Division of TennCare

May 30, 2019

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

RE: TennCare II, STC 44, Quarterly Progress Report

Dear Ms. Hollis:

Enclosed please find the Quarterly Progress Report for the January – March 2019 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]

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 January - March 2019)

Demonstration Year: 17 (7/1/18 - 6/30/19)
Federal Fiscal Quarter: 2/2019 (1/19 - 3/19)
Waiver Quarter: 3/2019 (1/19 - 3/19)

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 #
1/8/19	CMS sent the State a letter indicating that the submission of Amendment 38 (establishing workforce participation and community engagement as an expectation for certain TennCare enrollees) met the requirements for a complete amendment.	
1/31/19	The Monthly Call for January was held.	43
3/1/19	The State submitted the Quarterly Progress Report for the October-December 2018 quarter to CMS.	44
3/8/19	The Monthly Call originally scheduled for February 28 was held.	43
3/12/19	The State notified the public of its intent to submit to CMS Amendment 39 to the TennCare Demonstration. Amendment 39 outlined program reductions that would be necessary if the Tennessee General Assembly did not renew the annual hospital assessment.	15
3/19/19	The State submitted to CMS signed versions of Statewide MCO Contract Amendment 9 and TennCare Select Contract Amendment 44.	39
3/28/19	The Monthly Call for March was held.	43

II. Enrollment and Benefits Information

Information about enrollment by category is presented in Table 2.

Table 2
Enrollment Counts for the January – March 2019 Quarter
Compared to the Previous Two Quarters

Demonstration Populations	Total Number of TennCare Enrollees		
	Jul – Sept 2018	Oct – Dec 2018	Jan – Mar 2019
EG1 Disabled, Type 1 State Plan eligibles	139,465	134,672	136,735
EG9 H-Disabled, Type 2 Demonstration Population	271	258	264
EG2 Over 65, Type 1 State Plan eligibles	475	405	416
EG10 H-Over 65, Type 2 Demonstration Population	111	49	44
EG3 Children, Type 1 State Plan eligibles	745,822	724,253	740,473
EG4 Adults, Type 1 State Plan eligibles	394,191	373,142	376,086
EG5 Duals, Type 1 State Plan eligibles and EG11 H-Duals 65, Type 2 Demonstration Population	144,869	141,306	141,256
EG6E Expan Adult, Type 3 Demonstration Population	71	43	27
EG7E Expan Child, Type 3 Demonstration Population	1,462	1,569	1,471
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	6,523	7,376	8,161
EG12E Carryover, Type 3, Demonstration Population	1,459	1,334	1,217
TOTAL*	1,434,719	1,384,407	1,406,150

*** Unique member counts for reporting quarter, with at least 1 day of eligibility. To avoid duplication, the member counts are based on the last eligibility group (EG) of the quarter.**

The majority of TennCare's enrollment continues to be categorized as Type 1 EG3 children and Type 1 EG4 adults, with 79 percent of TennCare enrollees appearing in one of these categories.

The Managed Care Contractors providing services to TennCare enrollees as of the end of the quarter are listed in Table 3.

Table 3
TennCare Managed Care Contractors as of March 31, 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.

During the January-March 2019 quarter, TennCare and CMS continued their discussions concerning Amendment 35, including the possibility of using authority contained in federal opioid legislation (the SUPPORT Act) in lieu of modifications to the TennCare Demonstration. As of the end of the quarter, these discussions were ongoing.

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

[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.

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 January-March 2019 quarter, CMS's review of Amendment 36 was ongoing.

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

The primary modification to ECF CHOICES contained in Amendment 37 is the addition of two new sets of services and two new benefit groups in which the services would be available:

- ECF CHOICES Group 7 would serve 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—who are at significant risk of placement outside the home (e.g., State custody, hospitalization, residential treatment, incarceration)—would receive family-centered behavioral health treatment services with family-centered home and community-based services (HCBS).
- ECF CHOICES Group 8 would serve 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 would receive short-term intensive community-based behavioral-focused transition and stabilization services and supports.

Other proposed changes to ECF CHOICES contained in Amendment 37 include modifications to expenditure caps for existing benefit groups within the program, revised eligibility processes to facilitate transitions from institutional settings to community-based settings, and modifications and clarifications to certain ECF CHOICES service definitions.

Apart from the changes to ECF CHOICES, Amendment 37 would also revise 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.

During the January-March 2019 quarter, CMS continued its review of Amendment 37. Discussions between the State and CMS remained ongoing as of the end of the quarter.

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 January-March 2019 quarter, CMS was reviewing Amendment 38.

Demonstration Amendment 39: Program Modifications. During the January-March 2019 quarter, the State issued public notice of another amendment to be submitted to CMS. Amendment 39 outlines program changes that would be needed if the State's hospital assessment is not renewed in 2019. These changes have also been proposed in previous years, but were made unnecessary each year by the Tennessee legislature's passage or renewal of a one-year hospital assessment. Changes to the TennCare benefit package for non-exempt adults that would be necessary if the assessment were not renewed in 2019 are as follows:

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

The State opened its public notice and comment period regarding Amendment 39 on March 12, 2019. The comment period was scheduled to run through April 12, 2019.

Amendment 39 was scheduled to be withdrawn from consideration upon the Tennessee legislature's renewal of the hospital assessment. This legislation was still working its way through normal channels as of the end of the January-March 2019 quarter.

