TN Division of TennCare

November 27, 2019

Ms. Lorraine Nawara
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 S2-25-26
7500 Security Boulevard
Baltimore, Maryland 21244-1850

RE: TennCare II, STC 50, Quarterly Progress Report

Dear Ms. Nawara:

Enclosed please find the Quarterly Progress Report for the July – September 2019 quarter. This report is being submitted in accordance with STC 50 of the TennCare Demonstration.

Please let us know if you have comments or questions.

Sincerely,

[redacted]

John G. (Gabe) Roberts
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 2019)

Demonstration Year: 18 (7/1/19 - 6/30/20)
Federal Fiscal Quarter: 4/2019 (7/19 - 9/19)
Waiver Quarter: 1/2020 (7/19 - 9/19)

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 #
7/25/19	The Monthly Call for July was held.	49
8/5/19	The State notified the public of its intent to submit to CMS Demonstration Amendment 40. Amendment 40 would establish a "Katie Beckett" program to provide services and supports to certain children with disabilities and/or complex medical needs.	15
8/23/19	The Monthly Call for August was held.	49
8/29/19	The State submitted the Quarterly Progress Report for the April-June 2019 quarter to CMS.	50
9/9/19	The State notified the public of its intent to submit to CMS Demonstration Amendment 41. Amendment 41 would increase the amount of TennCare funding for graduate medical education in Tennessee, and would increase the amount of money that TennCare can distribute to qualifying hospitals for providing uncompensated care.	15
9/17/19	The State notified the public of its intent to submit to CMS Demonstration Amendment 42. Amendment 42 would convert the bulk of TennCare's federal funding to a block grant.	15
9/20/19	The State submitted Demonstration Amendment 40 to CMS.	6, 7
9/24/19	CMS site visit to the State. CMS and the State held a series	

Date	Action	STC #
	of on-site meetings to discuss the status of various aspects of the Demonstration.	
9/25/19	The Monthly Call for September was canceled.	49

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 July – September 2019 Quarter
Compared to the Previous Two Quarters

Demonstration Populations	Total Number of TennCare Enrollees		
	Jan – Mar 2019	Apr – Jun 2019	Jul – Sept 2019
EG1 Disabled, Type 1 State Plan eligibles	140,928	137,894	135,183
EG9 H-Disabled, Type 2 Demonstration Population	542	573	595
EG2 Over 65, Type 1 State Plan eligibles	327	297	366
EG10 H-Over 65, Type 2 Demonstration Population	43	51	55
EG3 Children, Type 1 State Plan eligibles	744,302	761,611	769,461
EG4 Adults, Type 1 State Plan eligibles	380,797	393,896	404,912
EG5 Duals, Type 1 State Plan eligibles and EG11 H-Duals 65, Type 2 Demonstration Population	142,892	144,766	145,972
EG6E Expan Adult, Type 3 Demonstration Population	27	14	14
EG7E Expan Child, Type 3 Demonstration Population	1	0	1
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	9,521	10,271	12,044

Demonstration Populations	Total Number of TennCare Enrollees		
	Jan – Mar 2019	Apr – Jun 2019	Jul – Sept 2019
EG12E Carryover, Type 3, Demonstration Population	2,536	2,396	2,288
TOTAL*	1,421,916	1,451,769	1,470,891

*** 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 September 30, 2019

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 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 that meet the definition of an institution for mental diseases (IMD). 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, current CMS regulations limit this option to treatment stays of no more than 15 days per calendar month. The State 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.

As of the end of the July-September 2019 quarter, CMS's review of Amendment 35 was ongoing.

[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.

Demonstration Amendment 36: Family Planning Providers. Amendment 36 was submitted to CMS in August 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 2019 quarter, CMS's review of Amendment 36 was ongoing.

Demonstration Amendment 37: Modifications to Employment and Community First CHOICES. On July 2, 2019, CMS approved Demonstration Amendment 37. Amendment 37 primarily concerned modifications to Employment and Community First (ECF) CHOICES, the State'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. Specifically, Amendment 37 added two new sets of services and two new benefit groups in which the services would be available:

- ECF CHOICES Group 7 serves 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. These children now receive family-centered behavioral health treatment services with family-centered home and community-based services (HCBS).
- ECF CHOICES Group 8 serves 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. Individuals in Group 8 now receive short-term intensive community-based behavioral-focused transition and stabilization services and supports.

Other changes to ECF CHOICES contained in Amendment 37 included 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.

Apart from the changes to ECF CHOICES, Amendment 37 also revised the list of populations automatically assigned to the TennCare Select health plan by allowing children receiving

Supplemental Security Income to have the same choice of managed care plans as virtually all other TennCare members.

Demonstration Amendment 38: Community Engagement. The State submitted Amendment 38 to CMS in December 2018. 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 of the end of the July-September 2019 quarter, discussions between TennCare and CMS on Amendment 38 were ongoing.

