TN Division of TennCare

August 29, 2017

Ms. Jessica Woodard
TennCare Project Officer
Division of State Demonstrations & Waivers
Center for Medicaid and CHIP Services
Centers for Medicare and Medicaid Services
Mail Stop S2-01-16
7500 Security Boulevard
Baltimore, Maryland 21244-1850

RE: TennCare II, STC 44, Quarterly Progress Report

Dear Ms. Woodard:

Enclosed please find the Quarterly Progress Report for the April – June 2017 quarter. This report is being submitted in accordance with STC 44 of the TennCare Demonstration.

Please let us know if you have comments or questions.

Sincerely,

[redacted]

Wendy Long, M.D., M.P.H.
Director, Division of TennCare

cc: Trina D. Roberts, Acting Associate Regional Administrator, Atlanta Regional Office
Kenni Howard, Tennessee Coordinator, Atlanta Regional Office

TennCare II

Section 1115 Quarterly Report

(For the period April - June 2017)

Demonstration Year: 15 (7/1/16 - 6/30/17)
Federal Fiscal Quarter: 3/2017 (4/17 - 6/17)
Waiver Quarter: 4/2017 (4/17 - 6/17)

I. Introduction

The goal of the TennCare Demonstration is to show that careful use of a managed care approach can enable the State to deliver quality care to all enrollees without spending more than would have been spent had the State continued its Medicaid program.

The Division of TennCare contracts with several Managed Care Contractors (MCCs) to provide services to more than 1.5 million enrollees. During this quarter, these entities included Managed Care Organizations (MCOs) for medical services, behavioral services, and certain Long-Term Services and Supports (LTSS); a Dental Benefits Manager (DBM) for dental services; and a Pharmacy Benefits Manager (PBM) for pharmacy services.

There are two major components of TennCare. "TennCare Medicaid" serves Medicaid eligibles, and "TennCare Standard" serves persons in the demonstration population.

The key dates of approval/operation in this quarter, together with the corresponding Special Terms and Conditions (STCs), if applicable, are presented in Table 1.

Table 1
Key Dates of Approval/Operation in the Quarter

Date	Action	STC #
4/17/17	The State submitted to CMS a proposed evaluation design for the 12/16/16 – 6/30/21 approval period of the TennCare Demonstration.	67
4/21/17	CMS approved Statewide MCO Contract Amendment 5 and TennCare Select Contract Amendment 40.	39
4/26/17	The Monthly Call for April was cancelled at CMS's request.	43
5/1/17	The State submitted to CMS enrollment target ranges for CHOICES Group 2 and for all ECF CHOICES benefit groups.	31.d.ii and 32.d.ii
5/24/17	The Monthly Call for May was cancelled at CMS's request.	43
5/30/17	The State submitted the Quarterly Progress Report for the January-March 2017 quarter to CMS.	44
6/13/17	The State notified the public of its intent to request a technical change to Attachment C of the TennCare Demonstration. The proposal would modify the limitations on private duty nursing services.	15
6/16/17	The State requested CMS approval of Statewide MCO Contract Amendment 6 and TennCare Select Contract Amendment 41.	39
6/21/17	CMS provided written feedback on the State's proposed evaluation design.	67
6/22/17	The Monthly Call for June was cancelled at CMS's request.	43

Date	Action	STC #
6/23/17	CMS and the State participated in a conference call to discuss the State's proposed evaluation design.	67
6/30/17	The State submitted point-in-time and annual aggregate data about the CHOICES and ECF CHOICES programs to CMS.	42

II. Enrollment and Benefits Information

Information about enrollment by category is presented in Table 2.

Table 2
Enrollment Counts for the April – June 2017 Quarter
Compared to the Previous Two Quarters

Demonstration Populations	Total Number of TennCare Enrollees		
	Oct – Dec 2016	Jan – Mar 2017	Apr – Jun 2017
EG1 Disabled, Type 1 State Plan eligibles	147,754	143,490	141,777
EG9 H-Disabled, Type 2 Demonstration Population	252	249	260
EG2 Over 65, Type 1 State Plan eligibles	203	294	353
EG10 H-Over 65, Type 2 Demonstration Population	43	45	87
EG3 Children, Type 1 State Plan eligibles	801,365	799,933	766,701
EG4 Adults, Type 1 State Plan eligibles	455,487	447,730	432,394
EG5 Duals, Type 1 State Plan eligibles and EG11 H-Duals 65, Type 2 Demonstration Population	153,409	152,740	149,395
EG6E Expan Adult, Type 3 Demonstration Population	710	521	364
EG7E Expan Child, Type 3 Demonstration Population	45	15	14
EG8, Med Exp Child, Type 2 Demonstration Population, Optional Targeted Low Income Children funded by Title XIX	0	0	0
Med Exp Child, Title XXI Demonstration Population	15,356	12,654	7,236

Demonstration Populations	Total Number of TennCare Enrollees		
	Oct – Dec 2016	Jan – Mar 2017	Apr – Jun 2017
EG12E Carryover, Type 3, Demonstration Population	2,393	2,200	2,018
TOTAL*	1,577,017	1,559,871	1,500,599

*** Unique member counts for reporting quarter, with at least 1 day of eligibility. To avoid duplication, the member counts are based on the last eligibility group (EG) of the quarter.**

The majority of TennCare's enrollment continues to be categorized as Type 1 EG3 children and Type 1 EG4 adults, with 80 percent of TennCare enrollees appearing in one of these categories.

The Managed Care Contractors providing services to TennCare enrollees as of the end of the quarter are listed in Table 3.

Table 3
TennCare Managed Care Contractors as of June 30, 2017

Managed Care Organizations	Amerigroup BlueCare[1] UnitedHealthcare Community Plan[2] TennCare Select[3]
Pharmacy Benefits Manager	Magellan Health Services
Dental Benefits Manager	DentaQuest

Demonstration Amendment 31: Program Modifications. As discussed in TennCare's previous Quarterly Report to CMS, a public notice and comment period was held during February and March 2017 to solicit feedback on a proposed demonstration amendment. Amendment 31 was based on proposed amendments from prior years that outlined program reductions that would allow TennCare to have a balanced budget in the event the Tennessee General Assembly did not renew a one-year hospital assessment fee. The reductions contemplated in Amendment 31 included limits on inpatient hospital services, outpatient hospital visits, health care practitioners' office visits, and lab and X-ray services, as well as the elimination of certain kinds of therapy.

As has been the case in previous years, however, the General Assembly renewed the hospital assessment fee, thereby eliminating any funding gap and the need for Amendment 31 to be submitted to CMS.

[1] BlueCare is operated by Volunteer State Health Plan, Inc. (VSHP), which is an independent licensee of the BlueCross BlueShield Association and a licensed HMO affiliate of its parent company, BlueCross BlueShield of Tennessee.
[2] UnitedHealthcare Community Plan is operated by UnitedHealthcare Plan of the River Valley, Inc.
[3] TennCare Select is operated by VSHP.

Tennessee Eligibility Determination System. Tennessee Eligibility Determination System (or "TEDS") is the name of the system that will be used by the State to process applications and identify persons who are eligible for TennCare and CoverKids (the State's separate CHIP program). Throughout the April-June 2017 quarter, TennCare continued collaborating with systems integrator partner Deloitte Consulting, LLP, on system design, a process that is nearing completion. As of the end of the quarter, Deloitte was scheduled to present formal design documents to TennCare in July 2017 and will commence system development and testing in the fall. Implementation of the TEDS system is planned for late 2018.

Cost Sharing Compliance Plan. In its April 18, 2012, letter approving TennCare's cost sharing compliance plan for the TennCare Standard population, CMS stipulated that "each Quarterly Report . . . must include a report on whether any families have contacted the State to document having reached their aggregate cap, and how these situations were resolved." During the April-June 2017 quarter, the State received no notifications that a family with members enrolled in TennCare Standard had met its cost sharing limit. It should be noted that this is the eighteenth consecutive quarter since the plan was implemented in which no notifications have been received.

III. Innovative Activities to Assure Access

Early and Periodic Screening, Diagnosis and Treatment (EPSDT). EPSDT—or "TennCare Kids"—outreach is a significant area of interest for TennCare. The State maintains a contract with the Tennessee Department of Health (TDH) to conduct a community outreach program for the purpose of educating families on EPSDT benefits and encouraging them to use those benefits, particularly preventive exams.