Tennessee Eligibility Determination System / TennCare Connect. The Tennessee Eligibility Determination System, along with a companion online consumer portal known as TennCare Connect, is the name of the system that is now used by the State to process applications and identify persons who are eligible for the TennCare and CoverKids programs. The State began piloting the new system in October 2018, and after several months of systems testing, officially launched TennCare Connect on a statewide basis in March 2019. This eligibility and enrollment system has a complex rules engine and many new interfaces that can be used to verify data submitted by applicants and that are used to make eligibility decisions.

TennCare Connect allows applicants and enrollees to submit online applications and requested verification information to the State, as well as view notices and eligibility periods. TennCare Connect also includes a new mobile application that allows applicants and enrollees to submit requested verifications, view notices and eligibility periods, and make changes to their demographic information via a mobile device (such as a smartphone). TEDS and TennCare Connect have been one of the largest and most complex IT systems launches in the State's history, and will significantly enhance the consumer experience for TennCare applicants and enrollees. These groups will now be able to apply for coverage and/or manage their accounts 24 hours per day, 7 days a week. Included within this capability are such functions as providing requested verifications, updating demographic information (e.g., income, addresses, household membership, etc.), and completing the annual eligibility renewal process. In addition, applicants and enrollees may indicate in the system whether to receive electronic notices or text messages to alert them when the TennCare agency has sent a communication.

Additionally, in January 2019, the State began piloting a fourth portal. The "TennCare Access Portal" is designed for use by hospitals and the Tennessee Department of Health in submitting applications for presumptive eligibility, and for long-term care partners to look up information on applicants. All partners in the presumptive eligibility process are now using the TennCare Access Portal statewide.

Cost Sharing Compliance Plan. In its April 18, 2012, letter approving TennCare's cost sharing compliance plan for the TennCare Standard population, CMS stipulated that "each Quarterly Report . . . must include a report on whether any families have contacted the State to document having reached their aggregate cap, and how these situations were resolved." During the January-March 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-fifth 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—

- 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 during the January-March 2019 quarter. Data is drawn from the two original pilot counties, as well as the first county (Madison) to be trained following the pilot project. As the CHANT program matures, data from multiple quarters will be furnished for purposes of comparison.

Table 4
CHANT Community Outreach Activity for EPSDT
January – March 2019

Activities	January – March 2019 Quarter
Referrals to CHANT program from State agencies and other community partners	352
Number of individuals successfully contacted as a result of referrals	263
Number of individuals successfully enrolled in CHANT program as a result of referrals	198
Number of outreach events (community fairs, local coalition meetings, etc.)	2,131
Number of attendees at outreach events	41,264
Articles for newspapers, newsletters, and magazines	1
Advertisement campaigns (billboards, television, magazines, websites)	30
Radio or television advertisements and/or	48

Activities	January – March 2019 Quarter
interviews	
Collaborations with MCOs and other stakeholders	2
Number of calls completed on primary care/EPSDT benefits	32,779
Number of primary care/EPSDT appointments scheduled	337
Number of calls completed on CHANT services/outreach to families with newborns	246
Number of CHANT screenings and assessments completed	192
Number of calls completed on dental benefits	7,837
Number of dental appointments scheduled	189

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 January-March 2019 Quarter, and Percentage that Passed Systems Edits, Compared to the Previous Two Quarters

	Jul – Sept 2018	Oct – Dec 2018	Jan – Mar 2019
No. of encounters received by TennCare (initial submission)	14,778,688	17,163,181	15,109,263
No. of encounters rejected by Edifecs upon initial submission	97,669[4]	38,524	57,737
Percentage of encounters that were compliant with State standards (including HIPAA) upon initial submission	99.34%	99.78%	99.62%

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

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 6
CHOICES Enrollment and Reserve Slots
for January-March 2019 Compared to the Previous Two Quarters

	Statewide Enrollment Targets and Reserve Capacity[5]	Enrollment and Reserve Slots Being Held as of the End of Each Quarter		
		Jul – Sept 2018	Oct – Dec 2018	Jan – Mar 2019
CHOICES 1	Not applicable	16,713	16,509	16,431
CHOICES 2	10,500	9,678	9,782	9,787
CHOICES 3 (including Interim CHOICES 3)	To be determined	2,750	2,678	2,629
Total CHOICES	Not applicable	29,141	28,969	28,847
Reserve capacity	300	300	300	300

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

Data and trends of the designated CHOICES data elements: STC 42.d.iv. requires the State to submit to CMS periodic statistical reports about the use of LTSS by TennCare enrollees. Fifteen separate reports of data pertaining to the CHOICES program have been submitted between August 2011 and September 2018.

Taken together, the reports depict a program evolving according to the characteristics of LTSS recipients, with institutional care available to individuals with the highest acuity of need, and Home and Community-Based Services (HCBS) available to individuals whose needs can be safely and effectively met at home or in other non-institutional settings. Point-in-time data revealed declining use of Nursing Facility (NF) services over time, with placement in institutional settings decreasing from 21,530 individuals on June 30, 2011, to 16,439 individuals on June 30, 2018. According to annual aggregate data contained in the reports, this downward trend was even more pronounced for new LTSS recipients, 81 percent of whom had been admitted to NFs in

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

the year prior to implementation of the CHOICES program, as compared with 63 percent admitted to NFs in the seventh year of CHOICES.

