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

August 30, 2012

Ms. Jessica Woodard
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 #47, Quarterly Progress Report

Dear Ms. Woodard:

Enclosed please find the Quarterly Progress Report for the April-June 2012 quarter. This report is being submitted in accordance with STC #47.

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 April - June 2012)

Demonstration Year: 10 (7/1/11 - 6/30/12)
Federal Fiscal Quarter: 3/2012 (4/12 - 6/12)
Waiver Quarter: 4/2012 (4/12 - 6/12)

I. Introduction

The goal of the TennCare Demonstration is to show that careful use of a managed care approach can enable the State to enroll a certain number of people who are not otherwise eligible for Medicaid and 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 1.2 million enrollees. During this quarter, these entities included Managed Care Organizations (MCOs) for medical, behavioral, and certain long-term services and supports, 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, if applicable.

Table 1
Key Dates of Approval/Operation in the Quarter

Date	Action	STC #
4/3/12	The State and CMS held a conference call to discuss Waiver Amendment 14.	7
4/3/12	The State withdrew Waiver Amendment 15, due to the Tennessee General Assembly's approval of an extension of the hospital assessment fee.	
4/11/12	The Medical Care Advisory Committee met and discussed the State's plan to request an extension of the TennCare Waiver.	
4/13/12	The State submitted Waiver Amendment 16 to CMS.	7
4/18/12	CMS approved the State's Cost-Sharing Implementation Plan, originally filed on 10/1/10.	37
4/19/12	The State received questions from CMS regarding Waiver Amendment 14.	7
4/25/12	The State submitted responses to CMS's 4/19/12 questions regarding Waiver Amendment 14.	7
4/26/12	The State and CMS held the monthly call.	46
5/7/12	The State posted a draft of the Waiver Extension Request on its website to initiate a 30-day public comment period.	
5/8/12	CMS approved the State's request to make changes to the definitions of CHOICES benefits in Attachment D.	7.c.
5/10/12	The State sent CMS copies of the following contract amendments: Amendment 12 to the Middle Tennessee	45.a.

Date	Action	STC #
	Contractor Risk Agreement; Amendment 9 to the East/West Tennessee Contractor Risk Agreement; and Amendment 28 to the TennCare Select contract.	
5/15/12	The first of two public meetings was held to receive comments on the draft Waiver Extension Request.	
5/22/12	The second of two public meetings was held to receive comments on the draft Waiver Extension Request.	
5/24/12	The State and CMS held the monthly call.	46
5/31/12	The State submitted the Quarterly Progress Report.	47
6/25/12	CMS approved Waiver Amendments 14 and 16. The State was notified that Jessica Woodard would replace Nicole Kaufman as the new TennCare Project Officer.	7
6/27/12	The State sent CMS the operational procedures for determining individuals "at risk" of institutionalization.	34.a.
6/28/12	The State submitted various CHOICES data reports to CMS.	45.d.
6/29/12	The State submitted a formal request for a Section 1115(f) extension of the TennCare Waiver. The request included an Interim Evaluation Report.	8, 71

II. Enrollment and Benefits Information

Information about enrollment by category is presented in Table 2.

Table 2
Enrollment Counts for the April - June 2012 Quarter
Compared to the Previous Two Quarters

Demonstration Populations	Total Number of TennCare Enrollees		
	Oct – Dec 2011	Jan – Mar 2012	Apr – Jun 2012
EG1 Disabled, Type 1 State Plan eligibles	129,555	129,409	127,642
EG1 Disabled and EG9 H-Disabled, Type 2 Demonstration Population	4,063	4,277	4,345
EG2 Over 65, Type 1 State Plan eligibles	308	320	515
EG2 Over 65 and EG10 H-Over 65, Type 2 Demonstration Population	25	32	35
EG3 Children, Type 1 State Plan eligibles	669,975	666,187	664,693
EG4 Adults, Type 1 State Plan	305,712	302,808	300,751

Demonstration Populations	Total Number of TennCare Enrollees		
	Oct – Dec 2011	Jan – Mar 2012	Apr – Jun 2012
eligibles			
EG4 Adults, Type 2 Demonstration Population	0	0	0
EG5 Duals, Type 1 State Plan eligibles	148,268	146,345	143,087
EG6E Expan Adult, Type 3 Demonstration Population	1,092	1,187	1,086
EG7E Expan Child, Type 3, Demonstration Population	2,694	2,355	2,163
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	22,081	18,591	17,332
TOTAL *	1,283,773	1,271,511	1,261,649

