TN Division of TennCare

November 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 July – September 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: Shantrina Roberts, Associate Regional Administrator, Atlanta Regional Office
Tandra Hodges, Tennessee State Coordinator, Atlanta Regional Office

TennCare II

Section 1115 Quarterly Report

(For the period July - September 2018)

Demonstration Year: 17 (7/1/18 - 6/30/19)
Federal Fiscal Quarter: 4/2018 (7/18 - 9/18)
Waiver Quarter: 1/2019 (7/18 - 9/18)

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 1.3 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 #
7/23/18	With regard to Amendment 35 (the State's request for authorization to pay for short-term substance use disorder services in facilities classified as institutions for mental diseases), CMS sent the State guidance for designing an implementation plan for the amendment.	
7/26/18	The Monthly Call for July was held.	43
8/10/18	The State submitted Demonstration Amendment 36 to CMS. Amendment 36 would allow the State to establish reasonable standards for providers of family planning services in the TennCare Demonstration.	6, 7
8/24/18	CMS sent the State a letter indicating that the submission of Amendment 36 met the requirements for a complete amendment.	
8/29/18	The State submitted the Quarterly Progress Report for the April-June 2018 quarter to CMS.	44
8/30/18	The Monthly Call for August was held.	43
8/31/18	The State notified the public of its intent to submit to CMS Demonstration Amendment 37. Amendment 37 would make modifications to the Employment and Community First CHOICES program, and would remove children receiving SSI from the list of populations automatically assigned to the TennCare Select health plan upon	15

Date	Action	STC #
	enrollment in TennCare.	
8/31/18	The State submitted point-in-time and annual aggregate data about the CHOICES program to CMS	42.d.iv
9/4/18	In relation to Amendment 35, CMS sent the State materials about the monitoring and evaluation of substance use disorder demonstration waivers.	
9/7/18	With regard to Amendment 33 (the State's request to change the payment structure of supplemental payments to Tennessee hospitals), CMS sent a version of the State's draft payment distribution methodology that incorporated revisions discussed throughout the negotiation process.	
9/24/18	The State notified the public of its intent to submit to CMS Demonstration Amendment 38. Amendment 38 would establish workforce participation and community engagement as an expectation for certain TennCare enrollees.	15
9/25/18	The Monthly Call for September was cancelled.	43

II. Enrollment and Benefits Information

Information about enrollment by category is presented in Table 2.

Table 2
Enrollment Counts for the July – September 2018 Quarter
Compared to the Previous Two Quarters

Demonstration Populations	Total Number of TennCare Enrollees		
	Jan – Mar 2018	Apr – Jun 2018	Jul – Sept 2018
EG1 Disabled, Type 1 State Plan eligibles	142,906	142,555	139,465
EG9 H-Disabled, Type 2 Demonstration Population	261	278	271
EG2 Over 65, Type 1 State Plan eligibles	414	446	475
EG10 H-Over 65, Type 2 Demonstration Population	54	66	111
EG3 Children, Type 1 State Plan eligibles	788,561	765,641	745,822
EG4 Adults, Type 1 State Plan eligibles	428,261	410,901	394,191

Demonstration Populations	Total Number of TennCare Enrollees		
	Jan – Mar 2018	Apr – Jun 2018	Jul – Sept 2018
EG5 Duals, Type 1 State Plan eligibles and EG11 H-Duals 65, Type 2 Demonstration Population	149,080	148,475	144,869
EG6E Expan Adult, Type 3 Demonstration Population	209	131	71
EG7E Expan Child, Type 3 Demonstration Population	865	1,042	1,462
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	4,236	4,827	6,523
EG12E Carryover, Type 3, Demonstration Population	1,666	1,544	1,459
TOTAL*	1,516,513	1,475,906	1,434,719

*** 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 79 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 September 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. In February 2018, the State submitted Amendment 33 to CMS. Amendment 33 concerns the

[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.

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 changes imposed on the supplemental payment structure during the most recent renewal of the TennCare Demonstration in 2016.

As submitted, Amendment 33 consisted 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 that supports clinics operated by Meharry Medical College; and
- Extending the implementation period of a new hospital payment structure that was scheduled to take effect on July 1, 2018.

During the July-September 2018 quarter, the State and CMS continued to finalize the details of the new payment system. After a number of discussions, both parties agreed that the issues contained in Amendment 33 could be addressed without amending the TennCare Demonstration. Accordingly, the State expected—as of the end of the reporting period—to formally withdraw Amendment 33 from further consideration during the October-December 2018 quarter.