Demonstration Amendment 40: "Katie Beckett" Program. From August 5 through September 6, 2019, the State held a public notice and comment period on another amendment to be submitted to CMS. Amendment 40 implements legislation from Tennessee's 2019 legislative session directing TennCare to seek CMS approval for a new "Katie Beckett" program. The proposal would assist children under age 18 with disabilities and/or complex medical needs who are not eligible for Medicaid because of their parents' income or assets.

The Katie Beckett program proposed in Amendment 40—developed in close collaboration with the Tennessee Department of Intellectual and Developmental Disabilities and other stakeholders—would be composed of two parts:

- **Part A** – Individuals in this group would receive the full TennCare benefits package, as well as essential wraparound home and community based services. These individuals would be subject to monthly premiums to be determined on a sliding scale based on the member's household income.
- **Part B** – Individuals in this group would receive a specified package of essential wraparound services and supports, including premium assistance.

In addition to Parts A and B, Amendment 40 provides for continued TennCare eligibility for children already enrolled in TennCare, who subsequently lose TennCare eligibility, and who would qualify for enrollment in Part A but for whom no Part A program slot is available.

During the notice and comment period on Amendment 40, the State received dozens of comments, the vast majority of which were supportive of the proposal. The State reviewed this feedback carefully and incorporated several suggestions into the final version of the amendment. Amendment 40 was submitted to CMS on September 20, 2019.

Demonstration Amendment 41: Supplemental Hospital Payments. On September 9, 2019, the State initiated a public notice and comment period for another demonstration amendment growing out of Tennessee's 2019 legislative session. The budget passed by the General Assembly in 2019 provides for an annual increase of $3,750,000 in State funding to support graduate medical education (GME) in Tennessee. One purpose of Amendment 41 is to draw federal matching funds for these GME expenditures, thereby maximizing the resources available to invest in this priority.

Another aim of Amendment 41 is to enhance the State's ability to reimburse qualifying Tennessee hospitals for costs realized as a result of Medicaid shortfall and charity care. Currently, the TennCare Demonstration authorizes two funds through which this type of reimbursement may occur:

- The Virtual Disproportionate Share Hospital (DSH) Fund, which provides for total annual payments of up to $463,996,853, and which may be used to pay for Medicaid shortfall and charity care costs; and
- The Uncompensated Care Fund for Charity Care, which provides for total annual payments of up to $252,845,886, and which may be used to pay for charity care costs.

Amendment 41 would raise the annual limit for payments from these funds by approximately $382 million. Specifically, the limit on reimbursement from the Virtual DSH Fund would be increased to $508,936,029, while the limit on reimbursement from the Uncompensated Care Fund for Charity Care would be increased to $589,886,294. In addition, the amendment would revise the distribution methodologies contained in the TennCare Demonstration for each of the two funds to account for the disbursement of additional monies, and would also create a new sub-pool within the Uncompensated Care Fund to address costs that are not met within the current system.

As of the end of the July-September 2019 quarter, the public notice and comment period for Amendment 41 was expected to last through October 11, 2019, with submission of the amendment to CMS to follow shortly thereafter.

Demonstration Amendment 42: Block Grant. Like several other amendments described in this report, Amendment 42 is the result of legislation passed by the Tennessee General Assembly. The law in question directs the TennCare agency to submit a demonstration amendment to CMS to convert the bulk of the program's federal funding to a block grant. The block grant proposed in Amendment 42 would be based on TennCare enrollment, using State Fiscal Years 2016, 2017, and 2018 as the base period for calculating the block grant amount. The block grant would be indexed for inflation and for enrollment growth beyond the experience reflected in the base period.

The proposed block grant is intended to cover core medical services delivered to TennCare's core population. Certain expenses would be excluded from the block grant and continue to be financed through the current Medicaid financing model. These excluded expenditures include

services carved out of the existing TennCare Demonstration, outpatient prescription drugs, uncompensated care payments to hospitals, services provided to members enrolled in Medicare, and administrative expenses.

Amendment 42 does not rely on reductions to eligibility or benefits in order to achieve savings under the block grant. Instead, it would leverage opportunities to deliver healthcare to TennCare members more effectively and would permit the State to implement new reform strategies that would yield benefits for both the State and the federal government.

The State launched a public notice and comment period on Amendment 42 on September 17, 2019. The notice and comment period was to run through October 18, 2019, and was to feature hearings at various sites in each of Tennessee's grand regions.

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 2019 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-seventh 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.