By contrast, appropriate use of HCBS by TennCare enrollees grew significantly during these years. The aggregate number of members accessing HCBS increased from 6,226 in the twelve-month period preceding CHOICES implementation in Middle Tennessee to 15,429 after CHOICES had been in place for seven full fiscal years. This trend was mirrored in point-in-time data as well: on the day prior to CHOICES implementation, 4,861 individuals were using HCBS, but the number had grown to 12,385 by June 30, 2018. This information is 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 – 6/30/17	Percent increase over a seven-year period	No. of TennCare enrollees accessing HCBS (E/D) on the day prior to CHOICES implementa-tion	No. of TennCare enrollees accessing HCBS (E/D) on 6/30/18	Percent increase from the day prior to CHOICES implementa-tion to 6/30/18
6,226	15,429	148%	4,861[6]	12,385	155%

Frequency and use of MCO-distributed transition allowances (CHOICES approval letter dated February 26, 2010): The allocation of CHOICES transition allowance funds is detailed in Table 8. Figures for the July-September 2018 and October-December 2018 quarters have been revised to reflect updated data received after the Quarterly Progress Reports in which these figures originally appeared.

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

Table 8
CHOICES Transition Allowances
for January – March 2019 Compared to the Previous Two Quarters

	Frequency and Use of Transition Allowances					
	Jul – Sept 2018		Oct – Dec 2018		Jan – Mar 2019	
Grand Region	# Distributed	Total Amount	# Distributed	Total Amount	# Distributed	Total Amount
East	17	$13,780	6	$8,403	15	$10,146
Middle	25	$20,033	24	$16,197	10	$7,381
West	38	$27,384	21	$20,794	16	$10,615
Statewide Total	80	$61,197	51	$45,394	41	$28,142

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 9
ECF CHOICES Enrollment, Enrollment Targets, and Reserve Slots for January – March 2019 Compared to the Previous Two Quarters

	Statewide Enrollment Targets and Reserve Capacity[7]	Enrollment and Reserve Slots Filled as of the End of Each Quarter		
		Jul – Sept 2018	Oct – Dec 2018	Jan – Mar 2019
ECF CHOICES 4	877	814	810	818
ECF CHOICES 5	1,501	1,313	1,309	1,345
ECF CHOICES 6	622	415	467	511
Total ECF CHOICES	3,000	2,542	2,586	2,674
Reserve capacity	650	249[8]	305	377
Waiver Transitions[9]	Not applicable	26	30	33

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

- The number of individuals with intellectual disabilities receiving HCBS through the TennCare program grew from 8,295 to 8,526.
- The number of individuals with developmental disabilities other than intellectual disabilities who received HCBS through the TennCare program grew from 0 to 519.

[7] Statewide enrollment targets and reserve capacity for Demonstration Year 17 (Fiscal Year 2019) were adjusted to reflect new appropriation authority, effective July 1, 2018. A total of 300 program slots were added to ECF CHOICES, including 100 new slots for individuals with a developmental disability who have an aging caregiver age 80 or older. The distribution of these slots as of the end of the July-September 2018 quarter reflect 21 additional slots in ECF CHOICES Group 4, 101 additional slots in Group 5, and 178 additional slots in Group 6. During the January-March 2019 quarter, 12 program slots were reallocated (6 from Group 5 to Group 4, and 6 from Group 5 to Group 6) across the Upper Limits of the three ECF CHOICES Benefit Groups in order best to meet the needs of program applicants and ensure the most efficient use of resources.

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

[9] Waiver transitions are instances in which an individual enrolled in a 1915(c) HCBS waiver program is transferred into the ECF CHOICES program. Since these individuals have an independent funding source (i.e., the money that would have been spent on their care in the 1915(c) program), their enrollment in ECF CHOICES does not count against the 3,000-person enrollment target. Waiver transition numbers are cumulative since the program began.

- 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 January-March 2019 quarter, the MCOs submitted their 2018 NAIC Annual Financial Statements. As of December 31, 2018, TennCare MCOs reported net worth as indicated in the table below.[10]

Table 10
Net Worth Reported by MCOs as of December 31, 2018

	Net Worth Requirement	Reported Net Worth	Excess/ (Deficiency)
Amerigroup Tennessee	$32,303,660	$187,159,719	$154,856,059
UnitedHealthcare Plan of the River Valley (UnitedHealthcare Community Plan)	$98,223,126	$462,998,137	$364,775,011
Volunteer State Health Plan (BlueCare & TennCare Select)	$53,841,080	$410,918,440	$357,077,360

During the January-March 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 December 31, 2018.

D. Episodes of Care / Payment Reform

Episodes of care is a delivery system reform strategy that focuses on acute or specialist-driven health care delivered during a specified time period to treat physical or behavioral conditions such as an acute diabetes exacerbation or total joint replacement. Each episode has a principal accountable provider who is in the best position to influence the cost and quality of the episode.

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

Of the 48 episodes that have been developed since the program began, 45 currently include financial accountability (i.e., gain sharing and risk sharing) for providers in 2019. The State is also implementing over 30 changes to the design of episodes in 2019 based on feedback received from stakeholders, including exempting providers with fewer than five episodes, avoiding duplicative accountability when multiple episodes overlap, and adjusting the reported costs of medications on episode reports.

Tennessee continues to lead the nation in transforming the health care delivery system. Humana, a national insurance company, has implemented three episodes using Tennessee's episode designs for maternity, total joint replacement, and spinal fusion. Details of the initiative that Humana modeled on Tennessee's program may be found online at https://www.humana.com/provider/news/value-based-care/payment-models/episode-based-models.