Demonstration Amendment 35: Substance Use Disorder Services. In May 2018, the State submitted Demonstration Amendment 35 to CMS. Amendment 35 would modify the TennCare benefits package to cover residential substance use disorder (SUD) treatment services in facilities with more than 16 beds. The federal government classifies such facilities as "institutions for mental diseases" (IMDs), and federal law prohibits the expenditure of federal Medicaid dollars for services delivered to adults in these facilities. Historically, TennCare's MCOs were permitted to cover residential treatment services in IMDs, if the MCO determined that such care was medically appropriate and cost-effective as compared to other treatment options. However, CMS recently issued regulations restricting the ability of MCOs to pay for services in these facilities. Specifically, the new federal regulation limits this option to treatment stays of no more than 15 days per calendar month. TennCare is seeking authority with Amendment 35 to allow enrollees to receive short-term services in IMDs beyond the 15-day limit in federal regulation, up to 30 days per admission.

During the July-September 2018 quarter, TennCare and CMS continued their negotiations concerning Amendment 35. The focus of discussions was the monitoring and evaluation requirements that CMS applies to SUD-related demonstration proposals. As of the end of the quarter, CMS's review of Amendment 35 was ongoing.

Demonstration Amendment 36: Family Planning Providers. Amendment 36 was submitted to CMS on August 10, 2018. Amendment 36 grew out of legislation passed by the Tennessee General Assembly in 2018 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.

Amendment 36 requests authority for TennCare to establish state-specific criteria for providers of family planning services, and to exclude any providers that do not meet these criteria from participation in the TennCare program. The State is proposing to exclude any entity that performed, or operated or maintained a facility that performed, more than 50 abortions in the previous year, including any affiliate of such an entity.

As of the end of the July-September 2018 quarter, CMS had begun its review of Amendment 36.

Demonstration Amendment 37: Modifications to Employment and Community First CHOICES. On August 31, 2018, TennCare launched the public notice and comment period for another demonstration amendment to be submitted to CMS. Amendment 37 primarily concerns modifications to be made to Employment and Community First (ECF) CHOICES, TennCare's managed long-term services and supports program that is specifically geared toward promoting and supporting integrated, competitive employment and independent, integrated living as the first and preferred option for people with intellectual and developmental disabilities.

Chief among the modifications to ECF CHOICES in Amendment 37 is the addition of two new benefits and two new benefit groups in which the services would be available. The first is targeted to a small group of children who live with their family and have intellectual and/or developmental disabilities (I/DD) and severe co-occurring behavioral health and/or psychiatric conditions that place the child or others at significant risk of harm and threaten the sustainability of the family living arrangement. These are children at significant risk of placement outside the home (e.g., State custody, hospitalization, residential treatment, incarceration). The second will provide short-term intensive community-based behavioral-focused transition and stabilization services and supports to assist adults with I/DD and severe behavioral and/or psychiatric conditions who are transitioning out of a highly structured and supervised environment to achieve and maintain stable, integrated lives in their communities.

Other changes to ECF CHOICES contained in Amendment 37 include modifications to expenditure caps for existing benefit groups within the program, revised eligibility processes to facilitate transitions from institutional settings to community-based settings, and modifications and clarifications to certain ECF CHOICES service definitions. Together with the changes to ECF CHOICES, Amendment 37 would also revise the list of populations automatically assigned to the TennCare Select health plan upon enrollment in TennCare by allowing children receiving Supplemental Security Income to have the same choice of managed care plans as virtually all other TennCare members.

The designated public notice and comment period for Amendment 37 was August 31 through October 1, 2018. As of the end of the July-September 2018 quarter, the State planned to proceed with submitting Amendment 37 to CMS after all public comments had been reviewed and considered.

Demonstration Amendment 38: Community Engagement. Like Amendment 36, Demonstration Amendment 38 was the result of legislation passed during Tennessee's 2018 legislative session. The legislation in question directed the State to submit a demonstration amendment to authorize the creation of reasonable work and community engagement requirements for non-pregnant, non-elderly, non-disabled adults enrolled in the TennCare program who do not have dependent children under the age of six. The legislation also required the State to seek approval from the U.S. Department of Health and Human Services (HHS) to use funds from the state's Temporary Assistance for Needy Families (TANF) program to support implementation of the community engagement program. As a result, the State began the process of planning and designing a community engagement initiative in accordance with this State law, including discussions with multiple stakeholders to inform the design process.

On August 20, 2018, TennCare held a stakeholder meeting in Nashville to gather input on this initiative. More than 70 individuals representing advocacy organizations, healthcare providers, managed care organizations, legislators and legislative staff, State agencies, and other interested parties participated in the meeting. During the event, TennCare staff led a series of focused discussions aimed at getting stakeholder input on key policy questions and design issues. Also in attendance at the August 20 stakeholder meeting were HHS representatives, from whom State officials sought guidance on how to secure approval to use TANF funds to implement TennCare's community engagement program.