TDH's outreach program continues to evolve over time. A new multi-discipline team model known as Community Health Access and Navigation in Tennessee (or "CHANT") is currently being implemented. The vision of CHANT is to promote the health of vulnerable populations—including TennCare-eligible and TennCare-enrolled pregnant women and children and youth under age 21—through such activities as the following:

- Improving access to care by arranging for or providing screening, assessment, and navigation of preventive services;
- Increasing awareness of the importance of primary prevention, including EPSDT services;
- Screening for social determinants of health and connecting individuals to relevant resources; and

- Coordinating services for children and youth with special healthcare needs.

Identification of individuals eligible for CHANT services occurs through referrals from State agencies (such as the Division of TennCare, TDH's Division of Family Health and Wellness, and the Division of Rehabilitation Services) and from other community partners, like primary care providers and TennCare MCOs. Once individuals within the target populations have been identified, TDH staff members communicate with them in the manner most suitable to the needs of the individual, whether by phone, or in person at such locations as the individual's home, a local health department, or a community event.

The CHANT program was initially implemented in two Tennessee counties (Montgomery and Sumner), and experience gained in those pilot regions has been used to prepare TDH teams across the state for statewide implementation. Table 4 summarizes community outreach activity conducted by the CHANT program. It should be noted that data from the January-March quarter was drawn from only three counties, whereas data from the April-June and July-September quarters reflects statewide implementation of the program.

Table 4
CHANT Community Outreach Activity for EPSDT
July – September 2019

Activities	January – March 2019 Quarter	April – June 2019 Quarter	July – September 2019 Quarter
Referrals to CHANT program from State agencies and other community partners	352	1,216	4,393
Number of individuals successfully contacted as a result of referrals	263	893	2,873
Number of individuals successfully enrolled in CHANT program as a result of referrals	198	776	2,274
Number of outreach events (community fairs, local coalition meetings, etc.)	2,131	884	145
Number of attendees at outreach events	41,264	25,590	17,640
Articles for newspapers, newsletters, and magazines	1	0	11
Advertisement campaigns (billboards, television, magazines, websites)	30	9	7

Activities	January – March 2019 Quarter	April – June 2019 Quarter	July – September 2019 Quarter
Radio or television advertisements and/or interviews	48	0	1
Collaborations with MCOs and other stakeholders	2	2	10
Number of calls completed on primary care/EPSDT benefits	32,779	18,478	17,974
Number of primary care/EPSDT appointments scheduled	337	282	369
Number of calls completed on CHANT services/outreach to families with newborns	246	477	2,510
Number of CHANT screenings and assessments completed	192	380	2,084
Number of calls completed on dental benefits	7,837	3,881	2,372
Number of dental appointments scheduled	189	140	52

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 5 illustrates the progress that has been made in reducing the number of claims that are returned to the MCOs due to data errors.

Table 5
Number of Initial Encounters Received by TennCare During the July-September 2019 Quarter, and Percentage that Passed Systems Edits, Compared to the Previous Two Quarters

	Jan – Mar 2019	Apr – Jun 2019	Jul – Sept 2019
No. of encounters received by TennCare (initial submission)	15,109,263	15,715,612	14,811,721
No. of encounters rejected by Edifecs upon	57,737	43,670	29,020

	Jan – Mar 2019	Apr – Jun 2019	Jul – Sept 2019
initial submission			
Percentage of encounters that were compliant with State standards (including HIPAA) upon initial submission	99.62%	99.72%	99.80%

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

A. CHOICES

As required by STC 32.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 6
CHOICES Enrollment and Reserve Slots
for July-September 2019 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		
		Jan – Mar 2019	Apr – Jun 2019	Jul – Sept 2019
CHOICES 1	Not applicable	16,431	16,609	16,527
CHOICES 2	11,000	9,787	9,914	9,964
CHOICES 3 (including Interim CHOICES 3)	To be determined	2,629	2,570	2,508
Total CHOICES	Not applicable	28,847	29,093	28,999
Reserve capacity	300	300	300	300

The CMS letter approving CHOICES implementation in Middle Tennessee dated February 26, 2010, and STC 48 require specific monitoring and reporting activities that include:

Data and trends of the designated CHOICES data elements: STC 48.d. requires the State to submit to CMS periodic statistical reports about the use of LTSS by TennCare enrollees. Sixteen separate reports of data pertaining to the CHOICES program have been submitted between August 2011 and June 2019.

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

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 eighth year of CHOICES. Furthermore, nursing facility expenditures in the year prior to CHOICES implementation accounted for more than 90 percent of total LTSS expenditures, whereas the percentage fell below 79 percent eight years later.

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 15,242 after CHOICES had been in place for eight full fiscal years. This trend was mirrored in point-in-time data as well: on the day prior to CHOICES implementation, 4,861 individuals were using HCBS, but the number had grown to 12,385 by June 30, 2018. The percentage of LTSS expenditures devoted to HCBS grew as well, rising from 9.75 percent in the year prior to CHOICES, to 21.07 percent after the CHOICES program had been in place for eight years.

