Division of TennCare

May 29, 2020

Ms. Lorraine Nawara
TennCare Project Officer
Division of Eligibility and Coverage 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 49, Quarterly Progress Report

Dear Ms. Nawara:

Enclosed please find the Quarterly Progress Report for the January – March 2020 quarter. This report is being submitted in accordance with STC 49 of the TennCare Demonstration.

Please let us know if you have comments or questions.

Sincerely,

[redacted]

Stephen Smith
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 2020)

Demonstration Year: 18 (7/1/19 - 6/30/20)
Federal Fiscal Quarter: 2/2020 (1/20 - 3/20)
Waiver Quarter: 3/2020 (1/20 - 3/20)

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 #
1/10/20	The Monthly Call originally scheduled for December 26, 2019, was held.	48
1/23/20	The Monthly Call for January was held.	48
2/13/20	The State notified the public of its intent to submit to CMS Demonstration Amendments 43 and 44. Amendment 43 would extend the State's medication therapy management pilot program for an additional 12 months. Amendment 44 outlined program reductions that would be necessary if the Tennessee General Assembly did not renew the annual hospital assessment.	15
2/28/20	The State submitted the Quarterly Progress Report for the October-December 2019 quarter to CMS.	49
3/6/20	The Monthly Call originally scheduled for February 27, 2020, was held.	48
3/19/20	The State submitted Amendment 43 to CMS. The State also notified CMS that, due to the renewal of Tennessee's hospital assessment, proposed Amendment 44 would not be submitted to CMS.	6, 7
3/24/20	The State notified CMS that in light of the COVID-19 public health emergency and consistent with the requirements of the Families First Coronavirus Response Act, it was temporarily suspending cost sharing for any	

Date	Action	STC #
	COVID-19 testing and treatment services that would otherwise be applicable under the demonstration.	
3/26/20	CMS approved Statewide MCO Contract Amendment 7 and TennCare Select Contract Amendment 42. CMS's approval was retroactive to January 1, 2018.	40
3/26/20	The Monthly Call for March was held.	48
3/31/20	CMS approved Statewide MCO Contract Amendment 8 and TennCare Select Contract Amendment 43. CMS's approval was retroactive to July 1, 2018.	40

II. Enrollment and Benefits Information

Information about enrollment by category is presented in Table 2.

Table 2
Enrollment Counts for the January – March 2020 Quarter
Compared to the Previous Two Quarters

Demonstration Populations	Total Number of TennCare Enrollees		
	Jul – Sept 2019	Oct – Dec 2019	Jan – Mar 2020
EG1 Disabled, Type 1 State Plan eligibles	135,183	131,908	131,834
EG9 H-Disabled, Type 2 Demonstration Population	595	606	629
EG2 Over 65, Type 1 State Plan eligibles	366	303	267
EG10 H-Over 65, Type 2 Demonstration Population	55	42	37
EG3 Children, Type 1 State Plan eligibles	769,461	764,508	771,745
EG4 Adults, Type 1 State Plan eligibles	404,912	403,143	406,370
EG5 Duals, Type 1 State Plan eligibles and EG11 H-Duals 65, Type 2 Demonstration Population	145,972	146,106	149,710
EG6E Expan Adult, Type 3 Demonstration Population	14	12	11
EG7E Expan Child, Type 3 Demonstration Population	1	6	11

Demonstration Populations	Total Number of TennCare Enrollees		
	Jul – Sept 2019	Oct – Dec 2019	Jan – Mar 2020
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	12,044	14,327	15,520
EG12E Carryover, Type 3, Demonstration Population	2,288	2,190	2,067
TOTAL*	1,470,891	1,463,151	1,478,201

*** 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 throughout the quarter are listed in Table 3.

Table 3
TennCare Managed Care Contractors as of March 31, 2020

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

Response to COVID-19 Crisis. On March 12, 2020, Tennessee Governor Bill Lee declared a state of emergency to help facilitate the State's response to the threat to public health and safety posed by coronavirus disease 2019 (or "COVID-19"). As the agency in Tennessee state government responsible for providing health insurance to more than 1.4 million individuals, the Division of TennCare has developed a multilayered response to the COVID-19 emergency. Working in tandem with partners and stakeholders at the federal and state levels, TennCare designed and deployed a strategy consisting of such elements as—

[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.