Using feedback obtained during the August 20 meeting, the State subsequently crafted a draft demonstration amendment outlining the agency's community engagement proposal. This draft version of Amendment 38 was posted for public review and comment on September 24, 2018. As of the end of the July-September 2018 quarter, the comment period was scheduled to run through October 26 2018, and was to include a public hearing in each grand region of the state.

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 TennCare to process applications and identify persons who are eligible for the TennCare and CoverKids programs. During the July-September 2018 quarter, readiness activities continued to focus on user acceptance testing. 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. In addition, TEDS-related Beta testing—a simulation of post-production processes—was completed during the quarter. Approximately 25 caseworkers and contractor partners participated in this four-week activity. As of the end of the quarter, the first pilot phase of implementation of the TEDS system was 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 July-September 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-third 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
July – September 2018 Compared to the Previous Two Quarters

Activities	Jan – Mar 2018	Apr – Jun 2018	Jul – Sept 2018
Number of outreach activities/events	1,941	1,926	1,860

Activities	Jan – Mar 2018	Apr – Jun 2018	Jul – Sept 2018
Number of people made contact with (mostly face to face at outreach events)	86,496	111,930	121,710
Number of educational materials distributed	57,069	78,441	93,900
Number of coalitions/advisory board meetings attended or conducted	102	91	62
Number of attendees at coalitions/advisory board meetings	1,915	1,345	1,032
Number of educational preventive health radio/TV broadcasts	584	576	584
Number of educational preventive health newsletter/magazine articles	8	24	8
Number of educational preventive health billboards, scrolling billboards and bulletin boards	3,310	2,830	2,001
Number of presentations made to enrollees/professional staff who work with enrollees	66	50	46
Number of individuals attending presentations	1,515	741	614
Number of completed telephone calls regarding the importance of dental checkups	146	248	189
Number of home visits completed	1,088	1,453	1,383

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
July – September 2018 Compared to the Previous Two Quarters

Activities	Jan – Mar 2018	Apr – Jun 2018	Jul – Sept 2018
Number of enrollees reached	38,500	42,751	24,478
Number of enrollees who were assisted in scheduling an EPSDT exam for their children	416	560	343
Number of enrollees who were assisted in arranging for transportation	42	33	43

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

	Jan – Mar 2018	Apr – Jun 2018	Jul – Sept 2018
No. of encounters received by TennCare (initial submission)	20,318,683	17,920,180	14,778,688
No. of encounters rejected by Edifecs upon initial submission	235,913[4]	21,534	97,669[5]
Percentage of encounters that were compliant with State standards (including HIPAA) upon initial submission	98.80%	99.88%	99.34%

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.

[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] During the July-September 2018 quarter, two files submitted by MCOs—one with 11,980 encounters and one with 65,000 encounters—were rejected in their entirety. These files were subsequently corrected, resubmitted, and accepted.

Table 7
CHOICES Enrollment and Reserve Slots
for July-September 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		
		Jan – Mar 2018	Apr – Jun 2018	Jul – Sept 2018
CHOICES 1	Not applicable	16,202	16,439	16,713
CHOICES 2	10,500	9,400	9,543	9,678
CHOICES 3 (including Interim CHOICES 3)	To be determined	2,882	2,842	2,750
Total CHOICES	Not applicable	28,484	28,824	29,141
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. Fifteen separate reports of data pertaining to the CHOICES program have been submitted between August 2011 and September 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 16,439 individuals on June 30, 2018. 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

[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.

data as well: on the day prior to CHOICES implementation, 4,861 individuals were using HCBS, but the number had grown to 12,385 by June 30, 2018. 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 6/30/18	Percent increase from the day prior to CHOICES implementa-tion to 6/30/18
6,226	15,429	148%	4,861[7]	12,385	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 July – September 2018 Compared to the Previous Two Quarters

	Frequency and Use of Transition Allowances					
	Jan – Mar 2018		Apr – Jun 2018		Jul – Sept 2018	
Grand Region	# Distributed	Total Amount	# Distributed	Total Amount	# Distributed	Total Amount
East	15	$5,287	17	$17,174	15	$13,780
Middle	18	$9,855	17	$13,928	26	$20,033
West	22	$16,343	20	$11,306	29	$27,022
Statewide Total	55	$31,485	54	$42,408	70	$60,835

[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).

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 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.

STC 32.d. requires the State to provide CMS information about ECF CHOICES groups, targets, and enrollment numbers. Due to technical issues related to ECF CHOICES data, this information will be submitted to CMS under separate cover.

