STATE OF TENNESSEE
DEPARTMENT OF FINANCE AND ADMINISTRATION
DIVISION OF HEALTH CARE FINANCE AND ADMINISTRATION
BUREAU OF TENNCARE
310 Great Circle Road
NASHVILLE, TENNESSEE 37243

February 27, 2015

Ms. Megan Lepore
TennCare Project Officer
Division of State Demonstrations & Waivers
Center for Medicaid and CHIP Services
Mail Stop S2-01-16
7500 Security Boulevard
Baltimore, Maryland 21244-1850

RE: TennCare II, STC 45, Quarterly Progress Report

Dear Ms. Lepore:

Enclosed please find the Quarterly Progress Report for the October – December 2014 quarter. This report is being submitted in accordance with STC 45.

Please let us know if you have comments or questions.

Sincerely,

[redacted]

Darin J. Gordon
Director, Bureau of TennCare

cc: Andrea Casart, Technical Director, Baltimore Office
Jackie Glaze, Associate Regional Administrator, Atlanta Regional Office
Kenni Howard, Tennessee Coordinator, Atlanta Regional Office
Shantrina D. Roberts, Medicaid and CHIP Policy Branch Manager, Atlanta Regional Office

TennCare II

Section 1115 Quarterly Report

(For the period October - December 2014)

Demonstration Year: 13 (7/1/14 - 6/30/15)
Federal Fiscal Quarter: 1/2015 (10/14 - 12/14)
Waiver Quarter: 2/2015 (10/14 - 12/14)

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.

TennCare contracts with several Managed Care Contractors (MCCs) to provide services to about 1.3 million enrollees. During this quarter, these entities included Managed Care Organizations (MCOs) for medical, behavioral, 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 are as follows, together with the corresponding Special Terms and Conditions (STCs), if applicable.

Table 1
Key Dates of Approval/Operation in the Quarter

Date	Action	STC #
Throughout the quarter	CMS and the State held conference calls on at least a weekly basis and sometimes twice weekly to discuss a potential waiver amendment called "Insure Tennessee." Insure Tennessee was intended to be an alternative proposal for delivering services to persons who would qualify in the "VIII Group," should that group be adopted for inclusion in the Medicaid State Plan in Tennessee. See Section II of this report.	
10/3/14	With regard to Demonstration Amendment 23 (adding expenditure authority for the provision of non-ambulatory services to pregnant women during periods of presumptive eligibility), the State sent CMS a letter accepting the Waiver List, Expenditure Authorities, and STCs that had accompanied CMS's approval of Amendment 23.	
10/22/14	The CMS Project Officer cancelled the Monthly Call scheduled for 10/23/14.	44
10/31/14	The State submitted the Draft Annual Report for Demonstration Year 12 to CMS	46
11/13/14	The State submitted the annual update of its Quality Improvement Strategy (QIS) to CMS.	43.c.
11/26/14	The State submitted the Quarterly Progress Report for the July-September 2014 quarter to CMS.	45

Date	Action	STC #
11/27/14	The CMS Project Officer cancelled the Monthly Call.	44
12/4/14	The State requested clarification from the CMS Project Officer on due dates for two evaluations: the evaluation of eligibility and enrollment systems required by STC 68 and the evaluation of uncompensated care costs for the uninsured required by STC 69.	
12/17/14	The State held a public forum to accept comments on the progress of the TennCare Demonstration.	10
12/18/14	A conference call between the State and CMS was held. The purpose of the call was to discuss a concept paper the State had submitted in June 2014 regarding the renewal and redesign of TennCare's LTSS delivery system for individuals with intellectual and developmental disabilities.	
12/25/14	The CMS Project Officer cancelled the Monthly Call.	44
12/26/14	The State followed up on its 12/4/14 request for clarification of the due dates associated with STC 68 and STC 69.	
12/30/14	The CMS Project Officer confirmed that the due date for the evaluation required by STC 68 is 12/31/15 and that the due date for the evaluation required by STC 69 is 10/31/16.	

II. Enrollment and Benefits Information

Information about enrollment by category is presented in Table 2.

Table 2
Enrollment Counts for the October – December 2014 Quarter
Compared to the Previous Two Quarters

Demonstration Populations	Total Number of TennCare Enrollees		
	Apr – Jun 2014	Jul – Sept 2014	Oct – Dec 2014
EG1 Disabled, Type 1 State Plan eligibles	134,896	135,500	136,442
EG9 H-Disabled, Type 2 Demonstration Population	291	324	341
EG2 Over 65, Type 1 State Plan eligibles	24	26	46
EG10 H-Over 65, Type 2 Demonstration Population	0	0	0
EG3 Children, Type 1 State Plan eligibles	667,448	681,230	700,096
EG4 Adults, Type 1 State Plan eligibles	316,441	332,388	353,854

Demonstration Populations	Total Number of TennCare Enrollees		
	Apr – Jun 2014	Jul – Sept 2014	Oct – Dec 2014
EG5 Duals, Type 1 State Plan eligibles and EG11 H-Duals 65, Type 2 Demonstration Population	130,810	132,440	136,188
EG6E Expan Adult, Type 3 Demonstration Population	1,134	1,193	1,257
EG7E Expan Child, Type 3 Demonstration Population	64	63	65
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	19,523	19,499	19,359
EG12E Carryover, Type 3, Demonstration Population	6,960	6,783	5,367[1]
TOTAL*	1,277,591	1,309,446	1,353,015

*** 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 seventy-eight percent of TennCare enrollees appearing in one of these categories.

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

Table 3
TennCare Managed Care Contractors as of December 31, 2014

	West Tennessee	Middle Tennessee	East Tennessee
Managed Care Organizations	BlueCare[2] UnitedHealthcare Community Plan[3]	Amerigroup UnitedHealthcare Community Plan	BlueCare UnitedHealthcare Community Plan

[1] The decline in EG12E enrollment in the October-December 2014 reporting period resulted from a lag in the entry of data during the July-September 2014 quarter. This data pertained to certain CHOICES members no longer in the Carryover Group because of an increase in acuity (such that the current Nursing Facility Level of Care criteria are met), as well as persons attaining SSI eligibility, and persons disenrolled from CHOICES and/or TennCare.

[2] 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.

[3] UnitedHealthcare Community Plan, formerly known as "AmeriChoice," is operated by UnitedHealthcare Plan of the River Valley, Inc.

	West Tennessee	Middle Tennessee	East Tennessee
	TennCare Select[4]	TennCare Select	TennCare Select
Pharmacy Benefits Manager	Magellan Health Services		
Dental Benefits Manager	DentaQuest		

Insure Tennessee. On December 15, 2014, Tennessee Governor Bill Haslam announced the Insure Tennessee plan, a two-year pilot program to provide health care coverage to Tennesseans who currently lack access to health insurance or who have limited options in that regard. The program rewards healthy behaviors, prepares members to transition to private coverage, promotes personal responsibility, and incentivizes choosing preventative and routine care instead of unnecessary use of emergency rooms.

