TN Division of TennCare

August 29, 2018

Ms. Annie Hollis
TennCare Project Officer
Division of Medicaid Expansion Demonstrations
State Demonstrations Group
Center for Medicaid and CHIP Services
Centers for Medicare and Medicaid Services
Mail Stop S2-03-17
7500 Security Boulevard
Baltimore, Maryland 21244-1850

RE: TennCare II, STC 44, Quarterly Progress Report

Dear Ms. Hollis:

Enclosed please find the Quarterly Progress Report for the April – June 2018 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: Davida Kimble, Acting Associate Regional Administrator, Atlanta Regional Office
Tandra Hodges, Tennessee State Coordinator, Atlanta Regional Office

TennCare II

Section 1115 Quarterly Report

(For the period April - June 2018)

Demonstration Year: 16 (7/1/17 - 6/30/18)
Federal Fiscal Quarter: 3/2018 (4/18 - 6/18)
Waiver Quarter: 4/2018 (4/18 - 6/18)

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 1.4 million enrollees. During this quarter, these entities included Managed Care Organizations (MCOs) for medical services, behavioral health 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 #
4/20/18	The State notified the public of its intent to submit to CMS Amendment 35 to the TennCare Demonstration. Amendment 35 would allow the State to pay for short-term substance use disorder services in facilities classified as institutions for mental diseases.	15
4/26/18	The Monthly Call for April was held.	43
5/1/18	The State submitted to CMS enrollment target ranges for CHOICES Group 2 and for all Employment and Community First (ECF) CHOICES benefit groups.	31.d.ii and 32.d.ii
5/25/18	The State submitted Amendment 35 to CMS.	
5/30/18	The State requested CMS approval of Statewide MCO Contract Amendment 8 and TennCare Select Contract Amendment 43.	39
5/30/18	The State submitted the Quarterly Progress Report for the January-March 2018 quarter to CMS.	44
5/31/18	The Monthly Call for May was held.	43
6/13/18	The State notified the public of its intent to submit to CMS Amendment 36 to the TennCare Demonstration. Amendment 36 would allow the State to establish reasonable standards for providers of family planning services in the TennCare Demonstration.	15
6/27/18	With regard to Amendment 33 (the State's request to	

Date	Action	STC #
	change the payment structure of supplemental payments to Tennessee hospitals), CMS sent proposed revisions to the State's draft payment distribution methodology.	
6/28/18	The Monthly Call for June was held.	43
6/30/18	The State submitted point-in-time and annual aggregate data about the CHOICES and ECF CHOICES programs to CMS.	42.d.iv

II. Enrollment and Benefits Information

Information about enrollment by category is presented in Table 2.

Table 2
Enrollment Counts for the April – June 2018 Quarter
Compared to the Previous Two Quarters

Demonstration Populations	Total Number of TennCare Enrollees		
	Oct – Dec 2017	Jan – Mar 2018	Apr – Jun 2018
EG1 Disabled, Type 1 State Plan eligibles	143,789	142,906	142,555
EG9 H-Disabled, Type 2 Demonstration Population	252	261	278
EG2 Over 65, Type 1 State Plan eligibles	350	414	446
EG10 H-Over 65, Type 2 Demonstration Population	57	54	66
EG3 Children, Type 1 State Plan eligibles	778,248	788,561	765,641
EG4 Adults, Type 1 State Plan eligibles	418,520	428,261	410,901
EG5 Duals, Type 1 State Plan eligibles and EG11 H-Duals 65, Type 2 Demonstration Population	149,247	149,080	148,475
EG6E Expan Adult, Type 3 Demonstration Population	269	209	131
EG7E Expan Child, Type 3 Demonstration Population	897	865	1,042
EG8, Med Exp Child, Type 2 Demonstration Population, Optional Targeted Low Income Children funded by Title XIX	0	0	0

Demonstration Populations	Total Number of TennCare Enrollees		
	Oct – Dec 2017	Jan – Mar 2018	Apr – Jun 2018
Med Exp Child, Title XXI Demonstration Population	4,529	4,236	4,827
EG12E Carryover, Type 3, Demonstration Population	1,731	1,666	1,544
TOTAL*	1,497,889	1,516,513	1,475,906

*** 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, 2018

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 33: Supplemental Payment Pools for Tennessee Hospitals. On February 7, 2018, TennCare submitted Amendment 33 to the TennCare Demonstration to CMS. Amendment 33 concerns the supplemental payments that TennCare makes to Tennessee hospitals to help offset the costs these facilities incur in providing uncompensated care. With Amendment 33, TennCare asked that CMS revisit certain changes imposed on the supplemental payment structure during the most recent renewal of the TennCare Demonstration in 2016.

Amendment 33 consists of three components:

- Restoration of approximately $90 million to the maximum amount TennCare is authorized to pay to hospitals each year for uncompensated care costs;
- Continuation of a special funding pool—which was scheduled to end on June 30, 2018—that supports clinics operated by Meharry Medical College; and

[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.

- Extending the implementation period of a new hospital payment structure currently scheduled to take effect on July 1, 2018.

By the end of the April-June quarter, TennCare and CMS were working on a path to address the issues raised by the State without the need for a formal demonstration amendment. Once these details have been finalized, TennCare expects to formally withdraw Amendment 33 from further consideration.