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 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 July-September 2018 quarter, the MCOs submitted their NAIC Second Quarter 2018 Financial Statements. As of June 30, 2018, TennCare MCOs reported net worth as indicated in the table below.[8]

Table 11
Net Worth Reported by MCOs as of June 30, 2018

	Net Worth Requirement	Reported Net Worth	Excess/ (Deficiency)
Amerigroup Tennessee	$30,058,528	$187,686,741	$157,628,213
UnitedHealthcare Plan of the River Valley (UnitedHealthcare Community Plan)	$65,141,772	$371,769,813	$306,628,041
Volunteer State Health Plan (BlueCare & TennCare Select)	$47,825,838	$511,857,768	$464,031,930

During the July-September 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.*).

[8] 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.

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 June 30, 2018:

Table 12
Company Action Level Reported by MCOs as of June 30, 2018

	Company Action Level Requirement	Reported Net Worth	Excess/ (Deficiency)
Amerigroup Tennessee	$110,985,558	$187,686,741	$76,701,183
UnitedHealthcare Plan of the River Valley (UnitedHealthcare Community Plan)	$221,464,280	$371,769,813	$150,305,533
Volunteer State Health Plan (BlueCare & TennCare Select)	$160,340,902	$511,857,768	$351,516,866

All TennCare MCOs exceeded their minimum net worth requirements and Company Action Level requirements as of June 30, 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 who is in the best position to influence the cost and quality of the episode.

In the 2017 performance period for TennCare's episodes of care, doctors and hospitals improved cost efficiency while maintaining or improving quality. The 2017 results show that episode costs were $28.6 million less than expected across the 19 episodes that were in a performance period. Across the state, gain sharing payments to providers who met quality metrics and efficiency standards exceeded risk sharing payments by $206,903, meaning that episode incentive payments had a net positive impact on providers.

The 19 episodes of care in the 2017 performance period were perinatal, acute asthma exacerbation, total joint replacement, colonoscopy, cholecystectomy, chronic obstructive

pulmonary disease, acute percutaneous coronary intervention, and non-acute percutaneous coronary intervention, upper GI endoscopy, gastrointestinal hemorrhage, respiratory infection, pneumonia, urinary tract infection – outpatient, urinary tract infection – inpatient, congestive heart failure acute exacerbation, oppositional defiant disorder, coronary artery bypass graft, valve repair and replacement, and bariatric surgery.

TennCare continues to plan for the implementation of additional episodes of care and to refine existing episodes based on program experience and stakeholder feedback.

E. Reimbursement Methodology for Nursing Facilities

TennCare's new acuity- and quality-based reimbursement methodology for nursing facilities (NFs) was implemented on August 1, 2018, with an effective date of July 1, 2018. TennCare has worked extensively with the Tennessee Health Care Association, nursing facility providers, residents and their family members, and other stakeholders to design the new reimbursement system. In addition, TennCare has provided numerous trainings and other forms of communication to help NFs prepare for these changes. The new methodology shifts TennCare reimbursement away from cost-based payments and toward a payment approach that takes into consideration the acuity of residents served in facilities, as well as facilities' performance relative to specified quality measures.

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[9] 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[10] has issued payments for six program years to Medicaid providers meeting relevant eligibility requirements.

EHR payments made by TennCare during the July-September 2018 quarter as compared with payments made throughout the life of the program appear in the table below:

[9] 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).

[10] 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 continues to refer to its initiative as "EHR Incentive Program" for purposes of clarity and consistency in communications with providers.

Table 13
EHR Payments
Quarterly and Cumulative

Payment Type	No. of Providers Paid During the Quarter	Quarterly Amount Paid (Jul-Sept 2018)	Cumulative Amount Paid To Date[11]
First-year payments	0	$0	$179,914,661
Second-year payments	50	$495,674	$58,915,433
Third-year payments	43	$381,650	$35,029,354
Fourth-year payments	66	$555,334	$6,865,179
Fifth-year payments	55	$467,500	$4,012,002
Sixth-year payments	45	$379,667	$2,028,099

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;
- Finalizing Program Year 2017 meaningful use attestations for returning eligible professionals;
- Partnering with the Tennessee Primary Care Association to provide clinical education and outreach to Federally Qualified Health Centers seeking to attest to meaningful use;
- Initiating changes to Tennessee's Provider Incentive Payment Program (PIPP) online portal to account for provisions of CMS's 2019 Inpatient Prospective Payment System final rule;
- 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 post-enrollment outreach efforts is on encouraging new attestations from providers who attested to EHR requirements only once or who have not attested in recent years. TennCare will continue to emphasized this strategy in exhibits at the upcoming Tennessee Medical Association Insurance Workshops; the 69th Annual Scientific Assembly of the Tennessee Academy of Family Physicians; and the Amerigroup Community Care and UnitedHealthcare Provider Information Expos.