Table 4 summarizes community outreach activity during this quarter and the previous two quarters. Quarterly variations in the categories presented here are usually the result of factors such as:

- Seasonal events. Each year, National Children's Dental Health Month in February, back-to-school events in August, and Child Health Week in October all have an influence on the focus and direction of outreach efforts during their respective quarters. TDH's communications strategy for each is based on an evaluation of past successes and current opportunities. During one round of Dental Health Month, for instance, TDH employed scrolling billboards prominently, whereas the strategy for Child Health Week eight months later placed greater emphasis on radio and television broadcasts and magazine articles.
- Collaborative partners. A variety of TDH's activities are dependent on the opportunities offered by other State agencies and by entities within the community. For example, publication of articles in newsletters and magazines is usually possible only when local media outlets offer space in their periodicals at no charge. Similarly, TDH's ability to educate the public through television and radio broadcasts is tied to the availability of

open timeslots in those platforms. Even certain types of telephone outreach require input from other sources: calls to families to reinforce the importance of dental checkups (detailed in Table 4), for instance, are possible only because of referrals from the School-Based Dental Prevention Program (SBDPP).

Table 4
Tennessee Department of Health
Community Outreach Activity for EPSDT
April – June 2017 Compared to the Previous Two Quarters

Activities	Oct – Dec 2016	Jan – Mar 2017	Apr – Jun 2017
Number of outreach activities/events	2,629	2,571	2,565
Number of people made contact with (mostly face to face at outreach events)	179,775	110,497	122,884
Number of educational materials distributed	126,813	85,324	88,999
Number of coalitions/advisory board meetings attended or conducted	87	192	75
Number of attendees at coalitions/advisory board meetings	1,824	2,057	1,361
Number of educational preventive health radio/TV broadcasts	803	912	667
Number of educational preventive health newsletter/magazine articles	21	20	8
Number of educational preventive health billboards, scrolling billboards and bulletin boards	4,161	4,086	4,469
Number of presentations made to enrollees/professional staff who work with enrollees	108	96	83
Number of individuals attending presentations	2,409	1,981	1,168
Number of completed telephone calls regarding the importance of dental checkups	560	595	248
Number of home visits completed	481	982	1,393

TennCare also contracts with TDH for a TennCare Kids Call Center that employs operators to call all newly enrolled and newly re-certified members with children to inform them about TennCare Kids and to offer assistance with appointment scheduling and transportation. Data from the Call Center is summarized in Table 5.

Table 5
Tennessee Department of Health
TennCare Kids Call Center Activity
April – June 2017 Compared to the
Previous Two Quarters

Activities	Oct – Dec 2016	Jan – Mar 2017	Apr – Jun 2017
Number of enrollees reached	25,181	31,106	31,680
Number of enrollees who were assisted in scheduling an EPSDT exam for their children	641	349	254
Number of enrollees who were assisted in arranging for transportation	29	44	44

IV. Collection and Verification of Encounter and Enrollment Data

Edifecs is the software system being used by the State to review encounter data sent from the MCOs and to identify encounters that are non-compliant so that they can be returned to the MCOs for correction. Edifecs enables the State to reject only the problem encounters, rather than rejecting and requiring resubmission of whole batches of encounter data because of a problem found. Table 6 illustrates the progress that has been made in reducing the number of claims that are returned to the MCOs due to data errors.

Table 6
Number of Initial Encounters Received by TennCare During the April-June 2017 Quarter, and Percentage that Passed Systems Edits, Compared to the Previous Two Quarters

	Oct – Dec 2016	Jan – Mar 2017	Apr – Jun 2017
No. of encounters received by TennCare (initial submission)	21,723,287	17,265,976	15,514,575
No. of encounters rejected by Edifecs upon initial submission	7,123	47,103	88,261
Percentage of encounters that were compliant with State standards (including HIPAA) upon initial submission	99.97%	99.73%	99.43%

V. Operational/Policy/Systems/Fiscal Developments/Issues

A. CHOICES

As required by STC 31.d., the State offers the following table delineating CHOICES enrollment as of the end of the quarter, as well as information about the number of available reserve slots.

Table 7
CHOICES Enrollment and Reserve Slots
for April – June 2017 Compared to the Previous Two Quarters

	Statewide Enrollment Targets and Reserve Capacity[4]	Enrollment and Reserve Slots Being Held as of the End of Each Quarter		
		Oct – Dec 2016	Jan – Mar 2017	Apr – Jun 2017
CHOICES 1	Not applicable	17,074	16,783	16,560
CHOICES 2	12,500	9,204	9,115	9,190
CHOICES 3 (including Interim CHOICES 3)	To be determined	3,511	3,391	3,191
Total CHOICES	Not applicable	29,789	29,289	28,941
Reserve capacity	300	300	300	300

The CMS letter approving CHOICES implementation in Middle Tennessee dated February 26, 2010, and STC 42 require specific monitoring and reporting activities that include:

Data and trends of the designated CHOICES data elements: STC 42.d. requires the State to submit to CMS periodic statistical reports about the use of LTSS by TennCare enrollees. Twelve separate reports of data pertaining to the CHOICES program have been submitted between August 2011 and June 2017.

Taken together, the reports depict a program evolving according to the characteristics of LTSS recipients, with institutional care available to individuals with the highest acuity of need, and Home and Community-Based Services (HCBS) available to individuals whose needs can be safely and effectively met at home or in other non-institutional settings. Point-in-time data revealed declining use of Nursing Facility (NF) services over time, with placement in institutional settings decreasing from 21,530 individuals on June 30, 2011, to 17,141 individuals on June 30, 2016. According to annual aggregate data contained in the reports, this downward trend was even more pronounced for new LTSS recipients, 81 percent of whom had been admitted to NFs in

[4] Of the three active CHOICES groups, only CHOICES 2 has an enrollment target. Interim CHOICES 3 closed to new enrollment on June 30, 2015; an enrollment target for CHOICES 3 has not been set at this time.

the year prior to implementation of the CHOICES program, as compared with 61 percent admitted to NFs in the sixth year of CHOICES.

By contrast, appropriate use of HCBS by TennCare enrollees grew significantly during these years. The aggregate number of members accessing HCBS increased from 6,226 in the twelve-month period preceding CHOICES implementation in Middle Tennessee to 15,937 after CHOICES had been in place for six full fiscal years. This trend was mirrored in point-in-time data as well: on the day prior to CHOICES implementation, 4,861 individuals were using HCBS, but the number had grown to 12,654 by June 30, 2016. This information is summarized in Table 8.

Table 8
Changes in Use of HCBS by Persons Who Are Elderly or Disabled (E/D) Before and After CHOICES Implementation

Annual Aggregate Data			Point-in-Time Data		
No. of TennCare enrollees accessing HCBS (E/D), 3/1/09 – 2/28/10	No. of TennCare enrollees accessing HCBS (E/D), 7/1/14 – 6/30/15	Percent increase over a five-year period	No. of TennCare enrollees accessing HCBS (E/D) on the day prior to CHOICES implementa-tion	No. of TennCare enrollees accessing HCBS (E/D) on 6/30/16	Percent increase from the day prior to CHOICES implementa-tion to 6/30/16
6,226	15,937	156%	4,861[5]	12,654	160%

Frequency and use of MCO-distributed transition allowances (CHOICES approval letter dated February 26, 2010): The allocation of CHOICES transition allowance funds is detailed in Table 9.

Table 9
CHOICES Transition Allowances
for April – June 2017 Compared to the Previous Two Quarters

	Frequency and Use of Transition Allowances					
	Oct – Dec 2016		**Jan – Mar 2017**		**Apr – Jun 2017**	
Grand Region	# Distributed	Total Amount	# Distributed	Total Amount	# Distributed	Total Amount
East	38	$34,993	14	$8,210	22	$30,988
Middle	39	$37,574	12	$16,432	16	$17,742

[5] The total of 4,861 comprises 1,479 individuals receiving HCBS (E/D) in Middle Tennessee on February 28, 2010 (the day prior to CHOICES implementation in that region), and 3,382 individuals receiving HCBS (E/D) in East and West Tennessee on July 31, 2010 (the day prior to CHOICES implementation in those regions).

Grand Region	Frequency and Use of Transition Allowances					
	Oct – Dec 2016		Jan – Mar 2017		Apr – Jun 2017	
West	28	$22,484	12	$14,791	21	$21,423
Statewide Total	105	$95,051	38	$39,433	59	$70,153

B. Employment and Community First CHOICES

Designed in partnership with people with intellectual and developmental disabilities, their families, advocates, and other stakeholders, Employment and Community First (ECF) CHOICES is the first managed LTSS program in the nation that is focused on promoting and supporting integrated, competitive employment and independent community living as the first and preferred option for people with intellectual and other types of developmental disabilities.

As required by STC 32.d., the State offers the following table delineating ECF CHOICES enrollment as of the end of the quarter, as well as information about enrollment targets and the number of available reserve slots.