Five key elements of the proposal are:

- A fiscally sound and sustainable program that will not create any new taxes for Tennesseans and will not add any State cost to the budget;
- The provision of two new private market choices for Tennesseans;
- Shifting the delivery model and payment of health care in Tennessee from fee-for-service to outcomes-based;
- Incentivizing Tennesseans to be more engaged and to take more personal responsibility in their health; and
- Preparing participants for eventual transition to commercial health coverage.

The Insure Tennessee plan stems from Governor Haslam's announcement in March 2013 that he would not expand the traditional Medicaid program but that he would work with the federal government on a plan for Tennessee that would take into consideration program cost, patient engagement, payment reform, and health outcomes.

Cost Sharing Compliance Plan. In its April 18, 2012, letter approving the Bureau of TennCare's cost sharing compliance plan for the TennCare Standard population, CMS stipulated that "each Quarterly Report . . . must include a report on whether any families have contacted the State to document having reached their aggregate cap, and how these situations were resolved." During the October-December 2014 quarter, the Bureau 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 eighth consecutive quarter since the plan was implemented in which no notifications have been received.

[4] TennCare Select is operated by Volunteer State Health Plan, Inc. (VSHP).

III. Innovative Activities to Assure Access

Early and Periodic Screening, Diagnosis and Treatment (EPSDT). EPSDT, or "TENNderCare," outreach is a significant area of interest for TennCare. The TennCare Bureau maintains a contract with the Tennessee Department of Health (TDH) to conduct a community outreach program for the purpose of educating families on EPSDT benefits and encouraging them to use those benefits, particularly preventive exams.

Table 4 summarizes the community outreach activity during this quarter and the previous two quarters. Quarterly variations in the categories presented here are usually the result of the following factors:

- Seasonal events. National Children's Dental Health Month in February, back-to-school events in August, and Child Health Week in October all have a profound influence on the focus and direction of outreach efforts during their respective quarters. TDH's communications strategy for each is based on an evaluation of past successes and current opportunities. During the 2013 round of Dental Health Month, for instance, TDH employed scrolling billboards prominently, whereas the strategy for Child Health Week eight months later placed greater emphasis on radio and television broadcasts and magazine articles.
- Collaborative partners. A variety of TDH's activities are dependent on the opportunities offered by other State agencies and by entities within the community. For example, publication of articles in newsletters and magazines is usually possible only when local media outlets offer space in their periodicals at no charge. Similarly, TDH's ability to educate the public through television and radio broadcasts is tied to the availability of open timeslots in those platforms. Even certain types of telephone outreach require input from other sources: calls to families to reinforce the importance of dental checkups (detailed in Table 4), for instance, are possible only because of referrals from the School-Based Dental Prevention Program (SBDPP).

Table 4
Tennessee Department of Health
Community Outreach Activity for EPSDT
October – December 2014 Compared to the Previous Two Quarters

Activities	Apr – Jun 2014	Jul – Sept 2014	Oct – Dec 2014
Number of outreach activities/events	2,789	2,903	2,956
Number of people made contact with (mostly face to face at outreach events)	135,734	159,165	175,176
Number of educational materials distributed	159,052	170,958	186,230
Number of coalitions/advisory board meetings attended or conducted	46	71	58

Activities	Apr – Jun 2014	Jul – Sept 2014	Oct – Dec 2014
Number of attendees at coalitions/advisory board meetings	675	974	1,034
Number of educational preventive health radio/TV broadcasts	19,658	3,250	1,748
Number of educational preventive health newsletter/magazine articles	143	192	263
Number of educational preventive health billboards, scrolling billboards and bulletin boards	7,002	7,769	6,612
Number of presentations made to enrollees/professional staff who work with enrollees	116	122	135
Number of individuals attending presentations	3,736	8,799	7,221
Number of attempted telephone calls regarding the importance of dental checkups	408	71	561
Number (approx) of completed telephone calls regarding the importance of dental checkups	199	32	285
Number of attempted home visits (educational materials left with these families)	17,534	16,407	12,746
Number of home visits completed	7,609	6,511	4,181

The TennCare Bureau also contracts with TDH for a TENNderCare Call Center that employs operators to call all newly enrolled and newly re-certified members with children to inform them about TENNderCare and to offer assistance with appointment scheduling and transportation. Data from the Call Center is summarized in Table 5.

Table 5
Tennessee Department of Health
TENNderCare Call Center Activity
October – December 2014 Compared to the Previous Two Quarters

Activities	Apr – Jun 2014	Jul – Sept 2014	Oct – Dec 2014
Number of families reached[5]	26,791	28,410	22,322
Number of families who were assisted in scheduling an EPSDT exam for their children	907	137	284
Number of families who were assisted in arranging for transportation	15	8	13

[5] Totals in this category for the July-September and October-December quarters include families reached through a TDH special project that focuses on educating enrollees about the importance of back-to-school immunizations and/or well-child examinations (as age-appropriate).

IV. Collection and Verification of Encounter and Enrollment Data

Edifecs is the software system being used by Information Systems staff to review encounter data sent from the MCOs and to identify encounters that are non-compliant so that they can be returned to the MCOs for correction. Edifecs enables the State to reject only the problem encounters, rather than rejecting and requiring resubmission of whole batches of encounter data because of a problem found. Table 6 illustrates the progress that has been made in reducing the number of claims that are returned to the MCOs due to data errors.

Table 6
Number of Initial Encounters Received by TennCare During the October – December 2014 Quarter, and Percentage that Passed Systems Edits, Compared to the Previous Two Quarters

	Apr – Jun 2014	Jul – Sept 2014	Oct – Dec 2014
No. of encounters received by TennCare (initial submission)	12,854,531	13,358,785	15,660,193
No. of encounters rejected by Edifecs upon initial submission	25,686	46,570	40,445
Percentage of encounters that were compliant with State standards (including HIPAA) upon initial submission	99.80%	99.65%	99.74%

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

A. CHOICES

As required by STC 32.d., the State offers the following table delineating CHOICES enrollment as of the end of the quarter, as well as information about the number of available reserve slots.

Table 7
TennCare CHOICES Enrollment and Reserve Slots
for October – December 2014 Compared to the Previous Two Quarters

	Statewide Enrollment Targets and Reserve Capacity[6]	Enrollment and Reserve Slots Being Held as of the End of Each Quarter		
		Apr – Jun 2014	Jul – Sept 2014	Oct – Dec 2014
CHOICES 1	Not applicable	18,018	17,943	17,944
CHOICES 2	12,500	8,729	8,600	8,508

[6] Of the three active CHOICES groups, only CHOICES 2 has an enrollment target.

