
Pinewood Springs	Maury County	$32,633
Starr Regional Medical Center – Athens	McMinn County	$198,928
Sweetwater Hospital Association	Monroe County	$196,944
Tennova Healthcare – Clarksville	Montgomery County	$204,360
Baptist Memorial Hospital – Union City	Obion County	$172,196
Livingston Regional Hospital	Overton County	$59,474
Cookeville Regional Medical Center	Putnam County	$225,660
Roane Medical Center	Roane County	$108,127
TriStar NorthCrest Medical Center	Robertson County	$147,642
Ascension Saint Thomas Rutherford Hospital	Rutherford County	$308,715
TriStar StoneCrest Medical Center	Rutherford County	$239,017
TrustPoint Hospital	Rutherford County	$204,294
LeConte Medical Center	Sevier County	$162,843
Baptist Memorial Restorative Care Hospital	Shelby County	$541
Baptist Memorial Hospital – Memphis	Shelby County	$1,030,245
Methodist University Hospital	Shelby County	$1,312,792
Crestwyn Behavioral Health	Shelby County	$152,458
Delta Specialty Hospital	Shelby County	$297,904
Encompass Health Rehabilitation Hospital of North Memphis	Shelby County	$493
Encompass Health Rehabilitation Hospital of Memphis	Shelby County	$955
Le Bonheur Children's Hospital	Shelby County	$4,744,919
Regional One Health	Shelby County	$2,774,708
Regional One Health Extended Care Hospital	Shelby County	$216
Saint Francis Hospital	Shelby County	$298,778
Saint Francis Hospital – Bartlett	Shelby County	$102,407
Saint Jude Children's Research Hospital	Shelby County	$745,923

Hospital Name	County	Second Quarter Payments – FY 2022
Bristol Regional Medical Center	Sullivan County	$199,245
Creekside Behavioral Health	Sullivan County	$57,188
Encompass Health Rehabilitation Hospital of Kingsport	Sullivan County	$409
Holston Valley Medical Center	Sullivan County	$235,283
Indian Path Community Hospital	Sullivan County	$100,062
TriStar Hendersonville Medical Center	Sumner County	$194,290
Sumner Regional Medical Center	Sumner County	$134,461
Baptist Memorial Hospital – Tipton	Tipton County	$124,284
Ascension Saint Thomas River Park Hospital	Warren County	$143,260
Johnson City Medical Center	Washington County	$1,945,914
Franklin Woods Community Hospital	Washington County	$163,923
Quillen Rehabilitation Hospital	Washington County	$270
Wayne Medical Center	Wayne County	$22,702
West Tennessee Healthcare Volunteer Hospital	Weakley County	$94,761
Ascension Saint Thomas Highlands Hospital	White County	$58,734
Williamson Medical Center	Williamson County	$79,670
Vanderbilt Wilson County Hospital	Wilson County	$329,291
TOTAL		**$38,443,286**

Number of Recipients on TennCare and Costs to the State

During the month of December 2021, there were 1,618,676 Medicaid eligibles and 21,564 Demonstration eligibles enrolled in TennCare, for a total of 1,640,240 persons.

Estimates of TennCare spending for the second quarter of State Fiscal Year 2022 are summarized in the table below.

Spending Category	Second Quarter FY 2022*
MCO services**	$1,556,907,600
Dental services	$37,041,500
Pharmacy services	$349,358,100
Medicare "clawback"***	$53,447,600

**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 2021 quarter, the MCOs submitted their NAIC Third Quarter 2021 Financial Statements. As of September 30, 2021, 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	$38,720,932	$362,442,119	$323,721,187
UnitedHealthcare Plan of the River Valley (UnitedHealthcare Community Plan)	$58,718,194	$532,082,053	$473,363,859
Volunteer State Health Plan (BlueCare & TennCare Select)	$59,296,934	$609,321,355	$550,024,421

During the October-December 2021 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, 2021.

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 2022 furnished for this report by the OIG are as follows:

Fraud and Abuse Allegations	Second Quarter FY 2022
Fraud Allegations	307
Abuse Allegations*	409
Arrest/Conviction/Judicial Diversion Totals	**Second Quarter FY 2022**
Arrests	11
Convictions	7
Judicial Diversions	8

***** *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 2022
Criminal Restitution Ordered	$111,018
Criminal Restitution Received[8]	$73,887
Civil Restitution/Civil Court Judgments	**Second Quarter FY 2022**
Civil Restitution Ordered[9]	$54,412
Civil Restitution Received[10]	$1,309

Recommendations for Review	Second Quarter FY 2022
Recommended TennCare Terminations[11]	409
Potential Savings[12]	$1,747,052

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. Although food stamps are not part of the TennCare program, OIG occasionally discovers evidence of fraud in this area during the course of a TennCare fraud investigation.

Type of Court-Ordered Payment	Grand Total for Period of 2004-2021
Restitution to Division of TennCare	$6,229,532
Restitution to TennCare MCOs	$90,768
Food Stamps	$81,337
Civil Restitution	$3,228,723

[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 $4,271.52).