Demonstration Amendment 34: Program Modifications. In March and April 2018, TennCare held a public notice and comment period for another amendment to the TennCare Demonstration that was being contemplated. Amendment 34 outlined program changes that would be needed if the hospital assessment were not renewed in 2018. These changes had also been proposed in previous years, but were ultimately made unnecessary each year by the Tennessee General Assembly's renewal of a one-year hospital assessment. The reductions contemplated in Amendment 34 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 Tennessee General Assembly renewed the hospital assessment, thereby eliminating any funding gap and the need for Amendment 34 to be submitted to CMS.

Demonstration Amendment 35: Substance Use Disorder Services. In April 2018, TennCare issued public notice regarding another proposal to be submitted to CMS. Amendment 35 would amend the TennCare benefits package to cover residential substance use disorder (SUD) treatment services in facilities with more than 16 beds. The federal government classifies facilities with more than 16 beds as "institutions for mental diseases" (IMDs), and federal law prohibits the expenditure of federal Medicaid dollars for services delivered to adults in these facilities.

Until the issuance of the 2016 managed care rule, the MCOs contracted with the TennCare program were permitted to cover residential treatment services in IMDs in lieu of providing these services in facilities that were not IMDs, if the MCO determined that such care was medically appropriate and cost-effective as compared to State Plan-covered services. However, the 2016 managed care rule limits this option to treatment stays of no more than 15 days per calendar month, in effect creating a gap in the State's benefit package as it relates to treatment of SUDs.

In light of this new federal restriction, with Amendment 35, TennCare is seeking authority to cover residential SUD treatment services in facilities that meet the definition of an IMD when medically necessary and appropriate. TennCare's proposal would allow enrollees to receive short-term services in IMDs beyond the 15-day limit in federal regulation, up to 30 days per admission.

The public notice and comment period for Amendment 35 lasted from April 20 through May 21, 2018, during which time no comments on the proposal were received. TennCare submitted Amendment 35 to CMS on May 25, 2018. As of the conclusion of the April-June 2018 quarter, CMS was continuing its review of Amendment 35.

Demonstration Amendment 36: Family Planning Providers. In June 2018, TennCare initiated its public notice and comment period for a demonstration amendment stemming from Tennessee's 2018 legislative session. On April 12, 2018, the Tennessee General Assembly enacted legislation establishing that it is the policy of the state of Tennessee to favor childbirth and family planning services that do not include elective abortions within the continuum of care or services, and to avoid the direct or indirect use of state funds to promote or support elective abortions.

Accordingly, Amendment 36 requests authority to establish state-specific criteria for providers of family planning services, and to exclude any providers that do not meet these criteria from participation in the TennCare program. Specifically—and as specified in the legislation passed by the General Assembly—Amendment 36 proposes to exclude any entity that performed, or operated or maintained a facility that performed, more than 50 abortions in the previous year, including any affiliate of such an entity.

The designated public notice and comment period for Amendment 36 was scheduled to run from June 13 through July 13, 2018. As of the end of the April-June 2018 quarter, TennCare planned to submit Amendment 36 to CMS at the conclusion of the public notice period and after all public comments had been reviewed.

Tennessee Eligibility Determination System. The Tennessee Eligibility Determination System (or "TEDS") is the name of the system (currently under development) that will be used by the Division of TennCare to process applications and identify persons who are eligible for the TennCare and CoverKids programs. During the April-June 2018 quarter, the focus of readiness activities was user acceptance testing, which began on April 9, 2018. This phase of the project allows staff to test TEDS using scripts and ad hoc scenarios in a simulated environment to ensure that the system is functioning effectively. Approximately 100 individuals engaged in TEDS user acceptance testing during the April-June quarter, and any defects noted were reported to Deloitte Consulting, LLP, TennCare's systems integrator partner. The first phase of 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 2018 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 twenty-second 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. TennCare 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 2018 Compared to the Previous Two Quarters

Activities	Oct – Dec 2017	Jan – Mar 2018	Apr – Jun 2018
Number of outreach activities/events	2,021	1,941	1,926
Number of people made contact with (mostly face to face at outreach events)	104,301	86,496	111,930
Number of educational materials distributed	81,439	57,069	78,441
Number of coalitions/advisory board meetings attended or conducted	76	102	91

Activities	Oct – Dec 2017	Jan – Mar 2018	Apr – Jun 2018
Number of attendees at coalitions/advisory board meetings	1,315	1,915	1,345
Number of educational preventive health radio/TV broadcasts	61	584	576
Number of educational preventive health newsletter/magazine articles	0	8	24
Number of educational preventive health billboards, scrolling billboards and bulletin boards	296	3,310	2,830
Number of presentations made to enrollees/professional staff who work with enrollees	75	66	50
Number of individuals attending presentations	2,163	1,515	741
Number of completed telephone calls regarding the importance of dental checkups	165	146	248
Number of home visits completed	964	1,088	1,453

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 2018 Compared to the Previous Two Quarters

Activities	Oct – Dec 2017	Jan – Mar 2018	Apr – Jun 2018
Number of enrollees reached	31,983	38,500	42,751
Number of enrollees who were assisted in scheduling an EPSDT exam for their children	282	416	560
Number of enrollees who were assisted in arranging for transportation	28	42	33

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 2018 Quarter, and Percentage that Passed Systems Edits, Compared to the Previous Two Quarters

	Oct – Dec 2017	Jan – Mar 2018	Apr – Jun 2018
No. of encounters received by TennCare (initial submission)	15,519,553	20,318,683	17,920,180
No. of encounters rejected by Edifecs upon initial submission	22,963	235,913[4]	21,534
Percentage of encounters that were compliant with State standards (including HIPAA) upon initial submission	99.85%	98.80%	99.88%

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 2018 Compared to the Previous Two Quarters

	Statewide Enrollment Targets and Reserve Capacity[5]	Enrollment and Reserve Slots Being Held as of the End of Each Quarter		
		Oct – Dec 2017	Jan – Mar 2018	Apr – Jun 2018
CHOICES 1	Not applicable	16,497	16,202	16,439
CHOICES 2	10,500	9,394	9,400	9,543
CHOICES 3 (including Interim CHOICES 3)	To be determined	3,020	2,882	2,842

[4] During the January-March 2018 quarter, UnitedHealthcare resubmitted encounter claims that had originally been coded as "T" for "Test" rather than as "P" for "Production." Absent this reprocessing, the percentage of encounter claims compliant on initial submission would have been 99.80%.