*** 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 just over three in four 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 June 30, 2012

	West Tennessee	Middle Tennessee	East Tennessee
Managed Care Organizations	BlueCare[1]	AmeriGroup	BlueCare
	UnitedHealthcare Community Plan[2]	UnitedHealthcare Community Plan	UnitedHealthcare Community Plan
	TennCare Select[3]	TennCare Select	TennCare Select

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

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

	West Tennessee	Middle Tennessee	East Tennessee
Pharmacy Benefits Manager	SXC Health Solutions Corp.		
Dental Benefits Manager	TennDent[4]		

Approval of Waiver Amendment 14. On June 15, 2012, TennCare received notification that CMS had approved Amendment 14 to the TennCare Demonstration. (Amendment 15, which dealt with program reductions that would be required if the Hospital Assessment Fee were not renewed by the General Assembly, was withdrawn on April 3 after the fee had passed.)

Amendment 14 proposed changes to TennCare's CHOICES program, which delivers Long-Term Services and Supports (LTSS) to persons who qualify for TennCare-reimbursed Nursing Facility care. Prior to Amendment 14, CHOICES had two groups:

- CHOICES Group 1, for persons receiving LTSS in a Nursing Facility; and
- CHOICES Group 2, for persons who are eligible for Nursing Facility care but who are receiving Home and Community Based Services (HCBS) as an alternative.

The waiver includes a third group, CHOICES Group 3, for persons who have been found to be "at risk" for Nursing Facility care, but this group has been closed since CHOICES began in 2010.

Under Amendment 14, an "interim" CHOICES Group 3 was to be added effective July 1, which would remain open for enrollment through December 31, 2013. Having this group open, with no enrollment target, means that the State can amend its "Level of Care" (LOC) criteria for Nursing Facility admission and ensure that Nursing Facility services are reserved for those with the highest acuity of need. The availability of Interim CHOICES 3 allows the State to make appropriate changes to the program while remaining in compliance with the "Maintenance of Effort" requirements of the Affordable Care Act.

"TennCare PLUS" Proposal to Integrate Care. On May 17, 2012, TennCare submitted a proposal to the Medicare-Medicaid Coordination Office (MMCO) within CMS. The program outlined within the proposal is called "TennCare PLUS", and the population the program is designed to serve is Full Benefit Dual Eligibles (FBDEs), meaning individuals enrolled in both Medicare and Medicaid.[5] FBDEs represent more than 11 percent of the total TennCare population and approximately 90 percent of TennCare members receiving Long-Term Services and Supports through the Bureau's CHOICES program.

[4] TennDent is operated by Delta Dental.

[5] The only FBDEs who would be ineligible to participate in TennCare PLUS are those individuals enrolled in TennCare's Program of All-Inclusive Care for the Elderly (PACE), which already offers a fully integrated set of Medicare and Medicaid benefits to eligible individuals in Hamilton County.

One of the principal health care problems that FBDEs face—the problem that TennCare PLUS is intended to address—is the fragmented nature of their coverage. Members of this population have one set of providers and benefits through Medicare and a different set through Medicaid. Medicare and Medicaid are not at all coordinated. The Medicare program does not even provide basic data to states to help them coordinate Medicaid services with Medicare benefits.

The Bureau's TennCare PLUS proposal seeks to eliminate this lack of coordination by assigning responsibility for each FBDE's Medicare and Medicaid benefits to a single entity: the individual's TennCare managed care organization (MCO). The MCO will deliver a comprehensive package of benefits—including primary care, acute care, prescription drug coverage, and long-term services and supports—which will be facilitated by care coordination. Savings achieved by Medicaid through this model of integration will be reinvested into the program and, if adequate, would be used to provide a supplemental set of dental, vision, and hearing benefits.

The TennCare PLUS proposal, available online at http://www.tn.gov/tenncare/forms/plusproposal.pdf, reflects not just the vision of the Bureau, but also the feedback provided by a variety of stakeholders in meetings dating back to February 2011 and in public hearings held on May 3 and 8, 2012. If MMCO approves the proposal as submitted, implementation of TennCare PLUS would begin on January 1, 2014.

