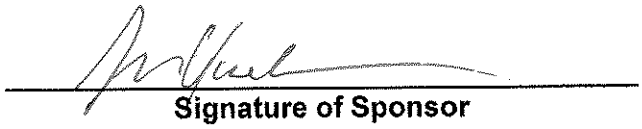
House TennCare Subcommittee Am. #1

Amendment No._____



Signature of Sponsor

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Date _____
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AMEND Senate Bill No. 2022 **House Bill No. 2170***

by deleting all language after the enacting clause and substituting the following:

SECTION 1. Tennessee Code Annotated, Title 71, Chapter 5, Part 20, is amended by deleting the part and substituting the following:

71-5-2001. Short title.

This part shall be known and may be cited as the "Annual Coverage Assessment Act of 2020."

71-5-2002. Part definitions.

As used in this part:

(1) "Annual coverage assessment" means the annual assessment imposed on covered hospitals as set forth in this part;

(2) "Annual coverage assessment base" means a covered hospital's net patient revenue as shown in its medicare cost report for its fiscal year that ended during calendar year 2016, on file with CMS as of September 30, 2018, subject to the following qualifications:

(A) If a covered hospital does not have a full twelve-month medicare cost report for 2016 on file with CMS but has a full twelve-month cost report for a subsequent year, then the first full twelve-month medicare cost report for a year following 2016 on file with CMS is the annual coverage assessment base;

(B) If a covered hospital does not have a full twelve-month medicare cost report for 2016 on file with CMS and does not have a full

twelve-month cost report for a subsequent year but has a cost report for 2016 that covers at least nine (9) months of 2016, then the assessment base is calculated by annualizing the 2016 cost report data;

(C) If a covered hospital was first licensed in 2016 or later and did not replace an existing hospital, and if the hospital has a medicare cost report on file with CMS, then the hospital's initial cost report on file with CMS is the base for the hospital assessment. If the hospital does not have an initial cost report on file with CMS but does have a complete twelve-month joint annual report filed with the department of health, then the net patient revenue from the first twelve-month joint annual report is the annual coverage assessment base. If the hospital does not have a medicare cost report or a full twelve-month joint annual report filed with the department of health, then the annual coverage assessment base is the covered hospital's projected net patient revenue for its first full year of operation as shown in its certificate of need application filed with the health services and development agency;

(D) If a covered hospital was first licensed in 2016 or later and replaced an existing hospital, then the annual coverage assessment base is the replacement hospital's initial medicare cost report on file with CMS. If the hospital does not have a medicare cost report on file with CMS, then the hospital's annual coverage assessment base is either the predecessor hospital's net patient revenue as shown in its medicare cost report for its fiscal year that ended during calendar year 2016, or, if the predecessor hospital does not have a 2016 medicare cost report, then the cost report for the first fiscal year following 2016 on file with CMS;

(E) If a covered hospital is not required to file an annual medicare cost report with CMS, then the hospital's annual coverage assessment

base is its net patient revenue for the fiscal year ending during calendar year 2016 or the first fiscal year that the hospital was in operation after 2016 as shown in the covered hospital's joint annual report filed with the department of health; and

(F) If a covered hospital's fiscal year 2016 medicare cost report is not contained in any of the CMS healthcare cost report information system files and if the hospital does not meet any of the other qualifications listed in subdivisions (2)(A)-(E), then the hospital must submit a copy of the hospital's 2016 medicare cost report to the bureau in order to allow for the determination of the hospital's net patient revenue for the state fiscal year 2020-2021 annual coverage assessment;

(3) "Bureau" means the bureau of TennCare;

(4) "CMS" means the federal centers for medicare and medicaid services;

(5) "Controlling person" means a person who, by ownership, contract, or otherwise, has the authority to control the business operations of a covered hospital. As used in this subdivision (5), "control" means indirect or direct ownership of ten percent (10%) or more of a covered hospital;

(6) "Covered hospital" means a hospital licensed under title 33 or title 68, as of July 1, 2020, but does not include an excluded hospital;