	Statewide Enrollment Targets and Reserve Capacity[6]	Enrollment and Reserve Slots Being Held as of the End of Each Quarter		
		Apr – Jun 2014	Jul – Sept 2014	Oct – Dec 2014
Interim CHOICES 3	Not applicable	4,321	4,688	4,901
Total CHOICES	Not applicable	31,068	31,231	31,353
Reserve capacity	300	300	300	300

The CMS letter approving CHOICES implementation in Middle Tennessee dated February 26, 2010, and STCs 43 and 45 require specific monitoring and reporting activities that include:

Data and trends of the designated CHOICES data elements: STC 43.d. requires the State to submit to CMS periodic statistical reports about the use of LTSS by TennCare enrollees. Seven separate reports—spanning the period of August 2011 through August 2014—had been submitted by the conclusion of the October-December 2014 quarter.

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 NF services over time, with placement in institutional settings decreasing from 21,530 individuals on June 30, 2011, to 18,018 individuals on June 30, 2014. The aggregate number of TennCare enrollees accessing HCBS, by comparison, grew from 6,226 in the twelve-month period preceding CHOICES implementation in Middle Tennessee to 15,311 after CHOICES had been in place for three 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 13,050 by June 30, 2014. This information is summarized in Table 8.

Table 8
Changes in Use of HCBS by Persons Who Are Elderly or Disabled (E/D) Before and After CHOICES Implementation

Annual Aggregate Data			Point-in-Time Data		
No. of TennCare enrollees accessing HCBS (E/D), 3/1/09 – 2/28/10	No. of TennCare enrollees accessing HCBS (E/D), 7/1/12 – 6/30/13	Percent increase over a four-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 6/30/14	Percent increase from the day prior to CHOICES implementa-tion to 6/30/14
6,226	15,311	146%	4,861[7]	13,050	168%

Enrollment of select members of the CHOICES population in Groups 1 and 2: STC 45.f. requires the State to provide "enrollment reports for individuals that would otherwise be eligible for *Interim* CHOICES 3 but meet the modified institutional level of care, and whether CHOICES 1 or CHOICES 2 was selected by the individual." The population of LTSS recipients described in this passage, then, consists of individuals who have been approved for Nursing Facility Level of Care in CHOICES 1 (NF) or CHOICES 2 (HCBS) despite having been assigned a score of less than 9 on the TennCare Nursing Facility Level of Care Acuity Scale. Each approval is based on a determination by TennCare that the applicant does not qualify for enrollment in Interim CHOICES 3. Such a determination would be made when the necessary intervention and supervision needed by the applicant could not be safely provided within the array of services and supports that would be available if the applicant were enrolled in Interim CHOICES 3, including—

- CHOICES HCBS up to the Expenditure Cap of $15,000;
- Non-CHOICES HCBS available through TennCare (e.g., home health);
- Services available through Medicare;
- Services available through private insurance or other funding sources; and
- Unpaid supports provided by family members and other caregivers.

During the period from October 1, 2014, through December 31, 2014, NF PreAdmission Evaluations were approved for 157 individuals with acuity scores lower than 9, and 85 of these individuals were subsequently enrolled in CHOICES 1 during the reporting period. Reasons that the remaining individuals were approved for—but not yet enrolled in—CHOICES 1 include:

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

- Pending notification by Nursing Facilities of the exhaustion of other sources of reimbursement (e.g., Medicare, other insurance, or private payment);
- Medicaid financial eligibility determination pending; and
- Failure of the individual to meet Medicaid financial eligibility requirements.

In the same reporting period, HCBS PreAdmission Evaluations were approved for 32 individuals with acuity scores lower than 9, and 29 of the individuals were subsequently enrolled in CHOICES Group 2. The remaining applicants did not meet Medicaid financial eligibility requirements or otherwise failed to qualify for, or proceed with, enrollment in CHOICES 2.

Frequency and use of MCO-distributed transition allowances (CHOICES approval letter dated February 26, 2010): The allocation of CHOICES transition allowance funds is detailed in Table 9. Distribution of such funds increased during the July-September 2014 quarter as the result of the MCOs' renewed efforts to maximize appropriate use of HCBS within the CHOICES population. An even larger increase occurred during the October-December 2014 quarter because of two factors: striving by the MCOs to reach their transition benchmarks, and the MCOs' newly available option to provide community living supports residential services as a cost-effective alternative to institutional care.

Table 9
TennCare CHOICES Transition Allowances
for October – December 2014 Compared to the Previous Two Quarters

	Frequency and Use of Transition Allowances					
	Apr – Jun 2014		**Jul – Sept 2014**		**Oct – Dec 2014**	
Grand Region	# Distributed	Total Amount	# Distributed	Total Amount	# Distributed	Total Amount
East	5	$2,885	5	$3,626	21	$15,587
Middle	2	$1,599	4	$4,767	17	$24,889
West	7	$8,065	15	$20,211	18	$18,109
Statewide Total	14	$12,549	24	$28,604	56	$58,585

B. 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 10 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 TennCare Contract (i.e., East, Middle, or West Grand Region) and by subcontractor (e.g., claims processed by a vision benefits manager). 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 enrollees. TDCI then performs an analysis and reports the results of the prompt pay analyses by NEMT and CHOICES claim types, by subcontractor, by TennCare contract, 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. The TennCare Bureau can 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 the TennCare Bureau can assess applicable liquidated damages against these entities.

Net Worth Requirement. By statute, the minimum net worth requirement for each TennCare MCO is calculated based on premium revenue for the most recent calendar year, as well as any TennCare payments made to the MCO that are not reported as premium revenue.

During this quarter, the MCOs submitted their National Association of Insurance Commissioners (NAIC) Third Quarter 2014 Financial Statements. As of September 30, 2014, TennCare MCOs reported net worth as indicated in the table below.[8]

Table 10
Net Worth Reported by MCOs as of September 30, 2014

	Net Worth Requirement	Reported Net Worth	Excess/ (Deficiency)
Amerigroup Tennessee	$17,550,992	$150,780,558	$133,229,566
UnitedHealthcare Plan of the River Valley (UnitedHealthcare	$64,885,278	$520,961,787	$456,076,509

[8] The "Net Worth Requirement" and "Reported Net Worth" figures in the table are based on the MCOs' company-wide operations, not merely their TennCare operations. Amerigroup and Volunteer State Health Plan, for instance, operate Medicare Advantage Plans, while UnitedHealthcare has several lines of business in Illinois, Iowa, Virginia, and Tennessee.