III. Innovative Activities to Assure Access

Early 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 (DOH) 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.

Table 4
Department of Health
Community Outreach Activity for EPSDT
April – June 2012 Compared to the Previous Two Quarters

Activities	Oct – Dec 2011	Jan – Mar 2012	Apr – Jun 2012
Number of educational materials distributed	207,367	200,969	212,881
Number of outreach activities/events	5,236	4,453	3,746
Number of people made contact with (mostly face to face at outreach events)	150,919	132,157[6]	147,939
Number of coalitions/advisory board meetings	31	32	24

[6] This figure was incorrectly reported last quarter as 157,046, which represented the total number of contacts achieved through all community outreach activities.

Activities	Oct – Dec 2011	Jan – Mar 2012	Apr – Jun 2012
presided over			
Number of attendees at coalitions/advisory board meetings	421	417	419
Number of educational preventive health radio/TV broadcasts[7]	9,619	11,131	12,807
Number of educational preventive health newsletter/magazine articles[8]	252	116	119
Number of educational preventive health billboards, scrolling billboards and bulletin boards	3,284	3,884	4,056
Number of presentations made to enrollees/professional staff who work with enrollees	542	530	339
Number of individuals attending presentations	12,454	11,554	8,402
Number of immunization reminder telephone calls made to households[9]	56	93	224
Number (approx) of completed telephone calls re: importance of immunizations	21	46	79
Number of attempted home visits (educational materials left with these families)	15,862	16,471	15,418
Number of home visits completed	8,570	8,455	8,204
Number of outreach activities to the homeless[10]	35 events	52 events	57 events

The TennCare Bureau also contracts with DOH 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.

[7] Radio and TV outreach occurs through public service announcements (PSAs). The availability of timeslots may cause fluctuation in the number of PSAs broadcast in any given quarter.

[8] The number of such articles varies from quarter to quarter according to the opportunities for no-cost publication made available by local media outlets.

[9] Quarterly variations in this category are attributable to the number of referrals made by the federally funded Women, Infants, and Children program.

[10] Many homeless individuals are transient, and the number of contacts fluctuates depending on the number of referrals from the agencies accessed by homeless individuals.

Table 5
Department of Health
TENNderCare Call Center Activity
April - June 2012 Compared to the
Previous Two Quarters

Activities	Oct – Dec 2011	Jan – Mar 2012	Apr – Jun 2012
Number of families reached	48,724	53,524	48,714
Number of families who were assisted in scheduling an EPSDT exam for their children	3,052	2,386	2,916
Number of families who were assisted in arranging for transportation	125	123	130

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 April – June 2012 Quarter, and Percentage that Passed Systems Edits, Compared to the Previous Two Quarters

	Oct – Dec 2011	Jan – Mar 2012	Apr – Jun 2012
No. of encounters received by TennCare (initial submission)	9,546,883	14,511,650[11]	11,466,818
No. of encounters rejected by Edifecs upon initial submission	54,277	44,313	57,371
Percentage of encounters that were compliant with State standards (including HIPAA) upon initial submission	99.43%	99.69%	99.50%

[11] Encounter claims received by TennCare rose during the January-March 2012 quarter because of a reprocessing effort undertaken by UnitedHealthcare. Extraction errors by the MCO in reference to 837 Institutional (also known as "837I") claims necessitated the reprocessing, which consisted of voiding erroneous encounters and resubmitting corrected encounters.

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

A. CHOICES

The Long-Term Care Community CHOICES Act of 2008 provided the framework that allowed the State to restructure its Long-Term Services and Supports delivery system, and the two-phased implementation of CHOICES was complete in August 2010. A primary aim of the CHOICES program is to increase the home and community based options that are available to meet the needs of adults who are elderly or who have physical disabilities and who require Nursing Facility care. Fulfillment of this goal is proceeding apace, as the percentage of individuals receiving long-term services and supports in the community has increased from 17 percent of the LTSS population when CHOICES began to just over 33 percent by the conclusion of June 2012. CMS's approval of Waiver Amendment 14—addressed previously in Part II of this report—is expected to boost TennCare's rebalancing efforts further and to achieve cost avoidance of nearly $16 million in State funds in Fiscal Year 2012-2013 alone.