Selected elements of the aforementioned CHOICES data are summarized in Table 7.

Table 7
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 – 6/30/18	Percent increase over an eight-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	15,242	145%	4,861[5]	12,385	155%

[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).

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 8.

Table 8
CHOICES Transition Allowances
for July – September 2019 Compared to the Previous Two Quarters

	Frequency and Use of Transition Allowances					
	Jan – Mar 2019		Apr – Jun 2019		Jul – Sept 2019	
Grand Region	# Distributed	Total Amount	# Distributed	Total Amount	# Distributed	Total Amount
East	15	$10,146	17	$11,777	16	$11,490
Middle	10	$7,381	34	$18,835	21	$13,602
West	16	$10,615	21	$19,998	18	$13,138
Statewide Total	41	$28,142	72	$50,610	55	$38,230

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 33.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 9
ECF CHOICES Enrollment, Enrollment Targets, and Reserve Slots for July – September 2019 Compared to the Previous Two Quarters

	Statewide Enrollment Targets and Reserve Capacity[6]	Enrollment and Reserve Slots Filled as of the End of Each Quarter[7]		
		Jan – Mar 2019	Apr – Jun 2019	Jul – Sept 2019
ECF CHOICES 4	905	818	820	844
ECF CHOICES 5	1,598	1,345	1,388	1,418
ECF CHOICES 6	797	511	593	680
ECF CHOICES 7	50	Not applicable	Not applicable	0
ECF CHOICES 8	50	Not applicable	Not applicable	2
Total ECF CHOICES	3,400	2,674	2,801	2,944
Reserve capacity	1,050	377	515	673
Waiver Transitions[8]	Not applicable	33	38	40

Data and trends of the designated ECF CHOICES data elements: STC 48.d. 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:

[6] Statewide enrollment targets and reserve capacity for Demonstration Year 19 (State Fiscal Year 2020) were adjusted to reflect new appropriation authority, effective July 1, 2019. A total of 300 slots were added to ECF CHOICES Groups 4, 5, and 6. The distribution of these slots as of the end of the July-September 2019 quarter reflect 25 additional slots in Group 4, 100 additional slots in Group 5, and 175 additional slots in Group 6. During the July-September 2019 quarter, three program slots were reallocated (from Group 5 to Group 4) across the Upper Limits of the ECF CHOICES Benefit Groups in order best to meet the needs of program applicants and ensure the most efficient use of resources. In addition, Groups 7 and 8 were approved by CMS and implemented in September 2019 upon the State's determination of MCOs' readiness to deliver services statewide and in accordance with program requirements. The enrollment target is set at 50 for each group.

[7] Note that enrollment and reserve slots filled do not include slots in "held" status that have been assigned to a person but for whom actual enrollment is pending determination of eligibility.

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

- 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.
- The number of working age adults with intellectual or developmental disabilities who are enrolled in HCBS programs, employed in an integrated setting, and earning at or above the minimum wage grew from 1,097 to 1,312, an increase of 20 percent.

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 2019 quarter, the MCOs submitted their NAIC Second Quarter 2019 Financial Statements. As of June 30, 2019, TennCare MCOs reported net worth as indicated in the table below.[9]

Table 10
Net Worth Reported by MCOs as of June 30, 2019

	Net Worth Requirement	Reported Net Worth	Excess/ (Deficiency)
Amerigroup Tennessee	$32,303,660	$176,483,930	$144,180,270
UnitedHealthcare Plan of the River Valley (UnitedHealthcare Community Plan)	$98,223,126	$449,022,171	$350,799,045
Volunteer State Health Plan (BlueCare & TennCare Select)	$53,841,080	$406,642,855	$352,801,775

During the July-September 2019 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.

All TennCare MCOs exceeded their minimum net worth requirements and Company Action Level requirements as of June 30, 2019.

D. Episodes of Care / Payment Reform

The State's episodes of care program is designed to transform the way specialty and acute healthcare services are delivered by incentivizing high-quality, cost-effective care, promoting evidence-based clinical pathways, encouraging care coordination, and reducing ineffective or

[9] The "Net Worth Requirement" and "Reported Net Worth" figures in the table are based on the MCOs' company-wide operations, not merely their TennCare operations.

inappropriate treatments. Episodes of care is part of the State's delivery system transformation initiative, which is changing healthcare delivery in Tennessee by moving from paying for volume to paying for value.

During this quarter, final results were released for the program's 2018 performance period, which includes 27 episode types with financial accountability. Estimated savings achieved in 2018 were approximately $38.3 million. During that time period, quality levels were either improved or maintained for the majority of episode types, and gain-sharing payments to providers exceeded risk-sharing payments by $686,000.