	Net Worth Requirement	Reported Net Worth	Excess/ (Deficiency)
Community Plan)			
Volunteer State Health Plan (BlueCare & TennCare Select)	$34,942,038	$310,096,757	$275,154,719

All TennCare MCOs met their minimum net worth requirements as of September 30, 2014.

C. MCO Readiness

In December 2013, TennCare announced that the three health plans already comprising TennCare's managed care network—Amerigroup, BlueCare, and UnitedHealthcare—had submitted successful bids to deliver physical health services, behavioral health services, and LTSS in all three of Tennessee's grand regions beginning on January 1, 2015. During the October-December 2014 quarter, TennCare continued to coordinate with the MCOs to ensure a seamless transition to this statewide service delivery model.

One of the most important elements of this preparation was the mailing of notification letters to individuals (approximately one-third of the TennCare population) who would be transferred from one MCO to another beginning on January 1, 2015. The notices, which were mailed on November 14, 2014, provided enrollees both the name of the new plan and instructions for remaining with their current plan if preferred. Complementing this effort were joint TennCare-MCO workgroups tasked with ensuring that the transfer of enrollee data—such as treatment histories, claims histories, scheduled (including re-occurring) non-emergent transportation trips, and impending surgery dates—that accompanied MCO reassignments was managed properly. TennCare carefully monitored the MCOs' activity to ensure that all applicable standards regarding data transfers were met and that all appropriate safeguards were observed.

Additionally, the Bureau conducted a total of six site visits in November and December to evaluate each plan's readiness to deliver behavioral health services and long-term services and supports in all three regions. Findings from the visits confirmed that the MCOs were adequately prepared for statewide implementation on January 1, 2015.

D. Budget Presentation

On December 5, 2014, three members of TennCare's executive staff—Director Darin Gordon, Deputy Director and Chief of Staff Dr. Wendy Long, and Chief Financial Officer Casey Dungan—presented the Fiscal Year 2016 proposed budget for the Division of Health Care Finance and Administration (HCFA) to Governor Haslam, Finance and Administration Commissioner Larry Martin, Budget Director David Thurman, and Chief Operating Officer Greg Adams.

The presentation document itself, which is available on HCFA's website at http://tn.gov/tenncare/forms/HCFAbudgetFY16.pdf, concisely summarizes the manner in which

TennCare has been able to deliver quality care and achieve high levels of member satisfaction while continuing to control inflationary growth. Evidence of these achievements as highlighted by the presentation includes the following:

- Improvement in 81 percent of the 47 HEDIS (Healthcare Effectiveness Data and Information Set) measures tracked since 2007;
- High rankings for TennCare health plans at regional and national levels;
- Enrollee satisfaction levels above 90 percent for several years in a row (including 93 percent in 2014); and
- Medical inflation levels less than half of those of commercial insurance programs and of Medicaid programs nationally.

A portion of the presentation was devoted to the opportunities and challenges faced by Tennessee as a result of Medicaid eligibility changes instituted by the Affordable Care Act. Despite ongoing difficulties with the vendor in development of the Tennessee Eligibility Determination System (TEDS) and in enrollment of eligible individuals through the Federally Facilitated Marketplace (FFM), HCFA successfully achieved the third highest new enrollment in 20 years during Calendar Year 2014. (As detailed in Table 2 above, total TennCare enrollment at the conclusion of the October-December 2014 quarter stood at 1,353,015 individuals.)

As Governor Haslam had requested of all State agencies, HCFA included within its budget presentation a proposal for reducing expenditures by seven percent. Potential cost-controlling measures ranged from reduced provider reimbursement rates and implementation of a limit on enrollment in CHOICES Group 3 to elimination of the hospice benefit, discretionary hospital grants, and the perinatal grant program.

Touching on the system of payment and delivery system reform that TennCare is pursuing, as well as the challenges posed by various cost drivers, the presentation laid out the environment in which HCFA will operate for years to come.

E. Beneficiary Survey

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

On November 17, 2014, CBER published a summary of the results of the most recent survey entitled “The Impact of TennCare: A Survey of Recipients 2014.” Although the findings of a single survey must be viewed in context of long-term trends, a number of results from the report were noteworthy:

- 93 percent of respondents covered by TennCare expressed satisfaction with the quality of care they had received. This level of satisfaction—the sixth straight year above 90 percent—is tied for the third highest in the program's history.
- The percentage of respondents classifying themselves as uninsured fell to 7.2 percent, a 25 percent decline from 2013's result. Likewise, the percentage of respondents classifying their children as uninsured fell to 2.4 percent, a 35 percent decline from 2013's result.
- Only 1 percent of respondents covered by TennCare reported that they sought initial medical care for their children at the hospital instead of at a doctor's office or clinic. This figure is significant because seeking initial care at the emergency room (in the absence of an emergency) is less cost-effective than seeking this care at a doctor's office or clinic. Redirection of enrollees to the most cost-effective source of care is a primary objective of a managed care program, and the evidence suggests that TennCare has been successful in meeting this goal.

In summary, the report notes, "TennCare continues to receive positive feedback from its recipients, with 93 percent reporting satisfaction with the program, indicating TennCare is providing medical care in a satisfactory manner and up to the expectations of those it serves." The report, which the State had submitted to CMS on September 25, 2014, is available online at http://cber.bus.utk.edu/tncare/tncare14.pdf.

F. *Wilson v. Gordon*

In July 2014, attorneys with the Tennessee Justice Center, the Southern Poverty Law Center, and the National Health Law Program filed a class action lawsuit against TennCare, the Tennessee Department of Finance and Administration, and the Tennessee Department of Human Services. The suit alleged a variety of flaws in the enrollment process TennCare had been using since January 1, 2014. Attorneys representing the State, however, pointed out that this process had been approved by the federal government and that more than 125,000 applications for TennCare coverage had been approved in the first eight months of 2014 alone.

These arguments were heard in the U.S. District Court for the Middle District of Tennessee by Judge Todd Campbell, who subsequently granted class action status to the suit and issued a preliminary injunction requiring the State to provide an opportunity for a fair hearing on any delayed adjudications. These "delay hearings" are required to be held within 45 days (or 90 days in disability cases) after a class member requests such a hearing and provides proof that an application was filed. TennCare took immediate action to comply with Judge Campbell's rulings but also filed an appeal with the U.S. Court of Appeals for the Sixth Circuit in Cincinnati.

During the October-December 2014 quarter, two additional developments in the case occurred. At the District Court level, Magistrate Judge John Bryant entered a Protective Order on November 3, 2014, based on a joint motion by Plaintiffs and Defendants. The purpose of the Order was to ensure that any confidential information regarding TennCare applicants used

within the course of the *Wilson* matter be protected. At the Court of Appeals level, the State filed its Opening Brief on November 26, 2014 (followed by the filing of a corrected Opening Brief on December 2, 2014). The brief outlined the State's position in the *Wilson* suit, including the basis for vacating or reversing Judge Campbell's preliminary injunction.