The following table delineates CHOICES enrollment in Tennessee as of the end of the quarter. The table also provides reserve slot information per STC #34.e.iii.(A).

Table 7
TennCare CHOICES Enrollment and Reserve Slots
for April – June 2012 Compared to the Previous Two Quarters

	Statewide Enrollment Targets and Reserve Capacity	Enrollment and Reserve Slots Being Held as of the End of Each Quarter		
		Oct – Dec 2011	Jan – Mar 2012	Apr – Jun 2012
CHOICES 1	Not applicable[12]	21,135	20,904	20,966
CHOICES 2	11,000	9,964	10,440	10,482
Total CHOICES	Not applicable	31,099	31,344	31,448
Reserve capacity	300	300	300	300

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

Data and trends of the designated CHOICES data elements: STC #45.d. requires the State to submit to CMS periodic statistical reports about the use of Long-Term Services and Supports (LTSS) within the TennCare program. Each report includes nine categories of data (or "data elements"), which—taken together—provide a comparison between the use of Nursing Facility

[12] Only CHOICES 2 has an enrollment target.

care and the use of Home and Community Based Services (HCBS) by TennCare enrollees. Two such reports have been submitted to CMS so far:

- On August 31, 2011, the State provided a statistical portrait of LTSS utilization before the CHOICES program was implemented in 2010.
- On June 28, 2012, the State submitted a side-by-side comparison of the pre-CHOICES utilization data with a year's worth of post-implementation data.

These reports are a positive indication that a central goal of CHOICES—rebalancing LTSS—is being fulfilled. The number of TennCare enrollees receiving HCBS, for instance, grew from 6,226 in the twelve-month period preceding CHOICES implementation to 9,789 once CHOICES had been in place for a year. Complementary to this trend was the finding that the number of TennCare enrollees accessing institutional care fell from 31,128 to 30,757 over the same period. This decrease could be seen not just in sheer numbers of recipients but in percentages as well: the portion of new LTSS recipients admitted to a Nursing Facility declined from 81.3 percent in the year before CHOICES to 66.9 percent in the year after implementation. In addition, the number of TennCare enrollees transitioned from institutional care to community-based alternatives rose from 129 to 567.

Although the evolution of TennCare's LTSS program depicted in these numbers (and in Table 7) is a gradual one, the State continues to capitalize on innovative opportunities for expanding options, as the implementation of Waiver Amendment 14 (described in Part I) and the progress of the "Money Follows the Person" (or "MFP") program demonstrate.

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
TennCare CHOICES Transition Allowances
for April – June 2012 Compared to the Previous Two Quarters

	Frequency and Use of Transition Allowances[13]					
	Oct – Dec 2011		Jan – Mar 2012		Apr – Jun 2012	
Grand Region	# Distributed	Total Amount	# Distributed	Total Amount	# Distributed	Total Amount
East	9	$13,578.00	7	$10,429.00	13	$18,249.75
Middle	8	$14,383.15	8	$11,798.00	18	$22,148.59
West	10	$15,676.61	7	$10,341.00	11	$13,651.47
Statewide Total	27	$43,637.76	22	$32,568.00	42	$54,049.81

[13] As the number of CHOICES 2 enrollees (i.e., individuals receiving long-term services and supports at home or in the community) has increased, the use of transition allowances has generally grown as well.

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) First Quarter 2012 Financial Statement. As of March 31, 2012, TennCare MCOs reported net worth as indicated in the table below.[14]

[14] 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, for instance, operates a Medicare Advantage Plan in Middle Tennessee, while UnitedHealthcare has several lines of business in Illinois, Iowa, Virginia, and Tennessee. Volunteer State Health Plan, by contrast, operates solely on TennCare's behalf.

Table 9
Net Worth Reported by MCOs as of March 31, 2012

	Net Worth Requirement	Reported Net Worth	Excess/ (Deficiency)
Amerigroup Tennessee	$17,551,988	$87,755,165	$70,203,177
UnitedHealthcare Plan of the River Valley (UnitedHealthcare Community Plan)	$62,651,284	$501,198,539	$438,547,255
Volunteer State Health Plan (BlueCare & TennCare Select)	$34,832,427	$179,596,924	$144,764,497

All TennCare MCOs met their minimum net worth requirements as of March 31, 2012.