- Coordinating with the provider community and TennCare's health plans to ensure access to care for TennCare members in need of testing or treatment for COVID-19;
- Assisting providers in offering covered services to TennCare members via telehealth when medically appropriate;
- Increasing care coordination services for members impacted by COVID-19 who are self-isolated, so that they can receive additional supports as needed;
- Pausing nearly all terminations of eligibility for TennCare and CoverKids (the state's separate CHIP program) members during the COVID-19 emergency;
- Working with TennCare's health plans to streamline or temporarily lift authorization requirements to ensure services are delivered promptly and claims paid quickly;
- Expediting access to home-based care for former nursing facility patients being discharged from hospitals and electing to transition home;
- Enhancing access to prescription drugs by allowing early refills of prescriptions and by allowing 90-day supplies to be prescribed for most medications;
- Obtaining a Section 1135 waiver from CMS that provides flexibilities to help ensure that TennCare members receive necessary services;
- Submitting a Section 1115 waiver application seeking CMS authorization to reimburse hospitals, physicians, and medical labs for providing COVID-19 treatment to uninsured individuals; and
- Assisting providers of long-term services and supports in reducing the spread of COVID-19 among individuals who are residents of nursing facilities.

Additional resources concerning TennCare's response to the COVID-19 pandemic are available on the agency's website at https://www.tn.gov/tenncare/information-statistics/tenncare-information-about-coronavirus.html.

TennCare Connect. TennCare Connect is the name of the system used by the State to process applications and identify persons who are eligible for the TennCare and CoverKids programs. TennCare 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.

The TennCare Connect online application portal has now been in use for more than one year. During that time, approximately 225,000 accounts have been created and more than 84,000 applications have been submitted online. In addition, over 83,000 TennCare Connect mobile apps have been downloaded to use for checking benefits, making address changes, accessing notices, and submitting requested verifications. During the January-March 2020 quarter, the State also rolled out enhanced functionality in the TennCare Access portal used by some TennCare providers. This functionality includes the ability to file full applications, submit changes, and complete renewals on behalf of enrollees.

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 January-March 2020 quarter, CMS's review of Amendment 35 was 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 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 2020 quarter, CMS's review of Amendment 36 was ongoing.

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 2020 quarter, discussions between TennCare and CMS on Amendment 38 were ongoing.

Demonstration Amendment 40: "Katie Beckett" Program. On September 20, 2019, the State submitted Amendment 40 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.

As of the end of the January-March 2020 quarter, CMS's review of Amendment 40 was ongoing.

Demonstration Amendment 41: Supplemental Hospital Payments. Amendment 41 is 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 ensure that the TennCare demonstration accurately recognizes the experience of Tennessee hospitals providing uncompensated care. Amendment 41 would 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 January-March 2020 quarter, CMS's review of Amendment 41 was ongoing.

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 submitted Amendment 42 to CMS on November 20, 2019. CMS's review of Amendment 42 was ongoing as of the end of the January-March 2020 quarter.

Demonstration Amendment 43: Extension of Medication Therapy Management Program. Medication therapy management (MTM) is a clinical service provided by licensed pharmacists, the aim of which is to optimize drug therapy and improve therapeutic outcomes for patients. MTM services include medication therapy reviews, pharmacotherapy consults, monitoring efficacy and safety of medication therapy, and other clinical services.

The State's MTM benefit was implemented in July 2018 for TennCare members affected by the state's patient-centered medical home (PCMH) program and health home program (known as "Health Link") who met specified clinical risk criteria. The State proposed to operate the MTM benefit on a two-year pilot basis in order to evaluate the impact of MTM services on health outcomes, as well as the cost and quality of care for affected members.

In Amendment 43, the State proposes to extend its MTM pilot program for an additional 12 months, through the end of June 2021. The purpose of this extension is to allow additional data on the effectiveness of the MTM program to be gathered to inform future decision-making about continuing the program, discontinuing it, and/or expanding it to additional populations.

From February 13 through March 14, 2020, the State held a public notice and comment period on Amendment 43. The proposal was then submitted to CMS on March 19, 2020, and, as of the end of the January-March 2020 quarter, CMS's review was ongoing.