(7) "Excluded hospital" means:

(A) A hospital that has been designated by CMS as a critical access hospital as of July 1, 2020;

(B) A mental health hospital owned by this state;

(C) A hospital providing primarily rehabilitative or long-term acute care services;

(D) A children's research hospital that does not charge patients for services beyond that reimbursed by third-party payers; and

(E) A hospital that is determined by the bureau as eligible to certify public expenditures for the purpose of securing federal medical assistance percentage payments;

(8) "Medicare cost report" means CMS-2552-10 or a subsequent form adopted by CMS for medicare cost reporting, the cost report for electronic filing of hospitals, for the period applicable as set forth in this section; and

(9) "Net patient revenue" from the medicare cost report means the amount calculated in accordance with generally accepted accounting principles for hospitals that is reported on Worksheet G-3, Column 1, Line 3, of the 2016 medicare cost report excluding long-term care inpatient ancillary and other non-hospital revenues, or, in the case of a hospital that did not file a 2016 medicare cost report, comparable data from the first complete cost report filed after 2016 by the hospital.

71-5-2003. Annual coverage assessment on covered hospitals.

(a) There is imposed on each covered hospital licensed as of July 1, 2020, an annual coverage assessment for fiscal year (FY) 2020-2021 as set forth in this part.

(b) The annual coverage assessment imposed by this part is not effective and validly imposed until the bureau has provided the Tennessee Hospital Association with written notice that includes:

(1) A determination from CMS that the annual coverage assessment is a permissible source of revenue that must not adversely affect the amount of federal financial participation in the TennCare program;

(2) Either:

(A) Approval from CMS for the distribution of the full amount of directed payments to hospitals to offset unreimbursed TennCare costs as

described in § 71-5-2005(d)(2) as long as no assessment installment is collected prior to the distribution of the installment of the directed payments; or

(B) The rules promulgated by the bureau pursuant to § 71-5-2004(j)(2); and

(3) Confirmation that all contracts between hospitals and managed care organizations comply with the hospital rate variation corridors set forth in § 71-5-161.

(c) The general assembly intends that the proceeds of the annual coverage assessment not be used as a justification to reduce or eliminate state funding to the TennCare program. The annual coverage assessment is not effective and validly imposed if the coverage or the amount of revenue available for expenditure by the TennCare program in FY 2020-2021 is less than:

(1) The governor's FY 2020-2021 recommended budget level; plus

(2) Additional appropriations made by the general assembly to the TennCare program for FY 2020-2021, except to the extent new federal funding is available to replace funds that are appropriated as described in subdivision (c)(1) and that are above the amount that the state receives from CMS under the regular federal matching assistance percentage.

(d)

(1)

(A) The general assembly intends that the proceeds of the annual coverage assessment not be used as justification for any TennCare managed care organization to implement across-the-board rate reductions to negotiated rates with covered or excluded hospitals or physicians in existence on July 1, 2020. For those rates in effect on July 1, 2020, the bureau shall include provisions in the managed care

organizations' contractor risk agreements that prohibit the managed care organizations from implementing across-the-board rate reductions to covered or excluded network hospitals or physicians by specific service, category, or type of provider. The requirements of the preceding sentence also apply to services or settings of care that are ancillary to the primary license of a covered or excluded hospital or physician, but do not apply to reductions in benefits or reimbursement for the ancillary services if the reductions:

(i) Are different from those items being funded in § 71-5-2005(d); and

(ii) Have been communicated in advance of implementation to the general assembly and the Tennessee Hospital Association.

(B)

(i) For purposes of this subsection (d), "services or settings of care that are ancillary to the primary license of a covered or excluded hospital or physician" includes all services where the physician or covered or excluded hospital, including a wholly owned subsidiary or controlled affiliate of a covered or excluded hospital or hospital system, holds more than a fifty percent (50%) controlling interest in the ancillary services or settings of care, but does not include any other ancillary services or settings of care. For across-the-board rate reductions to ancillary services or settings of care, the bureau shall include appropriate requirements for notice to providers in the managed care organizations' contractor risk agreements.