G. 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. The purpose of the program is to provide financial incentives to Medicaid providers[9] to replace outdated, often paper-based approaches to medical record-keeping with electronic systems that meet rigorous certification 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 administrative costs.

Currently, Medicaid providers may qualify for the following types of payments:

- First-year payments to providers (eligible hospitals or practitioners) who either—
  - Adopt, implement, or upgrade to certified EHR technology capable of meeting "meaningful use" in accordance with CMS standards, or
  - Achieve meaningful use of certified EHR technology for any period of 90 consecutive days;
- Second-year payments to providers who have received first-year payments and who achieved meaningful use for a subsequent period of 90 consecutive days;
- Third-year and fourth-year payments to providers who continue to demonstrate meaningful use.

EHR payments made by TennCare during the October-December 2014 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 (Oct-Dec 2014)	Cumulative Amount Paid To Date
First-year payments	146[10]	$4,208,453	$148,051,502

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

[10] Of the 146 providers receiving first-year payments in the October-December 2014 quarter, 6 earned their incentives by successfully attesting to meaningful use of EHR technology in their first year of participation in the program.

Payment Type	No. of Providers Paid During the Quarter	Quarterly Amount Paid (Oct-Dec 2014)	Cumulative Amount Paid To Date
Second-year payments	68	$5,222,234	$46,047,222
Third-year payments	53	$749,349	$5,143,483
Fourth-year payments	8	$68,000	$68,000

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

- Participation throughout the quarter in three Southeast Regional Collaboration for HIT/HIE (SERCH) calls;
- Telephone assistance throughout the quarter for eligible professionals attesting to Meaningful Use (with particular emphasis on the EHR final rule that took effect on October 1, 2014);
- Attendance at six Tennessee Medical Association workshops in October 2014, during which information was furnished to providers from the Chattanooga, Jackson, Kingsport, Knoxville, Memphis, and Nashville areas;
- Hosting an information booth at the Tennessee Academy of Family Physicians Conference in Gatlinburg in October 2014;
- Hosting a webinar entitled "CMS 2014 CEHRT Flexibility Rule Implementation in Tennessee" on December 18, 2014 (a pdf version of which is available at http://www.tnrec.org/wp-content/uploads/Final-2014Rule-Change-in-PIPP.pdf);
- Responding to more than 500 inquiries submitted to the EHR Meaningful Use email box;
- Monthly newsletters distributed by the Bureau's EHR ListServ; and
- A quarterly reminder issued through the Provider Incentive Payment Program ("PIPP") system to Tennessee providers who had registered at the federal level but who have not registered or attested at the state level.

TennCare continues to schedule EHR workshops with a variety of provider organizations to maintain the momentum of the program.

H. Public Forum on the TennCare Demonstration

In compliance with the federal regulation at 42 CFR § 431.420(c) and the terms of its Demonstration agreement with CMS, TennCare hosted a public forum in the downtown branch of the Nashville Public Library on December 17, 2014. The purpose of the forum was to provide members of the public an opportunity to comment on the progress of the TennCare Demonstration project, which has delivered Medicaid services to eligible Tennesseans under a managed care model since 1994.

The December 17 open meeting was not the only avenue through which feedback could be offered. Notice of the forum, which appeared on the TennCare website, included an email

address, a physical address, and a dedicated phone line at which comments would be accepted. Although the Bureau received no comments through any of these outlets, additional opportunities to assess the TennCare Demonstration will be available, as TennCare is required to convene a forum on this subject each year for the foreseeable future.

VI. Action Plans for Addressing Any Issues Identified

As reported in Section V, TennCare continues to comply with orders issued in the *Wilson v. Gordon* court action.

VII. Financial/Budget Neutrality Development Issues

In all three months of the October-December 2014 quarter, total state and local revenue collections were higher than they had been during the corresponding months of 2013 (nearly 6 percent higher in October and December).[11] In the arena of jobs, the unemployment rate fell steadily during the quarter, declining from 7.1 percent in October to 6.8 percent in November and even further to 6.6 percent in December. These figures represent a notable improvement—more than a full percentage point—on the state unemployment rate during the corresponding months of 2013; nonetheless, the levels also remained higher than the national unemployment rate—also by a full percentage point or more—throughout the quarter.[12]

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
October – December 2014

Eligibility Group	October 2014	November 2014	December 2014	Sum for Quarter Ending 12/31/14
Medicaid eligibles (Type 1)				
EG1 Disabled, Type 1 State Plan	136,843	136,383	135,841	409,067

[11] The Department of Revenue's collection summaries are available online at http://www.state.tn.us/revenue/statistics/summaries.shtml.
[12] Information about Tennessee's unemployment rate is available on the Department of Labor and Workforce Development's website at https://news.tn.gov/taxonomy/term/32.

Eligibility Group	October 2014	November 2014	December 2014	Sum for Quarter Ending 12/31/14
eligibles				
EG2 Over 65, Type 1 State Plan eligibles	31	37	45	113
EG3 Children, Type 1 State Plan eligibles	692,027	694,493	697,916	2,084,436
EG4 Adults, Type 1 State Plan eligibles	341,431	346,320	352,709	1,040,460
EG5 Duals, Type 1 State Plan eligibles	127,661	128,056	128,661	384,378
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	311	327	335	973
EG10 H-Over 65, Type 2 Demonstration Population	0	0	0	0
EG11 H-Duals, Type 2 Demonstration Population	5,936	5,940	6,045	17,921
TOTAL	1,304,240	1,311,556	1,321,552	3,937,348

Table 13
Member Month Reporting Not Used in Budget Neutrality Calculations
October – December 2014

Eligibility Group	October 2014	November 2014	December 2014	Sum for Quarter Ending 12/31/14
EG6E Expan Adult, Type 3, Demonstration Population	1,219	1,239	1,252	3,710
EG7E Expan Child, Type 3, Demonstration Population	65	64	64	193
Med Exp Child, Title XXI Demonstration Population	19,414	19,356	19,308	58,078
EG12E Carryover, Type 3, Demonstration Population	5,463	5,374	5,270	16,107
TOTAL	26,161	26,033	25,894	78,088

IX. Consumer Issues

Eligibility Appeals. Tennessee is currently a "determination" state, meaning that applicants in a MAGI-based eligibility category who apply through the FFM (which virtually all MAGI-based applicants currently do in Tennessee) have their eligibility determined by the FFM rather than by the State.

When the FFM denies an application, it has the responsibility of providing the applicant with an appeal of its decision, but current regulations give the applicant a choice of having the State hear the appeal instead. The State's ability to process an appeal, however, is dependent upon its having access to the information that the FFM used to deny the application. For a period of time, the FFM was unable to provide this information to the State.

