TN Division of TennCare

March 1, 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 October – December 2017 quarter. This report is being submitted in accordance with STC 44 of the TennCare Demonstration.

Please let us know if you have comments or questions.

Sincerely,

[redacted]

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

cc: Charles A. Friedrich, Acting Associate Regional Administrator, Atlanta Regional Office
Kenni Howard, Tennessee Coordinator, Atlanta Regional Office

TennCare II

Section 1115 Quarterly Report

(For the period October - December 2017)

Demonstration Year: 16 (7/1/17 - 6/30/18)
Federal Fiscal Quarter: 1/2018 (10/17 - 12/17)
Waiver Quarter: 2/2018 (10/17 - 12/17)

I. Introduction

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

The Division of TennCare contracts with several Managed Care Contractors (MCCs) to provide services to more than 1.4 million enrollees. During this quarter, these entities included Managed Care Organizations (MCOs) for medical services, behavioral health services, and certain Long-Term Services and Supports (LTSS); a Dental Benefits Manager (DBM) for dental services; and a Pharmacy Benefits Manager (PBM) for pharmacy services.

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

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

Table 1
Key Dates of Approval/Operation in the Quarter

Date	Action	STC #
10/5/17	CMS approved Statewide MCO Contract Amendment 6 for Amerigroup.	39
10/26/17	The Monthly Call for October was held.	43
10/27/17	The State submitted the Draft Annual Report for Demonstration Year 15 to CMS.	45
11/14/17	The State published the details (including date, time, and location) of a public forum at which comments on the progress of the TennCare Demonstration would be accepted.	10
11/20/17	The Monthly Call for November was cancelled.	43
11/29/17	The State submitted the Quarterly Progress Report for the July-September 2017 quarter to CMS.	44
12/1/17	The State notified the public of its intent to submit to CMS Amendment 33 to the TennCare Demonstration. With the amendment, the State would request modifications to the STCs governing the supplemental payment structure used to offset costs that Tennessee hospitals incur by providing uncompensated care.	15
12/1/17	The State requested approval by CMS of Statewide MCO Contract Amendment 7 and TennCare Select Contract Amendment 42.	39
12/14/17	The State held a public forum to accept comments on the	10

Date	Action	STC #
	progress of the TennCare Demonstration.	
12/20/17	The State submitted to CMS the 2017 Update to the Quality Assessment and Performance Improvement Strategy.	42.c.
12/28/17	The Monthly Call for December was cancelled.	43
12/28/17	The State submitted to CMS the annual report concerning Title XXI Medicaid Expansion Children.	45

II. Enrollment and Benefits Information

Information about enrollment by category is presented in Table 2. A change in the methodology by which enrollees are placed in eligibility groups was introduced this quarter and has been applied retroactively to the two preceding quarters to ensure meaningful comparison.

Table 2
Enrollment Counts for the October – December 2017 Quarter
Compared to the Previous Two Quarters

Demonstration Populations	Total Number of TennCare Enrollees		
	Apr – Jun 2017	Jul – Sept 2017	Oct – Dec 2017
EG1 Disabled, Type 1 State Plan eligibles	147,932	145,778	143,789
EG9 H-Disabled, Type 2 Demonstration Population	223	240	252
EG2 Over 65, Type 1 State Plan eligibles	209	245	350
EG10 H-Over 65, Type 2 Demonstration Population	40	44	57
EG3 Children, Type 1 State Plan eligibles	774,759	762,486	778,248
EG4 Adults, Type 1 State Plan eligibles	433,583	399,788	418,520
EG5 Duals, Type 1 State Plan eligibles and EG11 H-Duals 65, Type 2 Demonstration Population	146,630	142,614	142,855
EG6E Expan Adult, Type 3 Demonstration Population	366	302	269
EG7E Expan Child, Type 3 Demonstration Population	745	810	897

Demonstration Populations	Total Number of TennCare Enrollees		
	Apr – Jun 2017	Jul – Sept 2017	Oct – Dec 2017
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	4,461	4,394	4,529
EG12E Carryover, Type 3, Demonstration Population	1,980	1,839	1,731
TOTAL*	1,510,928	1,458,540	1,491,497

*** 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 December 31, 2017

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

Demonstration Amendment 32: Medication Therapy Management. As noted in TennCare's previous Quarterly Progress Report, on September 6, 2017, the Division of TennCare submitted a demonstration amendment to CMS to establish a two-year pilot project of 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 would make MTM available to TennCare members enrolled in the State's health home program, and to members whose primary care providers are participants in the State's patient-centered medical home program. The pilot project would implement legislation passed by Tennessee's General Assembly in 2017. During the October-December

[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.