(ii) For purposes of this subsection (d), "services or settings of care that are ancillary" means, but is not limited to, ambulatory surgical facilities, free standing emergency departments, outpatient treatment clinics or imaging centers, dialysis centers, home health and related services, home infusion therapy services, outpatient rehabilitation, or skilled nursing services.

(iii) For purposes of this subsection (d), "physician" includes a physician licensed under title 63, chapter 6 or chapter 9, and a group practice of physicians that hold a contract with a managed care organization.

(2) This subsection (d) does not preclude good faith negotiations between managed care organizations and covered or excluded hospitals, hospital systems, and physicians on an individualized, case-by-case basis, nor is this subsection (d) intended by the general assembly to serve as justification for managed care organizations in this state, covered or excluded hospitals, hospital systems, or physicians to unreasonably deny any party the ability to enter into the individualized, case-by-case good faith negotiations. Good faith negotiation necessarily implies mutual cooperation between the negotiating parties and may include, but is not limited to, the right to terminate contractual agreements, the ability to modify negotiated rates, pricing, or units of service, the ability to alter payment methodologies, and the ability to enforce existing managed care techniques or to implement new managed care techniques.

(3) This subsection (d) does not preclude the full implementation of the requirements set forth in § 71-5-161.

(4) Notwithstanding this subsection (d), if CMS mandates a TennCare program change or a change is required by state or federal law that impacts

rates, and that change is required to be implemented by the managed care organizations in accordance with their contracts, or if the annual coverage assessment becomes invalid, then nothing in this part prohibits the managed care organizations from implementing any rate changes as may be mandated by the bureau or by state or federal law.

71-5-2004. Amount of annual coverage assessment — Payment — Penalty — Suspension of payments — Civil action.

(a) The annual coverage assessment established for this part is four and eighty-seven hundredths percent (4.87%) of a covered hospital's annual coverage assessment base.

(b) The annual coverage assessment must be paid in installments pursuant to this subsection (b) if the requirements of § 71-5-2003(b) have been satisfied. The bureau shall establish a schedule of four (4) equal installment payments spread as evenly as possible throughout FY 2020-2021 with each installment payment due fifteen (15) days after the FY 2020-2021 directed payments approved by CMS to offset unreimbursed TennCare costs have been made to hospitals.

(c) To facilitate collection of the annual coverage assessment, the bureau shall send each covered hospital, at least thirty (30) days in advance of each installment payment due date, a notice of payment along with a return form developed by the bureau. Failure of a covered hospital to receive a notice and return form, however, does not relieve a covered hospital from the obligation of timely payment. The bureau shall also post the return form on its website.

(d) Failure of a covered hospital to pay an installment of the annual coverage assessment, when due, results in an imposition of a penalty of five hundred dollars ($500) per day until the installment is paid in full. The bureau at its discretion may waive the penalty if the hospital establishes that it attempted to mail or electronically transfer payment to the state on or before the date the payment was due.

(e) If a covered hospital ceases to operate or changes status to be an excluded hospital after July 1, 2020, and before July 1, 2021, the hospital's total annual coverage assessment is equal to its annual coverage assessment base multiplied by a fraction, the denominator of which is the number of calendar days from July 1, 2020, until July 1, 2021, and the numerator of which is the number of days from July 1, 2020, until the date the board for licensing healthcare facilities has recorded as the date that the hospital changed status or ceased operation.

(f) If a covered hospital ceases operation prior to payment of its full annual coverage assessment, then the person controlling the hospital as of the date the hospital ceased operation is jointly and severally responsible for any remaining annual coverage assessment installments and unpaid penalties associated with previous late payments.

(g) If a covered hospital is sold after July 1, 2020 and before July 1, 2021, the seller is responsible for any annual coverage assessment payments due for the period up to and including the date the sale is final. If the hospital continues to operate in this state and continues to meet the definition of a covered hospital, then the new owner is responsible for paying all coverage assessment amounts due for the period beginning on the day after the date of the sale until July 1, 2021.