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[11] to replace outdated, often paper-based approaches to medical record-keeping with Certified Electronic Health Record Technology (as defined by CMS) that meets rigorous criteria and that can improve health care delivery and quality. The federal government provides 100 percent of the funding for the incentive payments and 90 percent of the funding for administrative costs. Tennessee's EHR program[12] has issued payments for six years to eligible professionals and for three years to eligible hospitals.[13]

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

[11] 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).

[12] 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.

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

Table 11
EHR Payments
Quarterly and Cumulative

Payment Type	No. of Providers Paid During the Quarter	Quarterly Amount Paid (Jan-Mar 2019)	Cumulative Amount Paid To Date[14]
First-year payments	N/A	N/A	$180,229,124
Second-year payments	11	$22,667	$59,014,297
Third-year payments	81	$902,292	$36,574,794
Fourth-year payments	99	$705,502	$7,630,181
Fifth-year payments	57	$340,001	$4,377,503
Sixth-year payments	52	$342,834	$2,387,933

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 on a daily basis via emails (including targeted emails to eligible professionals attesting to "meaningful use" of EHR technology), technical assistance calls, webinars, and onsite visits;
- Weekly messaging in March 2019 to providers regarding the submission deadline for sixth-year payments;
- Acceptance of Program Year 2018 meaningful use attestations for returning eligible professionals;
- Partnering with the Tennessee Primary Care Association to provide clinical education and outreach to Federally Qualified Health Centers seeking to attest to meaningful use;
- Taking steps to ensure that Tennessee's attestation software is fully ready to accept and process 2018 program year submissions from participating providers;
- Participation in quarterly calls with CMS that cover various areas of the EHR incentive program; and
- Newsletters and alerts distributed by TennCare's EHR ListServ.

Although enrollment of new providers concluded on April 30, 2017, TennCare'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, with particular emphasis on the benefits of electronic health records for patients. The focus of post-enrollment outreach efforts for 2019 is to encourage provider participants who remain eligible to continue attesting and complete the program. In support of this outreach strategy, TennCare staff made preparations during the January-March 2019 quarter to exhibit at the April 2019 provider information expos hosted by Amerigroup

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

Community Care and UnitedHealthcare in Chattanooga, Jackson, Johnson City, Knoxville, Memphis, and Nashville.

F. New Pharmacy Benefits Manager

The State contracts with a pharmacy benefits manager, or PBM, to administer its outpatient drug formulary for enrollees with a pharmacy benefit. Following a competitive bidding process in which multiple companies submitted proposals, TennCare named Optum Rx., Inc. the program's new PBM on January 9, 2019. Optum will replace Magellan Medicaid Administration, which has held the role since 2013.

Although Optum 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 and loading it with all information (enrollee data, edits specific to TennCare's outpatient formulary, clinical/quantity requirements, etc.) necessary for adjudication of claims;
- Creating a call center and website to assist patients and providers; and
- Helping the State negotiate and collect supplemental rebates from pharmaceutical manufacturers.

The State's contract with Optum lasts through December 31, 2022, and contains an option for up to four renewals, each lasting as long as one year.

G. *Wilson v. Long*

Wilson v. Long is a class action lawsuit filed against the State 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 that the State has been using since implementation of the Affordable Care Act.

In October 2018, the *Wilson* case proceeded to trial with Judge William L. Campbell, Jr. presiding. On January 23, 2019, Judge Campbell issued a decision in favor of the State, finding "no evidence of on-going systemic problems in the TennCare application process." The Court further found that the State had provided applicants with an opportunity to contest delays in determining eligibility and had codified the appeals process in permanent rules. In addition, he vacated a preliminary injunction imposed on the State in September 2014 that required provision of fair hearings on any delayed adjudications of applications for TennCare coverage. The Plaintiffs did not subsequently appeal the decision, meaning that Judge Campbell's findings are final.

H. *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 is being heard by the U.S. District Court for the Middle District of Tennessee, concerns limitations placed by the State—and approved by CMS—on private duty nursing services for individuals aged 21 and older. These benefit limits for adults are specifically allowed by federal law. The purpose of the limitations—approved by CMS in 2008—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 State's limits 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.

The Plaintiff's Motion for Preliminary Injunction was heard in November 2018, and Judge Waverly Crenshaw, Jr. subsequently ordered the parties to submit post-hearing filings and to participate in mediation. This mediation took place on January 16, 2019, but was not successful in resolving the case. The Plaintiff subsequently elected to move into a long-term care facility to determine whether it would be a suitable alternative to the private duty nursing services he had been receiving at home. He withdrew the Motion for Preliminary Injunction and moved for a six-month stay of the litigation, which was granted. By August 26, 2019, the Plaintiff must either dismiss the case or move to have the stay of litigation lifted.

I. Changes in TennCare's Executive Leadership

During the January-March 2019 quarter, several individuals assumed new roles within the Division of TennCare.

John G. (Gabe) Roberts succeeds Dr. Wendy Long as Deputy Commissioner and Director of the Division of TennCare. Gabe initially joined TennCare in April 2013 as the agency's General Counsel, and subsequently moved into the role of Deputy Director and Chief Operating Officer. During his tenure at TennCare, Gabe has been instrumental in the design and implementation of many of the agency's key initiatives, including the Tennessee Health Care Innovation Initiative, the Employment and Community First CHOICES program, and the agency's strategy to combat the opioid epidemic in Tennessee.