2017 quarter, TennCare and CMS continued negotiations concerning the approval of Amendment 32.

Demonstration Amendment 33: Supplemental Payment Pools for Tennessee Hospitals. During the October-December 2017 quarter, TennCare held a public notice and comment period regarding another demonstration amendment to be submitted 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, the State is requesting that CMS revisit changes imposed on the supplemental payment structure during the most recent renewal of the TennCare Demonstration in 2016.

Amendment 33 will consist 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 the Meharry Medical College Pool—currently scheduled to end on June 30, 2018—for the duration of the TennCare Demonstration; and
- Extending the implementation period of a new hospital payment structure currently scheduled to take effect on July 1, 2018.

TennCare's public notice and comment period concerning Amendment 33 commenced on December 1, 2017. By the conclusion of the October-December 2017 quarter, one set of comments had been received. The commenter expressed support for the State's proposal, while also urging the State to strengthen support for children's hospitals by adding funds to TennCare's Essential Access Hospital Pool.

As of the end of the quarter, TennCare's notice and comment period regarding Amendment 33 was scheduled to expire after January 2, 2018. Further details concerning Amendment 33 are available on TennCare's website at https://www.tn.gov/content/dam/tn/tenncare/documents2/ComprehensiveNotice33.pdf.

Tennessee Eligibility Determination System. Tennessee Eligibility Determination System (or "TEDS") is the name of the system that will be used by the State to process applications and identify persons who are eligible for TennCare and Tennessee's separate CHIP program (known as "CoverKids"). Development of the system continued during the October-December 2017 quarter, with particular emphasis on systems integration test scripts, which will be used to verify that TEDS performs according to expectations. TennCare staff reviewed the scripts during the quarter to ensure accuracy and to identify any gaps that must be addressed for the scripts to function properly. In addition, Deloitte Consulting, LLP—one of TennCare's business partners in the TEDS project—began systems integration testing and is expected to complete this task by the end of March 2018. 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 October-December 2017 quarter, the State received no notifications that a family with members enrolled in TennCare Standard had met its cost sharing limit. It should be noted that this is the twentieth 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
October – December 2017 Compared to the Previous Two Quarters

Activities	Apr – Jun 2017	Jul – Sept 2017	Oct – Dec 2017
Number of outreach activities/events	2,565	2,348	2,021
Number of people made contact with (mostly face to face at outreach events)	122,884	134,467	104,301
Number of educational materials distributed	88,999	104,778	81,439
Number of coalitions/advisory board meetings attended or conducted	75	106	76
Number of attendees at coalitions/advisory board meetings	1,361	1,672	1,315
Number of educational preventive health radio/TV broadcasts	667	613	61
Number of educational preventive health newsletter/magazine articles	8	184	0
Number of educational preventive health billboards, scrolling billboards and bulletin boards	4,469	3,292	296
Number of presentations made to enrollees/professional staff who work with enrollees	83	74	75
Number of individuals attending presentations	1,168	1,108	2,163
Number of completed telephone calls regarding the importance of dental checkups	248	8	165
Number of home visits completed	1,393	878	964

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
October – December 2017 Compared to the Previous Two Quarters

Activities	Apr – Jun 2017	Jul – Sept 2017	Oct – Dec 2017
Number of enrollees reached	31,680	31,242	31,983
Number of enrollees who were assisted in	254	240	282

Activities	Apr – Jun 2017	Jul – Sept 2017	Oct – Dec 2017
scheduling an EPSDT exam for their children			
Number of enrollees who were assisted in arranging for transportation	44	31	28

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 October-December 2017 Quarter, and Percentage that Passed Systems Edits, Compared to the Previous Two Quarters

	Apr – Jun 2017	Jul – Sept 2017	Oct – Dec 2017
No. of encounters received by TennCare (initial submission)	15,514,575	15,388,873	15,519,553
No. of encounters rejected by Edifecs upon initial submission	88,261	37,408	22,963
Percentage of encounters that were compliant with State standards (including HIPAA) upon initial submission	99.43%	99.76%	99.85%

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 October-December 2017 Compared to the Previous Two Quarters

	Statewide Enrollment Targets and Reserve Capacity[4]	Enrollment and Reserve Slots Being Held as of the End of Each Quarter		
		Apr – Jun 2017	Jul – Sept 2017	Oct – Dec 2017
CHOICES 1	Not applicable	16,560	16,621	16,497
CHOICES 2	10,500	9,190	9,297	9,394
CHOICES 3 (including Interim CHOICES 3)	To be determined	3,191	3,076	3,020
Total CHOICES	Not applicable	28,941	28,994	28,911
Reserve capacity	300	300	300	300

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

Data and trends of the designated CHOICES data elements: STC 42.d. requires the State to submit to CMS periodic statistical reports about the use of LTSS by TennCare enrollees. 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

[4] Of the three active CHOICES groups, only CHOICES 2 has an enrollment target, which was updated on July 1, 2017. Interim CHOICES 3 closed to new enrollment on June 30, 2015; an enrollment target for CHOICES 3 has not been set at this time.