[5] 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.

	Statewide Enrollment Targets and Reserve Capacity[5]	Enrollment and Reserve Slots Being Held as of the End of Each Quarter		
		Oct – Dec 2017	Jan – Mar 2018	Apr – Jun 2018
Total CHOICES	Not applicable	28,911	28,484	28,824
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.iv. requires the State to submit to CMS periodic statistical reports about the use of LTSS by TennCare enrollees. Fourteen separate reports of data pertaining to the CHOICES program have been submitted between August 2011 and June 2018.

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 16,597 individuals on June 30, 2017. 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 the year prior to implementation of the CHOICES program, as compared with 63 percent admitted to NFs in the seventh 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 15,429 after CHOICES had been in place for seven 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 12,381 by June 30, 2017. 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), 7/1/16 – 6/30/17	Percent increase over a seven-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 6/30/17	Percent increase from the day prior to CHOICES implementa-tion to 6/30/17
6,226	15,429	148%	4,861[6]	12,381	155%

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 2018 Compared to the Previous Two Quarters

	Frequency and Use of Transition Allowances					
	Oct – Dec 2017		Jan – Mar 2018		Apr – Jun 2018	
Grand Region	# Distributed	Total Amount	# Distributed	Total Amount	# Distributed	Total Amount
East	18	$15,976	15	$5,287	17	$17,174
Middle	17	$9,105	18	$9,855	17	$13,928
West	21	$22,191	22	$16,343	20	$11,306
Statewide Total	56	$47,272	55	$31,485	54	$42,408

B. Employment and Community First CHOICES

Designed and implemented in partnership with people with intellectual and developmental disabilities, their families, advocates, providers, and other stakeholders, Employment and Community First CHOICES is the first managed LTSS program in the nation that is focused on

[6] 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).

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 2018 Compared to the Previous Two Quarters

	Statewide Enrollment Targets and Reserve Capacity[7]	Enrollment and Reserve Slots Filled as of the End of Each Quarter		
		Oct – Dec 2017	Jan – Mar 2018	Apr – Jun 2018
ECF CHOICES 4	850	767	841	838
ECF CHOICES 5	1,412	1,269	1,375	1,336
ECF CHOICES 6	438	245	296	358
Total ECF CHOICES	2,700	2,281	2,512	2,532
Reserve capacity	350	222	271	271
Waiver Transitions[8]	Not applicable	10	16	23

Data and trends of the designated ECF CHOICES data elements: STC 42.d.iv. requires the State to provide CMS periodic statistical reports about the ECF CHOICES program. On June 30, 2017, the State submitted baseline data preceding implementation of ECF CHOICES, and then on June 29, 2018, submitted data reflective of the first year of ECF CHOICES implementation. In

[7] Statewide enrollment targets and reserve capacity were previously adjusted to reflect new appropriation authority, effective July 1, 2017. Consistent with the State's May 1, 2017, letter to CMS setting enrollment target ranges for Demonstration Year 16, a total of 75 program slots were reallocated between the Group 4 and Group 5 Upper Limits during the October-December 2017 quarter in order best to meet the needs of program applicants and to ensure the most efficient use of resources. Early in the January-March 2018 quarter, an additional 25 program slots were reallocated from Group 5 to Group 6. Later in that quarter and continuing in the April-June 2018 quarter, in accordance with the State's January 30, 2018, letter to CMS, additional slots were reallocated across the Upper Limits of the three ECF CHOICES Benefit Groups (primarily to Group 6) in order to accommodate enrollment in the appropriate benefit group (e.g., when an adult cannot be safely served with the array of benefits available in Group 4 or 5 and must be enrolled into Group 6.

[8] 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 2,700-person enrollment target. Waiver transition numbers are cumulative since the program began.

comparing the baseline data with the post-implementation data, several notable trends emerged:

- The number of individuals with intellectual disabilities receiving HCBS through the TennCare program grew from 8,295 to 8,526.
- The number of individuals with developmental disabilities other than intellectual disabilities who received HCBS through the TennCare program grew from 0 to 519.
- Average LTSS expenditures for individuals with intellectual or developmental disabilities fell from $94,327 per person to $87,855 per person.

As ECF CHOICES gains enrollment capacity and further data about the program is gathered and submitted to CMS, future Quarterly Progress Reports will address the aforementioned data points—and others—in greater detail.

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 may also assess liquidated damages pursuant to the terms of the TennCare Contract. If the DBM and PBM do not meet their contractual prompt pay requirements, only TennCare may assess applicable liquidated damages against these entities.

Net Worth and Company Action Level Requirements. According to Tennessee's "Health Maintenance Organization Act of 1986" statute (T.C.A. § 56-32-101 *et seq.*), the minimum net worth requirement for each TennCare MCO is calculated based on premium revenue reported on the National Association of Insurance Commissioners (NAIC) Annual Financial Statement for the most recent calendar year, as well as any TennCare payments made to the MCO that are not reported as premium revenue.

