Division of
TennCare

May 30, 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 January – March 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 January - March 2018)

Demonstration Year: 16 (7/1/17 - 6/30/18)
Federal Fiscal Quarter: 2/2018 (1/18 - 3/18)
Waiver Quarter: 3/2018 (1/18 - 3/18)

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 1.5 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 #
1/25/18	The Monthly Call for January was held.	43
1/30/18	The State sent CMS a letter stating that enrollment slots for the Employment and Community First CHOICES program could be reallocated among the three benefit groups of the program.	32.d.
2/1/18	CMS issued written approval of Amendment 32, the State's proposal for a two-year pilot project in which certain TennCare enrollees would receive a medication therapy management benefit in addition to the traditional TennCare benefits package. Included with the approval were revised versions of the Waiver List, Expenditure Authorities, and STCs. The State has since begun implementing the MTM pilot program.	
2/7/18	The State submitted to CMS Amendment 33 to the TennCare Demonstration. Amendment 33 requests modifications to the STCs governing the supplemental payment structure used to offset costs that Tennessee hospitals incur by providing uncompensated care.	
2/16/18	CMS sent the State a letter indicating that the submission of Amendment 33 met the requirements for a complete amendment.	
2/21/18	The Monthly Call for February was cancelled.	43

Date	Action	STC #
2/27/18	The State sent CMS a letter accepting the approval of Amendment 32. The letter also identified a technical correction to be made to the waiver materials that had accompanied CMS' approval.	
3/1/18	The State submitted the Quarterly Progress Report for the October-December 2017 quarter to CMS.	44
3/6/18	The State notified the public of its intent to submit to CMS Amendment 34 to the TennCare Demonstration. Amendment 34 outlined program reductions that would be necessary if the Tennessee General Assembly did not renew the annual hospital assessment.	15
3/22/18	The Monthly Call for March was held.	43
3/30/18	The State submitted to CMS a new distribution methodology for the uncompensated care payments scheduled to go into effect on July 1, 2018.	54.c

II. Enrollment and Benefits Information

Information about enrollment by category is presented in Table 2.

Table 2
Enrollment Counts for the January – March 2018 Quarter
Compared to the Previous Two Quarters

Demonstration Populations	Total Number of TennCare Enrollees		
	Jul – Sept 2017	Oct – Dec 2017	Jan – Mar 2018
EG1 Disabled, Type 1 State Plan eligibles	145,778	143,789	142,906
EG9 H-Disabled, Type 2 Demonstration Population	240	252	261
EG2 Over 65, Type 1 State Plan eligibles	245	350	414
EG10 H-Over 65, Type 2 Demonstration Population	44	57	54
EG3 Children, Type 1 State Plan eligibles	762,486	778,248	788,561
EG4 Adults, Type 1 State Plan eligibles	399,788	418,520	428,261

Demonstration Populations	Total Number of TennCare Enrollees		
	Jul – Sept 2017	Oct – Dec 2017	Jan – Mar 2018
EG5 Duals, Type 1 State Plan eligibles and EG11 H-Duals 65, Type 2 Demonstration Population[1]	148,941	149,247	149,080
EG6E Expan Adult, Type 3 Demonstration Population	302	269	209
EG7E Expan Child, Type 3 Demonstration Population	810	897	865
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	4,394	4,529	4,236
EG12E Carryover, Type 3, Demonstration Population	1,839	1,731	1,666
TOTAL*	1,464,867	1,497,889	1,516,513

*** 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 March 31, 2018

Managed Care Organizations	Amerigroup BlueCare[2] UnitedHealthcare Community Plan[3] TennCare Select[4]
Pharmacy Benefits Manager	Magellan Health Services
Dental Benefits Manager	DentaQuest

[1] Enrollment figures in this category for the July-September 2017 and October-December 2017 quarters have been revised. Corresponding adjustments have also been made to the overall enrollment totals for those two quarters.
[2] 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.
[3] UnitedHealthcare Community Plan is operated by UnitedHealthcare Plan of the River Valley, Inc.
[4] TennCare Select is operated by VSHP.