Brooks Daverman is now serving as TennCare's Deputy Director and Chief Operating Officer, a role whose responsibilities include oversight of managed care operations, eligibility, and strategic planning. He previously served as the Director of Strategic Planning at TennCare. Brooks's projects in that role included working on health care delivery system transformation and integrating the administrative structure of Tennessee's separate CHIP program within the overall TennCare organization.

Stephen Smith joined TennCare's Executive team on January 21, 2019, in the role of Deputy Director and Chief of Staff. Prior to joining TennCare, he had served as Chief of Staff to Tennessee governor Bill Haslam, leading key initiatives on transportation infrastructure and broadband access. Stephen previously served as Deputy Commissioner for Policy and External Affairs at the Tennessee Department of Education, where he worked on key policy, legislative and legal issues.

Jessica Hill was appointed to serve as TennCare's Director of Strategic Planning & Innovation in January 2019. She is responsible for overseeing the Episodes of Care program, the State Innovation Model (SIM) federal grant, and various other strategic health care transformation efforts for TennCare. She previously served as TennCare's Episodes Strategy Manager for two years, directly managing TennCare's Episodes of Care program. Prior to her time at TennCare, she created and implemented a culture of safety program at Children's Hospital Colorado, which reduced preventable harm to children and transformed the hospital culture. She has also served as a Regional Leader for the Institute for Healthcare Improvement Open School.

VI. Action Plans for Addressing Any Issues Identified

During the January-March 2019 quarter, there were no identified issues requiring action plans.

VII. Financial/Budget Neutrality Development Issues

TennCare continued to demonstrate budget neutrality during the January-March 2019 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 were strong throughout the 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 three percent year-to-year improvement in January, close to an eight percent improvement in February, and better than a five percent improvement in March.[15]

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

Tennessee's unemployment rate not only reached an all-time low during the January-March 2019 quarter, but also remained that low for two of the three months of the reporting period. The state rate fell from 3.3 percent in January to 3.2 percent in February and March. In addition, the Tennessee unemployment rate was more than half a percentage point lower than the national rate during the same months (4.0 percent in January, and 3.8 percent in February and March), and was also lower than the state rate during the corresponding months of 2018 (3.6 percent in January, February, and March 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
January – March 2019

Eligibility Group	January 2019	February 2019	March 2019	Sum for Quarter Ending 3/31/19
Medicaid eligibles (Type 1)				
EG1 Disabled, Type 1 State Plan eligibles	136,967	136,370	135,734	409,071
EG2 Over 65, Type 1 State Plan eligibles	294	357	379	1,030
EG3 Children, Type 1 State Plan eligibles	727,355	731,829	735,803	2,194,987
EG4 Adults, Type 1 State Plan eligibles	363,597	367,559	371,875	1,103,031
EG5 Duals, Type 1 State Plan eligibles	132,002	130,619	130,399	393,020
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	235	237	256	728

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

Eligibility Group	January 2019	February 2019	March 2019	Sum for Quarter Ending 3/31/19
EG10 H-Over 65, Type 2 Demonstration Population	41	43	44	128
EG11 H-Duals, Type 2 Demonstration Population	6,404	6,399	6,440	19,243
TOTAL	1,366,895	1,373,413	1,380,930	4,121,238

Table 13
Member Month Reporting Not Used in Budget Neutrality Calculations
January – March 2019

Eligibility Group	January 2019	February 2019	March 2019	Sum for Quarter Ending 3/31/19
EG6E Expan Adult, Type 3, Demonstration Population	27	26	25	78
EG7E Expan Child, Type 3, Demonstration Population	1,521	1,509	1,454	4,484
Med Exp Child, Title XXI Demonstration Population	7,518	7,710	8,058	23,286
EG12E Carryover, Type 3, Demonstration Population	1,267	1,234	1,198	3,699
TOTAL	10,333	10,479	10,735	31,547

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 January – March 2019
Compared to the Previous Two Quarters

	Jul – Sept 2018	Oct – Dec 2018	Jan – Mar 2019
No. of appeals received	66,796	36,662	19,692
No. of appeals resolved or withdrawn	52,479	46,264	13,636

	Jul – Sept 2018	Oct – Dec 2018	Jan – Mar 2019
No. of appeals taken to hearing	3,011	2,782	2,286
No. of hearings resolved in favor of appellant	167	103	80

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 January – March 2019
Compared to the Previous Two Quarters

	Jul – Sept 2018	Oct – Dec 2018	Jan – Mar 2019
No. of appeals received	1,690	1,563	1,522
No. of appeals resolved	1,519	1,574	1,511
• Resolved at the MCC level	434	383	361
• Resolved at the TSU level	141	187	161
• Resolved at the LSU level	944	1,004	989
No. of appeals that did not involve a valid factual dispute	234	166	230
No. of directives issued	189	227	245
No. of appeals taken to hearing	944	1,004	989
No. of appeals that were withdrawn by the enrollee at or prior to the hearing	281	343	292
Appeals that went to hearing and were decided in the State's favor	376	376	359
Appeals that went to hearing and were decided in the appellant's favor	28	40	41

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 January – March 2019
Compared to the Previous Two Quarters

	Jul – Sept 2018	Oct – Dec 2018	Jan – Mar 2019
No. of appeals received	138	106	106
No. of appeals resolved or withdrawn	36	40	33
No. of appeals set for hearing	74	63	51
No. of hearings resolved in favor of appellant	0	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 as well as reactive program interventions that are cost-effective and that are tailored to each member's specific healthcare needs. The program, which emphasizes preventative care, identifies risky behaviors that are likely to lead to disease in the future (such as poor eating habits, physical inactivity, and drug use) and assists members in discontinuing such activities. Furthermore, PH provides interventions to assist members who already have a chronic or complex health condition. These interventions include making sure that members have access to necessary healthcare services, as well as addressing the social determinants of their health.