Table 10
ECF CHOICES Enrollment, Enrollment Targets, and Reserve Slots
for April – June 2017 Compared to the Previous Two Quarters

	Statewide Enrollment Targets and Reserve Capacity	Enrollment and Reserve Slots Being Held as of the End of Each Quarter		
		Oct – Dec 2016	Jan – Mar 2017	Apr – Jun 2017
ECF CHOICES 4	500	194	333	418
ECF CHOICES 5	1,000	427	689	843
ECF CHOICES 6	200	39	84	123
Total ECF CHOICES	1,700	660	1,106	1,384
Reserve capacity	250	213	200	165
Waiver Transitions[6]	Not applicable	1	1	4

Data and trends of the designated ECF CHOICES data elements: STC 42.d. requires the State to submit to CMS periodic statistical reports about the ECF CHOICES program, the first of which

[6] Waiver transitions are instances in which an individual enrolled in a 1915(c) HCBS waiver program is transferred into the ECF CHOICES program. Since these individuals have an independent funding source (i.e., the money that would have been spent on their care in the 1915(c) program), their enrollment in ECF CHOICES does not count against the 1,700-person enrollment target.

was submitted on June 30, 2017. Since this inaugural submission consisted entirely of baseline data preceding implementation of ECF CHOICES, it is impossible to offer any observations regarding trends. Among the data points offered in the report are the following:

- As of June 30, 2016, the number of individuals with intellectual disabilities receiving HCBS through the TennCare program was 8,025.
- As of June 30, 2016, there were no individuals with developmental disabilities other than intellectual disabilities receiving HCBS through the TennCare program.
- In the twelve-month period preceding implementation of ECF CHOICES, HCBS expenditures for individuals with intellectual or developmental disabilities comprised 77.8 percent of all LTSS expenditures for that population.
- In the twelve-month period preceding implementation of ECF CHOICES, the average LTSS expenditure per person with an intellectual or developmental disability was nearly two and a half times greater in an institutional setting than in a community-based setting.

As further data about the ECF CHOICES program is gathered and submitted to CMS, future Quarterly Progress Reports will address the aforementioned data points—and others—in terms of trends.

C. Financial Monitoring by the Tennessee Department of Commerce and Insurance

Claims Payment Analysis. The prompt pay requirements of T.C.A. § 56-32-126(b) mandate that each Managed Care Organization (MCO) ensure that 90 percent of clean claims for payment for services delivered to a TennCare enrollee are paid within 30 calendar days of the receipt of such claims and that 99.5 percent of all provider claims are processed within 60 calendar days of receipt. TennCare's contract with its Dental Benefits Manager (DBM) requires the DBM to process claims in accordance with this statutory standard as well. TennCare's contract with its Pharmacy Benefits Manager (PBM) requires the PBM to pay 100 percent of all clean claims submitted by pharmacy providers within 15 calendar days of receipt.

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 NF and applicable HCBS 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. TennCare can 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 can 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 April-June 2017 quarter, the MCOs submitted their NAIC First Quarter 2017 Financial Statements. As of March 31, 2017, TennCare MCOs reported net worth as indicated in the table below.[7]

Table 11
Net Worth Reported by MCOs as of March 31, 2017

	Net Worth Requirement	Reported Net Worth	Excess/ (Deficiency)
Amerigroup Tennessee	$33,420,759	$196,913,870	$163,493,111
UnitedHealthcare Plan of the River Valley (UnitedHealthcare Community Plan)	$57,158,856	$467,868,097	$410,709,241
Volunteer State Health Plan (BlueCare & TennCare Select)	$46,879,872	$431,981,971	$385,102,099

During the April-June 2017 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.

The following table compares the MCOs' net worth to the Company Action Level requirements as of March 31, 2017:

[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.

Table 12
Company Action Level Reported by MCOs as of March 31, 2017

	Company Action Level Requirement	Reported Net Worth	Excess/ (Deficiency)
Amerigroup Tennessee	$122,877,816	$196,913,870	$74,036,054
UnitedHealthcare Plan of the River Valley (UnitedHealthcare Community Plan)	$205,480,268	$467,868,097	$262,387,829
Volunteer State Health Plan (BlueCare & TennCare Select)	$148,059,416	$431,981,971	$283,922,555

All TennCare MCOs exceeded their minimum net worth requirements and Company Action Level requirements as of March 31, 2017.

D. Payment Reform

Tennessee's Health Care Innovation Initiative is changing health care payment to reward providers for high-quality and efficient treatment of medical conditions to help in maintaining people's health over time. The Initiative has strategies in three key areas: primary care transformation, episodes of care, and long-term services and supports. Notable developments in each of these strategies occurred during the April-June 2017 quarter.

Primary care transformation supports primary care providers in promoting the delivery of preventive services and managing chronic illnesses over time. Three elements of primary care transformation are the Patient-Centered Medical Home (PCMH) program, the Tennessee Health Link program, and a Care Coordination Tool designed for providers participating in those programs.

Following much stakeholder input and design work, the PCMH program was launched by TennCare and the Tennessee Health Care Innovation Initiative on January 2, 2017. PCMH is a comprehensive care delivery model designed to improve the quality of primary care services for TennCare members, the capabilities and practice standards of primary care providers, and the overall value of health care delivered to the TennCare population. Participating providers receive training and technical assistance, quarterly reports with actionable data, and access to the state's care coordination tool. These providers are compensated with ongoing financial support and an opportunity for an annual outcome payment based on quality and efficiency performance. As of the launch date, 29 practices and approximately 250,000 TennCare members were participating in the PCMH program, with additional practices to be added in subsequent years.

The Tennessee Health Link component of the primary care transformation strategy was implemented on a statewide basis on December 1, 2016. Providers in this program coordinate

health care services for TennCare members with the most significant behavioral health needs. The program is designed to produce improved member outcomes, greater provider accountability and flexibility in the delivery of care, and improved cost control for the State. From the launch date until May 2017, approximately 60,000 TennCare members have been enrolled in the program. TennCare continues to monitor enrollment and provider engagement with members and regularly solicits feedback on the implementation of the program.

Applications for new providers to enroll in PCMH and Tennessee Health Link for calendar year 2018 were released on May 1, 2017. The application deadline was June 30, 2017, and applicants were to be notified of whether they had been accepted during the July-September 2017 quarter.

Providers in the PCMH and Tennessee Health Link programs have access to the third element of the primary care transformation strategy: the Care Coordination Tool went live at the end of January 2017. The Care Coordination Tool allows participating primary care providers and behavioral health providers to see their attributed patient panel, view patient risk scores, and track the completeness of quality measures for their patients. The tool also alerts providers when their patients are admitted or transferred to—or discharged from—a hospital, including instances in which emergency room care is accessed. Physicians, nurses, coordinators, and other providers at participating practices received four weeks of user training on the tool in February 2017.

Episodes of care focuses on acute or specialist-driven health care delivered during a specified time period to treat physical or behavioral conditions such as an acute diabetes exacerbation or valve repair and replacement. Each episode has a principal accountable provider (sometimes referred to as the "quarterback") who is in the best position to influence the cost and quality of the episode. Episodes of care are implemented in groups or—in the terminology of the program—"waves."

Each episode is designed with significant input from stakeholders, including Tennessee providers, payers, administrators, and employers. For each episode, the program organizes Technical Advisory Groups (TAGs) composed of experts in the field to provide clinical feedback on each episode's design. The TAG meetings for Wave 7 episodes began in March 2017 and ended in May 2017. The nine episodes covered in Wave 7 are femur/pelvic fracture; knee arthroscopy; non-operative shoulder injury; non-operative wrist injury; non-operative knee injury; non-operative ankle injury; spinal fusion; spinal decompression without spinal fusion; and back/neck.

Long-term services and supports comprises quality- and acuity-based payment and delivery system reform for Nursing Facility (NF) services and Home and Community Based Services (HCBS). During this quarter, TennCare continued working with the Tennessee Health Care Association to draft rules for a new quality- and acuity-adjusted reimbursement methodology for nursing facilities. As part of TennCare's ongoing commitment to transparency, before publishing the draft rule, TennCare sought broad stakeholder input, hearing directly from

residents receiving NF services and their family members, as well as from staff of NFs participating in the State's Quality Improvement in Long-Term Services and Supports (QuILTSS) initiative. Each of the Medicaid NFs in the state and their Resident/Family Councils were invited to complete online survey tools to provide feedback regarding quality-related components of the new rule. Facility representatives also had the opportunity to discuss their experience with the QuILTSS initiative and ways in which the program could be improved, not only to aid the initiative's goal of improving quality of care and quality of life for NF residents, but also to minimize administrative burden on facilities.