During the April-June 2018 quarter, the MCOs submitted their NAIC First Quarter 2018 Financial Statements. As of March 31, 2018, TennCare MCOs reported net worth as indicated in the table below.[9]

Table 11
Net Worth Reported by MCOs as of March 31, 2018

	Net Worth Requirement	Reported Net Worth	Excess/ (Deficiency)
Amerigroup Tennessee	$30,058,528	$224,254,975	$194,196,447
UnitedHealthcare Plan of the River Valley (UnitedHealthcare Community Plan)	$65,141,772	$402,218,192	$337,076,420
Volunteer State Health Plan (BlueCare & TennCare Select)	$47,825,838	$496,583,640	$448,757,802

During the April-June 2018 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, 2018:

[9] 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, 2018

	Company Action Level Requirement	Reported Net Worth	Excess/ (Deficiency)
Amerigroup Tennessee	$110,985,558	$224,254,975	$113,269,417
UnitedHealthcare Plan of the River Valley (UnitedHealthcare Community Plan)	$221,464,280	$402,218,192	$180,753,912
Volunteer State Health Plan (BlueCare & TennCare Select)	$160,340,902	$496,583,640	$336,242,738

All TennCare MCOs exceeded their minimum net worth requirements and Company Action Level requirements as of March 31, 2018.

D. Update on Episodes of Care

Episodes of care is a payment reform strategy that 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 total joint 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 such as 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. A Urology TAG convened between March and April 2018 to design the program's ninth wave of episodes. The two episodes designed in Wave 9 are Cystourethroscopy and Acute Kidney and Ureter Stones.

In 2018, TennCare providers are receiving reports on 46 episodes of care. Of those episodes, 27 are in a performance period, and 19 are in a "preview" period (a one-year period of data collection and reporting that precedes the formal implementation of the episode). Estimates indicate that the Episodes of Care program saved Tennessee over $25 million in health care costs in calendar years 2015 (when three episodes were in a performance period) and 2016 (when eight episodes were in a performance period), while maintaining or in some cases improving quality of care.

E. Admission, Discharge, and Transfer Data

TennCare is continuing its work with Tennessee hospitals to coordinate the sharing of admission, discharge, and transfer (ADT) data. These data allow providers participating in

TennCare's care coordination initiatives to know when their patients go to an emergency room or are admitted to or discharged from a hospital. ADT data are the most actionable, real-time electronic information in health care. While many states are working to improve the sharing and use of ADT data, Tennessee has become a leader in this area. As of the end of June, 74 percent of Tennessee hospitals are sharing ADT data with TennCare, with more hospitals set to begin sharing these data in the coming months. The ADT data are delivered to primary care and behavioral health providers via TennCare's Care Coordination Tool in a usable format that—combined with other medical and pharmacy data—gives providers a workflow for prioritizing high-risk patients and highlights members' unmet medical needs. Providers have reported that this new information enables them to reach out to patients who are over-utilizing the emergency room, and to find hard-to-reach patients who may need follow-up care.

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[10] to replace outdated, often paper-based approaches to medical record-keeping with Certified Electronic Health Record Technology (as defined by CMS) that meets rigorous 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. Tennessee's EHR program[11] has issued payments for six program years to Medicaid providers meeting relevant eligibility requirements.

EHR payments made by TennCare during the April-June 2018 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 2018)	Cumulative Amount Paid To Date[12]
First-year payments	0	$0	$180,842,691

[10] 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).

[11] In April 2018, CMS announced that its EHR programs would be renamed "Promoting Interoperability (PI) Programs." While Tennessee's EHR initiative falls within the scope of CMS's PI Programs, TennCare will continue to refer to its initiative as "EHR Incentive Program" for purposes of clarity and consistency in communications with providers.

[12] Cumulative totals associated with first-year, second-year, and third-year payments reflect recoupments of payments from previous quarters. The need for these recoupments was identified through standard auditing processes.

Payment Type	No. of Providers Paid During the Quarter	Quarterly Amount Paid (Apr-Jun 2018)	Cumulative Amount Paid To Date[12]
Second-year payments	78	$663,000	$58,419,759
Third-year payments	73	$617,667	$34,647,704
Fourth-year payments	92	$782,000	$6,309,845
Fifth-year payments	59	$501,500	$3,544,502
Sixth-year payments	78	$649,098	$1,648,432

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

- Communicating with and assisting providers via emails (including targeted emails to eligible professionals attesting to "meaningful use" of EHR technology), technical assistance calls, webinars, and onsite visits;
- Acceptance of Program Year 2017 meaningful use attestations for returning eligible professionals[13];
- Submission of Tennessee's 2018 EHR Annual Report to CMS;
- Participation throughout the quarter in several Southeast Regional Collaboration for HIT/HIE (SERCH) calls; and
- Newsletters and alerts distributed by the TennCare's EHR ListServ.

Although enrollment of new providers concluded on April 30, 2017, 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 new enrollments to providers who attested to EHR requirements only once or who have not attested in recent years. TennCare emphasized this strategy in exhibits at the April 2018 Amerigroup Community Care and UnitedHealthcare Provider Information Expos in Chattanooga, Johnson City, Knoxville, Memphis, and Nashville.

G. *Wilson v. Gordon*

Wilson v. Gordon is a class action lawsuit filed against the Division of 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.

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. The State argued that there

[13] The deadline for submitting 2017 attestations had originally been set for March 31, 2018. As a result of problems reported by providers in the concluding weeks of the attestation period, CMS allowed the deadline to be extended to April 30, 2018.

were no remaining members in the Plaintiff class originally certified by the District Court, and that any eligibility issues arising in 2016 and thereafter were completely different from the issues that originally prompted the *Wilson* suit.