(h) If a covered hospital fails to pay an installment of the annual coverage assessment within thirty (30) days of its due date, then the bureau must suspend the payments to the hospital as required by § 71-5-2005(d)(2) or (d)(3) until the installment is paid and report the failure to the department that licenses the covered hospital. Notwithstanding any other law, failure of a covered hospital to pay an installment of the annual coverage assessment or any refund required by this part is considered a license deficiency and grounds for disciplinary action as set forth in the statutes and rules under which the covered hospital is licensed.

(i) In addition to the action required by subsection (h), the bureau is authorized to file a civil action against a covered hospital and its controlling person or persons to

collect delinquent annual coverage assessment installments, late penalties, and refund obligations established by this part. Exclusive jurisdiction and venue for a civil action authorized by this subsection (i) is in the chancery court for Davidson County.

(j)

(1) If any federal agency with jurisdiction over this annual coverage assessment determines that the annual coverage assessment is not a valid source of revenue or if there is a reduction of the coverage and funding of the TennCare program contrary to § 71-5-2003(c), or if the requirements of §§ 71-5-161 and 71-5-2003(b) are not fully satisfied, or if one (1) or more managed care organizations impose rate reductions contrary to § 71-5-2003(d), then:

(A) No subsequent installments of the annual coverage assessment are due and payable; and

(B) No further payments must be paid to hospitals pursuant to § 71-5-2005(d)(2) or (d)(3) after the date of the event.

(2)

(A) Notwithstanding this part, if CMS discontinues approval of or otherwise fails to approve the full amount of directed payments to hospitals to offset losses incurred from providing services to TennCare enrollees as authorized under § 71-5-2005(d), then the bureau must suspend any payments from or to covered hospitals otherwise required by this part and must promulgate rules that:

(i) Establish the methodology for determining the amounts, categories, and times of payments to hospitals, if any, instead of the payments that otherwise would have been paid under § 71-5-2005(d)(3) if approved by CMS;

(ii) Prioritize payments to hospitals as set forth in § 71-5-2005(d)(3);

(iii) Identify the benefits and services for which funds will be available in order to mitigate reductions or eliminations that otherwise would be imposed in the absence of the coverage assessment;

(iv) Determine the amount and timing of payments for benefits and services identified under subdivisions (j)(2)(A)(ii) and (iii) as appropriate;

(v) Reinstitute payments from or to covered hospitals as appropriate; and

(vi) Otherwise achieve the goals of this subdivision (j)(2).

(B) The rules adopted under this subdivision (j)(2) must, to the extent possible, achieve the goals of:

(i) Maximizing the amount of federal matching funds available for the TennCare program; and

(ii) Minimizing the variation between payments hospitals will receive under the rules as compared to payments hospitals would have received if CMS had approved the total payments described in § 71-5-2005(d).

(C) Notwithstanding any other law, the bureau is authorized to exercise emergency rulemaking authority to the extent necessary to meet the objectives of this subdivision (j)(2).

(3) Upon occurrence of any of the events set forth in subdivision (j)(1) or (j)(2), the bureau shall then have authority to make necessary changes to the TennCare budget to account for the loss of annual coverage assessment revenue.

(k) A covered hospital or an association representing covered hospitals, the membership of which includes thirty (30) or more covered hospitals, has the right to file a

petition for a declaratory order pursuant to § 4-5-223 to determine if there has been a failure to meet any of the requirements of this part. A covered hospital may not increase charges or add a surcharge based on, or as a result of, the annual coverage assessment.

71-5-2005. Deposits in Maintenance of Coverage Trust Fund — Expenditures — Quarterly Reports.

(a) The funds generated as a result of this part must be deposited in the maintenance of coverage trust fund created by § 71-5-160, the existence of which is continued as provided in subsection (b). The fund must not be used to replace any monies otherwise appropriated to the TennCare program by the general assembly or to replace any monies appropriated outside of the TennCare program.

(b) The maintenance of coverage trust fund must continue without interruption and must be operated in accordance with § 71-5-160 and this section.