[11] The cumulative total of first-year payments reflects recoupments of payments from previous quarters. The need for these recoupments was identified through standard auditing processes.

G. Dental Benefits Management Procurement

TennCare contracts with a dental benefits manager (DBM) to administer TennCare's dental benefit for enrollees with dental coverage (primarily children). With just over a year remaining until the contract between TennCare and its current DBM, DentaQuest USA Insurance Company, Inc., was scheduled to expire, TennCare issued a request for proposals (RFP) for DBM services on April 25, 2018. The deadline for potential bidders to respond to the RFP was July 2, 2018, and DentaQuest was the only company to submit a proposal. TennCare determined that the proposal satisfied the criteria outlined in the RFP, and proceeded to award the contract to DentaQuest. The start date for the new contract was September 1, 2019, with an eight-month readiness period to follow. Services delivered under the new contract are scheduled to begin on May 1, 2019.

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 July-September 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 continued to be strong in all three months of the quarter. Total state and local collections were higher during each month of the quarter than they were during the same months in 2017, with nearly a five percent improvement in July, more than a seven percent improvement in August, and more than a five percent improvement in September.[12]

The unemployment rate in Tennessee remained historically low throughout the quarter. Although the state rate ticked up from 3.5 percent in July to 3.6 percent in August and September, it was nonetheless lower than the national rate during the same months (3.9 percent in July and August, and 3.7 percent in September) and comparable to the state rate during the corresponding months of 2017 (3.5 percent, 3.4 percent, and 3.3 percent respectively).[13]

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

[13] 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.

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
July – September 2018

Eligibility Group	July 2018	August 2018	September 2018	Sum for Quarter Ending 9/30/18
Medicaid eligibles (Type 1)				
EG1 Disabled, Type 1 State Plan eligibles	138,627	133,036	132,952	404,615
EG2 Over 65, Type 1 State Plan eligibles	479	464	421	1,364
EG3 Children, Type 1 State Plan eligibles	720,536	694,216	699,582	2,114,334
EG4 Adults, Type 1 State Plan eligibles	378,254	352,310	354,579	1,085,143
EG5 Duals, Type 1 State Plan eligibles	134,816	131,531	131,385	397,732
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	271	258	264	793
EG10 H-Over 65, Type 2 Demonstration Population	85	106	110	301
EG11 H-Duals, Type 2 Demonstration Population	6,208	6,211	6,254	18,673
TOTAL	1,379,276	1,318,132	1,325,547	4,022,955

Table 15
Member Month Reporting Not Used in Budget Neutrality Calculations
July – September 2018

Eligibility Group	July 2018	August 2018	September 2018	Sum for Quarter Ending 9/30/18
EG6E Expan Adult, Type 3, Demonstration Population	72	58	46	176
EG7E Expan Child, Type 3, Demonstration Population	1,245	1,381	1,424	4,050
Med Exp Child, Title XXI Demonstration Population	5,659	6,229	6,379	18,267
EG12E Carryover, Type 3, Demonstration Population	1,469	1,446	1,439	4,354
TOTAL	8,445	9,114	9,288	26,847

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 July – September 2018
Compared to the Previous Two Quarters

	Jan – Mar 2018	Apr – Jun 2018	Jul – Sept 2018
No. of appeals received	36,293	48,076	66,796
No. of appeals resolved or withdrawn	34,120	40,905	52,479
No. of appeals taken to hearing	3,581	4,295	3,011
No. of hearings resolved in favor of appellant	189	208	167

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 July – September 2018
Compared to the Previous Two Quarters

	Jan – Mar 2018	Apr – Jun 2018	Jul – Sept 2018
No. of appeals received	1,483	1,645	1,690
No. of appeals resolved	1,962	1,608	1,519
• Resolved at the MCC level	525	509	434
• Resolved at the TSU level	151	138	141
• Resolved at the LSU level	1,286	961	944
No. of appeals that did not involve a valid factual dispute	279	365	234
No. of directives issued	214	197	189
No. of appeals taken to hearing	1,286	961	944
No. of appeals that were withdrawn by the enrollee at or prior to the hearing	392	310	281
Appeals that went to hearing and were decided in the State's favor	468	357	376
Appeals that went to hearing and were decided in the appellant's favor	35	14	28

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 July – September 2018
Compared to the Previous Two Quarters

	Jan – Mar 2018	Apr – Jun 2018	Jul – Sept 2018
No. of appeals received	130	140	138
No. of appeals resolved or withdrawn	39	41	36
No. of appeals set for hearing	60	64	74
No. of hearings resolved in favor of appellant	2	1	0

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 April-June 2018 quarter is provided in Table 19. Data for the period of July through September 2018 will be provided in the next Quarterly Progress Report.