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[5]	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 October – December 2017 Compared to the Previous Two Quarters

	Frequency and Use of Transition Allowances					
	Apr – Jun 2017		**Jul – Sept 2017**		**Oct – Dec 2017**	
Grand Region	# Distributed	Total Amount	# Distributed	Total Amount	# Distributed	Total Amount
East	22	$30,988	12	$14,646	18	$15,976
Middle	16	$17,742	14	$12,034	17	$9,105
West	21	$21,423	21	$20,980	21	$22,191
Statewide Total	59	$70,153	47	$47,660	56	$47,272

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

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.

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 October – December 2017 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		
		Apr – Jun 2017	Jul – Sept 2017	Oct – Dec 2017
ECF CHOICES 4	875	420	619	767
ECF CHOICES 5	1,525	844	1,089	1,269
ECF CHOICES 6	300	125	173	245
Total ECF CHOICES	2,700	1,389	1,881	2,281
Reserve capacity	350	165	215	222
Waiver Transitions[7]	Not applicable	4	7	10

Data and trends of the designated ECF CHOICES data elements: STC 42.d. requires the State to submit to CMS periodic statistical reports about the ECF CHOICES program, the first of which was submitted on June 30, 2017. Since this inaugural submission consisted entirely of baseline

[6] 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.

[7] 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.

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:

- 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 October-December 2017 quarter, the MCOs submitted their NAIC Third Quarter 2017 Financial Statements. As of September 30, 2017, TennCare MCOs reported net worth as indicated in the table below.[8]

Table 11
Net Worth Reported by MCOs as of September 30, 2017

	Net Worth Requirement	Reported Net Worth	Excess/ (Deficiency)
Amerigroup Tennessee	$33,420,759	$195,394,728	$161,973,969
UnitedHealthcare Plan of the River Valley (UnitedHealthcare Community Plan)	$57,158,856	$445,991,794	$388,832,938
Volunteer State Health Plan (BlueCare & TennCare Select)	$46,879,872	$458,687,006	$411,807,134

During the October-December 2017 quarter, the MCOs were also required to comply with Tennessee's "Risk-Based Capital for Health Organizations" statute (T.C.A. § 56-46-201 *et seq.*). Risk-based capital (RBC) involves a method of calculating the minimum amount of capital necessary for a health entity to support its overall business operations depending on its size and risk profile. A health entity with a higher amount of risk is required to hold a higher amount of capital. The RBC statute gives TDCI the authority and mandate to use preventive and corrective measures that vary depending on the amount of capital deficiency indicated by the RBC calculations. A "Company Action Level" deficiency (defined at T.C.A. § 56-46-203(a)) would require the submission of a plan to correct the entity's capital deficiency.

The following table compares the MCOs' net worth to the Company Action Level requirements as of September 30, 2017:

[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.

Table 12
Company Action Level Reported by MCOs as of September 30, 2017

	Company Action Level Requirement	Reported Net Worth	Excess/ (Deficiency)
Amerigroup Tennessee	$122,877,816	$195,394,728	$72,516,912
UnitedHealthcare Plan of the River Valley (UnitedHealthcare Community Plan)	$205,480,268	$445,991,794	$240,511,526
Volunteer State Health Plan (BlueCare & TennCare Select)	$148,059,416	$458,687,006	$310,627,590

All TennCare MCOs exceeded their minimum net worth requirements and Company Action Level requirements as of September 30, 2017.

D. Payment Reform

Tennessee's Health Care Innovation Initiative is changing the way TennCare and commercial insurance pays for health care by rewarding providers for high-quality and efficient treatment of medical conditions. Payment reform aims to maintain a member's health over time by aligning provider and patient incentives, creating provider accountability, and incentivizing care coordination. TennCare's payment reform initiative has strategies in three key domains: Episodes of Care, Long-Term Services and Supports, and Primary Care Transformation. Notable developments for Episodes of Care and Long-Term Services and Supports occurred during the October-December 2017 quarter.