During the July-September 2019 quarter, the episodes program also released a memo outlining changes that would take effect in the 2020 performance period (beginning on January 1, 2020). Using feedback offered by stakeholders over the past year (especially at the Annual Episodes Design Feedback Session meetings held in May 2019), the State is in the process of making 41 changes to episode design. Several new quality metrics are being added, including one for morphine equivalent dose per day that complements the State's opioid strategy. Another change is the introduction of a list of global clinical exclusions that apply to all episodes. This list will exclude episodes in which patients have rare, high-cost conditions, such as paralysis and coma.

In addition, the episodes program recently secured designation as an Advanced Alternative Payment Model (APM) by CMS through 2025. This designation not only gives more healthcare providers in Tennessee the ability to join the APM track of Medicare's Quality Payment Program (QPP) by participating in the episodes program, but also rewards these providers with the potential to earn additional bonuses from Medicare. The State secured this designation to ensure that providers have every opportunity and incentive and drive value in the health care market.

E. Electronic Health Record Incentive Program

The Electronic Health Records (EHR) Incentive Program is a partnership between federal and state governments that grew out of the Health Information Technology for Economic and Clinical Health (HITECH) Act of 2009. The purpose of the program is to provide financial incentives to Medicaid providers[10] to replace outdated, often paper-based approaches to medical record-keeping with Certified Electronic Health Record Technology (as defined by CMS) that meets rigorous criteria and that can improve health care delivery and quality. The federal government provides 100 percent of the funding for the incentive payments and 90 percent of

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

the funding for administrative costs. Tennessee's EHR program[11] has issued payments for six years to eligible professionals and for three years to eligible hospitals.[12]

EHR payments made by TennCare during the July-September 2019 quarter as compared with payments made throughout the life of the program appear in the table below:

Table 11
EHR Payments
Quarterly and Cumulative

Payment Type	No. of Providers Paid During the Quarter	Quarterly Amount Paid (Jul-Sept 2019)	Cumulative Amount Paid To Date[13]
First-year payments	3[14]	$358,292	$180,250,303
Second-year payments	8	$68,000	$59,872,997
Third-year payments	11	$93,500	$37,537,685
Fourth-year payments	2	$17,000	$8,406,515
Fifth-year payments	3	$25,500	$5,377,671
Sixth-year payments	1	$8,500	$2,988,590

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

- Providing daily technical assistance to providers via email and telephone calls;
- Working with the State's attestation software vendor to enable submission of 2019 attestations beginning on January 1, 2020;
- Participation in CMS-led calls regarding the EHR Incentive Program; and
- Newsletters and alerts distributed by the State's EHR ListServ.

Although enrollment of new providers concluded on April 30, 2017, the State's EHR Incentive Program will continue through the 2021 program year as required by CMS rules. Tennessee's 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 for 2020 is to encourage provider participants who remain eligible to continue attesting and complete the

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

[12] At present, all but three participating hospitals have received three years of incentive payments.

[13] In certain cases, cumulative totals reflect adjustments of payments from previous quarters. The need for these recoupments was identified through standard auditing processes.

[14] First-year payments are usually issued to providers newly enrolled in the EHR program, and enrollment of providers ended in April 2017. The providers to whom first-year payments were issued this quarter had enrolled prior to April 2017 but had submitted attestations requiring corrections. The providers made these corrections in 2019, and their first-year payments were issued during the July-September 2019 quarter.

program. As of the end of the July-September 2019 quarter, staff were preparing to advance this strategy by exhibiting at a series of events in October: the Tennessee Medical Association Symposiums in Chattanooga, Knoxville, Lebanon, and Memphis, and the 70th Annual Scientific Assembly of the Tennessee Academy of Family Physicians in Gatlinburg.

F. Pharmacy Benefits Manager Readiness Activities

In January 2019, the State announced that OptumRx, Inc. had been selected through a competitive procurement process to replace Magellan Medicaid Administration as TennCare's Pharmacy Benefits Manager (PBM). Although OptumRx will not start processing pharmacy claims for the State until January 1, 2020, the company began readiness activities in March 2019. Priorities during this period of transition include the following:

- Establishing and managing a pharmacy network;
- Building a claims processing system, loading it with all information (enrollee data, edits specific to TennCare's outpatient formulary, clinical/quantity requirements, etc.) necessary for adjudication of claims, and performing user acceptance testing of the system;
- Creating a call center and website to assist patients and providers;
- Helping the State negotiate and collect supplemental rebates from pharmaceutical manufacturers; and
- Finalizing member and provider communications.

During the July-September 2019 quarter, preparations focused on completing the construction of the claims processing system, training staff on its use, and ensuring that it complies with all requirements established by the State. Testing confirmed that the system is able to accept daily TennCare eligibility files and updates, and that deployment of communication strategies for both providers and members has begun. In addition, PBM communication channels (such as dedicated member and provider phone and fax lines) and existing prior authorization approvals are being transferred to OptumRx to ensure that a proper standard of care is maintained during this period of transition. A number of challenges—such as the difficulties involved with transferring provider services and member advocacy communication lines—have been anticipated and addressed with rigorous processes that have been monitored closely in real time.