Table 19
Population Health Data*, April – June 2018

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	569,205
Level 1: low or	Maternity Program	Engage pregnant women in timely	9,870

Risk Level	Intervention Type	Intervention Goal(s)	Number of Unique Members at End of Quarter
moderate risk		prenatal care and deliver a healthy, term infant without complications	
	Health Risk Management	Prevent, reduce, or delay exacerbation and complications of a condition or health risk behavior	703,834
	Care Coordination	Assure that members receive the services they need to reduce the risk of an adverse health outcome	26,935
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	23,678
	High Risk Pregnancy Management	Engage pregnant women in timely prenatal care and deliver a healthy, term infant without complications	10,830
	Complex Case Management	Move members to optimal levels of health and well-being through timely coordination of quality services and self-management support	9,588
Total PH Enrollment			**1,327,005**

*** 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, in this table, the number of individuals enrolled in Care Coordination is not included in the "Total PH Enrollment" figure.**

Provider Data Validation Report. In July 2018, TennCare's External Quality Review Organization (EQRO), Qsource, published the results of its provider data validation survey for the April-June 2018 quarter. Qsource took a sample of provider data files from TennCare's MCCs[14] 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)

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

- 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 "provider specialty / behavioral health service code" (94.7 percent accuracy), "services to patients age 21 or older" (94.4 percent accuracy), and "prenatal care services" (96.6 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 January-March 2018, 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 September 5, 2018. TennCare, in turn, had received, reviewed, and accepted all of the plans by September 11, 2018. Results for the July-September 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.

The State and CMS are currently working to finalize the evaluation design.

XII. Essential Access Hospital Pool[15]

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

[15] 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	Ballad Health ETSU Quillen Johnson City Medical Center Johnson City Community Health Center Woodridge Hospital Holston Valley Medical Center Bristol Regional Medical Center

Universities	Hospitals
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

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Date Submitted to CMS: November 29, 2018

Attachment A

Budget Neutrality Calculations for the Quarter

TennCare II

Section 1115 Quarterly Report – Supplement

(For the period July - September 2018)

Demonstration Year: 17 (7/1/18 - 6/30/19)
Federal Fiscal Quarter: 4/2018 (7/18 - 9/18)
Waiver Quarter: 1/2019 (7/18 - 9/18)

Employment and Community First CHOICES

In the Quarterly Progress Report submitted to CMS on November 29, 2018, the State noted that information about ECF CHOICES groups, targets, and enrollment numbers would be submitted to CMS under separate cover. (See Page 12 of the report.) The State presents that information in the following table:

ECF CHOICES Enrollment, Enrollment Targets, and Reserve Slots
For July – September 2018 Compared to the Previous Quarter

	Statewide Enrollment Targets and Reserve Capacity[1]	Enrollment and Reserve Slots Filled as of the End of Each Quarter		
		Jan – Mar 2018	April – June 2018	July – September 2018
ECF CHOICES 4	871	841	838	814
ECF CHOICES 5	1513	1,375	1,336	1,313
ECF CHOICES 6	616	296	358	415
Total ECF CHOICES	3,000	2,512	2,532	2,542
Reserve capacity	650	271	271	249[2]
Waiver Transitions[3]	Not applicable	16	23	26

[1] 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 to best 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 (beyond the 100) 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). Statewide enrollment targets and reserve capacity were adjusted to reflect new appropriation authority, effective July 1, 2018. A total of 300 slots were added for Fiscal Year 2019 to ECF CHOICES, including 100 new slots for individuals with a developmental disability that have an aging caregiver age 80 or older. The distribution of these slots as of the end of July-Sept 2018 quarter reflect 21 additional slots in Group 4, 101 additional slots in Group 5, and 178 additional slots in Group 6.

[2] The reduction in filled reserve capacity slots is the result of a change in reporting. Previous totals had inadvertently included reserve capacity slots that were "held" pending the person's eligibility determination and actual enrollment into the slot.

[3] 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 3,000-person enrollment target. Waiver transition numbers are cumulative since the program began.

Revised Data Regarding CHOICES Transition Allowances

The Quarterly Progress Report submitted to CMS on November 29, 2018, included data concerning the allocation of CHOICES transition allowance funds. (See Pages 11-12 of the report.) The State has determined that the transition allowance figures provided to CMS for the July-September 2018 quarter underrepresented the amount of money distributed. A corrected version of the data in question appears in the table below.