Demonstration Amendment 44: Program Modifications. During the January-March 2020 quarter, the State issued public notice of another amendment to be submitted to CMS. Amendment 44 outlined program changes that would have been needed if the hospital assessment were not renewed in 2020. These changes have also been proposed in previous years, but were made unnecessary each year by the General Assembly's passage or renewal of a one-year hospital assessment. Changes to the TennCare benefit package for non-exempt adults that would have been necessary if the assessment were not renewed in 2020 were—

- 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 held its public notice and comment period regarding Amendment 44 from February 13 through March 14, 2020. Shortly thereafter, the General Assembly renewed the hospital assessment, thereby eliminating any funding gap in the TennCare program. As a result, the State did not submit Amendment 44 to CMS.

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 2020 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-ninth 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") was recently 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.

Table 4 summarizes community outreach activity conducted by the CHANT program during the January-March 2020 quarter, as compared with the two preceding quarters.

Table 4
CHANT Community Outreach Activity for EPSDT
January – March 2020

Activities	Jul – Sept 2019 Quarter	Oct – Dec 2019 Quarter	Jan – Mar 2020 Quarter
Referrals to CHANT program from State agencies and other community partners	4,393	4,455	4,397

Activities	Jul – Sept 2019 Quarter	Oct – Dec 2019 Quarter	Jan – Mar 2020 Quarter
Number of individuals successfully contacted as a result of referrals	2,873	2,623	2,607
Number of individuals successfully enrolled in CHANT program as a result of referrals	2,274	1,906	2,128
Number of outreach events (community fairs, local coalition meetings, etc.)	145	246	229
Number of attendees at outreach events	17,640	16,687	8,619
Articles for newspapers, newsletters, and magazines	11	32	206
Advertisement campaigns (billboards, television, magazines, websites)	7	36	3
Radio or television advertisements and/or interviews	1	20	6
Collaborations with MCOs and other stakeholders	10	5	3
Number of calls completed on primary care/EPSDT benefits	17,974	11,433	14,863
Number of primary care/EPSDT appointments scheduled	369	260	225
Number of calls completed on CHANT services/outreach to families with newborns	2,510	2,134	1,926
Number of CHANT screenings and assessments completed	2,084	1,965	1,778
Number of calls completed on dental benefits	2,372	786	429
Number of dental appointments scheduled	52	5	5

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 2020 Quarter, and Percentage that Passed Systems Edits, Compared to the Previous Two Quarters

	Jul – Sept 2019	Oct – Dec 2019	Jan – Mar 2020
No. of encounters received by TennCare (initial submission)	14,811,721	15,553,010	17,933,276
No. of encounters rejected by Edifecs upon initial submission	29,020	24,664	66,211[4]
Percentage of encounters that were compliant with State standards (including HIPAA) upon initial submission	99.80%	99.84%	99.63%

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.

[4] The number of encounters rejected upon initial submission increased during the January-March 2020, in part because of issues associated with the transition to a new Pharmacy Benefits Administrator.

Table 6
CHOICES Enrollment and Reserve Slots
for January-March 2020 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 2019	Oct – Dec 2019	Jan – Mar 2020
CHOICES 1	Not applicable	16,527	16,495	16,439
CHOICES 2	11,000	9,964	9,838	9,806
CHOICES 3 (including Interim CHOICES 3)	To be determined	2,508	2,427	2,342
Total CHOICES	Not applicable	28,999	28,760	28,587
Reserve capacity	300	300	300	300

The CMS letter approving CHOICES implementation in Middle Tennessee dated February 26, 2010, and STC 47 require specific monitoring and reporting activities that include:

Data and trends of the designated CHOICES data elements: STC 47.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.

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.

[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.

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[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.

Table 8
CHOICES Transition Allowances
for January-March 2020 Compared to the Previous Two Quarters

	Frequency and Use of Transition Allowances					
	Jul – Sept 2019		Oct – Dec 2019		Jan – Mar 2020	
Grand Region	# Distributed	Total Amount	# Distributed	Total Amount	# Distributed	Total Amount
East	12	$10,103	11	$7,597	22	$16,285
Middle	21	$13,602	22	$13,854	24	$16,212

[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).