G. *Shackelford v. Roberts*

This lawsuit (formerly known as *Roan and Shackelford v. Long*) was filed against the State in December 2017 by the Tennessee Justice Center and the Legal Aid Society of Middle Tennessee and the Cumberlands. The litigation, which was heard by the U.S. District Court for the Middle District of Tennessee, concerned longstanding limitations placed by TennCare—and approved by CMS—on private duty nursing services for individuals aged 21 and older. The purpose of the limitations is to ensure that private duty nursing expenditures are managed in a medically appropriate yet financially sustainable manner.

When a child enrolled in TennCare receives private duty nursing services in excess of the limits applicable to adult enrollees, it is the policy of the enrollee's MCO to work with the child and his family prior to the child's 21st birthday to begin planning and supporting the transition to the appropriate level of benefits that best meets his needs (and that can include long-term services and supports). In *Shackelford v. Roberts*, a Plaintiff with disabilities who received private duty nursing services as a child challenged the State's ability to implement limits on the services he received as an adult. The Plaintiff alleged that the limits in question violated the Americans with Disabilities Act (ADA) and sought an injunction prohibiting the State from reducing the services he was receiving. The State timely filed a response to the Motion for Preliminary Injunction, as well as a Motion to Dismiss and a Notice of Constitutional Question.

In February 2019, the Plaintiff was granted a stay of proceedings in order to attempt to transition to institutional care. On August 22, 2019, Mr. Shackelford filed a motion to voluntarily dismiss his case, and the Court granted the dismissal on August 28, 2019, thus ending this litigation.

VI. Action Plans for Addressing Any Issues Identified

During the July-September 2019 quarter, there were no identified issues requiring action plans.

VII. Financial/Budget Neutrality Development Issues

TennCare continued to demonstrate budget neutrality during the July-September 2019 quarter. For more information about budget neutrality performance, see the spreadsheet submitted separately via the PMDA application.

From a state fiscal perspective, revenue collections continued to be strong during the July-September 2019 quarter. Total state and local collections were higher in all three months of the quarter than during the corresponding months of 2018, with more than a four percent year-to-year improvement in July, approximately an eight percent improvement in August, and better than a nine percent improvement in September.[15]

Tennessee's unemployment rate declined slightly over the course of the quarter, remaining very low from a historical and national perspective. The state rate fell from 3.5 percent in July and August to 3.4 percent in September. The Tennessee unemployment rate remained lower than the national rate during the same months (3.7 percent in July and August and 3.5 percent

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

in September), and was exactly the same as the state rate from the corresponding quarters of 2018.[16]

VIII. Member Month Reporting

Tables 12 and 13 below present the member month reporting by eligibility group for each month in the quarter.

Table 12
Member Month Reporting for Use in Budget Neutrality Calculations
July – September 2019

Eligibility Group	July 2019	August 2019	September 2019	Sum for Quarter Ending 9/30/19
Medicaid eligibles (Type 1)				
EG1 Disabled, Type 1 State Plan eligibles	136,042	131,752	130,409	398,203
EG2 Over 65, Type 1 State Plan eligibles	296	328	347	971
EG3 Children, Type 1 State Plan eligibles	759,065	758,638	754,378	2,272,081
EG4 Adults, Type 1 State Plan eligibles	392,500	391,937	390,916	1,175,353
EG5 Duals, Type 1 State Plan eligibles	137,594	135,896	135,162	408,652
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	572	592	593	1,757
EG10 H-Over 65, Type 2 Demonstration Population	54	52	54	160
EG11 H-Duals, Type 2 Demonstration Population	4,995	5,177	5,228	15,400
TOTAL	1,431,118	1,424,372	1,417,087	4,272,577

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

Table 13
Member Month Reporting Not Used in Budget Neutrality Calculations
July – September 2019

Eligibility Group	July 2019	August 2019	September 2019	Sum for Quarter Ending 9/30/19
EG6E Expan Adult, Type 3, Demonstration Population	14	14	14	42
EG7E Expan Child, Type 3, Demonstration Population	1	1	1	3
Med Exp Child, Title XXI Demonstration Population	10,880	11,474	11,927	34,281
EG12E Carryover, Type 3, Demonstration Population	2,313	2,276	2,238	6,827
TOTAL	13,208	13,765	14,180	41,153

IX. Consumer Issues

Eligibility Appeals. Table 14 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 14
Eligibility Appeals for July – September 2019
Compared to the Previous Two Quarters

	Jan – Mar 2019	Apr – Jun 2019	Jul – Sept 2019
No. of appeals received	19,692	27,259	48,747
No. of appeals resolved or withdrawn	13,636	20,710	26,443
No. of appeals taken to hearing	2,286	3,862	3,832
No. of hearings resolved in favor of appellant	80	159	583

Medical Service Appeals. Table 15 below presents a summary of the medical service appeals handled during the quarter, compared to the previous two quarters.