C. Application to Renew the TennCare Waiver

Unlike traditional fee-for-service Medicaid programs, TennCare is a demonstration project. In exchange for a waiver of certain federal statutes and regulations governing Medicaid, TennCare "demonstrates" the principle that a managed care approach to health care can extend coverage to people who would not otherwise be eligible for Medicaid, and can do so without increasing expenditures or diminishing the quality of care. One limitation imposed on demonstration projects, however, is that they may operate only for finite periods of time (referred to as "approval periods") before having to be renewed.

Although the TennCare Demonstration does not expire until July 1, 2013, federal regulations and the terms of the current waiver require Medicaid programs to submit applications for renewal a full year in advance.[15] Furthermore, in the interest of full transparency, such applications must be preceded by a 30-day public notice and comment period, during which time the details of the request for renewal must be made available for review, and the public must be provided multiple opportunities to provide feedback.[16] Therefore, in addition to publishing an abbreviated notice in several Tennessee newspapers and in the "Announcements" section of the *Tennessee Administrative Register*, TennCare created a dedicated page on its website. This webpage offered not only an overview of the TennCare Demonstration, but also a copy of the draft renewal application, an email address and telephone number for submitting comments, a link to CMS's own online resources regarding TennCare, and information about two public hearings hosted by the Bureau on May 15 and 22 to solicit public comments.

The State's application to renew the TennCare Demonstration was submitted to CMS on June 29, 2012.

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[15] See 42 C.F.R. § 431.412(c) and Paragraph 8 of the Special Terms and Conditions of the TennCare Demonstration Waiver.

[16] The details of the "State public notice process" are located at 42 C.F.R. § 431.408.

D. 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, as its name suggests, is to provide financial incentives to Medicaid providers[17] to replace outdated, often paper-based approaches to medical record-keeping with an electronic system that meets rigorous certification criteria and that can improve health care delivery and quality. Currently, Medicaid providers may qualify for two types of payments:

- First-year payments to providers who adopted, implemented, or upgraded to certified EHR technology capable of meeting "meaningful use" (i.e., use that is measurable in both quantity and quality) standards; and
- Second-year payments to providers who earned first-year payments in 2011 and achieved meaningful use of EHR technology for any period of 90 consecutive days in Fiscal Year 2012 (for eligible hospitals) and calendar year 2012 (for eligible professionals).

TennCare administers Tennessee's Medicaid EHR program, the funding for which is provided by the federal government.[18] During the April-June 2012 quarter, TennCare not only continued to distribute first-year incentives, but also opened the attestation process for—and began the distribution of—second-year incentives.

Building on the momentum that had been established during calendar year 2011 and that accelerated considerably during the January-March 2012 quarter, the Bureau exceeded even its own expectations from April through June 2012. In those three months alone, TennCare issued over $34 million of first-year payments to a total of 676 providers, including 399 physicians, 198 nurse practitioners, 36 hospitals, 34 dentists, 5 certified nurse midwives, and 4 physician assistants. This achievement is largely attributable to TennCare's evolving communications network related to the EHR program, some facets of which are a dedicated webpage (the introductory segment of which is located at http://www.tn.gov/tenncare/ehr_intro.shtml), newsletters distributed by the Bureau's EHR ListServ, and the TennCare Provider Incentive Payment Program ("PIPP") portal that became operational in November 2011.

Those tools played a significant role in TennCare's activation of the next phase of the program: second-year payments. The web portal, for instance, was the mechanism through which providers submitted documentation—or "attested"—that they met the meaningful use criteria for such payments. (Tennessee was one of only sixteen states to take this step in early April

[17] 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).

[18] The federal government covers 90% of administrative costs and 100% of the incentive payments.

2012.) In addition, because the standards for determining whether meaningful use has been achieved are highly technical, TennCare staff posted an overview of the subject on the Bureau's website at http://www.tn.gov/tenncare/mu.shtml; addressed the topic in ListServ newsletters on May 8 and June 5; hosted a webinar for providers on May 23; and made an in-person presentation at a meeting of Medical Directors hosted by the Tennessee Primary Care Association on May 18. Given this active outreach effort, 22 providers—11 physicians, 10 nurse practitioners, and 1 hospital—had successfully applied for and received second-year payments totaling $546,698 by the conclusion of the April-June quarter.