(c) The maintenance of coverage trust fund consists of:

(1) The balance of the trust fund remaining as of June 30, 2020;

(2) All annual coverage assessments received by the bureau;

(3) Investment earnings credited to the assets of the maintenance of coverage trust fund; and

(4) Penalties paid by covered hospitals for late payment of assessment installments imposed by this part or any prior statute authorizing an annual coverage assessment.

(d) Monies credited or deposited to the maintenance of coverage trust fund, together with all federal matching funds, must be available to and used by the bureau only for expenditures in the TennCare program and include the following purposes:

(1) Expenditure for benefits and services under the TennCare program, including those that would have been subject to reduction or elimination from

TennCare funding for FY 2020-2021, except for the availability of one-time funding for that year only, as follows:

(A) Replacement of across-the-board reductions in covered and excluded hospital and professional reimbursement rates described in the governor's recommended budgets since FY 2011 except for any reductions that were included on a list for a given year but then funded in a subsequent year with recurring state dollars;

(B) Maintenance of virtual DSH fund payments and uncompensated care fund for charity care payments in accordance with, and as those payments are defined in, the TennCare 1115 demonstration waiver from CMS, to the maximum amount of the virtual DSH fund and uncompensated care fund for charity care allowed by CMS under the TennCare waiver.

(C) Maintenance of payments for graduate medical education of at least fifty million dollars ($50,000,000);

(D) Maintenance of reimbursement for medicare part A crossover claims at the lesser of one hundred percent (100%) of medicare allowable or the billed amount;

(E) Avoidance of any coverage limitations relative to the number of hospital inpatient days per year or the annual cost of hospital services for a TennCare enrollee;

(F) Avoidance of any coverage limitations relative to the number of nonemergency outpatient visits per year for a TennCare enrollee;

(G) Avoidance of any coverage limitations relative to the number of physician office visits per year for a TennCare enrollee;

(H) Avoidance of coverage limitations relative to the number of laboratory and diagnostic imaging encounters per year for a TennCare enrollee;

(I) Maintenance of coverage for occupational therapy, physical therapy, and speech therapy services;

(J) In the total amount of five hundred seven-two thousand eight hundred forty dollars ($572,840) to maintain reimbursement at the same emergency care rate as in FY 2019-2020 for nonemergent care to children twelve (12) to twenty-four (24) months of age;

(K) In the total amount of two million forty-seven thousand three hundred twenty dollars ($2,047,320) to the bureau to offset the elimination of the provision in the TennCare managed care contractor risk agreements for hospitals as follows:

CRA 2.12.9.60-Specify in applicable provider agreements that all providers who participate in the federal 340B program give TennCare MCOs the benefit of 340B pricing;

(L) In the total amount of two hundred seventy-five thousand dollars ($275,000) to offset a portion of the hospital cost of providing admissions, discharge, and transfer (ADT) messages to the TennCare bureau to support the TennCare Patient Centered Medical Home initiative;

(M) In the total amount of seven hundred fifty thousand dollars ($750,000) to provide funding for stipends for physicians and other healthcare providers who commit to work in designated medically underserved areas in this state; and

(N) In the amount of three million dollars ($3,000,000) to offset the unreimbursed cost of charity care for critical access hospitals to be funded from funds remaining in the trust fund as of June 30, 2020.

(2) Directed payments to hospitals to reduce unreimbursed costs incurred by covered hospitals in providing services to TennCare patients, as approved by CMS and as directed in subdivision (d)(3)(B).