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

Each episode is designed with significant input from stakeholders such as Tennessee providers, payers, administrators, and employers. For each episode, the program organizes Technical Advisory Groups (TAGs) composed of experts in the field to provide clinical feedback on each episode's design. Three TAGs—Hospitalist Medicine, General Surgery, and Gynecological Surgery—convened between September and November 2017 to design the program's eighth wave of episodes. The ten episodes designed in Wave 8 are Acute Gastroenteritis, Acute Seizure, Appendectomy, Bronchiolitis, Colposcopy, Gastrointestinal Obstruction, Hernia Repair, Hysterectomy, Pediatric Pneumonia, and Syncope.

In 2018, 29 episodes of care will be in a performance period, with design having been completed for a total of 53 episodes. Estimates indicate that the Episodes of Care program saved Tennessee over $25 million in health care costs in Calendar Years 2015 (when three episodes were in a performance period) and 2016 (when eight episodes were in a performance period).

Long-term services and supports comprises quality- and acuity-based payment and delivery system reform for Nursing Facility (NF) services and Home and Community Based Services (HCBS). During this quarter, TennCare published a notice of rulemaking hearing outlining a proposed new reimbursement methodology for NFs. The new payment approach will take into consideration the acuity of residents served in facilities, as well as facilities' performance relative to specified quality measures. As part of TennCare's ongoing commitment to transparency, before publishing the draft rule, TennCare sought broad stakeholder input, hearing directly from residents receiving NF services and their family members, as well as from staff of NFs participating in 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. The new reimbursement methodology will be implemented in 2018.

E. 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 has issued payments for six program years to Medicaid providers meeting relevant eligibility requirements.

EHR payments made by TennCare during the October-December 2017 quarter, along 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).

Table 13
EHR Payments
Quarterly and Cumulative

Payment Type	No. of Providers Paid During the Quarter	Quarterly Amount Paid (Oct-Dec 2017)	Cumulative Amount Paid To Date[10]
First-year payments	8	$170,000	$181,245,428
Second-year payments	15	$127,500	$57,517,400
Third-year payments	9	$643,050	$32,944,555
Fourth-year payments	3	$25,500	$5,408,844
Fifth-year payments	10	$82,167	$2,858,835
Sixth-year payments	3	$19,000	$843,500

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, technical assistance calls, webinars, and onsite visits;
- Participation in the 69th Annual Scientific Assembly of the Tennessee Academy of Family Physicians in October 2017;
- Attendance in October and November 2017 at Tennessee Medical Association meetings in Chattanooga, Franklin, Jackson, Kingsport, Knoxville, and Memphis;
- Joining provider expos hosted by UnitedHealthcare in Knoxville and Nashville during October 2017;
- Participation throughout the quarter in several Southeast Regional Collaboration for HIT/HIE (SERCH) calls;
- Reconfiguration of TennCare's Provider Incentive Payment Program software to account for federally mandated changes related to "meaningful use" of EHR technology;
- Mailing of reminder notices to eligible professionals whose attestations were incomplete; and
- Newsletters and alerts distributed by the TennCare's EHR ListServ.

Per CMS rules, provider enrollment ended on April 30, 2017, and Tennessee's EHR Incentive program continues through Program Year 2021 for providers who are currently enrolled. TennCare staff members continue 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.

[10] Audits performed during the October-December 2017 quarter identified past payments to eligible hospitals to be recouped. The cumulative totals associated with first-year and second-year payments reflect these recoupments.

F. *Wilson v. Gordon*

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

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

Oral argument and supplemental briefing on the State's Motion took place during the first half of Calendar Year 2017. On November 9, 2017, Plaintiffs and Defendants jointly requested that a pretrial conference scheduled for late November and a trial scheduled for December be postponed until the District Court rules on the Motion to Decertify the Class and Dismiss the Case. This request was granted on November 14, 2017. As of the conclusion of the October-December 2017 quarter, the District Court had not reached a decision on the State's Motion.

G. Public Forum on the TennCare Demonstration

In compliance with the federal regulation at 42 CFR § 431.420(c) and the Special Terms and Conditions of the TennCare Demonstration, the State hosted a public forum in Nashville on December 14, 2017. The purpose of the forum was to provide members of the public an opportunity to comment on the progress of the TennCare Demonstration project, which has delivered Medicaid services to eligible Tennesseans under a managed care model since 1994.

The December 14 open meeting was not the only avenue through which feedback could be offered. Notice of the forum, which appeared on the TennCare website, included an email address and a physical address at which comments would be accepted. TennCare is required to convene a forum on this subject each year for the foreseeable future.