E. Approval of Waiver Amendment 16

On June 15, 2012, CMS notified the Bureau that Amendment 16 to the TennCare Demonstration had been approved. The purpose of Amendment 16 is to enable TennCare to take full advantage of the Medicaid Disproportionate Share Hospital (DSH) allotment appropriated to the State by Congress for Federal Fiscal Year 2012.

Prior to Amendment 16, certain payments made to hospitals by TennCare were subject to an annual cap of $540 million. This cap was developed on the basis of the amount of DSH funding appropriated by Congress when the current Demonstration extension was approved in 2007. It would not have been possible for the State to make use of the entire new DSH allotment appropriated by Congress and remain within the cap.

Therefore, the State proposed in Amendment 16 to reconfigure the current Special Terms and Conditions of the Demonstration so that the State would always have the capacity to make use of any DSH allotments made by Congress to Tennessee. TennCare estimates that implementation of Amendment 16 will result in an increase in aggregate annual expenditures of up to $28 million in State funds in the fiscal year.

F. New Pharmacy Leadership

On May 14, 2012, Bryan Leibowitz and Michael Polson joined the team responsible for managing TennCare's Pharmacy Division.

Dr. Leibowitz, who succeeds Nicole Woods as the Bureau's Director of Pharmacy, earned a Doctorate of Pharmacy degree from the Ernest Mario School of Pharmacy at Rutgers University. The range of his experience as a pharmacist—more than a decade spent in such varied disciplines as home infusion/specialty, hospital, retail, and pharmacy benefit management—uniquely qualifies Dr. Leibowitz to oversee the complexities of a program that accounted for more than $826 million of TennCare's budget in State Fiscal Year 2012.

Dr. Polson joins the Pharmacy Division as its Clinical Director. The chief function of this role is to ensure that TennCare's pharmacy benefit is clinically appropriate based on the latest guidelines and medical research. Dr. Polson's educational achievements—a bachelor's degree in mathematical sciences, a master's degree in statistics, and a Doctorate of Pharmacy—in

conjunction with his previous work experience at TennCare (within the Health Care Informatics Division) make him ideally suited for the position.

Providing optimal pharmaceutical care to TennCare enrollees within a fiscally responsible framework is the priority that both individuals have established in their tenure with the Bureau thus far.

G. Enhanced Coordination of Pharmacy Benefits and SXC Client Innovation Award

TennCare's Pharmacy Benefits Manager SXC Health Solutions presented its 2012 Client Innovation Award to TennCare on April 25. The honor was bestowed on the Bureau in recognition of its successful implementation of SXC's Enhanced Coordination of Benefits (Enhanced COB) program in July 2011. Accepting the award on behalf of TennCare were Director Darin Gordon and Chief Medical Officer Wendy Long.

Enhanced COB enables TennCare to detect other forms of pharmacy insurance that an enrollee may have before a claim is processed. Instead of paying for a medication initially and then pursuing reimbursement from another insurer at a later point (a cycle frequently referred to as "pay and chase"), TennCare may now identify other forms of coverage before payment is rendered and require the pharmacist who filled the prescription to seek compensation from those sources first. Information provided to the pharmacist in response to a submitted claim is much more detailed than in the past and is designed to make redirection easier. Conservative estimates indicate that savings generated by the Enhanced COB program are twice as much as those produced prior to its implementation. As a result, "enhanced third party pharmacy collection" was included in TennCare's budget for State Fiscal Year 2013 as a method of reducing the Bureau's expenditures by $9,634,600 ($7,200,000 of federal funds and $2,434,600 of state funds).

The benefits of Enhanced COB are not limited to cost avoidance alone. When multiple insurers pay for an individual's medications, there is less coordination of care and, consequently, a greater likelihood that hazardous drug interactions or excessive drug quantities may result. By continually directing pharmacists to their patients' primary source of prescription drug coverage, conversely, more effective monitoring of medication regimens may be achieved. Although the impact of Enhanced COB on patient safety is difficult to quantify, the principle of improved coordination among insurers and providers is a central tenet of TennCare's vision of health care.

H. Quality Oversight Awards

As part of its quarterly meeting with the Bureau's External Quality Review Organization and Managed Care Contractors (MCCs) on June 12, TennCare's Division of Quality Oversight presented its second annual awards to the MCCs that demonstrated "excellence in improving healthcare for members as well as innovative and emerging best practices."