Demonstration Amendment 32: Medication Therapy Management. In September 2017, the Division of TennCare submitted a demonstration amendment to CMS to establish a two-year pilot program in which certain TennCare enrollees will receive medication therapy management (MTM) services. MTM is a clinical service provided by licensed pharmacists, the aim of which is to optimize drug therapy and improve therapeutic outcomes for patients. Amendment 32 proposed to make MTM available to TennCare members enrolled in TennCare's health home program (Tennessee Health Link), and to members whose primary care providers participate in TennCare's patient-centered medical home (PCMH) program.

On February 1, 2018, TennCare received CMS approval of Amendment 32. Based on CMS' approval of Amendment 32, TennCare has proceeded with implementing the MTM program and has been enrolling pharmacists to provide MTM services. These pharmacy providers will work as part of the extended care teams within the Tennessee Health Link and PCMH initiatives, engaging members to actively manage their drug therapy by identifying, preventing, and resolving medication-related problems. During the pilot, the pharmacists providing MTM services to TennCare enrollees will be particularly focused on providing their expertise to patients with the highest levels of clinical risk.

Demonstration Amendment 33: Supplemental Payment Pools for Tennessee Hospitals. On February 7, 2018, TennCare submitted Amendment 33 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—currently scheduled to end on June 30, 2018—that supports clinics operated by Meharry Medical College; and
- Extending the implementation period of a new hospital payment structure currently scheduled to take effect on July 1, 2018.

On February 16, 2018, CMS sent the State a letter acknowledging receipt of Amendment 33 and verifying that the State's submission contained all necessary components. As of the conclusion of the January-March 2018 quarter, CMS was continuing its review of the proposal.

Demonstration Amendment 34: Program Modifications. During the January-March 2018 quarter, TennCare issued public notice of another amendment to be submitted to CMS. Amendment 34 outlines program changes that would be needed if the hospital assessment is not renewed by the Tennessee legislature in 2018. These changes have also been proposed in previous years, but were made unnecessary each year by the legislature's passage or renewal

of a one-year hospital assessment. Changes to the TennCare benefit package for non-exempt adults that would be necessary if the assessment were not renewed in 2018 are as follows:

- A combined annual limit of eight days per person for inpatient hospital and inpatient psychiatric hospital services;
- An annual limit on non-emergency outpatient hospital visits of eight occasions per person;
- A combined annual limit on health care practitioners' office visits of eight occasions per person;
- An annual limit on lab and X-ray services of eight occasions per person; and
- Elimination of coverage for occupational therapy, speech therapy, and physical therapy.

TennCare opened its public notice and comment period regarding Amendment 34 on March 6, 2018.

Amendment 34 was scheduled to be withdrawn from consideration upon renewal of the hospital assessment, which was still working its way through the legislative process as of the end of the January-March 2018 quarter.

Tennessee Eligibility Determination System. Tennessee Eligibility Determination System (or "TEDS") is the name of the system—currently under development—that will be used by the State to process applications and identify persons who are eligible for TennCare and CoverKids (Tennessee's separate CHIP program). Preparations for implementation of the system progressed throughout the January-March 2018 quarter. The focal point of these activities during this period was systems integration testing, which is designed to ensure that various components (or sub-systems) of TEDS perform effectively and appropriately in conjunction with one another. Successful systems integration testing is a necessary precondition to the next stage of the project, user acceptance testing, which was expected to begin in April. Other tasks addressed during the January-March 2018 quarter included State review of system training materials and finalization of the TEDS pilot plan. 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 January-March 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-first 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
January – March 2018 Compared to the Previous Two Quarters

Activities	Jul – Sept 2017	Oct – Dec 2017	Jan – Mar 2018
Number of outreach activities/events	2,348	2,021	1,941
Number of people made contact with (mostly face to face at outreach events)	134,467	104,301	86,496
Number of educational materials distributed	104,778	81,439	57,069
Number of coalitions/advisory board meetings attended or conducted	106	76	102

Activities	Jul – Sept 2017	Oct – Dec 2017	Jan – Mar 2018
Number of attendees at coalitions/advisory board meetings	1,672	1,315	1,915
Number of educational preventive health radio/TV broadcasts	613	61	584
Number of educational preventive health newsletter/magazine articles	184	0	8
Number of educational preventive health billboards, scrolling billboards and bulletin boards	3,292	296	3,310
Number of presentations made to enrollees/professional staff who work with enrollees	74	75	66
Number of individuals attending presentations	1,108	2,163	1,515
Number of completed telephone calls regarding the importance of dental checkups	8	165	146
Number of home visits completed	878	964	1,088