In this year's forum, TennCare received one set of comments, concerning Employment and Community First CHOICES, the State's managed long-term services and supports program for individuals with intellectual and other types of developmental disabilities. Specifically, the comments acknowledge improvements that have been made to the program by the State, while also identifying areas of additional opportunity. These comments will be used to inform future program planning.

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 October-December 2017 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 October-December 2017 quarter were even stronger than the robust totals seen in the first three quarters of the year. In each month, total state and local collections were significantly larger than those from the corresponding months of 2016, with a three percent improvement in October, nearly a five and a half percent improvement in November, and almost an eleven percent improvement in December.[11]

Employment in Tennessee remained strong during the quarter. While ticking up slightly each month, the unemployment rate nonetheless remained extremely low compared to national and historical trends. The unemployment rate moved from 3.0 percent in October to 3.1 percent in November and then to 3.2 percent in December. These levels were not only lower than the national rate during the same period (4.1 percent in all three months) but also two percentage points lower than the state rate during the corresponding months of 2016 (5.0 percent, 5.1 percent, and 5.1 percent respectively).[12]

VIII. Member Month Reporting

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

[11] The Department of Revenue's collection summaries are available online at https://www.tn.gov/content/dam/tn/revenue/documents/pubs/2017/coll201710.pdf.

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

Table 14
Member Month Reporting for Use in Budget Neutrality Calculations
October – December 2017

Eligibility Group	October 2017	November 2017	December 2017	Sum for Quarter Ending 12/31/17
Medicaid eligibles (Type 1)				
EG1 Disabled, Type 1 State Plan eligibles	144,260	143,474	142,625	430,359
EG2 Over 65, Type 1 State Plan eligibles	251	280	314	845
EG3 Children, Type 1 State Plan eligibles	760,655	768,134	767,822	2,296,611
EG4 Adults, Type 1 State Plan eligibles	399,109	405,844	409,243	1,214,196
EG5 Duals, Type 1 State Plan eligibles	140,488	140,310	139,648	420,446
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	232	236	247	715
EG10 H-Over 65, Type 2 Demonstration Population	42	52	56	150
EG11 H-Duals, Type 2 Demonstration Population	6,183	6,220	6,199	18,602
TOTAL	1,451,220	1,464,550	1,466,154	4,381,924

Table 15
Member Month Reporting Not Used in Budget Neutrality Calculations
October – December 2017

Eligibility Group	October 2017	November 2017	December 2017	Sum for Quarter Ending 12/31/17
EG6E Expan Adult, Type 3, Demonstration Population	273	252	231	756

Eligibility Group	October 2017	November 2017	December 2017	Sum for Quarter Ending 12/31/17
EG7E Expan Child, Type 3, Demonstration Population	865	848	854	2,567
Med Exp Child, Title XXI Demonstration Population	4,482	4,457	4,445	13,384
EG12E Carryover, Type 3, Demonstration Population	1,776	1,734	1,708	5,218
TOTAL	7,396	7,291	7,238	21,925

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 October – December 2017
Compared to the Previous Two Quarters

	Apr – Jun 2017	Jul – Sept 2017	Oct – Dec 2017
No. of appeals received	49,377	24,180	25,882
No. of appeals resolved or withdrawn	32,941	37,833	21,069
No. of appeals taken to hearing	2,216	2,167	2,462
No. of hearings resolved in favor of appellant	117	109	141

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 October – December 2017
Compared to the Previous Two Quarters

	Apr – Jun 2017	Jul – Sept 2017	Oct – Dec 2017
No. of appeals received	2,356	2,259	2,547
No. of appeals resolved	2,308	2,153	2,390
• Resolved at the MCC level	868	685	769

	Apr – Jun 2017	Jul – Sept 2017	Oct – Dec 2017
• Resolved at the TSU level • Resolved at the LSU level	197 1,243	184 1,284	194 1,427
No. of appeals that did not involve a valid factual dispute	145	151	196
No. of directives issued	338	278	285
No. of appeals taken to hearing	1,243	1,284	1,427
No. of appeals that were withdrawn by the enrollee at or prior to the hearing	395	387	489
Appeals that went to hearing and were decided in the State's favor	446	437	426
Appeals that went to hearing and were decided in the appellant's favor	26	43	34

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 October – December 2017
Compared to the Previous Two Quarters