Comments gathered from NF staff members suggest that the QuILTSS initiative has been beneficial but challenging to administer. According to the respondents, QuILTSS is having a positive impact on facilities by helping them increase resident/family engagement, focus more on residents and their needs, and advance culture change and person-centered care. At the same time, the feedback indicates that the current process-based approach could be simplified in ways that would reduce administrative burden. A commonly expressed opinion is that QuILTSS should accelerate the transition to a more outcome-based approach, which would allow NFs to innovate and tailor improvement efforts to their unique needs. With regard to performance measures, there is a desire for clear definitions, reasonable baselines, flexibility for adjustment when needed, and rewards for facilities that demonstrate significant improvement as well as those that demonstrate strong performance relative to established benchmarks. An especially helpful insight gained from the stakeholder process is that the majority of responding facilities and the overwhelming majority of resident/family council respondents want the quality component of the reimbursement rate to be higher than provided in the original draft in order to incentivize facilities to focus efforts on quality improvement. A more detailed summary of responses is available at: http://tn.gov/assets/entities/tenncare/attachments/QuILTSSResidentAndStakeholderRulesSurvey.pdf

E. AARP Scorecard of Long-Term Services and Supports

On June 14, 2017, AARP released its *2017 Long-Term Services and Supports (LTSS) State Scorecard*, a copy of which is available with supplemental information at http://www.longtermscorecard.org/2017-scorecard. This is the third in a series of annual scorecards that offer a state-by-state comparison of performance across an array of measures defined by AARP as constituting a high performing LTSS system.

Tennessee is identified in the report as the most improved state, and the only state to demonstrate substantial improvement across 13 of the 23 measures, including all 6 measures related to effective transitions. However, Tennessee's overall ranking advanced only from 48th to 47th.

Many of the Scorecard measures are beyond the scope of the Medicaid program, and require solutions at a national and/or state policy level (e.g., Nurse Practice Acts, family caregiver leave policies, volunteer driver policies, housing affordability). Other measures may be difficult if not

impossible for a state's Medicaid program to affect at all (e.g., the average private pay rates for nursing home or home care, the median income of state residents, whether or not people choose to purchase long-term care insurance, federal funding allocations for certain programs). Furthermore, the data on which the report is based is characterized by a lag (five years in some data elements) and, therefore, is not reflective of program improvements that have occurred subsequently.

Despite the limited applicability of the report to Medicaid programs, Tennessee, along with other states, agrees that measuring performance can help drive quality improvement and is committed to this approach in TennCare's LTSS programs.

F. Electronic Health Record Incentive Program

The Electronic Health Record (EHR) Incentive Program is a partnership between federal and state governments that grew out of the Health Information Technology for Economic and Clinical Health (HITECH) Act of 2009. The purpose of the program is to provide financial incentives to Medicaid providers[8] to replace outdated, often paper-based approaches to medical record-keeping with electronic systems that meet rigorous certification criteria and that can improve health care delivery and quality. The federal government provides 100 percent of the funding for the incentive payments and 90 percent of the funding for administrative costs.

Currently, Medicaid providers may qualify for the following types of payments:

- First-year payments (through the 2016 Program Year) to eligible hospitals or practitioners who either—
    - Adopt, implement, or upgrade to certified EHR technology capable of meeting "meaningful use" in accordance with CMS standards, or
    - Achieve meaningful use of certified EHR technology for a period of 90 consecutive days;
- Second-year payments to providers who have received first-year payments and who achieved meaningful use for a subsequent period of 90 consecutive days;
- Third-year, fourth-year, fifth-year, and sixth-year payments to providers who continue to demonstrate meaningful use of certified EHR technology.

Eligible practitioners who successfully attest may receive incentive payments in up to six program years. With CMS approval, TennCare chose to divide the full amount of incentive payments available to eligible hospitals among three program years. Eligible hospitals must

[8] CMS allows two types of providers to participate in the Medicaid EHR Incentive Program: medical professionals (medical and osteopathic physicians, nurse practitioners, certified nurse midwives, dentists, and physician assistants who meet certain criteria) and hospitals (acute care hospitals, critical access hospitals, and children's hospitals).

continue to attest annually beyond the three years of payments in order to avoid Medicare payment adjustments.

EHR payments made by TennCare during the April-June 2017 quarter as compared with payments made throughout the life of the program appear in the table below:

Table 13
EHR Payments
Quarterly and Cumulative

Payment Type	No. of Providers Paid During the Quarter	Quarterly Amount Paid (Apr-Jun 2017)	Cumulative Amount Paid To Date
First-year payments	380[9]	$7,590,871	$181,372,240
Second-year payments	76	$1,357,793	$56,964,360
Third-year payments	69	$1,773,396	$30,503,055
Fourth-year payments	70	$592,167	$4,584,342
Fifth-year payments	63	$527,001	$1,929,501
Sixth-year payments	50	$425,000	$586,500

Technical assistance activities, outreach efforts, and other EHR-related projects conducted by TennCare staff during the quarter included the following:

- Acceptance of Program Year 2017 Modified Stage 2 and Stage 3 attestations beginning on April 3, 2017 (a development facilitated by updates to TennCare's Provider Incentive Payment Program—or "PIPP"—attestation software);
- Achieving a cumulative total of 1,951 EHR incentive attestations (1,144 of which related to Meaningful Use) for the 2016 EHR Incentive Year by the conclusion of the April-June 2017 quarter;
- Holding more than 100 technical assistance calls, 16 of which related to Meaningful Use;
- Responding to over 800 emails received in the EHR Incentive mailbox, and to over 400 emails received in the EHR Meaningful Use mailbox;
- Distributing EHR-related information at regional provider expos hosted by TennCare health plans in May 2017 in Chattanooga, Jackson, Johnson City, Knoxville, Memphis, and Nashville;
- Participation throughout the quarter in several Southeast Regional Collaboration for HIT/HIE (SERCH) calls;
- Newsletters and alerts distributed by the TennCare's EHR ListServ; and
- A quarterly reminder to Tennessee providers who had registered at the federal level but who have not registered or attested at the state level.

[9] Of the 380 providers receiving first-year payments in the April-June 2017 quarter, 4 earned their incentives by successfully attesting to meaningful use of EHR technology.

TennCare's EHR Incentive Program team continues to work with a variety of provider organizations to maintain the momentum of the program. The focus of outreach efforts has shifted from enrolling new providers in the program to bringing back providers who attested to EHR requirements only once.

G. *Wilson v. Gordon*

Wilson v. Gordon is a class action lawsuit filed against the TennCare by the Tennessee Justice Center, the Southern Poverty Law Center, and the National Health Law Program. The suit, which is being heard by the U.S. District Court for the Middle District of Tennessee, alleges federal noncompliance in the Medicaid application and appeals process TennCare has been using since implementation of the Affordable Care Act.

Central to the *Wilson* suit is the issue of whether applications for TennCare coverage are being resolved in a proper and timely manner. In the fall of 2016, the State filed a Motion to Decertify the Class and Dismiss the Case. The basis of the motion was that processes used by TennCare and CMS for Medicaid applications and application appeals in Tennessee had evolved substantially. As a result of this evolution, the Motion contends, there are no remaining members in the Plaintiff class originally certified by the District Court, and any eligibility issues arising in 2016 are completely different from the issues that originally prompted the *Wilson* suit.

On April 27, 2017, oral argument on the State's Motion was heard. Magistrate Judge Alistair Newbern ordered both sides of the suit to submit supplemental briefing in support of their oral arguments, and both sides did so on May 11, 2017. Each party also responded to the other's supplemental brief on May 25, 2017. As of the end of the April-June 2017 quarter, Magistrate Judge Newbern had not rendered a decision on the State's Motion.

VI. Action Plans for Addressing Any Issues Identified

TennCare continues to comply with orders issued in the *Wilson v. Gordon* court action.

VII. Financial/Budget Neutrality Development Issues

Revenue collections were consistently strong throughout the April-June 2017 quarter. All three months achieved growth in total state and local collections relative to the corresponding months of 2016, with nearly a four percent improvement in April, more than a four percent improvement in May, and more than a five and a half percent improvement in June. In

addition, total state and local collections for State Fiscal Year 2017 were nearly four percent higher than they were in State Fiscal Year 2016.[10]

Employment prospects improved in an even more robust manner during the quarter. The unemployment rate within the state declined each month, falling from 4.7 percent in April 2017 to 4.0 percent in May 2017 and then again to 3.6 percent in June 2017. The Tennessee unemployment rate in May and June was not only lower than the national rate during the same months (4.3 percent and 4.4 percent respectively) but also significantly lower than the state rate during the corresponding months of 2016 (4.6 percent and 4.7 percent respectively). Perhaps most significantly, the 3.6 percent state unemployment rate in June was the lowest in Tennessee's recorded history.[11]

TennCare continued to demonstrate budget neutrality during the April-June 2017 quarter. For more information about budget neutrality performance, see the spreadsheet comprising Attachment A to this Quarterly Progress Report.