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
January – March 2018 Compared to the Previous Two Quarters

Activities	Jul – Sept 2017	Oct – Dec 2017	Jan – Mar 2018
Number of enrollees reached	31,242	31,983	38,500
Number of enrollees who were assisted in scheduling an EPSDT exam for their children	240	282	416
Number of enrollees who were assisted in arranging for transportation	31	28	42

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

	Jul – Sept 2017	Oct – Dec 2017	Jan – Mar 2018
No. of encounters received by TennCare (initial submission)	15,388,873	15,519,553	20,318,683
No. of encounters rejected by Edifecs upon initial submission	37,408	22,963	235,913[5]
Percentage of encounters that were compliant with State standards (including HIPAA) upon initial submission	99.76%	99.85%	98.80%

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 January-March 2018 Compared to the Previous Two Quarters

	Statewide Enrollment Targets and Reserve Capacity[6]	Enrollment and Reserve Slots Being Held as of the End of Each Quarter		
		Jul – Sept 2017	Oct – Dec 2017	Jan – Mar 2018
CHOICES 1	Not applicable	16,621	16,497	16,202
CHOICES 2	10,500	9,297	9,394	9,400
CHOICES 3 (including Interim CHOICES 3)	To be determined	3,076	3,020	2,882

[5] 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%.

[6] 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[6]	Enrollment and Reserve Slots Being Held as of the End of Each Quarter		
		Jul – Sept 2017	Oct – Dec 2017	Jan – Mar 2018
Total CHOICES	Not applicable	28,994	28,911	28,484
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. Thirteen separate reports of data pertaining to the CHOICES program have been submitted between August 2011 and September 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 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 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 12,381 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), 7/1/14 – 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[7]	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 January – March 2018 Compared to the Previous Two Quarters

	Frequency and Use of Transition Allowances					
	Jul – Sept 2017		Oct – Dec 2017		Jan – Mar 2018	
Grand Region	# Distributed	Total Amount	# Distributed	Total Amount	# Distributed	Total Amount
East	12	$14,646	18	$15,976	15	$5,287
Middle	14	$12,034	17	$9,105	18	$9,855
West	21	$20,980	21	$22,191	22	$16,343
Statewide Total	47	$47,660	56	$47,272	55	$31,485

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

[7] 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 January – March 2018 Compared to the Previous Two Quarters

	Statewide Enrollment Targets and Reserve Capacity[8]	Enrollment and Reserve Slots Filled as of the End of Each Quarter		
		Jul – Sept 2017	Oct – Dec 2017	Jan – Mar 2018
ECF CHOICES 4	875	619	767	841
ECF CHOICES 5	1,466	1,089	1,269	1,375
ECF CHOICES 6	359	173	245	296
Total ECF CHOICES	2,700	1,881	2,281	2,512
Reserve capacity	350	215	222	271
Waiver Transitions[9]	Not applicable	7	10	16

Data and trends of the designated ECF CHOICES data elements: STC 42.d.iv. requires the State to submit to CMS periodic statistical reports about the ECF CHOICES program, the first of which was submitted on June 30, 2017. Since this inaugural submission consisted entirely of baseline data preceding implementation of ECF CHOICES, it is not yet possible to offer any observations regarding trends. Among the data points offered in the report are the following:

[8] 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 the quarter, in accordance with the State's January 30, 2018, letter to CMS, additional slots were reallocated across the Upper Limits of all three ECF CHOICES Benefit Groups 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 5 and must be enrolled into Group 6.

[9] 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.