	Apr – Jun 2017	Jul – Sept 2017	Oct – Dec 2017
No. of appeals received	175	125	121
No. of appeals resolved or withdrawn	79	60	58
No. of appeals set for hearing	112	49	57
No. of hearings resolved in favor of appellant	2	0	0

X. Quality Assurance/Monitoring Activity

Beneficiary Survey. Every year since 1993, the Boyd Center for Business and Economic Research (BCBER) at the University of Tennessee in Knoxville has conducted a survey of Tennessee citizens—TennCare enrollees, individuals with private insurance, and uninsured individuals alike—to assess their opinions about health care. Respondents provide feedback on a range of topics, including demographics (age, household income, family size, etc.), perceptions of quality of care received, and behavior relevant to health care (the type of provider from whom an individual is most likely to seek initial care, the frequency with which care is sought, etc.).

On December 1, 2017, BCBER published a summary of the results of the most recent survey titled "The Impact of TennCare: A Survey of Recipients, 2017". Although the findings of a single survey must be viewed in context of long-term trends, several results from the report are noteworthy:

- Satisfaction with TennCare remained high. Ninety-five percent of respondents covered by TennCare expressed satisfaction with the quality of care they had received. This level of satisfaction ties for the highest in the program's history and is the fourth time in seven years that this peak has been attained. In addition, 2017 is the ninth straight year in which survey respondents have reported satisfaction levels exceeding ninety percent.
- The uninsured rate in Tennessee remained relatively low. Although the percentage of respondents classifying themselves as uninsured rose from 5.5 percent in 2016 to 6.0 percent in 2017, the current mark is nonetheless the fourth lowest level in the 25-year history of the survey. Furthermore, the percentage of individuals classifying their children as uninsured fell from 1.8 percent in 2016 to 1.5 percent in 2017, tying the all-time lowest level established in 2015.
- TennCare families sought care from physicians more frequently than the Tennessee population as a whole. Thirty-three percent of heads of households with TennCare reported seeing a doctor weekly or monthly, and seventeen percent reported doing so for their children. By contrast, only fourteen percent of all heads of households

reported seeing a doctor weekly or monthly, and only eight percent reported doing so for their children.

In summary, the report notes, "TennCare continues to receive positive feedback from its recipients, with 95 percent reporting satisfaction with the program. This positive feedback is a strong indication that TennCare is providing satisfactory medical care and meeting the expectations of those it serves." BCBER's report may be viewed in its entirety online at http://cber.haslam.utk.edu/tncare/tncare17.pdf.

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 July-September 2017 quarter is provided in Table 19. Data for the period of October through December 2017 will be provided in the next Quarterly Progress Report.

Table 19
Population Health Data*, July – September 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	634,031
Level 1: low or moderate risk	Maternity Program	Engage pregnant women in timely prenatal care and deliver a healthy, term infant without complications	9,369
	Health Risk Management	Prevent, reduce, or delay exacerbation and complications of a condition or health risk behavior	710,283
	Care Coordination	Assure that members receive the services they need to reduce the risk of an adverse health outcome	23,541

Risk Level	Intervention Type	Intervention Goal(s)	Number of Unique Members at End of Quarter
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	4,729
	High Risk Pregnancy Management	Engage pregnant women in timely prenatal care and deliver a healthy, term infant without complications	1,456
	Complex Case Management	Move members to optimal levels of health and well-being through timely coordination of quality services and self-management support	1,247
Total PH Enrollment			**1,384,656**

*** 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 October 2017, TennCare's External Quality Review Organization (EQRO), Qsource, published the results of its provider data validation survey for the July-September 2017 quarter. Qsource took a sample of provider data files from TennCare's MCCs[13] 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

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" (97.4 percent accuracy), "provider specialty / behavioral health service code" (98.3 percent accuracy), "routine care services" (97.1

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

percent accuracy), "urgent care services" (96.9 percent accuracy), "primary care services" (99.2 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 April-June 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 December 5, 2017. TennCare, in turn, had received, reviewed, and accepted all of the plans by December 10, 2017. Results for the October-December 2017 quarter will be discussed in the next Quarterly Progress Report.

XI. Demonstration Evaluation

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

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

XII. Essential Access Hospital Pool[14]

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)

[14] 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.