VIII. Member Month Reporting

Tables 14 and 15 below present the member month reporting by eligibility group for each month in the quarter.

Table 14
Member Month Reporting for Use in Budget Neutrality Calculations
April – June 2017

Eligibility Group	April 2017	May 2017	June 2017	Sum for Quarter Ending 6/30/17
Medicaid eligibles (Type 1)				
EG1 Disabled, Type 1 State Plan eligibles	140,584	140,623	138,967	420,174
EG2 Over 65, Type 1 State Plan eligibles	304	251	292	847
EG3 Children, Type 1 State Plan eligibles	751,962	743,513	739,772	2,235,247
EG4 Adults, Type 1 State Plan eligibles	418,981	416,458	380,403	1,215,842

[10] The Department of Revenue's collection summaries are available online at https://www.tn.gov/revenue/article/revenue-collections-summaries.
[11] Information about Tennessee's unemployment rate is available on the Department of Labor and Workforce Development's website at https://www.tn.gov/workforce/news.

Eligibility Group	April 2017	May 2017	June 2017	Sum for Quarter Ending 6/30/17
EG5 Duals, Type 1 State Plan eligibles	139,536	139,224	136,669	415,429
EG8 Med Exp Child, Type 2 Demonstration Population, Optional Targeted Low Income Children funded by Title XIX	0	0	0	0
EG9 H-Disabled, Type 2 Demonstration Population	245	247	254	746
EG10 H-Over 65, Type 2 Demonstration Population	46	48	85	179
EG11 H-Duals, Type 2 Demonstration Population	6,036	6,100	6,096	18,232
TOTAL	1,457,694	1,446,464	1,402,538	4,306,696

Table 15
Member Month Reporting Not Used in Budget Neutrality Calculations
April – June 2017

Eligibility Group	April 2017	May 2017	June 2017	Sum for Quarter Ending 6/30/17
EG6E Expan Adult, Type 3, Demonstration Population	369	346	321	1,036
EG7E Expan Child, Type 3, Demonstration Population	11	13	14	38
Med Exp Child, Title XXI Demonstration Population	7,433	7,167	7,069	21,669
EG12E Carryover, Type 3, Demonstration Population	2,114	2,050	1,976	6,140
TOTAL	9,927	9,576	9,380	28,883

IX. Consumer Issues

Eligibility Appeals. Table 16 presents a summary of eligibility appeal activity during the quarter, compared to the previous two quarters. It should be noted that appeals (whether

related to eligibility, medical services, or LTSS) may be resolved or taken to hearing in a quarter other than the one in which they are initially received by TennCare.

During this quarter, TennCare experienced an increase in the number of eligibility appeals. This is attributable to three primary factors. First, implementation of Tennessee's approved redetermination plan has increased annual redeterminations of eligibility. Second, TennCare has increased the number of enrollees who are selected on a quarterly basis for failure to report a valid Social Security number in at least twelve months. Third, there has been an increase in appeals related to redetermination that are often resolved administratively by remailing redetermination-related notices.

Table 16
Eligibility Appeals for April – June 2017
Compared to the Previous Two Quarters

	Oct – Dec 2016	Jan – Mar 2017	Apr – Jun 2017
No. of appeals received	23,173	28,586	49,377
No. of appeals resolved or withdrawn	19,920	26,297	32,941
No. of appeals taken to hearing	2,314	2,710	2,216
No. of hearings resolved in favor of appellant	147	192	117

Medical Service Appeals. Table 17 below presents a summary of the medical service appeals handled during the quarter, compared to the previous two quarters.

Table 17
Medical Service Appeals for April – June 2017
Compared to the Previous Two Quarters

	Oct – Dec 2016	Jan – Mar 2017	Apr – Jun 2017
No. of appeals received	2,293	2,259	2,356
No. of appeals resolved	2,097	2,071	2,308
• Resolved at the MCC level	763	720	868
• Resolved at the TSU level	186	202	197
• Resolved at the LSU level	1,148	1,149	1,243
No. of appeals that did not involve a valid factual dispute	211	173	145
No. of directives issued	271	304	338
No. of appeals taken to hearing	1,148	1,149	1,243
No. of appeals that were withdrawn by the enrollee at or prior to the hearing	383	420	395
Appeals that went to hearing and were	385	399	446

	Oct – Dec 2016	Jan – Mar 2017	Apr – Jun 2017
decided in the State's favor			
Appeals that went to hearing and were decided in the appellant's favor	25	34	26

By way of explanation:

- The "MCC" level is the level of the Managed Care Contractors. MCCs sometimes reverse their decisions or develop new recommendations for addressing an issue after reviewing an appeal.

- The "TSU" level is the TennCare Solutions Unit. The TSU is a unit within TennCare that reviews requests for hearings. The TSU might overturn the decision of the MCC and issue a directive requiring the MCC to approve provision of the service under appeal. Alternatively, if, following review, TennCare agrees with the MCC's decision, the appeal typically proceeds to TennCare's Legal Solutions Unit (LSU), where it is scheduled for administrative hearing before an Administrative Law Judge.

- The "LSU" level is the Legal Solutions Unit. This unit within TennCare ensures that enrollees receive those procedural rights to which they are entitled under the law. LSU represents TennCare and its MCCs at administrative hearings and takes those steps necessary to ensure that such appeals come to a timely resolution.

LTSS Appeals. The following table provides information regarding certain appeals administered by the Long-Term Services and Supports Division for the quarter (e.g., appeals of PreAdmission Evaluation denials, appeals of PreAdmission Screening and Resident Review determinations, etc.), compared to the previous two quarters.

Table 18
Long-Term Services and Supports Appeals for April – June 2017
Compared to the Previous Two Quarters

	Oct – Dec 2016	Jan – Mar 2017	Apr – Jun 2017
No. of appeals received	194	203	175
No. of appeals resolved or withdrawn	89	103	79
No. of appeals set for hearing	116	89	112
No. of hearings resolved in favor of appellant	5	0	2

X. Quality Assurance/Monitoring Activity

Population Health. "Population Health" (PH) is TennCare's model of targeted health care interventions. Key benefits of PH include—

- Selection of a much larger portion of the TennCare population than had been attempted previously;
- Identification of risky behaviors likely to lead to disease in the future (such as poor eating habits, physical inactivity, and drug use);
- Assistance to enrollees in discontinuing such activities; and
- Interventions to assist enrollees who already have a complex chronic condition.

Enrollees are assigned to one of three levels of health risk and one of seven programs for reducing risk. Information on the risk levels addressed by PH, the manner in which these risks are addressed, and the total number of unique members enrolled in PH at the conclusion of the January-March 2017 quarter is provided in Table 19. Data for the period of April through June 2017 will be provided in the next Quarterly Progress Report.

Table 19
Population Health Data*, January – March 2017

Risk Level	Intervention Type	Intervention Goal(s)	Number of Unique Members at End of Quarter
Level 0: no identified risk	Wellness Program	Keep members healthy as long as possible	663,318
Level 1: low or moderate risk	Maternity Program	Engage pregnant women in timely prenatal care and deliver a healthy, term infant without complications	9,365
	Health Risk Management	Prevent, reduce, or delay exacerbation and complications of a condition or health risk behavior	705,808
	Care Coordination	Assure that members receive the services they need to reduce the risk of an adverse health outcome	23,277
Level 2: high risk	Chronic Care Management	Provide intense self-management education and support to members with multiple chronic conditions to improve their quality of life, health status, and use of services	5,399
	High Risk Pregnancy Management	Engage pregnant women in timely prenatal care and deliver a healthy,	1,582

Risk Level	Intervention Type	Intervention Goal(s)	Number of Unique Members at End of Quarter
		term infant without complications	
	Complex Case Management	Move members to optimal levels of health and well-being through timely coordination of quality services and self-management support	1,560
Total PH Enrollment			**1,410,309**

*** The data in this table is a snapshot of PH enrollment on the last day of the reporting period. Because members move between risk levels and intervention types, enrollment may vary on a daily basis.**

Provider Data Validation Report. In April 2017, TennCare's External Quality Review Organization (EQRO), Qsource, published the results of its provider data validation survey for the January-March 2017 quarter. Qsource took a sample of provider data files from TennCare's MCCs[12] and reviewed each for accuracy in the following categories:

- Contract status with MCC
- Provider address
- Provider credentialed specialty / behavioral health service code
- Open / closed to new patients
- Services to patients under age 21
- Services to patients age 21 or older (MCO only)
- Primary care services (MCO only)
- Prenatal care services (MCO only)
- Availability of routine care services
- Availability of urgent care services

The validity of such information is one measure of providers' availability and accessibility to TennCare enrollees. Qsource's report demonstrated generally strong performance by the MCCs, especially in the categories of "contract status with MCC" (98.2 percent accuracy), "provider credentialed specialty / behavioral health service code" (97.5 percent accuracy), "routine care services" (97.8 percent accuracy), "urgent care services" (98.2 percent accuracy), "primary care services" (99.5 percent accuracy), and "prenatal care services" (100.0 percent accuracy).