PH program members are stratified based on risk factors to one of three levels of health risk, and are then provided services and interventions from one or more of seven programs. Information on the risk levels addressed by PH, the manner in which these risks are addressed, and the total number of members enrolled in PH at the end of the October-December 2018 quarter is provided in Table 17. Data for the period of January through March 2019 will be provided in the next Quarterly Progress Report.

Table 17
Population Health Data*, October – December 2018

Risk Level	Intervention Type	Intervention Goal(s)	Number of Unique Members at End of Quarter
Level 0: no identified risk	Wellness Program	Keep members healthy as long as possible	533,243
Level 1: low, medium, or high risk	Low Risk Maternity	Engage pregnant women in timely prenatal care and deliver a healthy, term infant without complications	8,531
	Health Risk Management	Prevent, reduce, or delay exacerbation and complications of a condition or health risk behavior	742,830
	Care Coordination	Assure that members receive the services they need to reduce the risk of an adverse health outcome	23,751
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	22,346
	High Risk Pregnancy Management	Engage pregnant women in timely prenatal care and deliver a healthy, term infant without complications	9,729
	Complex Case Management	Move members to optimal levels of health and well-being through timely coordination of quality services and self-management support	10,829
Total PH Enrollment			**1,327,508**

*** 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 January 2019, TennCare's External Quality Review Organization (EQRO), Qsource, published the results of its provider data validation survey for the October-December 2018 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

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

- 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 "provider specialty / behavioral health service code" (97.2 percent accuracy), "prenatal care services" (98.3 percent accuracy), "availability of routine care services" (96.5 percent accuracy), and "availability of urgent care services" (96.4 percent accuracy).

Because the MCOs' transition to a statewide service delivery model occurred relatively recently, progress in accuracy rates is currently being measured on a quarter-to-quarter basis. Compared with the period of July-September 2018, the MCCs—according to the report—"have maintained relatively high accuracy rates this quarter." Nonetheless, to ensure ongoing improvement in all ten categories of the survey, TennCare required each of its MCCs to submit a Corrective Action Plan no later than March 5, 2019. TennCare, in turn, had received, reviewed, and accepted all of the plans by March 20, 2019. Results for the January-March 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. 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. 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 Employment and Community First CHOICES program reflected in the evaluation design also commenced at program launch, subject to methodological limitations described in the

document. Currently, only quality of life data collection processes have not yet begun, but are expected to be initiated in 2019.

As of the end of the January-March 2019 quarter, the State and CMS were working to finalize the evaluation design.

XII. Essential Access Hospital Pool

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 55 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. The following hospitals received payments from those two funds during the January-March 2019 quarter:

Vanderbilt University Medical Center
LeBonheur Children's Hospital
Regional One Health
East Tennessee Children's Hospital
Erlanger Medical Center
University of Tennessee Medical Center
Johnson City Medical Center
Parkridge Medical Center
Methodist University Hospital
Saint Jude Children's Research Hospital
Baptist Memorial Hospital – Memphis
TriStar Centennial Medical Center
Jackson – Madison County General Hospital
TriStar Skyline Medical Center
Nashville General Hospital
Parkwest Medical Center
Tennova Healthcare – Lebanon
Saint Francis Hospital
Delta Medical Center
Saint Thomas Rutherford Hospital
Saint Thomas Midtown Hospital
Fort Sanders Regional Medical Center
Tennova Healthcare – Physicians Regional Medical Center
Holston Valley Medical Center
Maury Regional Hospital
Ridgeview Psychiatric Hospital and Center
TriStar Horizon Medical Center

Lincoln Medical Center
Pathways of Tennessee
TriStar Summit Medical Center
West Tennessee Healthcare Dyersburg Hospital
TriStar Southern Hills Medical Center
TriStar StoneCrest Medical Center
TriStar Hendersonville Medical Center
Blount Memorial Hospital
Sweetwater Hospital Association
Cookeville Regional Medical Center
LeConte Medical Center
Tennova Healthcare – Cleveland
Tennova Healthcare – Clarksville
Bristol Regional Medical Center
Sumner Regional Medical Center
Morristown – Hamblen Healthcare System
Jellico Community Hospital
Methodist Medical Center of Oak Ridge
Indian Path Community Hospital
NorthCrest Medical Center
Saint Thomas River Park Hospital
Henry County Medical Center
Baptist Memorial Hospital – Tipton
Sycamore Shoals Hospital
Franklin Woods Community Hospital
Laughlin Memorial Hospital
Hardin Medical Center
Tennova Healthcare – Newport Medical Center
Baptist Memorial Hospital – Union City
Tennova Healthcare – Harton
Tennova Healthcare – LaFollette Medical Center
Southern Tennessee Regional Health System – Winchester
Starr Regional Medical Center – Athens
Unity Medical Center
Roane Medical Center
West Tennessee Healthcare Volunteer Hospital
TrustPoint Hospital
Southern Tennessee Regional Health System – Pulaski
Williamson Medical Center
Wayne Medical Center
Southern Tennessee Regional Health System – Lawrenceburg
Livingston Regional Hospital
Tennova Healthcare – Shelbyville
Tennova Healthcare – Lakeway Regional Hospital