Table 15
Medical Service Appeals for July – September 2019
Compared to the Previous Two Quarters

	Jan – Mar 2019	Apr – Jun 2019	Jul – Sept 2019
No. of appeals received	1,522	1,508	1,441
No. of appeals resolved	1,511	1,535	1,568
• Resolved at the MCC level	361	404	370
• Resolved at the TSU level	161	188	203
• Resolved at the LSU level	989	943	995
No. of appeals that did not involve a valid factual dispute	230	201	193
No. of directives issued	245	251	245
No. of appeals taken to hearing	989	943	995
No. of appeals that were withdrawn by the enrollee at or prior to the hearing	292	321	331
Appeals that went to hearing and were decided in the State's favor	359	310	345
Appeals that went to hearing and were decided in the appellant's favor	41	30	30

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 16
Long-Term Services and Supports Appeals for July – September 2019
Compared to the Previous Two Quarters

	Jan – Mar 2019	Apr – Jun 2019	Jul – Sept 2019
No. of appeals received	106	123	138
No. of appeals resolved or withdrawn	33	49	64
No. of appeals set for hearing	51	59	67
No. of hearings resolved in favor of appellant	1	1	1

X. Quality Assurance/Monitoring Activity

Population Health. Population Health (PH) is a healthcare management approach that targets the entire TennCare population. The Population Health program improves members' health across the entire care continuum by providing proactive 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 2019 quarter is provided in Table 17. Data for the period of July through September 2019 will be provided in the next Quarterly Progress Report.

Table 17
Population Health Data*, April – June 2019

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	513,925
Level 1: low,	Low Risk Maternity	Engage pregnant women in timely	11,735

Risk Level	Intervention Type	Intervention Goal(s)	Number of Unique Members at End of Quarter
medium, or high 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	784,738
	Care Coordination	Assure that members receive the services they need to reduce the risk of an adverse health outcome	26,828
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	43,215
	High Risk Pregnancy Management	Engage pregnant women in timely prenatal care and deliver a healthy, term infant without complications	8,355
	Complex Case Management	Move members to optimal levels of health and well-being through timely coordination of quality services and self-management support	23,824
Total PH Enrollment			**1,385,792**

*** 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 2019, TennCare's External Quality Review Organization (EQRO), Qsource, published the results of its provider data validation survey for the April-June 2019 quarter. Qsource took a sample of provider data files from TennCare's MCCs[17] 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)

[17] 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 "active contract status" (95.5 percent accuracy), "services to patients under age 21" (95.3 percent accuracy), "primary care services" (95.2 percent accuracy), and "prenatal care services" (96.3 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 2019, 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, 2019. TennCare, in turn, had received, reviewed, and accepted all of the plans by September 16, 2019. Results for the July-September 2019 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. The CHOICES program is being compared with nursing facility services and the Section 1915(c) waiver that existed prior to implementation of CHOICES. The ECF CHOICES program is being compared with the three Section 1915(c) waivers for individuals with intellectual disabilities and Intermediate Care Facilities for Individuals with Intellectual Disabilities that continue to operate outside the TennCare Demonstration.

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. In order to identify baseline performance (i.e., performance prior to implementation of each managed LTSS program component) and to measure performance improvement, the State created a baseline data plan for each program. Data collection processes for the CHOICES program reflected in the evaluation design have been ongoing since the program's inception.

Data collection processes for the ECF CHOICES program reflected in the evaluation design also commenced at program launch, subject to methodological limitations described in the document. Processes have been established for collection of the quality of life measurement data for ECF CHOICES using the *National Core Indicators*™, the same tool used for some time to gather annual quality of life measurement data for persons enrolled in Tennessee's Section 1915(c) HCBS waivers. TennCare is working with the Department of Intellectual and Developmental Disabilities to leverage their existing agreement with the National Association of State Directors of Developmental Disabilities Services (NASDDDS) and the Human Services Research Institute. A unique sample will be collected for ECF CHOICES, with oversampling in order to compare health plan performance. Meetings have been held with The Arc Tennessee to engage self-advocates in conducting the face-to-face assessments.

On April 2, 2019 CMS issued written approval of TennCare's evaluation design. The State's interim evaluation report is due to CMS one year prior to the expiration of the TennCare Demonstration (i.e., on June 30, 2020), or at the time the State submits an application to extend the TennCare Demonstration.