Grand Region	Frequency and Use of Transition Allowances					
	Jul – Sept 2019		Oct – Dec 2019		Jan – Mar 2020	
	# Distributed	Total Amount	# Distributed	Total Amount	# Distributed	Total Amount
West	18	$13,138	20	$12,740	10	$9,113
Statewide Total	51	$36,843	53	$34,191	56	$41,610

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 January – March 2020 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[8]		
		Jul – Sept 2019	Oct – Dec 2019	Jan – Mar 2020
ECF CHOICES 4	903	844	848	867
ECF CHOICES 5	1,598	1,418	1,443	1,478
ECF CHOICES 6	799	680	751	797
ECF CHOICES 7	50	0	2	11
ECF CHOICES 8	50	2	9	11

[7] 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. During the January-March 2020 quarter, three program slots were reallocated (two from Group 4 to Group 5, and one from Group 4 to Group 6) 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.

[8] 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.

	Statewide Enrollment Targets and Reserve Capacity[7]	Enrollment and Reserve Slots Filled as of the End of Each Quarter[8]		
		Jul – Sept 2019	Oct – Dec 2019	Jan – Mar 2020
Total ECF CHOICES	3,400	2,944	3,053	3,164
Reserve capacity	1,050	673	740	824
Waiver Transitions[9]	Not applicable	40	41	44

Data and trends of the designated ECF CHOICES data elements: STC 47.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:

- 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

[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 enrollment target. Waiver transition numbers are cumulative since the program began.

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 2020 quarter, the MCOs submitted their 2019 NAIC Annual Financial Statements. As of December 31, 2019, TennCare MCOs reported net worth as indicated in the table below.[10]

Table 10
Net Worth Reported by MCOs as of December 31, 2019

	Net Worth Requirement	Reported Net Worth	Excess/ (Deficiency)
Amerigroup Tennessee	$33,562,799	$231,587,192	$198,024,393

[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.

	Net Worth Requirement	Reported Net Worth	Excess/ (Deficiency)
UnitedHealthcare Plan of the River Valley (UnitedHealthcare Community Plan)	$77,500,193	$615,878,537	$538,378,344
Volunteer State Health Plan (BlueCare & TennCare Select)	$56,256,150	$489,759,698	$433,503,548

During the January-March 2020 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, 2019.

D. Transition to New TennCare Director

On January 17, 2020, Gabe Roberts announced his decision to step down from the role of TennCare Director. Mr. Roberts continued in that role until March 2, 2020, at which point Tennessee Governor Bill Lee announced that Stephen Smith would succeed Mr. Roberts as TennCare Director.

Mr. Smith had served as TennCare's Deputy Director and Chief of Staff for the preceding year, in which capacity he was instrumental in providing leadership for a number of key TennCare initiatives. Prior to joining TennCare, he had served as Chief of Staff to Governor Bill Haslam, leading initiatives on transportation infrastructure and broadband access. Mr. Smith 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. Mr. Smith is a licensed attorney and formerly worked in private law practice as well as the nonprofit sector, representing clients in both a legal and consulting capacity. He is a graduate of the University of Tennessee, Knoxville, and the Nashville School of Law.

E. New Pharmacy Benefits Manager (PBM)

On January 1, 2020, following months of intensive preparation, the State successfully transitioned all pharmacy services (e.g., claims processing, formulary utilization, rebates, call center operations, clinical support services) to its new PBM, OptumRx. By the conclusion of the January-March 2020 quarter, the new pharmacy claims processing system had been fully

stabilized, and the PBM was able to help the State respond to Tennessee's March tornadoes and the COVID-19 crisis. In addition to ensuring that TennCare members maintained access to vitally important drug therapy, OptumRx made it easier for members to comply with stay-at-home requirements through such measures as—

- Processing certain maintenance medications (other than opioids and other controlled medications) for up to a 90-day supply;
- Automatically extending prior authorizations that are due to expire on or before June 15, 2020, for medications on TennCare's automatic exemption list and prescriber attestation list; and
- Covering mail or delivery options offered by local pharmacies.

Preliminary reports indicate that this period of transition and stabilization was successful. The State monitored the rollout carefully and determined that access to outpatient drug therapy was maintained and that patients continued to receive necessary and appropriate care.

F. Update on Episodes of Care

The State's episodes of care program aims 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 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.

As of January 1, 2020, all 48 of the state's episodes of care are in a performance period. This milestone means that all 48 episodes that were planned for release have accountable providers who are receiving quarterly cost and quality performance reports with financial accountability. The State will continue to collaborate with relevant stakeholders to improve upon the program's design.

G. 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[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

[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).

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.