- 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 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 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 January-March 2018 quarter, the MCOs submitted their 2017 NAIC Annual Financial Statements. As of December 31, 2017, TennCare MCOs reported net worth as indicated in the table below.[10]

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

	Net Worth Requirement	Reported Net Worth	Excess/ (Deficiency)
Amerigroup Tennessee	$30,058,528	$233,172,332	$203,113,804
UnitedHealthcare Plan of the River Valley (UnitedHealthcare Community Plan)	$65,141,772	$446,288,192	$381,146,420
Volunteer State Health Plan (BlueCare & TennCare Select)	$47,825,838	$479,849,260	$432,023,422

During the January-March 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 December 31, 2017:

[10] 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 December 31, 2017

	Company Action Level Requirement	Reported Net Worth	Excess/ (Deficiency)
Amerigroup Tennessee	$110,985,558	$233,172,332	$122,186,774
UnitedHealthcare Plan of the River Valley (UnitedHealthcare Community Plan)	$221,464,280	$446,288,192	$224,823,912
Volunteer State Health Plan (BlueCare & TennCare Select)	$160,340,902	$479,849,260	$319,508,358

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

D. Implementing Strategies to Address Opioid Misuse and Dependence

On January 16, 2018, TennCare implemented a new limit on its coverage of opioids for first-time and non-chronic opioid users experiencing an acute health event that requires a prescription for opioid pain medications. This limit for new and non-chronic users is based on TennCare's review of current medical literature, which demonstrates that reducing prolonged exposure to opioids is effective in preventing chronic opioid dependence and opioid misuse from occurring. Under this new policy, first-time and non-chronic TennCare opioid users may receive opioid prescription coverage for 15 days' supply up to a maximum dosage of 40 morphine milligram equivalents (MME) per day every 6 months. A TennCare member's first opioid prescription is limited to a maximum of 5 days at a maximum dosage of 40 MME per day. Any subsequent prescription after the initial five-day prescription requires prior authorization. TennCare's limit allows targeted clinical exceptions for patients who may experience more frequent acute pain events, such as sickle cell disease, severe cancer pain undergoing active treatment, or hospice or end-of-life care.

This limit is one part of TennCare's larger strategy to combat opioid misuse and dependence within the TennCare population. TennCare intends to monitor the implementation and impact of this policy on an ongoing basis to ensure that TennCare enrollees have access to medically necessary care while minimizing the risk of prolonged exposure to opioids that can lead to dependence and addiction.

E. Reimbursement Methodology for Nursing Facilities

During this quarter, TennCare continued its work toward implementing a new reimbursement methodology for nursing facilities (NFs) participating in the TennCare program. The new payment approach is part of TennCare's larger payment reform efforts. The new approach transitions away from a cost-based system to a system that will take into consideration the

acuity of residents served in facilities, as well as facilities' performance relative to specified quality measures. As part of an ongoing commitment to transparency, TennCare has sought broad stakeholder input throughout the development process for the new payment system, hearing directly from residents receiving NF services and their family members, as well as from staff of NFs participating in TennCare'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 surveys 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. Implementation of the new reimbursement methodology will take place in State Fiscal Year 2019.

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[11] 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 has issued payments for six program years to Medicaid providers meeting relevant eligibility requirements.

EHR payments made by TennCare during the January-March 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 (Jan-Mar 2018)	Cumulative Amount Paid To Date[12]
First-year payments	0	$0	$180,885,192
Second-year payments	30	$256,359	$57,773,759
Third-year payments	71	$1,102,482	$34,047,037
Fourth-year payments	15	$119,001	$5,527,845

[11] 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).

[12] Audits performed during the January-March 2018 quarter identified past payments to eligible hospitals to be recouped. The cumulative totals associated with first-year and second-year payments reflect these recoupments.

Payment Type	No. of Providers Paid During the Quarter	Quarterly Amount Paid (Jan-Mar 2018)	Cumulative Amount Paid To Date[12]
Fifth-year payments	22	$184,167	$3,043,002
Sixth-year payments	19	$155,834	$999,334

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;
- Enhancements to TennCare's Provider Incentive Payment Program attestation software, including implementation of an update of federally mandated changes related to meaningful use, as well as improvements to the attestation review process;
- Submission of Tennessee's updated State Medicaid Health Information Technology Plan 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. Plans were made during the quarter to continue this outreach by exhibiting at the upcoming Amerigroup Community Care and UnitedHealthcare Provider Information Expos in Chattanooga, Johnson City, Knoxville, Memphis, and Nashville.