XII. Uncompensated Care Fund for Charity Care

On July 1, 2018, the structure for uncompensated care payments made by TennCare to Tennessee hospitals changed. Among the changes to the structure that went into effect on that date was the elimination of the Essential Access Hospital Pool and the Critical Access Hospital Pool. Now, as detailed in STC 61 of the TennCare Demonstration, uncompensated care payments to Tennessee hospitals are made from the Virtual DSH Fund and the Uncompensated Care Fund for Charity Care. As detailed in Attachment H of the TennCare Demonstration, these two funds are further divided into several sub-pools. The hospitals that received payments from the Virtual DSH Fund and the Uncompensated Care Fund for Charity Care during the July-September 2019 quarter, as well as the sub-pool(s) to which they are assigned, are provided below.

<u>Children's Safety Net Sub-Pool</u>
East Tennessee Children's Hospital
LeBonheur Children's Hospital

<u>Other Essential Acute Sub-Pool</u>
Jellico Community Hospital
Saint Thomas Stones River Hospital
Claiborne Medical Center
Unity Medical Center
Saint Thomas DeKalb Hospital
Jamestown Regional Medical Center
Milan General Hospital
Hardin Medical Center

Henderson County Community Hospital
Lincoln Medical Center
Livingston Regional Hospital
TrustPoint Hospital
Wayne Medical Center
Tennova Healthcare – Shelbyville
Tennova Healthcare – LaFollette Medical Center
Sycamore Shoals Hospital
Tennova Healthcare – Newport Medical Center
Tennova Healthcare – Harton
TriStar Horizon Medical Center
West Tennessee Healthcare Dyersburg Hospital
Southern Tennessee Regional Health System – Winchester
Southern Tennessee Regional Health System – Pulaski
Laughlin Memorial Hospital
Morristown – Hamblen Healthcare System
Henry County Medical Center
Tennova Healthcare – Jefferson Memorial Hospital
Southern Tennessee Regional Health System – Lawrenceburg
Starr Regional Medical Center – Athens
Sweetwater Hospital Association
Baptist Memorial Hospital – Union City
Roane Medical Center
NorthCrest Medical Center
LeConte Medical Center
Delta Medical Center
Indian Path Community Hospital
Baptist Memorial Hospital – Tipton
Saint Thomas River Park Hospital
Franklin Woods Community Hospital
West Tennessee Healthcare Volunteer Hospital
Tennova Healthcare – Lebanon
Methodist Medical Center of Oak Ridge
Blount Memorial Hospital
Tennova Healthcare – Cleveland
TriStar Southern Hills Medical Center
Saint Thomas Midtown Hospital
TriStar Centennial Medical Center
TriStar Skyline Medical Center
TriStar Summit Medical Center
Parkridge Medical Center
Fort Sanders Regional Medical Center
Tennova Healthcare – North Knoxville Medical Center
Parkwest Medical Center

Jackson – Madison County General Hospital
Maury Regional Hospital
Tennova Healthcare – Clarksville
Cookeville Regional Medical Center
Saint Thomas Rutherford Hospital
TriStar StoneCrest Medical Center
Baptist Memorial Hospital – Memphis
Methodist University Hospital
Saint Francis Hospital
Bristol Regional Medical Center
Holston Valley Medical Center
Sumner Regional Medical Center
TriStar Hendersonville Medical Center
Williamson Medical Center

Safety Net Sub-Pool
Nashville General Hospital
Erlanger Medical Center
Regional One Health
Vanderbilt University Medical Center
University of Tennessee Medical Center
Johnson City Medical Center

Psychiatric Facilities Sub-Pool
Ridgeview Psychiatric Hospital and Center
Pathways of Tennessee
Ten Broeck Tennessee
Crestwyn Behavioral Health
Rolling Hills Hospital

Other Safety Net Sub-Pool
Vanderbilt University Medical Center
University of Tennessee Medical Center
Johnson City Medical Center

Research and Rehabilitation Facilities Sub-Pool
Vanderbilt Stallworth Rehabilitation Hospital
Siskin Hospital for Physical Rehabilitation
HealthSouth Rehabilitation Hospital – Chattanooga
Kindred Hospital – Chattanooga
Saint Jude Children's Research Hospital
HealthSouth Rehabilitation Hospital – Memphis
Baptist Memorial Restorative Care Hospital
HealthSouth Rehabilitation Hospital – North Memphis

Regional One Health Extended Care Hospital
HealthSouth Rehabilitation Hospital – Kingsport
Quillen Rehabilitation Hospital
Spire Cane Creek Rehabilitation Hospital
HealthSouth Rehabilitation Hospital – Franklin

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
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

The hospitals currently designated as active Critical Access Hospitals by the Tennessee Department of Health and TennCare are as follows:

Bolivar General Hospital

Camden General Hospital
Erlanger Bledsoe Hospital
Hancock County Hospital
Houston County Community Hospital
Johnson County Community Hospital
Lauderdale Community Hospital
Macon Community 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

State Contact:

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

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