EHR payments made by the State during the January-March 2020 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 (Jan-Mar 2020)	Cumulative Amount Paid To Date[13]
First-year payments	N/A	N/A	$180,155,394
Second-year payments	1	$8,500	$59,837,155
Third-year payments	12	$102,000	$37,636,852
Fourth-year payments	16	$133,167	$8,542,515
Fifth-year payments	17	$144,500	$5,519,338
Sixth-year payments	28	$229,501	$3,229,424

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

- Reminding eligible professionals who previously received five payments of the Program Year 2019 submission period and the need to attest for a sixth and final payment;
- Working with the State's attestation software vendor to assure that the Program Year 2019 submission process runs smoothly for all participating providers;
- Extending the Program Year 2019 attestation deadline to June 30, 2020, to accommodate providers affected by the March 2020 tornadoes or the coronavirus crisis;
- Providing daily technical assistance to providers via email and telephone calls;
- 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

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

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

encourage provider participants who remain eligible to continue attesting and complete the program.

H. *A.M.C, et al., v. Smith* Lawsuit

On March 19, 2020, the Tennessee Justice Center filed a federal lawsuit on behalf of a proposed class of plaintiffs against the Division of TennCare. The lawsuit alleges statutory and constitutional deficiencies with TennCare's redetermination process and the Tennessee Eligibility Determination System. Another allegation within the suit is that TennCare is violating the Americans with Disabilities Act by not providing reasonable accommodations, thereby preventing disabled individuals from participating in the TennCare program. The State intends to timely seek dismissal of this lawsuit.

Plaintiffs have two pending motions before the court: one for class certification and one for preliminary injunction, both of which TennCare opposes. Final briefing for these motions is due in early June, with a ruling expected thereafter.

VI. Action Plans for Addressing Any Issues Identified

During the January-March 2020 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 2020 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 January-March 2020 quarter (before the economic impact of COVID-19 began to be felt). Total state and local collections were higher in all three months of the quarter than during the corresponding months of 2019, with more than an eleven percent year-to-year improvement in January, better than a seven percent improvement in February, and approximately a six percent improvement in March.[14]

Tennessee's unemployment rate—while remaining low during the quarter—ticked up each month as the effects of the national emergency began to be felt. The rate rose from 3.3 percent in January to 3.4 percent in February and then to 3.5 percent in March. The state rate was lower than the national rate during the same months (3.6 percent in January, 3.5 percent in February,

[14] 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.

and 4.4 percent in March), and was nearly identical to the state rate from the corresponding quarters of 2019.[15]

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 2020

Eligibility Group	January 2020	February 2020	March 2020	Sum for Quarter Ending 3/31/20
Medicaid eligibles (Type 1)				
EG1 Disabled, Type 1 State Plan eligibles	132,468	131,437	130,194	394,099
EG2 Over 65, Type 1 State Plan eligibles	229	232	241	702
EG3 Children, Type 1 State Plan eligibles	760,247	758,078	753,951	2,272,276
EG4 Adults, Type 1 State Plan eligibles	392,404	389,826	384,393	1,166,623
EG5 Duals, Type 1 State Plan eligibles	139,933	140,319	139,942	420,194
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	582	602	618	1,802
EG10 H-Over 65, Type 2 Demonstration Population	36	34	37	107
EG11 H-Duals, Type 2 Demonstration Population	5,478	5,546	5,648	16,672
TOTAL	1,431,377	1,426,074	1,415,024	4,272,475

[15] 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 and on the U.S. Bureau of Labor Statistics' website at https://www.bls.gov/eag/eag.tn.htm.

Table 13
Member Month Reporting Not Used in Budget Neutrality Calculations
January – March 2020

Eligibility Group	January 2020	February 2020	March 2020	Sum for Quarter Ending 3/31/20
EG6E Expan Adult, Type 3, Demonstration Population	12	12	11	35
EG7E Expan Child, Type 3, Demonstration Population	4	7	11	22
Med Exp Child, Title XXI Demonstration Population	14,279	14,435	14,916	43,630
EG12E Carryover, Type 3, Demonstration Population	2,092	2,048	2,013	6,153
TOTAL	16,387	16,502	16,951	49,840

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 2020
Compared to the Previous Two Quarters

	Jul – Sept 2019	Oct – Dec 2019	Jan – Mar 2020
No. of appeals received	48,747	41,245	33,938
No. of appeals resolved or withdrawn	26,443	32,805	41,052
No. of appeals taken to hearing	3,832	3,815	3,891
No. of hearings resolved in favor of appellant	583	886	620