During the July-September 2014 quarter, the State still had not received any MAGI-based eligibility appeals from the FFM but—by the conclusion of the quarter—had begun processing eligibility appeals submitted by applicants and enrollees directly to TennCare. These circumstances changed in the October-December 2014 quarter, when the FFM began supplying appeal information to the State, and TennCare started handling appeals concerning the date on which an individual's TennCare coverage should begin (also referred to as "effective date appeals").

Eligibility appeals concerning non-MAGI eligibility categories continued to be processed by the Tennessee Department of Human Services (DHS), while the Bureau maintained responsibility for effective date appeals and other MAGI-related eligibility appeals submitted directly to TennCare. Table 14 presents a summary of eligibility appeal activity by TennCare and DHS during the quarter, compared to the previous two quarters.

Table 14
Eligibility Appeals Handled by TennCare and the Department of Human Services
During the October – December 2014 Quarter, Compared to the Previous Two Quarters

	Apr – Jun 2014	Jul – Sept 2014	Oct – Dec 2014
No. of appeals received[13]	2,981	4,017	5,839
No. of appeals resolved or withdrawn	323	469	727
No. of appeals taken to hearing	102	140	326

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

[13] The "no. of appeals received" for each of the previous two quarters has been adjusted to include appeals received by TennCare as well as by DHS.

Table 15
Medical Service Appeals Handled by the Bureau of TennCare
During the October – December 2014 Quarter, Compared to the Previous Two Quarters

	Apr – Jun 2014	Jul – Sept 2014	Oct – Dec 2014
No. of appeals received	1,602	1,832	1,547
No. of appeals resolved	1,384	1,672	1,628
• Resolved at the MCC level	704	883	645
• Resolved at the TSU level	100	114	129
• Resolved at the LSU level	580	675	854
No. of appeals that did not involve a valid factual dispute	276	243	349
No. of directives issued	169	195	182
No. of appeals taken to hearing	580	675	854
No. of appeals that were withdrawn by the enrollee at or prior to the hearing	212	229	272
Appeals that went to hearing and were decided in the State's favor	149	193	285
Appeals that went to hearing and were decided in the appellant's favor	31	29	29

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 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 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. In the CMS letter approving CHOICES implementation in Middle Tennessee dated February 26, 2010, the Bureau was asked to monitor and provide information on CHOICES-specific appeals. In the approval letter sent to the State on August 3, 2010, CMS said that they looked forward to "continuing our collaboration with the State for monitoring the

CHOICES Program through sharing of standardized reports, monthly Demonstration monitoring calls, and the Quarterly and Annual Reports." The following table provides information regarding certain appeals administered by the Long-Term Services and Supports Division for the quarter, compared to the previous two quarters. Recent improvements made to medical eligibility determination processes—including earlier safety determinations—coincide with a decline in the number of LTSS appeals filed during the October-December 2014 quarter.

Table 16
Long-Term Services and Supports Appeals for October – December 2014
Compared to the Previous Two Quarters

	Apr – Jun 2014	Jul – Sept 2014	Oct – Dec 2014
No. of appeals of PreAdmission Evaluation (PAE) denials	302	356	202
No. of appeals of PASRR determinations	5	8	7
No. of appeals of denial for enrollment into CHOICES	11	10	4
No. of appeals of involuntary disenrollment from CHOICES	4	6	5
No. of appeals of denial of Consumer Direction	1	0	1
No. of appeals of involuntary withdrawal of Consumer Direction	0	0	0
No. of appeals of involuntary disenrollment from an HCBS waiver for individuals with intellectual disabilities	1	0	1
No. of appeals resolved in appellant's favor prior to hearing	159	174	121
No. of appeals withdrawn prior to hearing	23	24	10
No. of appeals dismissed at hearing	72	61	23
No. of appeals continued at hearing	11	3	2
No. of appeals that went to hearing and were decided in the State's favor	26	13	8
No. of appeals that went to hearing and were decided in the appellant's favor	6	6	0

X. Quality Assurance/Monitoring Activity

Population Health. "Population Health" (PH) is the model of targeted health care interventions implemented by TennCare in the months leading up to—and culminating on—July 1, 2013. Advantages of PH over the "Disease Management" program it replaced include—

- Selection of a much larger portion of the TennCare population than had been attempted previously;
- Identification of risky behaviors likely to lead to disease in the future (such as poor eating habits, physical inactivity, and drug use);
- Assistance to enrollees in discontinuing such activities; and
- Interventions to assist enrollees who already have a complex chronic condition.

Enrollees are assigned to one of three levels of health risk and one of seven programs for reducing risk. Information on the risk levels addressed by PH, the manner in which these risks are addressed, and the total number of unique members enrolled in PH at the conclusion of the July-September 2014 quarter is provided in Table 17. Data for the period of October through December 2014 will be provided in the next Quarterly Progress Report.

Table 17
Population Health Data*, July – September 2014

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	508,379
Level 1: low or moderate risk	Maternity Program	Engage pregnant women in timely prenatal care and deliver a healthy, term infant without complications	19,030
	Health Risk Management	Prevent, reduce, or delay exacerbation and complications of a condition or health risk behavior	738,450
	Care Coordination	Assure that members receive the services they need to reduce the risk of an adverse health outcome	17,046[14]
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	5,907
	High Risk Pregnancy Management	Engage pregnant women in timely prenatal care and deliver a healthy, term infant without complications	2,738

[14] Each recipient of care coordination services is also enrolled in another PH intervention program. To avoid duplication, therefore, the enrollment total for care coordination is not included in the overall PH enrollment total.

Risk Level	Intervention Type	Intervention Goal(s)	Number of Unique Members at End of Quarter
	Complex Case Management	Move members to optimal levels of health and well-being through timely coordination of quality services and self-management support	1,108
Total PH Enrollment			**1,275,612**

*** The data in this table is a snapshot of PH enrollment on the last day of the reporting period. Because members move between risk levels and intervention types, enrollment may vary on a daily basis.**

Provider Data Validation Report. In October 2014, TennCare's External Quality Review Organization (EQRO), Qsource, published the results of its provider data validation survey for the July-September 2014 quarter. Qsource took a sample of provider data files from TennCare's MCCs[15] and reviewed each for accuracy in the following categories:

- Contract status with MCC
- Provider address
- Provider credentialed specialty / behavioral health service code
- Open / closed to new patients
- Services to patients under age 21
- Services to patients age 21 or older
- Primary care services
- Prenatal care services
- 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 concluded that "[o]verall, the MCCs' accuracy rates have maintained a high level," especially in the categories of "active contract status with MCC" (98.6 percent accuracy), "provider credentialed specialty / behavioral health service code" (97.2 percent accuracy), "primary care services" (99.5 percent accuracy), and "prenatal care services" (99.7 percent accuracy).