CHOICES Transition Allowances
for July – September 2018 Compared to the Previous Two Quarters

	Frequency and Use of Transition Allowances					
	Jan – Mar 2018		Apr – Jun 2018		Jul – Sept 2018	
Grand Region	# Distributed	Total Amount	# Distributed	Total Amount	# Distributed	Total Amount
East	15	$5,287	17	$17,174	29	$17,620
Middle	18	$9,855	17	$13,928	41	$25,278
West	22	$16,343	20	$11,306	46	$32,576
Statewide Total	55	$31,485	54	$42,408	116	$75,474

Actual TennCare Budget Neutrality (July - Sept 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)	405,408
2-Child <=18	2,114,334
3-Adult >= 65	1,665
4-Adult <= 64	1,085,143
Duals (17)	416,405
Total	**4,022,955**

Ceiling without DSH

	Baseline * MM
1-Disabled (can be any ages)	$772,385,469
2-Child <=18	$1,132,223,092
3-Adult >= 65	$2,037,347
4-Adult <= 64	$1,205,959,598
17s	$325,496,875
Total	**$3,438,102,381**

DSH

DSH Adjustment (Quarterly)	$115,999,213

Total Ceiling

Budget Neutrality Cap	
Total w/DSH Adj.	**$3,554,101,594**

II. Actual Expenditures

Group 1 and 2

1-Disabled (can be any ages)	$	531,812,059
2-Child <=18	$	457,417,495
3-Adult >= 65	$	2,965,049
4-Adult <= 64	$	385,485,358
Duals (17)	$	391,489,036
Total	**$**	**1,769,168,997**

Group 3

1-Disabled (can be any ages)	$	-
2-Child <=18	$	5,014,214
3-Adult >= 65	$	21,815,763
4-Adult <= 64	$	33,345
Duals (17)	$	-
Total	**$**	**26,863,322**

Pool Payments and Admin

Total Pool Payments	$	348,155,335
Admin		112,806,279
Quarterly Drug Rebates		(190,456,934)
Quarterly Premium Collections	$	-

Total Net Quarterly Expenditures	**$ 2,066,536,999**

III. Surplus/(Deficit)

	$1,487,564,595
Federal Share	**$966,321,961**

HCI Result	MM201807	MM201808	MM201809	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)	138,627	133,036	132,952	404,615	$66,399,391	$119,088,733	$1,645,532	$330,466,515	$0	$0	8,971,790	$0	$0	$526,571,960
EG1-TYPE2 (disabled, type2 transition group)				0	$0	$0	$0	$0	$0	$0	-	$0	$0	$0
EG2-TYPE1 (over 65, type1 state plan eligibles)	479	464	421	1,364	$0	$65,609	$0	$1,597,800	$0	$0	28,833	$0	$0	$1,692,241
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)	720,536	694,216	699,582	2,114,334	$13,636,968	$61,292,750	$36,009,568	$338,684,681	$0	$0	7,793,529	$0	$0	$457,417,495
Med Exp Child (Title XXI Demo Pop; EG3-Type2)	5,659	6,229	6,379	18,267	$48,534	$693,633	$357,043	$2,804,742	$0	$0	67,669	$0	$0	$3,971,621
EG4-TYPE1 (adults, type1 State plan eligibles)	378,254	352,310	354,579	1,085,143	$1,221,276	$77,798,993	$2,436,481	$297,460,667	$0	$0	6,567,941	$0	$0	$385,485,358
EG4-TYPE2 (adults, type2 demonstration pop)				0	$0	$0	$0	$0	$0	$0	-	$0	$0	$0
EG5-TYPE1 (duals, state plan eligibles)	134,816	131,531	131,385	397,732	$1,443,410	$855,027	$34,339	$301,444,296	$0	$0	5,265,501	$0	$0	$309,042,573
EG6E-TYPE3 (Expan adult, type3 demonstration pop)	72	58	46	176	$0	$1,807	$0	$30,970	$0	$0	568	$0	$0	$33,345
EG7E-TYPE3 (Expan child, type3 demonstration pop)	1,245	1,381	1,424	4,050	$34,530	$288,351	$72,701	$629,247	$0	$0	17,764	$0	$0	$1,042,593
EG8-TYPE2 (med exp child)				0	$0	$0	$0	$0	$0	$0	-	$0	$0	$0
EG9 H-Disabled (TYPE 2 Eligibles)	271	258	264	793	$0	$274,454	$0	$4,876,363	$0	$0	89,281	$0	$0	$5,240,098
EG10 H-Senior	85	106	110	301	$0	$11,370	$0	$1,239,751			21,686			$1,272,808
EG11H, H-Dual	6,208	6,211	6,254	18,673	$50	$9,382	$0	$81,032,300	$0	$0	1,404,732	$0	$0	$82,446,464
EG12E, Carryovers	1,469	1,446	1,439	4,354	$0	$93,522	$0	$21,350,541	$0	$0	371,699	$0	$0	$21,815,763
Total	**1,387,721**	**1,327,246**	**1,334,835**	**4,049,802**	**$82,784,159**	**$260,473,631**	**$40,555,663**	**$1,381,617,874**	**$0**	**$0**	**$30,600,992**	**$0**	**$0**	**$1,796,032,319**