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 2020
Compared to the Previous Two Quarters

	Jul – Sept 2019	Oct – Dec 2019	Jan – Mar 2020
No. of appeals received	1,441	1,315	1,127
No. of appeals resolved	1,568	1,335	1,264
• Resolved at the MCC level	370	295	346
• Resolved at the TSU level	203	189	122
• Resolved at the LSU level	995	851	796
No. of appeals that did not involve a valid factual dispute	193	206	124
No. of directives issued	245	254	188
No. of appeals taken to hearing	995	851	796
No. of appeals that were withdrawn by the enrollee at or prior to the hearing	331	237	266
Appeals that went to hearing and were decided in the State's favor	345	290	262
Appeals that went to hearing and were decided in the appellant's favor	30	42	32

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 2020
Compared to the Previous Two Quarters

	Jul – Sept 2019	Oct – Dec 2019	Jan – Mar 2020
No. of appeals received	138	129	111
No. of appeals resolved or withdrawn	64	65	52
No. of appeals set for hearing	67	72	51
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 October-December 2019 quarter is provided in Table 17. Data for the period of January through March 2020 will be provided in the next Quarterly Progress Report.

Table 17
Population Health Data*, October – December 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	516,961

Risk Level	Intervention Type	Intervention Goal(s)	Number of Unique Members at End of Quarter
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	13,720
	Health Risk Management	Prevent, reduce, or delay exacerbation and complications of a condition or health risk behavior	781,296
	Care Coordination	Assure that members receive the services they need to reduce the risk of an adverse health outcome	21,984
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	46,477
	High Risk Pregnancy Management	Engage pregnant women in timely prenatal care and deliver a healthy, term infant without complications	10,451
	Complex Case Management	Move members to optimal levels of health and well-being through timely coordination of quality services and self-management support	18,126
Total PH Enrollment			**1,387,031**

*** 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 2020, TennCare's External Quality Review Organization (EQRO), Qsource, published the results of its provider data validation survey for the October-December 2019 quarter. Qsource took a sample of provider data files from TennCare's MCCs[16] 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)

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

- 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 "services to patients under age 21" (96.2 percent accuracy), "primary care services" (96.3 percent accuracy), and "prenatal care services" (99.0 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 2019, the MCCs—according to the report—"maintained high accuracy rates for 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, 2020. TennCare, in turn, had received, reviewed, and accepted all of the plans by March 11, 2020. Results for the January-March 2020 quarter will be discussed in the next Quarterly Progress Report.

XI. Demonstration Evaluation

CMS approval of the State's evaluation design for the TennCare Demonstration was received on April 2, 2019. As previously reported, the State is leveraging its contract with its independent External Quality Review Organization, Qsource, to conduct the evaluation.

The five objectives related to the CHOICES program as described in the State's approved evaluation design are as follows:

1. Expand access to HCBS for older adults and adults with physical disabilities.
2. Rebalance TennCare spending on long-term services and supports to increase the proportion that goes to HCBS.
3. Provide cost-effective care in the community for persons who would otherwise require nursing facility care.
4. Provide HCBS that will enable persons who would otherwise be required to enter nursing facilities to be diverted to the community.
5. Provide HCBS that will enable persons receiving services in nursing facilities to be able to transition back to the community.

Data collection processes for the CHOICES program have been ongoing since the program's inception. CHOICES data was provided to Qsource on July 7, 2019. Qsource submitted a

preliminary draft report sample on certain elements of this data to the State in October 2019, followed by an updated draft in April 2020. The State is currently reviewing this updated draft.

The five objectives related to the Employment and Community First CHOICES program as described in the State's draft evaluation design are as follows:

1. Expand access to HCBS for individuals with intellectual and developmental disabilities.
2. Provide more cost-effective services and supports in the community for persons with intellectual and developmental disabilities.
3. Continue balancing TennCare spending on long-term services and supports for individuals with intellectual and developmental disabilities to increase the proportion spent on HCBS.
4. Increase the number and percentage of persons with intellectual and developmental disabilities enrolled in HCBS programs who are employed in an integrated setting earning at or above the minimum wage.
5. Improve the quality of life of individuals with intellectual and developmental disabilities enrolled in HCBS programs.