While the results were comparable to the overall scores obtained last quarter and one year ago, to ensure improvement in these and other areas (such as "services to patients age 21 or older," which demonstrated only 92.5 percent accuracy), TennCare required each of its MCCs to submit a Corrective Action Plan no later than December 5, 2014. The Bureau, in turn, had received, reviewed, and accepted all of the plans by December 12, 2014. Results for the October-December 2014 quarter will be discussed in the next Quarterly Progress Report.

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

XI. Demonstration Evaluation

On June 29, 2012, the State submitted its application to renew the TennCare Waiver, Part VI of which was an Interim Evaluation Report addressing progress in three areas: 1) medical and behavioral health measures; 2) efficiency, stability and viability measures; and 3) new measures for the TennCare CHOICES program.

In addition, on October 31, 2014, the State submitted the Draft Annual Report as required by STC 46. Part V of that report provided the progress to date on the performance measures outlined in the approved Evaluation Design. It is the State's intention to provide updated information on the performance measures in each Annual Report.

Furthermore, on November 13, 2014, the State submitted its annual update of the strategy to evaluate and improve the quality and accessibility of care offered to enrollees through the managed care network. The document, entitled *2014 Annual Update Report of the 2013 Quality Assessment and Performance Improvement Strategy*, is available on TennCare's website at http://www.tn.gov/tenncare/forms/qualitystrategy.pdf.

XII. Essential Access Hospital Pool[16]

A. Safety Net Hospitals

Regional Medical Center at Memphis (The MED)
Vanderbilt University Hospital
Erlanger Medical Center
University of Tennessee Memorial Hospital
Johnson City Medical Center Hospital (with Woodridge Psych)
Metro Nashville General Hospital

B. Children's Hospitals

LeBonheur Children's Medical Center
East Tennessee Children's Hospital

C. Free Standing Psychiatric Hospitals

Pathways of Tennessee
Ridgeview Psychiatric Hospital and Center
Rolling Hills Hospital

[16] Within the four Essential Access Hospital (EAH) groupings (Safety Net Hospitals, Children's Hospitals, Free Standing Psychiatric Hospitals, and Other Acute Care Hospitals), hospitals are arranged—in descending order—according to the amount of compensation each receives from the EAH pool.

D. Other Acute Care Hospitals

Parkridge Medical Center (with Parkridge Valley Psych)
Jackson – Madison County General Hospital
Methodist Healthcare – Memphis Hospitals
Methodist Healthcare – South
Saint Jude Children's Research Hospital
University Medical Center (with McFarland Psych)
Saint Thomas Midtown Hospital
TriStar Skyline Medical Center (with Madison campus)
Wellmont Holston Valley Medical Center
Fort Sanders Regional Medical Center
TriStar Centennial Medical Center
Methodist Healthcare – North
Saint Francis Hospital
Parkridge East Hospital
Maury Regional Hospital
Parkwest Medical Center (with Peninsula Psych)
Saint Thomas Rutherford Hospital
Pathways of Tennessee
Wellmont Bristol Regional Medical Center
Cookeville Regional Medical Center
Tennova Healthcare – Physicians Regional Medical Center
Methodist Hospital – Germantown
Baptist Memorial Hospital for Women
Skyridge Medical Center
Blount Memorial Hospital
Gateway Medical Center
TriStar Horizon Medical Center
TriStar StoneCrest Medical Center
TriStar Summit Medical Center
NorthCrest Medical Center
Delta Medical Center
Dyersburg Regional Medical Center
LeConte Medical Center
Morristown – Hamblen Healthcare System
Southern Hills Medical Center
Heritage Medical Center
Sumner Regional Medical Center
Takoma Regional Hospital
Tennova Healthcare – Newport Medical Center
Sweetwater Hospital Association
Laughlin Memorial Hospital
Methodist Medical Center of Oak Ridge

TriStar Hendersonville Medical Center
Harton Regional Medical Center
Henry County Medical Center
Tennova Healthcare – LaFollette Medical Center
Grandview Medical Center
Sycamore Shoals Hospital
Skyridge Medical Center – Westside
Regional Hospital of Jackson
Baptist Memorial Hospital – Union City
Lakeway Regional Hospital
Indian Path Medical Center
Wellmont Hawkins County Memorial Hospital
Jellico Community Hospital
Hardin Medical Center
McNairy Regional Hospital
Starr Regional Medical Center – Athens
River Park Hospital
Henderson County Community Hospital
Roane Medical Center
United Regional Medical Center
Hillside Hospital
Crockett Hospital
Livingston Regional Hospital
McKenzie Regional Hospital
Haywood Park Community Hospital
Volunteer Community Hospital
Bolivar General Hospital
Wayne Medical Center
Erlanger Health System – East Campus
Baptist Memorial Hospital – Huntingdon
DeKalb Community Hospital
Methodist Healthcare – Fayette
Emerald Hodgson Hospital

XIII. Graduate Medical Education (GME) Hospitals

Note: Attachment A to the STCs directs the State to list its GME hospitals and their affiliated teaching universities in each quarterly report. As CMS is aware, Tennessee does not make GME payments to hospitals. These payments are made, rather, to medical schools. The medical schools disburse many of these dollars to their affiliated teaching hospitals, but they also use them to support primary care clinics and other arrangements.

The GME medical schools and their affiliated universities are listed below:

Universities	Hospitals
East Tennessee State University	Mountain State Health Alliance Wellmont ETSU Quillen Mission Hospital Johnson City Medical Center Johnson City Health Center Woodridge Hospital Holston Valley Medical Center Bristol Regional Medical Center
Meharry Medical College	Metro General Meharry Medical Group
University of Tennessee at Memphis	The Regional Medical Center (The MED) Methodist LeBonheur Erlanger Jackson Madison St. Francis
Vanderbilt University	Vanderbilt Hospital

XIV. Critical Access Hospitals

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

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Attachment A

Budget Neutrality Calculations for the Quarter

Actual TennCare Budget Neutrality (October - December 2014)

I. The Extension of the Baseline

Baseline PMPM

	SFY 2015 PMPM
1-Disabled (can be any ages)	$1,641.09
2-Child <=18	$484.39
3-Adult >= 65	$1,069.19
4-Adult <= 64	$962.76
Duals (17)	$683.02

Actual Member months of Groups I and II

1-Disabled (can be any ages)	410,040
2-Child <=18	2,084,436
3-Adult >= 65	113
4-Adult <= 64	1,040,460
Duals (17)	402,299
Total	3,937,348

Ceiling without DSH

	Baseline * MM
1-Disabled (can be any ages)	$672,914,454
2-Child <=18	$1,009,683,742
3-Adult >= 65	$120,819
4-Adult <= 64	$1,001,716,228
17s	$274,779,790
Total	**$2,959,215,033**