HCI Result	MM201807	MM201808	MM201809	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)	138,627	133,036	132,952	404,615	$164.11	$294.33	$4.07	$816.74	$0.00	$0.00	$22.17	$0.00	$0.00	$1,301.41
EG1-TYPE2 (disabled, type2 transition group)	0	0	0	-										
EG2-TYPE1 (over 65, type1 state plan eligibles)	479	464	421	1,364	$0.00	$48.10	$0.00	$1,171.41	$0.00	$0.00	$21.14	$0.00	$0.00	$1,240.65
EG2-TYPE2 (over 65, type2 state plan eligibles)	0	0	0	-	-	-	-	-	-	-	-	-	-	-
EG3-TYPE1 (children, type1 state plan eligibles)	720,536	694,216	699,582	2,114,334	$6.45	$28.99	$17.03	$160.19	$0.00	$0.00	$3.69	$0.00	$0.00	$216.34
Med Exp Child (Title XXI Demo Pop; EG3-Type2)	5,659	6,229	6,379	18,267	$2.66	$37.97	$19.55	$153.54	$0.00	$0.00	$3.70	$0.00	$0.00	$217.42
EG4-TYPE1 (adults, type1 State plan eligibles)	378,254	352,310	354,579	1,085,143	$1.13	$71.69	$2.25	$274.12	$0.00	$0.00	$6.05	$0.00	$0.00	$355.24
EG4-TYPE2 (adults, type2 demonstration pop)	0	0	0	-										
EG5-TYPE1 (duals, state plan eligibles)	134,816	131,531	131,385	397,732	$3.63	$2.15	$0.09	$757.91	$0.00	$0.00	$13.24	$0.00	$0.00	$777.01
EG6E-TYPE3 (Expan adult, type3 demonstration pop)	72	58	46	176	$0.00	$10.27	$0.00	$175.97	$0.00	$0.00	$3.23	$0.00	$0.00	$189.46
EG7E-TYPE3 (Expan child, type3 demonstration pop)	1,245	1,381	1,424	4,050	$8.53	$71.20	$17.95	$155.37	$0.00	$0.00	$4.39	$0.00	$0.00	$257.43
EG8-TYPE2 (emd exp child)	0	0	0	-										
EG9 H-Disabled (TYPE 2 Eligibles)	271	258	264	793	$0.00	$346.10	$0.00	$6,149.26	$0.00	$0.00	$112.59	$0.00	$0.00	$6,607.94
EG10 H-Senior	85	106	110	301	$0.00	$37.78	$0.00	$4,118.77	$0.00	$0.00	$72.05			
EG11H, H-Dual	6,208	6,211	6,254	18,673	$0.00	$0.50	$0.00	$4,339.54	$0.00	$0.00	$75.23	$0.00	$0.00	$4,415.28
EG12E, Carryovers	1,469	1,446	1,439	4,354	$0.00	$21.48	$0.00	$4,903.66	$0.00	$0.00	$85.37	$0.00	$0.00	$5,010.51
Total	**1,387,721**	**1,327,246**	**1,334,835**	**4,049,802**	**$20.44**	**$64.32**	**$10.01**	**$341.16**	$0.00	$0.00	$7.56	$0.00	$0.00	$443.49

* Unknown allocation was performed within the Service category totals.

allocated payment in unknown in each EG Group

29.32%	8,971,790	
0.00%	-	
0.09%	28,833	
0.00%	-	
25.47%	7,793,529	
0.22%	67,669	
21.46%	6,567,941	
0.00%	-	
17.21%	5,265,501	
0.00%	568	
0.06%	17,764	
0.00%	-	
0.29%	89,281	
0.07%	21,686	
4.59%	1,404,732	
1.21%	371,699	
$1,765,431,326	30,600,992	

payment in blank category in each subject

MEDICAL	$	604,518
PHARMACY	$	206,518
DENTAL	$	121,783
CAP	$	29,668,174
TOTAL	**$**	**30,600,992**

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

Enrollment changes	Cumulative Total	AVG. Enrollment
SFY2018Q3	4,266,570	1,422,190.00
SFY2018Q4	4,049,802	1,349,934.00
% Changes in Total:	-5.08%	-5.08%

CAP PMPM changes:	CAP PMPM	Total CAP in QTR	Payment changes from current QTR to previous QTR
SFY2018Q3	$337.53	$ 1,465,366,001	
SFY2018Q4	$341.16	$ 1,411,286,047	$ (54,079,954)
	1.07%	-3.69%	