Oral argument and supplemental briefing on the State's Motion took place during the first half of Calendar Year 2017. On June 5, 2018, Judge William L. Campbell, Jr.[14] denied the State's Motion, finding that there continue to be members in the Plaintiff class. As a result, the case will proceed to trial on October 9, 2018.

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

TennCare continued to demonstrate budget neutrality during the April-June 2018 quarter. For more information about budget neutrality performance, see the spreadsheet comprising Attachment A to this Quarterly Progress Report.

From a state fiscal perspective, revenue collections remained robust throughout the quarter. All three months achieved growth in total state and local collections relative to the corresponding months of 2017, with more than a four percent improvement in April and May, and more than a three percent improvement in June.[15]

The unemployment rate in Tennessee continued to be historically low in all three months of the quarter. Moving from 3.4 percent in April to 3.5 percent in May and June, the unemployment rate was not only lower than the national rate during the same months (3.9 percent, 3.8 percent, and 4.0 percent respectively) but also lower than the state rate during the corresponding months of 2017 (4.0 percent, 3.8 percent, and 3.6 percent respectively).[16]

VIII. Member Month Reporting

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

[14] The *Wilson* suit was previously assigned to Judge Curtis Collier, but—pursuant to an administrative order entered on January 18, 2018—was reassigned to Judge Campbell.

[15] The Department of Revenue's collection summaries are available online at https://www.tn.gov/revenue/tax-resources/statistics-and-collections/collections-summaries.html.

[16] Information about Tennessee's unemployment rate is available on the Department of Labor and Workforce Development's website at https://www.tn.gov/workforce/general-resources/news.html.

Table 14
Member Month Reporting for Use in Budget Neutrality Calculations
April – June 2018

Eligibility Group	April 2018	May 2018	June 2018	Sum for Quarter Ending 6/30/18
Medicaid eligibles (Type 1)				
EG1 Disabled, Type 1 State Plan eligibles	141,245	139,652	139,612	420,509
EG2 Over 65, Type 1 State Plan eligibles	456	469	400	1,325
EG3 Children, Type 1 State Plan eligibles	741,507	736,710	738,568	2,216,785
EG4 Adults, Type 1 State Plan eligibles	394,689	389,858	392,789	1,177,336
EG5 Duals, Type 1 State Plan eligibles	137,741	136,398	136,558	410,697
Demonstration eligibles (Type 2)				
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	268	276	273	817
EG10 H-Over 65, Type 2 Demonstration Population	105	95	62	262
EG11 H-Duals, Type 2 Demonstration Population	6,138	6,211	6,252	18,601
TOTAL	1,422,149	1,409,669	1,414,514	4,246,332

Table 15
Member Month Reporting Not Used in Budget Neutrality Calculations
April – June 2018

Eligibility Group	April 2018	May 2018	June 2018	Sum for Quarter Ending 6/30/18
EG6E Expan Adult, Type 3, Demonstration Population	131	107	86	324

Eligibility Group	April 2018	May 2018	June 2018	Sum for Quarter Ending 6/30/18
EG7E Expan Child, Type 3, Demonstration Population	845	837	992	2,674
Med Exp Child, Title XXI Demonstration Population	4,130	3,907	4,542	12,579
EG12E Carryover, Type 3, Demonstration Population	1,596	1,545	1,520	4,661
TOTAL	6,702	6,396	7,140	20,238

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.

Table 16
Eligibility Appeals for April – June 2018
Compared to the Previous Two Quarters

	Oct – Dec 2017	Jan – Mar 2018	Apr – Jun 2018
No. of appeals received	25,882	36,293	48,076
No. of appeals resolved or withdrawn	21,069	34,120	40,905
No. of appeals taken to hearing	2,462	3,581	4,295
No. of hearings resolved in favor of appellant	141	189	208

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 2018
Compared to the Previous Two Quarters

	Oct – Dec 2017	Jan – Mar 2018	Apr – Jun 2018
No. of appeals received	2,547	1,483	1,645
No. of appeals resolved	2,390	1,962	1,608
• Resolved at the MCC level	769	525	509

	Oct – Dec 2017	Jan – Mar 2018	Apr – Jun 2018
• Resolved at the TSU level • Resolved at the LSU level	194 1,427	151 1,286	138 961
No. of appeals that did not involve a valid factual dispute	196	279	365
No. of directives issued	285	214	197
No. of appeals taken to hearing	1,427	1,286	961
No. of appeals that were withdrawn by the enrollee at or prior to the hearing	489	392	310
Appeals that went to hearing and were decided in the State's favor	426	468	357
Appeals that went to hearing and were decided in the appellant's favor	34	35	14

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 TennCare's 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 2018
Compared to the Previous Two Quarters

	Oct – Dec 2017	Jan – Mar 2018	Apr – Jun 2018
No. of appeals received	121	130	140
No. of appeals resolved or withdrawn	58	39	41
No. of appeals set for hearing	57	60	64
No. of hearings resolved in favor of appellant	0	2	1

X. Quality Assurance/Monitoring Activity

Population Health. Population Health (PH) is a healthcare management approach that targets the entire TennCare population. The Population Health program improves members' health across the entire care continuum by providing proactive as well as reactive program interventions that are cost-effective and that are tailored to each member's specific healthcare needs. The program, which emphasizes preventative care, identifies risky behaviors that are likely to lead to disease in the future (such as poor eating habits, physical inactivity, and drug use) and assists members in discontinuing such activities. Furthermore, PH provides interventions to assist members who already have a chronic or complex health condition. These interventions include making sure that members have access to necessary healthcare services, as well as addressing the social determinants of their health.