Because the MCOs' transition to a statewide service delivery model occurred relatively recently, progress in accuracy rates is currently being measured on a quarter-to-quarter basis. Compared with the period of October-December 2016, the MCCs—according to the report—"have maintained relatively high accuracy rates this quarter." Nonetheless, to ensure ongoing

[12] TennCare's Pharmacy Benefits Manager (PBM) was not included in the survey.

improvement in all ten categories of the survey, TennCare required each of its MCCs to submit a Corrective Action Plan no later than June 5, 2017. TennCare, in turn, had received, reviewed, and accepted all of the plans by June 9, 2017. Results for the April-June 2017 quarter will be discussed in the next Quarterly Progress Report.

XI. Demonstration Evaluation

When CMS approved the State's application to extend the TennCare Demonstration on December 16, 2016, the terms and conditions of the approval stipulated that the State's evaluation efforts should focus "on the CHOICES program, ECF CHOICES program and the state plan and demonstration populations enrolled in those programs." On April 17, 2017, therefore, the State submitted to CMS its proposed evaluation design for the current approval period of the TennCare Demonstration (December 16, 2016, through June 30, 2021). The central issue addressed by the design is how the CHOICES and ECF CHOICES managed LTSS programs compare with various fee-for-service LTSS programs operated by the State in the past and present. To guide evaluation efforts, the design includes five program objectives related to CHOICES and five related to ECF CHOICES, each of which is supported with appropriate data elements.

On June 21, 2017, CMS sent the State written feedback on the proposed evaluation design. The State and CMS are currently working to finalize the evaluation design.

XII. Essential Access Hospital Pool[13]

A. Safety Net Hospitals

Vanderbilt University Hospital
Regional One Health
Erlanger Medical Center
University of Tennessee Memorial Hospital
Johnson City Medical Center Hospital (with Woodridge Psych)
Metro Nashville General Hospital

B. Children's Hospitals

LeBonheur Children's Medical Center
East Tennessee Children's Hospital

[13] Within the four Essential Access Hospital (EAH) groupings (Safety Net Hospitals, Children's Hospitals, Free Standing Psychiatric Hospitals, and Other Acute Care Hospitals), hospitals are arranged—in descending order—according to the amount of compensation each receives from the EAH pool.

C. Free Standing Psychiatric Hospitals

Pathways of Tennessee
Ridgeview Psychiatric Hospital and Center
Rolling Hills Hospital
PremierCare Tennessee, Inc.

D. Other Acute Care Hospitals

Parkridge Medical Center (with Parkridge Valley Psych)
Jackson – Madison County General Hospital
TriStar Centennial Medical Center
Methodist Healthcare – Memphis Hospitals
Saint Jude Children's Research Hospital
Methodist Healthcare – South
Parkridge East Hospital
TriStar Skyline Medical Center (with Madison campus)
Parkwest Medical Center (with Peninsula Psych)
Baptist Memorial Hospital – Memphis
Methodist Healthcare – North
University Medical Center (with McFarland Psych)
Saint Francis Hospital
Saint Thomas Rutherford Hospital
Lincoln Medical Center
Baptist Memorial Hospital for Women
Wellmont – Holston Valley Medical Center
Fort Sanders Regional Medical Center
Saint Thomas Midtown Hospital
Wellmont – Bristol Regional Medical Center
Cookeville Regional Medical Center
Maury Regional Hospital
Tennova Healthcare – Newport Medical Center
TriStar StoneCrest Medical Center
Tennova Healthcare
Blount Memorial Hospital
TriStar Horizon Medical Center
TriStar Summit Medical Center
Gateway Medical Center
TriStar Southern Hills Medical Center
Sumner Regional Medical Center
Skyridge Medical Center
TriStar Hendersonville Medical Center
Dyersburg Regional Medical Center
NorthCrest Medical Center

Morristown – Hamblen Healthcare System
LeConte Medical Center
Methodist Medical Center of Oak Ridge
Jellico Community Hospital
Takoma Regional Hospital
Tennova Healthcare – Harton Regional Medical Center
Tennova Healthcare – LaFollette Medical Center
Indian Path Medical Center
Sycamore Shoals Hospital
Starr Regional Medical Center – Athens
Skyridge Medical Center – Westside
Grandview Medical Center – Jasper
Heritage Medical Center
Bolivar General Hospital
Regional Hospital of Jackson
Southern Tennessee Regional Health System – Winchester
Henry County Medical Center
Baptist Memorial Hospital – Union City
Henderson County Community Hospital
Saint Thomas River Park Hospital
Hardin Medical Center
Roane Medical Center
Lakeway Regional Hospital
Southern Tennessee Regional Health System – Lawrenceburg
Hillside Hospital
Claiborne County Hospital
McKenzie Regional Hospital
Erlanger Health System – East Campus
Saint Thomas DeKalb Hospital
Jamestown Regional Medical Center
Saint Thomas Stones River Hospital
Volunteer Community Hospital
Wayne Medical Center
United Regional Medical Center and Medical Center of Manchester
Southern Tennessee Regional Health System – Sewanee

XIII. Graduate Medical Education (GME) Hospitals

Note: Attachment A to the STCs directs the State to list its GME hospitals and their affiliated teaching universities in each quarterly report. As CMS is aware, Tennessee does not make GME payments to hospitals. These payments are made, rather, to medical schools. The medical schools disburse many of these dollars to their affiliated teaching hospitals, but they also use them to support primary care clinics and other arrangements.

The GME medical schools and their affiliated universities are listed below:

Universities	Hospitals
East Tennessee State University	Mountain State Health Alliance Wellmont ETSU Quillen Mission Hospital Johnson City Medical Center Johnson City Health Center Woodridge Hospital Holston Valley Medical Center Bristol Regional Medical Center
Meharry Medical College	Metro General Meharry Medical Group
University of Tennessee at Memphis	The Regional Medical Center (The MED) Methodist LeBonheur Erlanger Jackson Madison St. Francis
Vanderbilt University	Vanderbilt Hospital

XIV. Critical Access Hospitals

Camden General Hospital
Copper Basin Medical Center
Cumberland River Hospital
Erlanger Bledsoe Hospital
Johnson County Community Hospital
Lauderdale Community Hospital
Macon County General Hospital
Marshall Medical Center
Rhea Medical Center
Riverview Regional Medical Center
Saint Thomas Hickman Hospital
Three Rivers Hospital
TriStar Ashland City Medical Center
Trousdale Medical Center
Wellmont Hancock County Hospital

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Date Submitted to CMS: August 29, 2017

Attachment A

Budget Neutrality Calculations for the Quarter

Actual TennCare Budget Neutrality (April - Jun 2017)

I. The Extension of the Baseline

Baseline PMPM

	SFY 2017 PMPM
1-Disabled (can be any ages)	$1,862.93
2-Child <=18	$577.17
3-Adult >= 65	$1,188.25
4-Adult <= 64	$1,106.64
Duals (17)	$774.54

Actual Member months of Groups I and II

1-Disabled (can be any ages)	420,920
2-Child <=18	2,235,247
3-Adult >= 65	847
4-Adult <= 64	1,215,842
Duals (17)	433,661
Total	4,306,517

Ceiling without DSH

	Baseline * MM
1-Disabled (can be any ages)	$784,145,903
2-Child <=18	$1,290,124,578
3-Adult >= 65	$1,006,452
4-Adult <= 64	$1,345,494,764
17s	$335,887,387
Total	**$3,756,659,084**

DSH

DSH Adjustment (Quarterly)	$115,999,213

Total Ceiling

Budget Neutrality Cap	
Total w/DSH Adj.	**$3,872,658,297**

II. Actual Expenditures

Group 1 and 2

1-Disabled (can be any ages)	$ 529,445,187
2-Child <=18	$ 475,343,939
3-Adult >= 65	$ 970,926
4-Adult <= 64	$ 407,781,030

Duals (17)	$	369,627,396
Total		**1,783,168,478**

Group 3

1-Disabled (can be any ages)	$	-
2-Child <=18	$	5,169,224
3-Adult >= 65	$	30,103,605
4-Adult <= 64	$	217,416
Duals (17)	$	-
Total		**35,490,246**