G. *Roan and Shackleford v. Long*

This lawsuit was filed against TennCare in December 2017 by the Tennessee Justice Center and the Legal Aid Society of Middle Tennessee and the Cumberlands. The litigation, which was filed with the U.S. District Court for the Middle District of Tennessee, concerns limitations placed by TennCare on private duty nursing services for individuals aged 21 and older.

Federal Medicaid law requires states to provide an expansive benefits package to children (defined as persons younger than age 21) but allows states more discretion to manage the scope of benefits for adults age 21 and older. In 2008, TennCare (with CMS approval) implemented limitations on private duty nursing services for adults. At that time, expenditures for private duty nursing were growing at a dramatic and unsustainable rate, and TennCare determined that additional cost containment strategies were necessary. In some instances,

children enrolled in TennCare may be receiving services in excess of these limits. In those cases, the enrollee's MCO works with them and their family prior to the enrollee's 21st birthday to help them transition to a different level of benefits that best meets their needs (and that can include long-term services and supports).

In *Roan and Shackleford v. Long*, two plaintiffs with disabilities who received private duty nursing services as children have challenged TennCare's ability to implement limits on the services they receive as adults. The plaintiffs allege that TennCare's limits violate the Americans with Disabilities Act (ADA) and are seeking an injunction prohibiting TennCare from reducing the services they receive.

The State has timely filed a response to the Motion for Preliminary Injunction, a Motion to Dismiss, and a Notice of Constitutional Question. The Notice contends that if the plaintiffs are entitled to the relief they seek under Title II of the ADA, then the federal statute is unconstitutional as applied to this case. Neither motion had been set for oral argument by the end of the January-March 2018 quarter.

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 January-March 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 during the January-March 2018 quarter were generally strong. Although total state and local collections in January 2018 were more than two percent lower than those from January 2017, performance was more vigorous in the other two months of the quarter. Total collections in February 2018 were more than four percent higher than in February 2017, while March 2018 collections achieved a nine percent improvement over March 2017 collections.[13]

The unemployment rate in Tennessee remained low throughout the quarter. Moving from 3.3 percent in January to 3.4 percent in February and March, the unemployment rate was especially low in comparison to the national rate (4.1 percent in all three months of the

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

quarter) and the state rate during the corresponding months of 2017 (5.1 percent, 4.4 percent, and 4.2 percent respectively).[14]

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
January – March 2018

Eligibility Group	January 2018	February 2018	March 2018	Sum for Quarter Ending 3/31/18
Medicaid eligibles (Type 1)				
EG1 Disabled, Type 1 State Plan eligibles	142,553	141,941	141,825	426,319
EG2 Over 65, Type 1 State Plan eligibles	420	450	376	1,246
EG3 Children, Type 1 State Plan eligibles	773,647	754,291	753,301	2,281,239
EG4 Adults, Type 1 State Plan eligibles	414,247	404,481	402,837	1,221,565
EG5 Duals, Type 1 State Plan eligibles	139,502	138,347	138,409	416,258
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	256	276	258	790
EG10 H-Over 65, Type 2 Demonstration Population	49	97	52	198
EG11 H-Duals, Type 2 Demonstration Population	6,216	6,162	6,170	18,548
TOTAL	1,476,890	1,446,045	1,443,228	4,366,163

[14] 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 15
Member Month Reporting Not Used in Budget Neutrality Calculations
January – March 2018

Eligibility Group	January 2018	February 2018	March 2018	Sum for Quarter Ending 3/31/18
EG6E Expan Adult, Type 3, Demonstration Population	212	203	156	571
EG7E Expan Child, Type 3, Demonstration Population	839	855	853	2,547
Med Exp Child, Title XXI Demonstration Population	4,247	4,265	4,199	12,711
EG12E Carryover, Type 3, Demonstration Population	1,680	1,665	1,634	4,979
TOTAL	6,978	6,988	6,842	20,808

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 January – March 2018
Compared to the Previous Two Quarters

	Jul – Sept 2017	Oct – Dec 2017	Jan – Mar 2018
No. of appeals received	24,180	25,882	36,293
No. of appeals resolved or withdrawn	37,833	21,069	34,120
No. of appeals taken to hearing	2,167	2,462	3,581
No. of hearings resolved in favor of appellant	109	141	189