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
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 Holston Valley Medical Center Bristol Regional Medical Center
Meharry Medical College	Metro General Meharry Medical Group
University of Tennessee at Memphis	The Regional Medical Center (The MED) Methodist LeBonheur Erlanger Jackson Madison St. Francis
Vanderbilt University	Vanderbilt Hospital

XIV. Critical Access Hospitals

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

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Date Submitted to CMS: March 1, 2018

Attachment A

Budget Neutrality Calculations for the Quarter

Actual TennCare Budget Neutrality (Oct-Dec 2017)

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)	431,074
2-Child <=18	2,296,611
3-Adult >= 65	995
4-Adult <= 64	1,214,196
Duals (17)	439,048
Total	**4,381,924**

Ceiling without DSH

	Baseline * MM
1-Disabled (can be any ages)	$821,284,468
2-Child <=18	$1,229,832,187
3-Adult >= 65	$1,217,514
4-Adult <= 64	$1,349,380,976
17s	$343,196,532
Total	**$3,744,911,677**

DSH

DSH Adjustment (Quarterly)	$115,999,213

Total Ceiling

Budget Neutrality Cap	
Total w/DSH Adj.	**$3,860,910,890**

II. Actual Expenditures

Group 1 and 2

1-Disabled (can be any ages)	$	527,691,758
2-Child <=18	$	492,036,528
3-Adult >= 65	$	2,674,836
4-Adult <= 64	$	419,902,826
Duals (17)	$	375,429,336
Total	**$**	**1,817,735,283**

Group 3

1-Disabled (can be any ages)	$	-
2-Child <=18	$	3,645,522
3-Adult >= 65	$	25,470,079
4-Adult <= 64	$	169,161
Duals (17)	$	-
Total	**$**	**29,284,763**

Pool Payments and Admin

Total Pool Payments	$	51,195,440

Admin	157,869,719

Quarterly Drug Rebates	(228,331,930)
Quarterly Premium Collections	$ -
Total Net Quarterly Expenditures	**$ 1,827,753,275**

III. Surplus/(Deficit)

	$2,033,157,615
Federal Share	**$1,320,739,187**

HCI Result	MM201710	MM201711	MM201712	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)	144,260	143,474	142,625	430,359	$66,135,706	$125,975,187	$1,668,126	$321,297,737	$0	$0	7,774,046	$0	$0	$522,850,801
EG1-TYPE2 (disabled, type2 transition group)					$0	$0	$0	$0	$0	$0	-	$0	$0	$0
EG2-TYPE1 (over 65, type1 state plan eligibles)	251	280	314	845	$0	$49,323	$0	$1,219,998	$0	$0	19,158	$0	$0	$1,288,478
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)	760,655	768,134	767,822	2,296,611	$10,905,751	$70,015,669	$36,263,270	$367,535,957	$0	$0	7,315,882	$0	$0	$492,036,528
Med Exp Child (Title XXI Demo Pop; EG3-Type2)	4,482	4,457	4,445	13,384	$60,084	$794,959	$365,948	$2,231,161	$0	$0	52,103	$0	$0	$3,504,255
EG4-TYPE1 (adults, type1 State plan eligibles)	399,109	405,844	409,243	1,214,196	$1,166,594	$79,561,679	$2,734,383	$330,196,813	$0	$0	6,243,357	$0	$0	$419,902,826
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)	140,488	140,310	139,648	420,446	$1,533,471	$802,073	$31,080	$292,743,571	$0	$0	4,454,094	$0	$0	$299,564,289
EG6E-TYPE3 (Expan adult, type3 demonstration pop)	273	252	231	756	$0	$24,799	$0	$141,847	$0	$0	2,515	$0	$0	$169,161
EG7E-TYPE3 (Expan child, type3 demonstration pop)	865	848	854	2,567	$7,863	$75,403	$4,843	$51,058	$0	$0	2,100	$0	$0	$141,267
EG8-TYPE2 (med exp child)	0	0	0	0	$0	$0	$0	$0	$0	$0	-	$0	$0	$0
EG9 H-Disabled (TYPE 2 Eligibles)	232	236	247	715	$3,230	$241,012	$0	$4,524,736	$0	$0	71,978	$0	$0	$4,840,956
EG10 H-Senior	42	52	56	150	$0	$13,987	$0	$1,351,757			20,613			$1,386,358
EG11H, H-Dual	6,183	6,220	6,199	18,602	$0	$5,958	$0	$74,731,084	$0	$0	1,128,005	$0	$0	$75,865,047
EG12E, Carryovers	1,776	1,734	1,708	5,218	$0	$101,164	$0	$24,990,212	$0	$0	378,704	$0	$0	$25,470,079
Total	**1,458,616**	**1,471,841**	**1,473,392**	**4,403,849**	**$79,812,698**	**$277,661,212**	**$41,067,651**	**$1,421,015,930**	**$0**	**$0**	**$27,462,555**	**$0**	**$0**	**$1,847,020,046**