Saint Thomas DeKalb Hospital
Tennova Healthcare – Jefferson Memorial Hospital
Claiborne Medical Center
Saint Thomas Stones River Hospital
Crestwyn Behavioral Health
Milan General Hospital
Jamestown Regional Medical Center
Henderson County Community Hospital
Rolling Hills Hospital
Baptist Memorial Restorative Care Hospital
Siskin Hospital for Physical Rehabilitation
HealthSouth Rehabilitation Hospital – Kingsport
Quillen Rehabilitation Hospital
HealthSouth Rehabilitation Hospital – Chattanooga
HealthSouth Rehabilitation Hospital – Memphis
HealthSouth Rehabilitation Hospital – North Memphis
Kindred Hospital – Chattanooga
Regional One Health Extended Care Hospital
Spire Cane Creek Rehabilitation Hospital
Vanderbilt Stallworth 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

Universities	Hospitals
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

As detailed in Section XII above, the Critical Access Hospital pool was eliminated on July 1, 2018. Tennessee hospitals now receive supplemental payments for providing uncompensated care from the Virtual DSH Fund and the Uncompensated Care Fund for Charity Care. A list of hospitals receiving payments from those funds during the January-March 2019 quarter appears in Section XII of this report.

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

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

State Contact:

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

Date Submitted to CMS: May 30, 2019

Attachment A

Budget Neutrality Calculations for the Quarter

Actual TennCare Budget Neutrality (Jan - Mar 2019)

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)	409,799
2-Child <=18	2,194,987
3-Adult >= 65	1,158
4-Adult <= 64	1,103,031
Duals (17)	412,263
Total	**4,121,238**

Ceiling without DSH

	Baseline * MM
1-Disabled (can be any ages)	$780,751,226
2-Child <=18	$1,175,412,668
3-Adult >= 65	$1,416,966
4-Adult <= 64	$1,225,839,195
17s	$322,259,142
Total	**$3,505,679,196**

DSH

DSH Adjustment (Quarterly)	$115,999,213

Total Ceiling

Budget Neutrality Cap	
Total w/DSH Adj.	**$3,621,678,409**

II. Actual Expenditures

Group 1 and 2

1-Disabled (can be any ages)	$ 601,114,178
2-Child <=18	$ 842,402,923
3-Adult >= 65	$ 2,219,407
4-Adult <= 64	$ 671,000,611
Duals (17)	$ 477,345,471
Total	**$ 2,594,082,591**

Group 3

1-Disabled (can be any ages)	$	-
2-Child <=18	$	8,137,324
3-Adult >= 65	$	20,535,123
4-Adult <= 64	$	52,246
Duals (17)	$	-
Total	**$**	**28,724,693**

Pool Payments and Admin

Total Pool Payments	$	219,802,924
Admin		174,441,618
Quarterly Drug Rebates		(167,073,115)
Quarterly Premium Collections	$	-
Total Net Quarterly Expenditures	**$**	**2,849,978,710**

III. Surplus/(Deficit)

	$771,699,699
Federal Share	**$501,296,124**

HCI Result	MM201901	MM201902	MM201903	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)	136,967	136,370	135,734	409,071	$77,058,870	$125,672,424	$1,521,871	$382,532,916	$0	$0	8,869,133	$0	$0	$595,655,214
EG1-TYPE2 (disabled, type2 transition group)	-	-	-	0	$0	$0	$0	$0	$0	$0	-	$0	$0	$0
EG2-TYPE1 (over 65, type1 state plan eligibles)	294	357	379	1,030	$0	$95,582	$0	$1,126,781	$0	$0	18,476	$0	$0	$1,240,839
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)	727,355	731,829	735,803	2,194,987	$12,954,482	$72,495,744	$33,727,023	$710,682,540	$0	$0	12,543,134	$0	$0	$842,402,923
Med Exp Child (Title XXI Demo Pop; EG3-Type2)	7,518	7,710	8,058	23,286	$92,606	$967,489	$402,297	$5,044,063	$0	$0	98,344	$0	$0	$6,604,798
EG4-TYPE1 (adults, type1 State plan eligibles)	363,597	367,559	371,875	1,103,031	$1,166,606	$87,176,064	$2,295,701	$570,371,234	$0	$0	9,991,004	$0	$0	$671,000,611
EG4-TYPE2 (adults, type2 demonstration pop)				0	$0	$0	$0	$0	$0	$0	-	$0	$0	$0
EG5-TYPE1 (duals, state plan eligibles)	132,002	130,619	130,399	393,020	$1,438,082	$1,136,444	$38,210	$374,236,109	$0	$0	5,695,981	$0	$0	$382,544,826
EG6E-TYPE3 (Expan adult, type3 demonstration pop)	27	26	25	78	$0	$63	$0	$51,405	$0	$0	778	$0	$0	$52,246
EG7E-TYPE3 (Expan child, type3 demonstration pop)	1,521	1,509	1,454	4,484	$49,303	$364,224	$70,457	$1,025,724	$0	$0	22,819	$0	$0	$1,532,526
EG8-TYPE2 (med exp child)				0	$0	$0	$0	$0	$0	$0	-	$0	$0	$0
EG9 H-Disabled (TYPE 2 Eligibles)	235	237	256	728	$0	$397,098	$0	$4,980,584	$0	$0	81,282	$0	$0	$5,458,964
EG10 H-Senior	41	43	44	128	$0	$7,959	$0	$956,039			14,571			$978,569
EG11H, H-Dual	6,404	6,399	6,440	19,243	$2,172	$8,048	$0	$93,378,871	$0	$0	1,411,554	$0	$0	$94,800,645
EG12E, Carryovers	1,267	1,234	1,198	3,699	$0	$56,772	$0	$20,172,589	$0	$0	305,762	$0	$0	$20,535,123
Total	**1,377,228**	**1,383,892**	**1,391,665**	**4,152,785**	**$92,762,123**	**$288,377,911**	**$38,055,558**	**$2,164,558,854**	**$0**	**$0**	**$39,052,837**	**$0**	**$0**	**$2,622,807,285**