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 January – March 2018
Compared to the Previous Two Quarters

	Jul – Sept 2017	Oct – Dec 2017	Jan – Mar 2018
No. of appeals received	2,259	2,547	1,483
No. of appeals resolved	2,153	2,390	1,962
• Resolved at the MCC level	685	769	525
• Resolved at the TSU level	184	194	151
• Resolved at the LSU level	1,284	1,427	1,286
No. of appeals that did not involve a valid factual dispute	151	196	279
No. of directives issued	278	285	214
No. of appeals taken to hearing	1,284	1,427	1,286
No. of appeals that were withdrawn by the enrollee at or prior to the hearing	387	489	392
Appeals that went to hearing and were decided in the State's favor	437	426	468
Appeals that went to hearing and were decided in the appellant's favor	43	34	35

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 January – March 2018
Compared to the Previous Two Quarters

	Jul – Sept 2017	Oct – Dec 2017	Jan – Mar 2018
No. of appeals received	125	121	130
No. of appeals resolved or withdrawn	60	58	39
No. of appeals set for hearing	49	57	60
No. of hearings resolved in favor of appellant	0	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 October-December 2017 quarter is provided in Table 19. Data for the period of January through March 2018 will be provided in the next Quarterly Progress Report.

Table 19
Population Health Data*, October – December 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	648,353
Level 1: low or moderate risk	Maternity Program	Engage pregnant women in timely prenatal care and deliver a healthy, term infant without complications	9,033

Risk Level	Intervention Type	Intervention Goal(s)	Number of Unique Members at End of Quarter
	Health Risk Management	Prevent, reduce, or delay exacerbation and complications of a condition or health risk behavior	723,449
	Care Coordination	Assure that members receive the services they need to reduce the risk of an adverse health outcome	22,417
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	4,452
	High Risk Pregnancy Management	Engage pregnant women in timely prenatal care and deliver a healthy, term infant without complications	1,287
	Complex Case Management	Move members to optimal levels of health and well-being through timely coordination of quality services and self-management support	1,189
Total PH Enrollment			**1,410,180**

*** 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 January 2018, TennCare's External Quality Review Organization (EQRO), Qsource, published the results of its provider data validation survey for the October-December 2017 quarter. Qsource took a sample of provider data files from TennCare's MCCs[15] and reviewed each for accuracy in the following categories:

- 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

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

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" (97.9 percent accuracy), "provider specialty / behavioral health service code" (97.8 percent accuracy), "routine care services" (97.0 percent accuracy), "urgent care services" (97.2 percent accuracy), "primary care services" (99.4 percent accuracy), and "prenatal care services" (99.9 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 July-September 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 February 5, 2018. TennCare, in turn, had received, reviewed, and accepted all of the plans by February 12, 2018. Results for the January-March 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[16]

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

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
Methodist Healthcare – North
Saint Francis Hospital
University Medical Center (with McFarland Psych)
Saint Thomas Rutherford Hospital

[16] 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.

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	Mountain State Health Alliance Wellmont ETSU Quillen Mission Hospital Johnson City Medical Center Johnson City Health Center Woodridge Hospital

Universities	Hospitals
	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
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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Attachment A

Budget Neutrality Calculations for the Quarter

Actual TennCare Budget Neutrality (Jan-Mar 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)	427,109
2-Child <=18	2,281,239
3-Adult >= 65	1,444
4-Adult <= 64	1,221,565
Duals (17)	434,806
Total	**4,366,163**

Ceiling without DSH

	Baseline * MM
1-Disabled (can be any ages)	$813,730,329
2-Child <=18	$1,221,600,501
3-Adult >= 65	$1,766,924
4-Adult <= 64	$1,357,570,419
17s	$339,880,631
Total	**$3,734,548,804**

DSH

DSH Adjustment (Quarterly)	$115,999,213

Total Ceiling

Budget Neutrality Cap	
Total w/DSH Adj.	**$3,850,548,017**

II. Actual Expenditures

Group 1 and 2

1-Disabled (can be any ages)	$ 587,761,953
2-Child <=18	$ 549,621,829
3-Adult >= 65	$ 2,172,815
4-Adult <= 64	$ 461,925,061
Duals (17)	$ 393,624,014
Total	**$ 1,995,105,672**