PH program members are stratified based on risk factors to one of three levels of health risk, and are then provided services and interventions from one or more of seven programs. Information on the risk levels addressed by PH, the manner in which these risks are addressed, and the total number of members enrolled in PH at the end of the January-March 2018 quarter is provided in Table 19. Data for the period of April through June 2018 will be provided in the next Quarterly Progress Report.

Table 19
Population Health Data*, January – March 2018

Risk Level	Intervention Type	Intervention Goal(s)	Number of Unique Members at End of Quarter[17]
Level 0: no identified risk	Wellness Program	Keep members healthy as long as possible	354,455
Level 1: low or moderate risk	Maternity Program	Engage pregnant women in timely prenatal care and deliver a healthy, term infant without complications	12,780
	Health Risk Management	Prevent, reduce, or delay exacerbation and complications of a condition or health risk behavior	568,817
	Care Coordination	Assure that members receive the services they need to reduce the risk of an adverse health outcome	11,611
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	11,622
	High Risk Pregnancy Management	Engage pregnant women in timely prenatal care and deliver a healthy, term infant without complications	4,646
	Complex Case Management	Move members to optimal levels of health and well-being through timely coordination of quality services and self-management support	6,184
Total PH Enrollment			**970,115**

*** The data in this table is a snapshot of PH enrollment on the last day of the reporting period. Because members move between stratification levels and programs, enrollment may vary on a daily basis. Members receiving Care Coordination services may also be receiving services in another PH program simultaneously. As a result, total PH enrollment reflects some duplication.**

Provider Data Validation Report. In April 2018, TennCare's External Quality Review Organization (EQRO), Qsource, published the results of its provider data validation survey for the January-March 2018 quarter. Qsource took a sample of provider data files from TennCare's MCCs[18] and reviewed each for accuracy in the following categories:

[17] Table 19 contains PH enrollment figures from three of TennCare's four MCOs. Enrollment figures submitted by the fourth MCO were based on erroneous stratification data and have therefore been excluded from the table. The software problem that produced the erroneous data has been corrected, and future PH updates will contain complete enrollment figures.

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

- Active contract status
- Provider address
- Provider specialty / behavioral health service code
- Provider panel status
- 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 "active contract status" (99.2 percent accuracy), "provider specialty / behavioral health service code" (99.2 percent accuracy), "urgent care services" (97.6 percent accuracy), "primary care services" (99.7 percent accuracy), and "prenatal care services" (99.7 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 2017, the MCCs—according to the report—"have maintained relatively high accuracy rates this quarter." Nonetheless, to ensure ongoing 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, 2018. TennCare, in turn, had received, reviewed, and accepted all of the plans by June 11, 2018. Results for the April-June 2018 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[19]

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

Le Bonheur Children's Hospital
East Tennessee Children's Hospital

C. Free Standing Psychiatric Hospitals

Pathways of Tennessee
Ridgeview Psychiatric Hospital and Center
Rolling Hills Hospital

D. Other Acute Care Hospitals

Parkridge Medical Center (with Parkridge Valley Psych)
Jackson – Madison County General Hospital
TriStar Skyline Medical Center (with Madison campus)
Saint Jude Children's Research Hospital
Methodist Healthcare – Memphis Hospitals
TriStar Centennial Medical Center
Parkridge East Hospital
Methodist Healthcare – South
Delta Medical Center
Parkwest Medical Center (with Peninsula Psych)
Baptist Memorial Hospital for Women
Saint Thomas Midtown Hospital

[19] 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.

Methodist Healthcare – North
Saint Francis Hospital
University Medical Center (with McFarland Psych)
Saint Thomas Rutherford Hospital
Baptist Memorial Hospital – Memphis
Fort Sanders Regional Medical Center
Wellmont – Holston Valley Medical Center
Erlanger North Hospital
Maury Regional Hospital
TriStar StoneCrest Medical Center
Methodist Le Bonheur Germantown Hospital
TriStar Horizon Medical Center
Tennova Healthcare
Wellmont – Bristol Regional Medical Center
TriStar Summit Medical Center
Cookeville Regional Medical Center
Blount Memorial Hospital
Gateway Medical Center
TriStar Southern Hills Medical Center
Dyersburg Regional Medical Center
Lincoln Medical Center
Morristown – Hamblen Healthcare System
Skyridge Medical Center
LeConte Medical Center
Sumner Regional Medical Center
Methodist Medical Center of Oak Ridge
Takoma Regional Hospital
TriStar Hendersonville Medical Center
Tennova Healthcare – Newport Medical Center
Saint Francis Hospital – Bartlett
Jellico Community Hospital
Tennova Healthcare – Harton Regional Medical Center
Indian Path Medical Center
Starr Regional Medical Center – Athens
Tennova Healthcare – LaFollette Medical Center
NorthCrest Medical Center
Parkridge West Hospital
Henry County Medical Center
Southern Tennessee Regional Health System – Winchester
Regional Hospital of Jackson
Wellmont Hawkins County Memorial Hospital
Roane Medical Center
Sycamore Shoals Hospital
Saint Thomas River Park Hospital