Pool Payments and Admin

Total Pool Payments	$	142,967,898

Admin		164,393,635

Quarterly Drug Rebates		(275,658,236)
Quarterly Premium Collections	$	-

Total Net Quarterly Expenditures	**$**	**1,850,362,021**

III. Surplus/(Deficit)

	$2,022,296,276
Federal Share	**$1,315,200,383**

HCI Result	MM201704	MM201705	MM201706	TOTAL	HCI ASO	HCI Rx	HCI DTL	HCI MCO CAP (TCS Admin)	HCI BHO CAP	State-Only Allocation	UNK Allocation	Taxes	Allocation on Differences between DV and HCI-CAP	TOTAL
EG1-TYPE1 (disabled, type1 state plan eligibles)	140,584	140,623	138,967	420,174	$75,483,816	$125,400,175	$1,786,916	$318,683,266	$0	$0	3,496,951	$0	$0	$524,851,125
EG1-TYPE2 (disabled, type2 transition group)	0	0	0	0	$0	$0	$0	$0	$0	$0	-	$0	$0	$0
EG2-TYPE1 (over 65, type1 state plan eligibles)	304	251	292	847	$410	$42,769	$0	$921,278	$0	$0	6,469	$0	$0	$970,926
EG2-TYPE2 (over 65, type2 state plan eligibles)	0	0	0	0	$0	$0	$0	$0	$0	$0	-	$0	$0	$0
EG3-TYPE1 (children, type1 state plan eligibles)	751,962	743,513	739,772	2,235,247	$11,627,939	$65,566,153	$34,514,098	$360,468,651	$0	$0	3,167,097	$0	$0	$475,343,939
Med Exp Child (Title XXI Demo Pop; EG3-Type2)	7,433	7,167	7,069	21,669	$124,057	$1,357,163	$502,905	$3,141,511	$0	$0	34,380	$0	$0	$5,160,015
EG4-TYPE1 (adults, type1 State plan eligibles)	418,981	416,458	380,403	1,215,842	$1,406,686	$78,877,566	$2,793,190	$321,986,646	$0	$0	2,716,943	$0	$0	$407,781,030
EG4-TYPE2 (adults, type2 demonstration pop)	0	0	0	0	$0	$0	$0	$0	$0	$0	-	$0	$0	$0
EG5-TYPE1 (duals, state plan eligibles)	139,536	139,224	136,669	415,429	$1,604,382	$863,279	$38,514	$293,046,939	$0	$0	1,982,404	$0	$0	$297,535,518
EG6E-TYPE3 (Expan adult, type3 demonstration pop)	369	346	321	1,036	$0	$10,221	$0	$205,746	$0	$0	1,449	$0	$0	$217,416
EG7E-TYPE3 (Expan child, type3 demonstration pop)	11	13	14	38		$2,414	$642	$6,091	$0	$0	61	$0	$0	$9,209
EG8-TYPE2 (med exp child)	0	0	0	0	$0	$0	$0	$0	$0	$0	-	$0	$0	$0
EG9 H-Disabled (TYPE 2 Eligibles)	245	247	254	746	$3,852	$256,889	$0	$4,302,712	$0	$0	30,609	$0	$0	$4,594,062
EG10 H-Senior	46	48	85	179	$0	$17,648	$0	$792,249			5,432			$815,330
EG11H, H-Dual	6,036	6,100	6,096	18,232	$0	$6,793	$0	$71,604,754	$0	$0	480,330	$0	$0	$72,091,878
EG12E, Carryovers	2,114	2,050	1,976	6,140	$0	$107,365	$0	$28,985,770	$0	$0	195,140	$0	$0	$29,288,276
Total	**1,467,621**	**1,456,040**	**1,411,918**	**4,335,579**	**$90,251,141**	**$272,508,437**	**$39,636,265**	**$1,404,145,614**	**$0**	**$0**	**$12,117,266**	**$0**	**$0**	**$1,818,658,724**

HCI Result	MM201704	MM201705	MM201706	TOTAL	HCI ASO PMPM	HCI Rx PMPM	HCI DTL PMPM	HCI MCO CAP (TCS Admin)	HCI BHO CAP	State-Only Allocation	UNK Allocation	Taxes	Allocation on Differences between DV and HCI-CAP	TOTAL
EG1-TYPE1 (disabled, type1 state plan eligibles)	140,584	140,623	138,967	420,174	$179.65	$298.45	$4.25	$758.46	$0.00	$0.00	$8.32	$0.00	$0.00	$1,249.13
EG1-TYPE2 (disabled, type2 transition group)	0	0	0	-										
EG2-TYPE1 (over 65, type1 state plan eligibles)	304	251	292	847	$0.48	$50.49	$0.00	$1,087.70	$0.00	$0.00	$7.64	$0.00	$0.00	$1,146.31
EG2-TYPE2 (over 65, type2 state plan eligibles)	0	0	0	-	-	-	-	-	-	-	-	-	-	-
EG3-TYPE1 (children, type1 state plan eligibles)	751,962	743,513	739,772	2,235,247	$5.20	$29.33	$15.44	$161.27	$0.00	$0.00	$1.42	$0.00	$0.00	$212.66
Med Exp Child (Title XXI Demo Pop; EG3-Type2)	7,433	7,167	7,069	21,669	$5.73	$62.63	$23.21	$144.98	$0.00	$0.00	$1.59	$0.00	$0.00	$238.13
EG4-TYPE1 (adults, type1 State plan eligibles)	418,981	416,458	380,403	1,215,842	$1.16	$64.87	$2.30	$264.83	$0.00	$0.00	$2.23	$0.00	$0.00	$335.39
EG4-TYPE2 (adults, type2 demonstration pop)	0	0	0	-										
EG5-TYPE1 (duals, state plan eligibles)	139,536	139,224	136,669	415,429	$3.86	$2.08	$0.09	$705.41	$0.00	$0.00	$4.77	$0.00	$0.00	$716.21
EG6E-TYPE3 (Expan adult, type3 demonstration pop)	369	346	321	1,036	$0.00	$9.87	$0.00	$198.60	$0.00	$0.00	$1.40	$0.00	$0.00	$209.86
EG7E-TYPE3 (Expan child, type3 demonstration pop)	11	13	14	38	$0.00	$63.54	$16.90	$160.29	$0.00	$0.00	$1.61	$0.00	$0.00	$242.34
EG8-TYPE2 (emd exp child)	0	0	0	-										
EG9 H-Disabled (TYPE 2 Eligibles)	245	247	254	746	$5.16	$344.36	$0.00	$5,767.71	$0.00	$0.00	$41.03	$0.00	$0.00	$6,158.26
EG10 H-Senior	46	48	85	179	$0.00	$98.59	$0.00	$4,425.97	$0.00	$0.00	$30.35			
EG11H, H-Dual	6,036	6,100	6,096	18,232	$0.00	$0.37	$0.00	$3,927.42	$0.00	$0.00	$26.35	$0.00	$0.00	$3,954.14
EG12E, Carryovers	2,114	2,050	1,976	6,140	$0.00	$17.49	$0.00	$4,720.81	$0.00	$0.00	$31.78	$0.00	$0.00	$4,770.08
Total	**1,467,621**	**1,456,040**	**1,411,918**	**4,335,579**	**$20.82**	**$62.85**	**$9.14**	**$323.87**	**$0.00**	**$0.00**	**$2.79**	**$0.00**	**$0.00**	**$419.47**

* Unknown allocation was performed within the Service category totals.

alloated payment in unknown in each EG Group

					payment in blank category in each subject
28.86%	3,496,951	**MEDICAL**	$	610,059
0.00%	-	**PHARMACY**	$	487,124
0.05%	6,469	**DENTAL**	$	87,796
0.00%	-	**CAP**	$	10,932,288
26.14%	3,167,097			
0.28%	34,380	**TOTAL**	**$**	**12,117,266**
22.42%	2,716,943			
0.00%	-			
16.36%	1,982,404			
0.01%	1,449			
0.00%	61			
0.00%	-			
0.25%	30,609			
0.04%	5,432			
3.96%	480,330			
1.61%	195,140			
$1,806,541,457	12,117,266			

(Used to calculate approximate percentages for each EG group -- O18 = Q18+S18)

Enrollment changes	Cumulative Total	AVG. Enrollment
SFY2017Q2	4,537,915	1,551,740.33
SFY2017Q3	4,335,579	1,445,193.00
% Changes in Total:	-4.46%	-6.87%

CAP PMPM changes:	CAP PMPM	Total CAP in QTR	Payment changes from current QTR to previous QTR
SFY2017Q2	$327.81	$ 1,488,567,809	
SFY2017Q3	$323.87	$ 1,415,077,902	$ (73,489,907)
	-1.20%	-4.94%	

CMS 64 Budget Neutrality Totals - June Q 2017

All reported totals are based on total computable dollars.