(3)

(A) If CMS does not approve directed payments to hospitals to offset unreimbursed costs incurred in serving TennCare patients, but instead approves hospital supplemental pools in the TennCare waiver for that purpose, then payments required by this subdivision (d)(3) must be made from the allocated pools to covered hospitals to offset losses incurred in providing services to TennCare enrollees as set forth in this subdivision (d)(3) as first priority before any other supplemental payments authorized in the TennCare waiver are distributed;

(B) Directed payments to hospitals must be based on the amounts paid to covered hospitals during each quarter of FY 2020-2021. Each covered hospital is entitled to payments for FY 2020-2021 of a portion of its unreimbursed TennCare costs of providing services to TennCare enrollees. As used in this subdivision (d)(3)(B), "unreimbursed TennCare costs" means the excess of TennCare costs over TennCare net revenue. TennCare charges and net revenue are calculated using data from Schedule E, items (A)(1)(e) and (A)(1)(f) from the hospital's 2018 joint annual report (JAR) filed with the department of health. As used in this subdivision (d)(3)(B), "TennCare costs" means the quotient of a facility's cost-to-charge ratio, calculated as B(3) (total expenses) divided by A(3)(e) (total gross patient charges) from Schedule E of the 2018 JAR,

times TennCare charges. The amount of the payment to covered hospitals must be no less than forty-three and eight-tenths percent (43.80%) of unreimbursed TennCare costs for all hospitals licensed by the state that reported TennCare charges and revenue and total expenses on the 2018 joint annual report (JAR), excluding state-owned hospitals;

(C) The payments required by this subdivision (d)(3) must be made in four (4) equal installments. The bureau shall provide to the Tennessee Hospital Association a schedule showing the payments to each hospital at least seven (7) days in advance of the payments; and

(D) The payments required by this subdivision (d)(3) may be made by the bureau directly or by the TennCare managed care organizations with the direction to make payments to hospitals as required by this subsection (d). The payments to a hospital pursuant to this subdivision (d)(3) are not part of the reimbursement to which a hospital is entitled under its contract with a TennCare managed care organization;

(4) Refunds to covered hospitals based on the payment of annual coverage assessments or penalties to the bureau through error, mistake, or a determination that the annual coverage assessment was invalidly imposed; and

(5) Payments authorized under rules promulgated by the bureau pursuant to § 71-5-2004(j)(2).

(e) The bureau shall modify the contracts with TennCare managed care organizations and otherwise take action necessary to assure the use and application of the assets of the maintenance of coverage trust fund, as described in subsection (d).

(f) The bureau shall submit requests to CMS to modify the medicaid state plan, the contractor risk agreements, or the TennCare II Section 1115 demonstration project, as necessary, to implement the requirements of this part.

(g) At quarterly intervals beginning September 1, 2020, the bureau shall submit a report to the finance, ways and means committees of the senate and the house of representatives, to the health and welfare committee of the senate, and to the health committee of the house of representatives, which report must include:

(1) The status, if applicable, of the determination and approval by CMS set forth in § 71-5-2003(b) of the annual coverage assessment;

(2) The balance of funds in the maintenance of coverage trust fund; and

(3) The extent to which the maintenance of coverage trust fund has been used to carry out this part.

(h) No part of the maintenance of coverage trust fund must be diverted to the general fund or used for any purpose other than as set forth in this part.

71-5-2006. Expiration of part — Survival of certain rights and obligations.

This part expires on July 1, 2021. However, the following rights and obligations survive the expiration:

(1) The authority of the bureau to impose late payment penalties and to collect unpaid annual coverage assessments and required refunds;

(2) The rights of a covered hospital or an association of covered hospitals to file a petition for declaratory order to determine compliance with this part;

(3) The existence of the maintenance of coverage trust fund and the obligation of the bureau to use and apply the assets of the maintenance of coverage trust fund; and

(4) The obligation of the bureau to implement and maintain the requirements of § 71-5-161.

71-5-2007. Audit of expenditure of funds from maintenance of coverage trust fund.

The comptroller of the treasury may audit the expenditure of funds pursuant to this part from the maintenance of coverage trust fund. At the discretion of the comptroller of the treasury, the audit may be prepared by a certified public accountant, a public accountant, or the department of audit. Notwithstanding § 71-5-2005, the bureau of TennCare and the maintenance of coverage trust fund must bear the full costs of the audit.

SECTION 2. Tennessee Code Annotated, Section 71-5-2005(d)(1), is amended by adding the following as a new subdivision:

(O) In the total amount of fifty thousand dollars ($50,000) to fund the cost of a pilot program with the TennCare managed care organizations (MCOs) to improve care coordination for TennCare enrollees and reduce administrative burden.