Southern Tennessee Regional Health System – Lawrenceburg
Heritage Medical Center
Skyridge Medical Center – Westside
Hardin Medical Center
Bolivar General Hospital
Baptist Memorial Hospital – Union City
Erlanger Health System – East Campus
McKenzie Regional Hospital
Lakeway Regional Hospital
Hillside Hospital
Starr Regional Medical Center – Etowah
Livingston Regional Hospital
TrustPoint Hospital
United Regional Medical Center
Tennova Healthcare – Jefferson Memorial Hospital
Volunteer Community Hospital
Claiborne County Hospital
Saint Thomas DeKalb Hospital
Saint Thomas Stones River Hospital
Henderson County Community Hospital
Jamestown Regional Medical Center
Milan General Hospital
Wayne Medical Center
Decatur County General Hospital
Kindred Hospital – Chattanooga
Southern Tennessee Regional Health System – Sewanee
Houston County Community Hospital

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	Ballad Health ETSU Quillen Johnson City Medical Center

Universities	Hospitals
	Johnson City Community Health Center Woodridge Hospital Holston Valley Medical Center Bristol Regional Medical Center
Meharry Medical College	Metro Nashville General Hospital Meharry Medical Group
University of Tennessee at Memphis	Regional One Health Methodist Le Bonheur Erlanger Jackson – Madison Co. General Hospital Saint Francis Hospital – Memphis Saint Thomas
Vanderbilt University	Vanderbilt University Hospital

XIV. Critical Access Hospitals

Bolivar General Hospital
Camden General Hospital
Cumberland River Hospital
Erlanger Bledsoe Hospital
Houston County Community 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

State Contact:

Aaron Butler
Director of Policy
Division of TennCare
310 Great Circle Road
Nashville, TN 37243
Phone: 615-507-6448
Email: aaron.c.butler@tn.gov

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Attachment A

Budget Neutrality Calculations for the Quarter

Actual TennCare Budget Neutrality (Apr-Jun 2018)

I. The Extension of the Baseline

Baseline PMPM

	SFY 2018 PMPM
1-Disabled (can be any ages)	$1,905.21
2-Child <=18	$535.50
3-Adult >= 65	$1,223.63
4-Adult <= 64	$1,111.34
Duals (17)	$781.68

Actual Member months of Groups I and II

1-Disabled (can be any ages)	421,326
2-Child <=18	2,216,785
3-Adult >= 65	1,587
4-Adult <= 64	1,177,336
Duals (17)	429,298
Total	**4,246,332**

Ceiling without DSH

	Baseline * MM
1-Disabled (can be any ages)	$802,712,527
2-Child <=18	$1,187,085,468
3-Adult >= 65	$1,941,904
4-Adult <= 64	$1,308,417,093
17s	$335,575,119
Total	**$3,635,732,111**

DSH

DSH Adjustment (Quarterly)	$115,999,213

Total Ceiling

Budget Neutrality Cap	
Total w/DSH Adj.	**$3,751,731,324**

II. Actual Expenditures

Group 1 and 2

1-Disabled (can be any ages)	$ 550,713,926
2-Child <=18	$ 484,114,368
3-Adult >= 65	$ 3,333,911
4-Adult <= 64	$ 416,328,789
Duals (17)	$ 385,448,812
Total	**$ 1,839,939,805**

Group 3

1-Disabled (can be any ages)	$ -
2-Child <=18	$ 3,516,806
3-Adult >= 65	$ 23,190,465
4-Adult <= 64	$ 61,744
Duals (17)	$ -
Total	**$ 26,769,015**

Pool Payments and Admin

Total Pool Payments	$ 209,488,779

Admin	176,273,894

Quarterly Drug Rebates	(88,238,780)
Quarterly Premium Collections	

Total Net Quarterly Expenditures	**$ 2,164,232,714**

III. Surplus/(Deficit)

	$1,587,498,610
Federal Share	**$1,031,239,097**

HCI Result	MM201804	MM201805	MM201806	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)	141,245	139,652	139,612	420,509	$78,483,014	$119,282,785	$1,637,853	$338,284,220	$0	$0	7,797,220	$0	$0	$545,485,091
EG1-TYPE2 (disabled, type2 transition group)	-	-	-	0	$0	$0	$0	$0	$0	$0	-	$0	$0	$0
EG2-TYPE1 (over 65, type1 state plan eligibles)	456	469	400	1,325	$0	$63,023	$0	$1,892,644	$0	$0	28,360	$0	$0	$1,984,027
EG2-TYPE2 (over 65, type2 state plan eligibles)	-	-	-	0	$7	$0	$0	$0	$0	$0	0	$0	$0	$7
EG3-TYPE1 (children, type1 state plan eligibles)	741,507	736,710	738,568	2,216,785	$13,077,198	$63,035,216	$35,080,651	$366,001,322	$0	$0	6,919,980	$0	$0	$484,114,368
Med Exp Child (Title XXI Demo Pop; EG3-Type2)	4,130	3,907	4,542	12,579	$64,948	$564,041	$246,500	$1,873,667	$0	$0	39,867	$0	$0	$2,789,022
EG4-TYPE1 (adults, type1 State plan eligibles)	394,689	389,858	392,789	1,177,336	$1,635,368	$81,378,155	$2,346,015	$325,018,204	$0	$0	5,951,046	$0	$0	$416,328,789
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)	137,741	136,398	136,558	410,697	$1,281,493	$1,022,898	$30,316	$298,516,627	$0	$0	4,362,762	$0	$0	$305,214,095
EG6E-TYPE3 (Expan adult, type3 demonstration pop)	131	107	86	324	$0	$4,056	$0	$56,806	$0	$0	883	$0	$0	$61,744
EG7E-TYPE3 (Expan child, type3 demonstration pop)	845	837	992	2,674	$27,035	$243,988	$57,024	$389,334	$0	$0	10,403	$0	$0	$727,784
EG8-TYPE2 (med exp child)	0	0	0	0	$0	$0	$0	$0	$0	$0	-	$0	$0	$0
EG9 H-Disabled (TYPE 2 Eligibles)	268	276	273	817	$0	$251,382	$0	$4,902,711	$0	$0	74,741	$0	$0	$5,228,834
EG10 H-Senior	105	95	62	262	$0	$13,108	$0	$1,317,473	-	-	19,295	-	-	$1,349,876
EG11H, H-Dual	6,138	6,211	6,252	18,601	$0	$6,366	$0	$79,081,468	$0	$0	1,146,883	$0	$0	$80,234,717
EG12E, Carryovers	1,596	1,545	1,520	4,661	$0	$88,963	$0	$22,770,015	$0	$0	331,487	$0	$0	$23,190,465
Total	1,428,851	1,416,065	1,421,654	4,266,570	$94,569,063	$265,953,981	$39,398,358	$1,440,104,491	$0	$0	$26,682,927	$0	$0	$1,866,708,821