Group 3

1-Disabled (can be any ages)	$ -
2-Child <=18	$ 5,105,953
3-Adult >= 65	$ 24,376,782
4-Adult <= 64	$ 121,704
Duals (17)	$ -
Total	**$ 29,604,438**

Pool Payments and Admin

Total Pool Payments	$ 333,481,449
Admin	173,416,030

Quarterly Drug Rebates	(239,936,151)
Quarterly Premium Collections	$ (40)

Total Net Quarterly Expenditures	**$ 2,291,671,397**

III. Surplus/(Deficit)

	$1,558,876,620
Federal Share	**$1,012,646,252**

HCI Result	MM201801	MM201802	MM201803	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)	142,553	141,941	141,825	426,319	$60,091,316	$122,103,544	$1,613,479	$395,571,691	$0	$0	3,148,118	$0	$0	$582,528,148
EG1-TYPE2 (disabled, type2 transition group)				0	$0	$0	$0	$0	$0	$0	-	$0	$0	$0
EG2-TYPE1 (over 65, type1 state plan eligibles)	420	450	376	1,246	$0	$60,680	$0	$958,002	$0	$0	5,535	$0	$0	$1,024,217
EG2-TYPE2 (over 65, type2 state plan eligibles)				0	$0	$0	$0	$0	$0	$0	-	$0	$0	$0
EG3-TYPE1 (children, type1 state plan eligibles)	773,647	754,291	753,301	2,281,239	$11,342,376	$73,275,678	$33,719,261	$428,314,230	$0	$0	2,970,284	$0	$0	$549,621,829
Med Exp Child (Title XXI Demo Pop; EG3-Type2)	4,247	4,265	4,199	12,711	$66,719	$691,563	$273,562	$3,394,450	$0	$0	24,051	$0	$0	$4,450,343
EG4-TYPE1 (adults, type1 State plan eligibles)	414,247	404,481	402,837	1,221,565	$1,385,746	$80,392,728	$2,287,533	$375,362,703	$0	$0	2,496,350	$0	$0	$461,925,061
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)	139,502	138,347	138,409	416,258	$1,348,430	$831,562	$26,937	$310,323,031	$0	$0	1,698,162	$0	$0	$314,228,122
EG6E-TYPE3 (Expan adult, type3 demonstration pop)	212	203	156	571	$38	$3,757	$0	$117,251	$0	$0	658	$0	$0	$121,704
EG7E-TYPE3 (Expan child, type3 demonstration pop)	839	855	853	2,547	$36,796	$156,413	$27,191	$431,666	$0	$0	3,543	$0	$0	$655,609
EG8-TYPE2 (med exp child)	0	0	0	0	$0	$0	$0	$0	$0	$0	-	$0	$0	$0
EG9 H-Disabled (TYPE 2 Eligibles)	256	276	258	790	-$17	$226,472	$0	$4,979,065	$0	$0	28,285	$0	$0	$5,233,805
EG10 H-Senior	49	97	52	198	$0	$16,176	$0	$1,126,215			6,207			$1,148,598
EG11H, H-Dual	6,216	6,162	6,170	18,548	$0	$9,084	$0	$78,957,733	$0	$0	429,074	$0	$0	$79,395,892
EG12E, Carryovers	1,680	1,665	1,634	4,979	$0	$102,589	$0	$24,142,455	$0	$0	131,738	$0	$0	$24,376,782
Total	**1,483,868**	**1,453,033**	**1,450,070**	**4,386,971**	**$74,271,405**	**$277,870,245**	**$37,947,963**	**$1,623,678,492**	**$0**	**$0**	**$10,942,004**	**$0**	**$0**	**$2,024,710,109**