SECTION 3. The headings to sections, chapters, and parts in this act are for reference purposes only and do not constitute a part of the law enacted by this act. However, the Tennessee Code Commission is requested to include the headings in any compilation or publication containing this act.

SECTION 4. Section 1 of this act shall take effect July 1, 2020, the public welfare requiring it. Section 2 of this act shall take effect upon becoming a law, the public welfare requiring it.

House TennCare Subcommittee Am. #1

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Date _____
Time _____
Clerk _____
Comm. Amdt. _____

Amendment No. _____

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Signature of Sponsor

AMEND Senate Bill No. 2123 **House Bill No. 2138***

by deleting all language after the enacting clause and substituting instead the following:

SECTION 1. Tennessee Code Annotated, Section 71-5-1002(h)(1), is amended by deleting the language "FY 2019-2020" and substituting instead the language "FY 2020-2021".

SECTION 2. Tennessee Code Annotated, Section 71-5-1003(c), is amended by deleting the language "from July 1, 2019, through June 30, 2020" and substituting instead the language "from July 1, 2020, through June 30, 2021".

SECTION 3. Tennessee Code Annotated, Section 71-5-1003(c)(1), is amended by deleting the language "July 1, 2019" and substituting instead the language "July 1, 2020".

SECTION 4. Tennessee Code Annotated, Section 71-5-1003(c)(2), is amended by deleting the language "July 1, 2019" and substituting instead the language "July 1, 2020".

SECTION 5. Tennessee Code Annotated, Section 71-5-1003(c)(3), is amended by deleting the language "July 1, 2019" and substituting instead the language "July 1, 2020".

SECTION 6. Tennessee Code Annotated, Section 71-5-1003(c)(4), is amended by deleting the language "after July 1, 2019, shall pay in FY 2019-2020" and substituting instead the language "after July 1, 2020, shall pay in FY 2020-2021".

SECTION 7. Tennessee Code Annotated, Section 71-5-1003(c)(5), is amended by deleting the language "from July 1, 2019, through June 30, 2020" and substituting instead the language "from July 1, 2020, through June 30, 2021".

SECTION 8. Tennessee Code Annotated, Section 71-5-1010(a), is amended by deleting the language "June 30, 2020" and substituting instead the language "June 30, 2021".

SECTION 9. This act shall take effect July 1, 2020, the public welfare requiring it.

House TennCare Subcommittee Am. #1

Amendment No._____

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Signature of Sponsor

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Date _____
Time _____
Clerk _____
Comm. Amdt. _____

AMEND Senate Bill No. 2384* **House Bill No. 2574**

by deleting all language after the enacting clause and substituting instead the following:

SECTION 1. Tennessee Code Annotated, Title 71, Chapter 5, Part 1, is amended by adding the following language as a new section:

Any contract executed by the department of finance and administration and a managed care organization for the administration of health care for citizens of this state under the TennCare program must provide that all data collected or generated by the managed care organization is the property of the state and not that of the managed care organization.

SECTION 2. This act shall take effect upon becoming a law, the public welfare requiring it, and applies to contracts entered into or renewed on and after such date.

House TennCare Subcommittee Am. #1

Amendment No._____

Signature of Sponsor

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Date _____
Time _____
Clerk _____
Comm. Amdt. _____

AMEND Senate Bill No. 2585 **House Bill No. 2830***

by deleting all language after the enacting clause and substituting instead the following:

SECTION 1. Tennessee Code Annotated, Section 71-5-118, is amended by adding the following as a new subsection:

(e) The participating provider shall strive to process hospital presumptive eligibility applications within the first twenty-four (24) hours of the date of admission, when practicable. To the extent a participating provider fails to adhere to this standard, the bureau of TennCare may take remedial steps as allowed by federal law.

SECTION 2. This act shall take effect upon becoming a law, the public welfare requiring it, and applies to agreements entered into or renewed on or after the effective date of this act.

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