HCI Result	MM201901	MM201902	MM201903	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)	136,967	136,370	135,734	409,071	$188.38	$307.21	$3.72	$935.13	$0.00	$0.00	$21.68	$0.00	$0.00	$1,456.12
EG1-TYPE2 (disabled, type2 transition group)	0	0	0	-										
EG2-TYPE1 (over 65, type1 state plan eligibles)	294	357	379	1,030	$0.00	$92.80	$0.00	$1,093.96	$0.00	$0.00	$17.94	$0.00	$0.00	$1,204.70
EG2-TYPE2 (over 65, type2 state plan eligibles)	0	0	0	-										
EG3-TYPE1 (children, type1 state plan eligibles)	727,355	731,829	735,803	2,194,987	$5.90	$33.03	$15.37	$323.78	$0.00	$0.00	$5.71	$0.00	$0.00	$383.78
Med Exp Child (Title XXI Demo Pop; EG3-Type2)	7,518	7,710	8,058	23,286	$3.98	$41.55	$17.28	$216.61	$0.00	$0.00	$4.22	$0.00	$0.00	$283.64
EG4-TYPE1 (adults, type1 State plan eligibles)	363,597	367,559	371,875	1,103,031	$1.06	$79.03	$2.08	$517.09	$0.00	$0.00	$9.06	$0.00	$0.00	$608.32
EG4-TYPE2 (adults, type2 demonstration pop)	0	0	0	-										
EG5-TYPE1 (duals, state plan eligibles)	132,002	130,619	130,399	393,020	$3.66	$2.89	$0.10	$952.21	$0.00	$0.00	$14.49	$0.00	$0.00	$973.35
EG6E-TYPE3 (Expan adult, type3 demonstration pop)	27	26	25	78	$0.00	$0.81	$0.00	$659.03	$0.00	$0.00	$9.97	$0.00	$0.00	$669.82
EG7E-TYPE3 (Expan child, type3 demonstration pop)	1,521	1,509	1,454	4,484	$11.00	$81.23	$15.71	$228.75	$0.00	$0.00	$5.09	$0.00	$0.00	$341.78
EG8-TYPE2 (emd exp child)	0	0	0	-										
EG9 H-Disabled (TYPE 2 Eligibles)	235	237	256	728	$0.00	$545.46	$0.00	$6,841.46	$0.00	$0.00	$111.65	$0.00	$0.00	$7,498.58
EG10 H-Senior	41	43	44	128	$0.00	$62.18	$0.00	$7,469.05	$0.00	$0.00	$113.83			
EG11H, H-Dual	6,404	6,399	6,440	19,243	$0.11	$0.42	$0.00	$4,852.62	$0.00	$0.00	$73.35	$0.00	$0.00	$4,926.50
EG12E, Carryovers	1,267	1,234	1,198	3,699	$0.00	$15.35	$0.00	$5,453.52	$0.00	$0.00	$82.66	$0.00	$0.00	$5,551.53
Total	**1,377,228**	**1,383,892**	**1,391,665**	**4,152,785**	**$22.34**	**$69.44**	**$9.16**	**$521.29**	**$0.00**	**$0.00**	**$9.40**	**$0.00**	**$0.00**	**$631.64**

* Unknown allocation was performed within the Service category totals.

allocated payment in unknown in each EG Group

22.71%	8,869,133	**MEDICAL**	$	817,215
0.00%	-	**PHARMACY**	$	1,474,621
0.05%	18,476	**DENTAL**	$	266,823
0.00%	-	**CAP**	$	36,494,178
32.12%	12,543,134			
0.25%	98,344	**TOTAL**	$	**39,052,837**
25.58%	9,991,004			
0.00%	-			
14.59%	5,695,981			
0.00%	778			
0.06%	22,819			
0.00%	-			
0.21%	81,282			
0.04%	14,571			
3.61%	1,411,554			
0.78%	305,762			
$2,583,754,447	39,052,837			

payment in blank category in each subject

(Used to calculate approximate percentages for each EG group -- G18 = Q18+S18)

Enrollment changes:	Cumulative Total	AVG. Enrollment
SFY2019Q1	4,000,559	1,343,519.67
SFY2019Q2	4,152,785	1,384,261.67
% Changes in Total:	3.03%	3.03%

CAP PMPM changes:	CAP PMPM	Total CAP in QTR	Payment changes from current QTR to previous QTR
SFY2019Q1	$347.17	$ 1,427,507,264	
SFY2019Q2	$521.23	$ 2,201,053,033	$ 773,545,768
	50.14%	54.19%	