	CMS reported June Q	
Critical Access Hospitals	-	
CPE	53,171,407	
Essential Access Hospitals	25,000,000	
DSH	45,985,000	
GME	16,029,200	
MeHarry	2,500,000	
Hospital Enhanced Coverage	282,291	
IGT	-	
All Eligibility Waviers for quarter	1,596,288,119	including EG asst. and admin.
Administration	164,393,635	Total Admin.
Premium Refunds	0	
Drug Rebates	(275,658,236)	

HCI Result	MM201701	MM201702	MM201703	TOTAL	HCI ASO	HCI Rx	HCI DTL	HCI MCO CAP (TCS Admin)	HCI BHO CAP	State-Only Allocation	UNK Allocation	Taxes	Allocation on Difference	TOTAL
EG1-TYPE1 (disabled, type1 state plan eligibles)	144,464	142,460	141,006	427,930	$76,409,024	$135,411,644	$1,681,705	$328,143,927	$0	$0	2,862,166	$0	$0	$544,508,466
EG1-TYPE2 (disabled, type2 transition group)	0	0	0	0	$0	$0	$0	$0	$0	$0	-	$0	$0	$0
EG2-TYPE1 (over 65, type1 state plan eligibles)	192	228	273	693	$537	$25,810	$0	$637,757	$0	$0	3,509	$0	$0	$667,612
EG2-TYPE2 (over 65, type2 state plan eligibles)	0	0	0	0	$0	$0	$0	$0	$0	$0	-	$0	$0	$0
EG3-TYPE1 (children, type1 state plan eligibles)	790,559	781,221	760,017	2,331,797	$10,128,622	$74,720,535	$35,323,831	$372,031,356	$0	$0	2,600,905	$0	$0	$494,805,249
Med Exp Child (Title XXI Demo Pop; EG3-Type2)	12,887	11,021	8,434	32,342	$187,958	$1,891,842	$631,122	$4,237,351	$0	$0	36,716	$0	$0	$6,984,989
EG4-TYPE1 (adults, type1 State plan eligibles)	435,308	430,961	422,667	1,288,936	$1,698,237	$78,121,601	$2,734,335	$347,842,415	$0	$0	2,256,329	$0	$0	$432,652,916
EG4-TYPE2 (adults, type2 demonstration pop)	0	0	0	0	$0	$0	$0	$0	$0	$0	-	$0	$0	$0
EG5-TYPE1 (duals, state plan eligibles)	143,859	143,211	141,993	429,063	$1,561,586	$1,060,677	$19,364	$319,463,984	$0	$0	1,702,070	$0	$0	$323,807,681
EG6E-TYPE3 (Expan adult, type3 demonstration pop)	524	476	428	1,428	$0	$40,355	$0	$254,034	$0	$0	1,556	$0	$0	$295,944
EG7E-TYPE3 (Expan child, type3 demonstration pop)	15	15	15	45		$3,570	$907	$10,095	$0	$0	77	$0	$0	$14,650
EG8-TYPE2 (med exp child)	0	0	0	0	$0	$0	$0	$0	$0	$0	-	$0	$0	$0
EG9 H-Disabled (TYPE 2 Eligibles)	221	236	247	704	$2,142	$279,289	$0	$4,379,725	$0	$0	24,630	$0	$0	$4,685,787
EG10 H-Senior	41	42	44	127	$0	$15,678	$0	$804,449			4,334			$824,460
EG11H, H-Dual	6,065	6,087	6,086	18,238	$0	$20,026	$0	$76,199,071	$0	$0	402,757	$0	$0	$76,621,854
EG12E, Carryovers	2,269	2,182	2,161	6,612	$0	$123,603	$0	$33,584,265	$0	$0	178,119	$0	$0	$33,885,987
Total	**1,536,404**	**1,518,140**	**1,483,371**	**4,537,915**	**$89,988,106**	**$291,714,631**	**$40,391,264**	**$1,487,588,429**	**$0**	**$0**	**$10,073,167**	**$0**	**$0**	**$1,919,755,596**

HCI Result	MM201701	MM201702	MM201703	TOTAL	HCI ASO PMPM	HCI Rx PMPM	HCI DTL PMPM	HCI MCO CAP (TCS Admin)	HCI BHO CAP	State-Only Allocation	UNK Allocation	Taxes	Allocation on Difference	TOTAL
EG1-TYPE1 (disabled, type1 state plan eligibles)	144,464	142,460	141,006	427,930	$178.55	$316.43	$3.93	$766.82	$0.00	$0.00	$6.69	$0.00	$0.00	$1,272.42
EG1-TYPE2 (disabled, type2 transition group)	0	0	0	-										
EG2-TYPE1 (over 65, type1 state plan eligibles)	192	228	273	693	$0.77	$37.24	$0.00	$920.28	$0.00	$0.00	$5.06	$0.00	$0.00	$963.37
EG2-TYPE2 (over 65, type2 state plan eligibles)	0	0	0	-	-	-	-	-	-	-	-	-	-	-
EG3-TYPE1 (children, type1 state plan eligibles)	790,559	781,221	760,017	2,331,797	$4.34	$32.04	$15.15	$159.55	$0.00	$0.00	$1.12	$0.00	$0.00	$212.20
Med Exp Child (Title XXI Demo Pop; EG3-Type2)	12,887	11,021	8,434	32,342	$5.81	$58.49	$19.51	$131.02	$0.00	$0.00	$1.14	$0.00	$0.00	$215.97
EG4-TYPE1 (adults, type1 State plan eligibles)	435,308	430,961	422,667	1,288,936	$1.32	$60.61	$2.12	$269.87	$0.00	$0.00	$1.75	$0.00	$0.00	$335.67
EG4-TYPE2 (adults, type2 demonstration pop)	0	0	0	-										
EG5-TYPE1 (duals, state plan eligibles)	143,859	143,211	141,993	429,063	$3.64	$2.47	$0.05	$744.56	$0.00	$0.00	$3.97	$0.00	$0.00	$754.69
EG6E-TYPE3 (Expan adult, type3 demonstration pop)	524	476	428	1,428	$0.00	$28.26	$0.00	$177.89	$0.00	$0.00	$1.09	$0.00	$0.00	$207.24
EG7E-TYPE3 (Expan child, type3 demonstration pop)	15	15	15	45	$0.00	$79.34	$20.15	$224.34	$0.00	$0.00	$1.71	$0.00	$0.00	$325.55
EG8-TYPE2 (emd exp child)	0	0	0	-										
EG9 H-Disabled (TYPE 2 Eligibles)	221	236	247	704	$3.04	$396.72	$0.00	$6,221.20	$0.00	$0.00	$34.99	$0.00	$0.00	$6,655.95
EG10 H-Senior	41	42	44	127	$0.00	$123.45	$0.00	$6,334.24	$0.00	$0.00	$34.12			
EG11H, H-Dual	6,065	6,087	6,086	18,238	$0.00	$1.10	$0.00	$4,178.04	$0.00	$0.00	$22.08	$0.00	$0.00	$4,201.22
EG12E, Carryovers	2,269	2,182	2,161	6,612	$0.00	$18.69	$0.00	$5,079.29	$0.00	$0.00	$26.94	$0.00	$0.00	$5,124.92
Total	**1,536,404**	**1,518,140**	**1,483,371**	**4,537,915**	**$19.83**	**$64.28**	**$8.90**	**$327.81**	**$0.00**	**$0.00**	**$2.22**	**$0.00**	**$0.00**	**$423.03**

* Unknown allocation was performed within the Service category totals.

	alloated payment in unknown in each EG Group			payment in blank category in each subject
28.51%		2,872,166	**MEDICAL**	$ 478,190
0.00%		-	**PHARMACY**	$ 948,813
0.03%		3,522	**DENTAL**	$ 80,884
0.00%		-	**CAP**	$ 8,565,280
25.91%		2,609,992		
0.37%		36,844	**TOTAL**	**$ 10,073,167**
22.66%		2,282,152		
0.00%		-		
16.96%		1,708,016		
0.02%		1,561		
0.00%		77		
0.00%		-		
0.25%		24,717		
0.04%		4,349		
4.01%		404,164		
1.77%		178,741		
$1,909,682,429		10,126,301		

(Used to calculate approximate percentages for each EG group -- O18 = Q18+S18)

Enrollment changes	Cumulative Total	AVG. Enrollment
SFY2017Q1	4,655,221	1,551,740.33
SFY2017Q2	4,537,915	1,512,638.33
% Changes in Total:	-2.52%	-2.52%

CAP PMPM changes:	CAP PMPM	Total CAP in QTR	Payment changes from current QTR to previous QTR
SFY2017Q1	$319.31	$ 1,488,567,809	
SFY2017Q2	$327.81	$ 1,496,153,708	$ 7,585,899
	2.66%	0.51%	