HCI Result	MM201804	MM201805	MM201806	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)	141,245	139,652	139,612	420,509	$186.64	$283.66	$3.89	$804.46	$0.00	$0.00	$18.54	$0.00	$0.00	$1,297.20
EG1-TYPE2 (disabled, type2 transition group)	0	0	0	-										
EG2-TYPE1 (over 65, type1 state plan eligibles)	456	469	400	1,325	$0.00	$47.56	$0.00	$1,428.41	$0.00	$0.00	$21.40	$0.00	$0.00	$1,497.38
EG2-TYPE2 (over 65, type2 state plan eligibles)	0	0	0	-	-	-	-	-	-	-	-	-	-	-
EG3-TYPE1 (children, type1 state plan eligibles)	741,507	736,710	738,568	2,216,785	$5.90	$28.44	$15.83	$165.10	$0.00	$0.00	$3.12	$0.00	$0.00	$218.39
Med Exp Child (Title XXI Demo Pop; EG3-Type2)	4,130	3,907	4,542	12,579	$5.16	$44.84	$19.60	$148.95	$0.00	$0.00	$3.17	$0.00	$0.00	$221.72
EG4-TYPE1 (adults, type1 State plan eligibles)	394,689	389,858	392,789	1,177,336	$1.39	$69.12	$1.99	$276.06	$0.00	$0.00	$5.05	$0.00	$0.00	$363.62
EG4-TYPE2 (adults, type2 demonstration pop)	0	0	0	-										
EG5-TYPE1 (duals, state plan eligibles)	137,741	136,398	136,558	410,697	$3.12	$2.49	$0.07	$726.85	$0.00	$0.00	$10.62	$0.00	$0.00	$743.16
EG6E-TYPE3 (Expan adult, type3 demonstration pop)	131	107	86	324	$0.00	$12.52	$0.00	$175.33	$0.00	$0.00	$2.72	$0.00	$0.00	$190.57
EG7E-TYPE3 (Expan child, type3 demonstration pop)	845	837	992	2,674	$10.11	$91.24	$21.33	$145.60	$0.00	$0.00	$3.89	$0.00	$0.00	$272.17
EG8-TYPE2 (emd exp child)	0	0	0	-										
EG9 H-Disabled (TYPE 2 Eligibles)	268	276	273	817	$0.00	$307.69	$0.00	$6,000.87	$0.00	$0.00	$91.48	$0.00	$0.00	$6,400.04
EG10 H-Senior	105	95	62	262	$0.00	$50.03	$0.00	$5,028.52	$0.00	$0.00	$73.65			
EG11H, H-Dual	6,138	6,211	6,252	18,601	$0.00	$0.34	$0.00	$4,251.46	$0.00	$0.00	$61.66	$0.00	$0.00	$4,313.46
EG12E, Carryovers	1,596	1,545	1,520	4,661	$0.00	$19.09	$0.00	$4,885.22	$0.00	$0.00	$71.12	$0.00	$0.00	$4,975.43
Total	1,428,851	1,416,065	1,421,654	4,266,570	$22.17	$62.33	$9.23	$337.53	$0.00	$0.00	$6.25	$0.00	$0.00	$437.51

* Unknown allocation was performed within the Service category totals

#NAME?

allocated payment in unknown in each EG group

payment in blank category in each subject

29.22%	7,797,220	MEDICAL	$	954,805
0.00%	-	PHARMACY	$	341,141
0.11%	28,360	DENTAL	$	123,671
0.00%	0	CAP	$	25,243,110
25.93%	6,919,980			
0.15%	39,867	TOTAL	$	26,682,927
22.30%	5,951,046			
0.00%	-			
16.35%	4,362,762			
0.00%	883			
0.04%	10,403			
0.00%	-			
0.28%	74,741			
0.07%	19,295			
4.30%	1,146,883			
1.24%	331,487			
$1,840,025,893	26,682,927			

(Used to calculate approximate percentages for each EG group -- D18 = D28+E18)

Enrollment changes	Cumulative Total	AVG. Enrollment
SFY2018Q2	4,366,971	1,482,323.67
SFY2018Q3	4,366,570	1,422,193.00
% Changes in Total:	-2.74%	-2.74%

CAP PMPM changes:	CAP PMPM	Total CAP in QTR	Payment changes from current QTR to previous QTR
SFY2018Q2	$370.11	$ 1,633,861,544	
SFY2018Q3	$337.53	$ 1,465,368,001	$ (168,495,543)
	-8.80%	-10.31%	