HCI Result	MM201801	MM201802	MM201803	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)	142,553	141,941	141,825	426,319	$140.95	$286.41	$3.78	$927.88	$0.00	$0.00	$7.38	$0.00	$0.00	$1,366.41
EG1-TYPE2 (disabled, type2 transition group)	0	0	0	-										
EG2-TYPE1 (over 65, type1 state plan eligibles)	420	450	376	1,246	$0.00	$48.70	$0.00	$768.86	$0.00	$0.00	$4.44	$0.00	$0.00	$822.00
EG2-TYPE2 (over 65, type2 state plan eligibles)	0	0	0	-	-	-	-	-	-	-	-	-	-	-
EG3-TYPE1 (children, type1 state plan eligibles)	773,647	754,291	753,301	2,281,239	$4.97	$32.12	$14.78	$187.76	$0.00	$0.00	$1.30	$0.00	$0.00	$240.93
Med Exp Child (Title XXI Demo Pop; EG3-Type2)	4,247	4,265	4,199	12,711	$5.25	$54.41	$21.52	$267.05	$0.00	$0.00	$1.89	$0.00	$0.00	$350.12
EG4-TYPE1 (adults, type1 State plan eligibles)	414,247	404,481	402,837	1,221,565	$1.13	$65.81	$1.87	$307.28	$0.00	$0.00	$2.04	$0.00	$0.00	$378.14
EG4-TYPE2 (adults, type2 demonstration pop)	0	0	0	-										
EG5-TYPE1 (duals, state plan eligibles)	139,502	138,347	138,409	416,258	$3.24	$2.00	$0.06	$745.51	$0.00	$0.00	$4.08	$0.00	$0.00	$754.89
EG6E-TYPE3 (Expan adult, type3 demonstration pop)	212	203	156	571	$0.07	$6.58	$0.00	$205.34	$0.00	$0.00	$1.15	$0.00	$0.00	$213.14
EG7E-TYPE3 (Expan child, type3 demonstration pop)	839	855	853	2,547	$14.45	$61.41	$10.68	$169.48	$0.00	$0.00	$1.39	$0.00	$0.00	$257.40
EG8-TYPE2 (emd exp child)	0	0	0	-										
EG9 H-Disabled (TYPE 2 Eligibles)	256	276	258	790	-$0.02	$286.67	$0.00	$6,302.61	$0.00	$0.00	$35.80	$0.00	$0.00	$6,625.07
EG10 H-Senior	49	97	52	198	$0.00	$81.70	$0.00	$5,687.95	$0.00	$0.00	$31.35			
EG11H, H-Dual	6,216	6,162	6,170	18,548	$0.00	$0.49	$0.00	$4,256.94	$0.00	$0.00	$23.13	$0.00	$0.00	$4,280.56
EG12E, Carryovers	1,680	1,665	1,634	4,979	$0.00	$20.60	$0.00	$4,848.86	$0.00	$0.00	$26.46	$0.00	$0.00	$4,895.92
Total	1,483,868	1,453,033	1,450,070	4,386,971	$16.93	$63.34	$8.65	$370.11	$0.00	$0.00	$2.49	$0.00	$0.00	$461.52

* Unknown allocation was performed within the Service category totals.

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

allocated payment in unknown in each EG Group

28.77%	3,148,118	
0.00%	-	
0.05%	5,535	
0.00%	-	
27.15%	2,970,284	
0.22%	24,051	
22.81%	2,496,350	
0.00%	-	
15.52%	1,698,162	
0.01%	658	
0.03%	3,543	
0.00%	-	
0.26%	28,285	
0.06%	6,207	
3.92%	429,074	
1.20%	131,738	
$2,013,768,105	10,942,004	

payment in blank category in each subject

MEDICAL	$ 314,745
PHARMACY	$ 389,124
DENTAL	$ 55,082
CAP	$ 10,183,053
TOTAL	**$ 10,942,004**

Enrollment changes:	Cumulative Total	AVG. Enrollment
SFY2018Q1	4,375,539	1,458,513.00
SFY2018Q2	4,386,971	1,462,323.67
% Changes in Total:	0.26%	0.26%

CAP PMPM changes:	CAP PMPM	Total CAP in QTR	Payment changes from current QTR to respective FSTR
SFY2018Q1	$324.76	$ 1,446,799,573	
SFY2018Q2	$370.11	$ 1,633,861,544	$ 187,061,971
	13.97%	12.93%	

Note: In February 2018, there was a large increase in capitation payments for EG1, EG3, EG4 and EG8. Specifically for capitation incurred in the months between 04/2017 - 12/2017.