DSH

DSH Adjustment (Quarterly)	$115,999,213

Total Ceiling

Budget Neutrality Cap	
Total w/DSH Adj.	**$3,075,214,246**

II. Actual Expenditures

Group 1 and 2

1-Disabled (can be any ages)	$ 583,243,508
2-Child <=18	$ 458,632,912
3-Adult >= 65	$ 60,820
4-Adult <= 64	$ 403,267,512

Duals (17)	$	333,113,498
Total		**1,778,318,249**

Group 3

1-Disabled (can be any ages)	$	-
2-Child <=18	$	12,773,723
3-Adult >= 65	$	78,703,691
4-Adult <= 64	$	1,716,422
Duals (17)	$	-
Total		**93,193,836**

Pool Payments and Admin

Total Pool Payments		$68,202,843

Admin	$	98,593,899

Quarterly Drug Rebates	$	164,499,082
Quarterly Premium Collections	$	535
Total Net Quarterly Expenditures	**$**	**1,873,809,210**

III. Surplus/(Deficit)

	$1,201,405,036
Federal Share	**$784,397,348**

HCI Result	MM201410	MM201411	MM201412	TOTAL	HCI ASO	HCI Rx	HCI DTL	HCI MCO CAP (TCS Admin)	UNK Allocation	TOTAL
EG1-TYPE1 (disabled, type1 state plan eligibles)	136,843	136,383	135,841	409,067	$94,579,147	$105,844,139	$1,680,938	$376,664,453	(593,471)	$578,175,205
EG1-TYPE2 (disabled, type2 transition group)	0	0	0	-				$0	-	$0
EG2-TYPE1 (over 65, type1 state plan eligibles)	31	37	45	113	$2,199	$5,433	$0	$53,249	(62)	$60,820
EG2-TYPE2 (over 65, type2 state plan eligibles)	0	0	0	-				$0	-	$0
EG3-TYPE1 (children, type1 state plan eligibles)	692,027	694,493	697,916	2,084,436	$13,931,112	$66,679,837	$30,756,178	$347,736,579	(470,795)	$458,632,912
Med Exp Child (Title XXI Demo Pop; EG3-Type2)	19,414	19,356	19,308	58,078	$55,285	$3,455,051	$1,122,024	$8,103,529	(13,059)	$12,722,830
EG4-TYPE1 (adults, type1 State plan eligibles)	341,431	346,320	352,709	1,040,460	$1,047,781	$57,085,585	$2,546,816	$343,001,293	(413,964)	$403,267,512
EG4-TYPE2 (adults, type2 demonstration pop)	0	0	0	-				$0	-	$0
EG5-TYPE1 (duals, state plan eligibles)	127,661	128,056	128,661	384,378	$1,135,670	$915,896	$794,075	$279,392,460	(289,451)	$281,948,650
EG6E-TYPE3 (Expan adult, type3 demonstration pop)	1,219	1,239	1,252	3,710		$330,842	$3,695	$1,383,647	(1,762)	$1,716,422
EG7E-TYPE3 (Expan child, type3 demonstration pop)	65	64	64	193		$22,085	$2,205	$26,655	(52)	$50,893
EG8-TYPE2 (emd exp child)	0	0	0	-		$0		$0	-	$0
EG9 H-Disabled (TYPE 2 Eligibles)	311	327	335	973		$321,593	$0	$4,751,913	(5,203)	$5,068,302
EG11H, H-Dual	5,936	5,940	6,045	17,921		$27,298	$8,574	$51,181,503	(52,527)	$51,164,848
EG12E, Carryovers	5,463	5,374	5,270	16,107		$266,219	$18,184	$78,500,071	(80,783)	$78,703,691
Total	**1,330,401**	**1,337,589**	**1,347,446**	**4,015,436**	**$110,751,195**	**$234,953,979**	**$36,932,689**	**$1,490,795,353**	**-$1,921,131**	**$1,871,512,084**

HCI Result	MM201410	MM201411	MM201412	TOTAL	HCI ASO PMPM	HCI Rx PMPM	HCI DTL PMPM	HCI MCO CAP (TCS Admin)	UNK Allocation	TOTAL
EG1-TYPE1 (disabled, type1 state plan eligibles)	136,843	136,383	135,841	409,067	$231.21	$258.75	$4.11	$920.79	-$1.45	$1,413.40
EG1-TYPE2 (disabled, type2 transition group)	0	0	0	-						
EG2-TYPE1 (over 65, type1 state plan eligibles)	31	37	45	113	$19.46	$48.08	$0.00	$471.23	-$0.55	$538.23
EG2-TYPE2 (over 65, type2 state plan eligibles)	0	0	0	-	-	-	-	-	-	-
EG3-TYPE1 (children, type1 state plan eligibles)	692,027	694,493	697,916	2,084,436	$6.68	$31.99	$14.76	$166.83	-$0.23	$220.03
Med Exp Child (Title XXI Demo Pop; EG3-Type2)	19,414	19,356	19,308	58,078	$0.95	$59.49	$19.32	$139.53	-$0.22	$219.06
EG4-TYPE1 (adults, type1 State plan eligibles)	341,431	346,320	352,709	1,040,460	$1.01	$54.87	$2.45	$329.66	-$0.40	$387.59
EG4-TYPE2 (adults, type2 demonstration pop)	0	0	0	-						
EG5-TYPE1 (duals, state plan eligibles)	127,661	128,056	128,661	384,378	$2.95	$2.38	$2.07	$726.87	-$0.75	$733.52
EG6E-TYPE3 (Expan adult, type3 demonstration pop)	1,219	1,239	1,252	3,710	$0.00	$89.18	$1.00	$372.95	-$0.47	$462.65
EG7E-TYPE3 (Expan child, type3 demonstration pop)	65	64	64	193	$0.00	$114.43	$11.43	$138.11	-$0.27	$263.69
EG8-TYPE2 (emd exp child)	0	0	0	-						
EG9 H-Disabled (TYPE 2 Eligibles)	311	327	335	973	$0.00	$330.52	$0.00	$4,883.77	-$5.35	$5,208.94
EG11H, H-Dual	5,936	5,940	6,045	17,921	$0.00	$1.52	$0.48	$2,855.95	-$2.93	$2,855.02
EG12E, Carryovers	5,463	5,374	5,270	16,107	$0.00	$16.53	$1.13	$4,873.66	-$5.02	$4,886.30
Total	**1,330,401**	**1,337,589**	**1,347,446**	**4,015,436**	**$27.58**	**$58.51**	**$9.20**	**$371.27**	**-$0.48**	**$466.08**

* Unknown allocation was performed within the Service category totals.

$12,773,723
$78,703,691
$1,716,422