Data collection processes for the Employment and Community First CHOICES program also commenced at program launch, subject to methodological limitations described in the evaluation design document. The State sent the Employment and Community First CHOICES 2016 and 2017 baseline data (the initial baseline and first performance period) to Qsource for the first four data elements. Data for 2018 will be sent upon resolution of the data issue described below.

There are concerns with the data collection methodology for Objective 4.1: *Increase the number and percentage of working age adults with I/DD enrolled in HCBS programs who are employed in an integrated setting earning at or above the minimum wage during each demonstration year compared to the baseline year.* To date, the State has submitted data collected from the *Individual Employment Data Survey*,[17] which is conducted annually for each person receiving HCBS as part of the annual person-centered plan review process. However, because person-centered planning processes occur over the course of the year, nearly a full year can elapse before the annual ECF CHOICES Data reporting period. This means that the data fails to account for persons who have secured competitive integrated employment since that time. Significant discrepancies in results for this objective had been identified based on the reporting lag. This issue has now been resolved, as changes to the 2020 Individual Employment Data Survey were implemented to ensure its completion annually *and* within a specified period, whenever changes to integrated employment status occur.

Additional efforts have been made to validate 2018 and 2019 data from the Individual Employment Data Survey against alternative data sources, including longstanding employment reports collected from MCOs, and, for persons enrolled in Section 1915(c) HCBS waivers, employment data collected by the Department of Intellectual and Developmental Disabilities

[17] This document is available on TennCare's website at https://www.tn.gov/content/dam/tn/tenncare/documents/IndividualEmploymentDataSurvey.pdf.

(the contracted Operating Agency). Once this process is complete, applicable metrics for both 2018 and 2019 data will be submitted to CMS and to Qsource.

Processes have been established for collection of the quality of life measurement data for ECF CHOICES using the National Core Indicators™ (NCI), the same tool used for some time to gather annual quality of life measurement data for persons enrolled in the State's Section 1915(c) HCBS waivers. The State has successfully collaborated with the Department of Intellectual and Developmental Disabilities (DIDD) to leverage their existing agreement with the National Association of State Directors of Developmental Disabilities Services (NASDDDS) and the Human Services Research Institute (HSRI). In addition, the State successfully finalized a contract with The Arc of Tennessee in December 2019. This contract engaged self-advocates, direct support professionals, and disability field professionals in conducting the face-to-face NCI assessments. The NCI in-person survey was completed in March 2020. This year's survey cycle will establish the baseline and set the stage for measurement of improvement going forward. Data to establish the baseline measure will be available in fall 2020; the first year of improvement data will not be available until fall 2021.

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 60 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 January-March 2020 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
Baptist Memorial Hospital – Carroll County
Claiborne Medical Center
Unity Medical Center
Decatur County General Hospital
Saint Thomas DeKalb Hospital
Milan General Hospital
Henderson County Community Hospital

Lincoln Medical Center
Livingston Regional Hospital
TrustPoint Hospital
Big South Fork Medical Center
Unicoi County 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
Morristown – Hamblen Healthcare System
Hardin Medical Center
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
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
Greeneville Community Hospital
Parkridge Medical Center
Fort Sanders Regional Medical Center
Parkwest Medical Center

Tennova Healthcare – North Knoxville Medical Center
Jackson – Madison County General Hospital
Maury Regional Medical Center
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
Saint Francis Hospital – Bartlett
Bristol Regional Medical Center
Holston Valley Medical Center
Sumner Regional Medical Center
TriStar Hendersonville Medical Center
Williamson Medical Center
Vanderbilt Wilson County Hospital

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
Creekside Behavioral Health

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
Encompass Health Rehabilitation Hospital of Chattanooga
Saint Jude Children's Research Hospital
Encompass Health Rehabilitation Hospital of Memphis

Baptist Memorial Restorative Care Hospital
Select Specialty Hospital – Memphis
Encompass Health Rehabilitation Hospital of North Memphis
Regional One Health Extended Care Hospital
Encompass Health Rehabilitation Hospital of Kingsport
Select Specialty Hospital – TriCities
Quillen Rehabilitation Hospital
West Tennessee Healthcare Rehabilitation Hospital Cane Creek
Encompass Health Rehabilitation Hospital of 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 hospitals and their affiliated teaching 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:

Ascension Saint Thomas Hickman
Big South Fork Medical Center
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
Three Rivers Hospital
TriStar Ashland City Medical Center
Trousdale Medical Center

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