HCI Result	MM201710	MM201711	MM201712	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)	144,260	143,474	142,625	430,359	$153.68	$292.72	$3.88	$746.58	$0.00	$0.00	$18.06	$0.00	$0.00	$1,214.92
EG1-TYPE2 (disabled, type2 transition group)	0	0	0	-										
EG2-TYPE1 (over 65, type1 state plan eligibles)	251	280	314	845	$0.00	$58.37	$0.00	$1,443.78	$0.00	$0.00	$22.67	$0.00	$0.00	$1,524.83
EG2-TYPE2 (over 65, type2 state plan eligibles)	0	0	0	-	-	-	-	-	-	-	-	-	-	-
EG3-TYPE1 (children, type1 state plan eligibles)	760,655	768,134	767,822	2,296,611	$4.75	$30.49	$15.79	$160.03	$0.00	$0.00	$3.19	$0.00	$0.00	$214.24
Med Exp Child (Title XXI Demo Pop; EG3-Type2)	4,482	4,457	4,445	13,384	$4.49	$59.40	$27.34	$166.70	$0.00	$0.00	$3.89	$0.00	$0.00	$261.82
EG4-TYPE1 (adults, type1 State plan eligibles)	399,109	405,844	409,243	1,214,196	$0.96	$65.53	$2.25	$271.95	$0.00	$0.00	$5.14	$0.00	$0.00	$345.83
EG4-TYPE2 (adults, type2 demonstration pop)	0	0	0	-										
EG5-TYPE1 (duals, state plan eligibles)	140,488	140,310	139,648	420,446	$3.65	$1.91	$0.07	$696.27	$0.00	$0.00	$10.59	$0.00	$0.00	$712.49
EG6E-TYPE3 (Expan adult, type3 demonstration pop)	273	252	231	756	$0.00	$32.80	$0.00	$187.63	$0.00	$0.00	$3.33	$0.00	$0.00	$223.76
EG7E-TYPE3 (Expan child, type3 demonstration pop)	865	848	854	2,567	$3.06	$29.37	$1.89	$19.89	$0.00	$0.00	$0.82	$0.00	$0.00	$55.03
EG8-TYPE2 (emd exp child)	0	0	0	-										
EG9 H-Disabled (TYPE 2 Eligibles)	232	236	247	715	$4.52	$337.08	$0.00	$6,328.30	$0.00	$0.00	$100.67	$0.00	$0.00	$6,770.57
EG10 H-Senior	42	52	56	150	$0.00	$93.25	$0.00	$9,011.72	$0.00	$0.00	$137.42			
EG11H, H-Dual	6,183	6,220	6,199	18,602	$0.00	$0.32	$0.00	$4,017.37	$0.00	$0.00	$60.64	$0.00	$0.00	$4,078.33
EG12E, Carryovers	1,776	1,734	1,708	5,218	$0.00	$19.39	$0.00	$4,789.23	$0.00	$0.00	$72.58	$0.00	$0.00	$4,881.20
Total	**1,458,616**	**1,471,841**	**1,473,392**	**4,403,849**	**$18.12**	**$63.05**	**$9.33**	**$322.68**	**$0.00**	**$0.00**	**$6.24**	**$0.00**	**$0.00**	**$419.41**

* Unknown allocation was performed within the Service category totals.

allocated payment in unknown in each EG Group

			payment in blank category in each subject	
28.31%	7,774,046	**MEDICAL**	$	1,278,410
0.00%	-	**PHARMACY**	$	350,717
0.07%	19,158	**DENTAL**	$	49,786
0.00%	-	**CAP**	$	25,783,643
26.64%	7,315,882			
0.19%	52,103	**TOTAL**	**$**	**27,462,555**
22.73%	6,243,357			
0.00%	-			
16.22%	4,454,094			
0.01%	2,515			
0.01%	2,100			
0.00%	-			
0.26%	71,978			
0.08%	20,613			
4.11%	1,128,005			
1.38%	378,704			
$1,819,557,490	27,462,555			

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

Enrollment changes	Cumulative Total	AVG. Enrollment
SFY2017Q4	4,264,230	1,421,410.00
SFY2018Q1	4,403,849	1,467,949.67
% Changes in Total:	3.27%	3.27%

CAP PMPM changes:	CAP PMPM	Total CAP in QTR	Payment changes from current QTR to previous QTR
SFY2017Q4	$326.38	$ 1,416,002,581	
SFY2018Q1	$322.68	$ 1,446,799,573	$ 30,796,992
	-1.13%	2.17%	