Nominations and awards were based on recommendations from TennCare's Quality Oversight staff, TennCare's Medical Director, and the MCCs themselves. While some honors (such as "2012 Highest Annual Quality Survey Score Award" and "2011 Highest NCQA-Ranked TennCare Health Plan Award") recognized MCCs, others (like "Disease Management Collaboration Award" and "CHOICES Care Coordinator of the Year Award") were bestowed on individual MCC staff members. The "Best All Around Award", which acknowledges exceptional performance across a broad spectrum of disciplines, was presented to Amerigroup.

VI. Action Plans for Addressing Any Issues Identified

There were no action plans developed this quarter to address identified problems.

VII. Financial/Budget Neutrality Development Issues

On June 14, 2012, the Center for Business and Economic Research at the University of Tennessee released its biannual report describing the business and economic outlook for the state. While noting that economic growth at the national level is currently "plodding forward at only a modest pace,"[19] the report compared the Tennessee economy favorably to that of the entire United States: "Recent data portray a marginally healthier state economy compared to the national economy, although there are exceptions."[20]

Nonfarm employment was specifically cited as one area of the economy that, in 2011 and the first quarter of 2012, performed considerably better in Tennessee than in the nation as a whole. However, over the same time period, there were some weak spots for Tennessee, such as manufacturing employment growth. Nevertheless, 2011 "represented the best year of income and nonfarm employment growth for the state economy since before the start of the recession."[21] Furthermore, while conceding that setbacks are possible, the authors of the report anticipate that 2012 should continue along a similar path to 2011, and that further growth will most likely be achieved in 2013.

In addition to this moderately favorable economic report, data from the Tennessee Department of Finance and Administration also suggest reason for optimism. Total tax collections in April, May, and June were well above budgeted expectations. June revenues were especially promising, coming in at $125.4 million more than had been anticipated.[22]

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[19] Center for Business and Economic Research, University of Tennessee, "Tennessee Business and Economic Outlook: Spring 2012," June 14, 2012, page 1. See http://cber.bus.utk.edu/tefs/spr12.pdf.
[20] Ibid., page 5.
[21] Ibid., page 5.
[22] See http://www.tn.gov/finance/newsrel/newsroom.shtml.

VIII. Member Month Reporting

Tables 10 and 11 below present the member month reporting by eligibility group for each month in the quarter.

Table 10
Member Month Reporting for Use in Budget Neutrality Calculations
April - June 2012

Eligibility Group	April 2012	May 2012	June 2012	Average for Quarter Ending 6/30/12
EG1 Disabled, Type 1 State Plan eligibles	126,604	126,106	125,171	125,960
EG1 Disabled, Type 2 Demonstration Population	0	0	0	0
EG9 H-Disabled, Type 2 Demonstration Population	4,222	4,218	4,235	4,225
EG2 Over 65, Type 1 State Plan eligibles	262	314	464	347
EG2 Over 65, Type 2 Demonstration Population	0	0	0	0
EG10 H-Over 65, Type 2 Demonstration Population	28	31	35	31
EG3 Children, Type 1 State Plan eligibles	649,331	649,216	648,945	649,164
EG4 Adults, Type 1 State Plan eligibles	283,192	283,241	282,762	283,065
EG4 Adults, Type 2 Demonstration Population	0	0	0	0
EG5 Duals, Type 1 State Plan eligibles	140,792	139,939	138,482	139,738
EG8 Med Exp Child, Type 2 Demonstration Population, Optional Targeted Low Income Children funded by Title XIX	0	0	0	0
TOTAL	1,204,431	1,203,065	1,200,094	1,202,530

- **Rounding may cause a discrepancy between the sum of the quarterly averages and their respective totals.**

Table 11
Member Month Reporting Not Used in Budget Neutrality Calculations
April - June 2012

Eligibility Group	April 2012	May 2012	June 2012	Average for Quarter Ending 6/30/12
EG6E Expan Adult, Type 3, Demonstration Population	1,082	1,017	976	1,025
EG7E Expan Child, Type 3, Demonstration Population	2,039	2,060	2,015	2,038
Med Exp Child, Title XXI Demonstration Population	16,051	16,679	15,889	16,206
TOTAL	19,172	19,756	18,880	19,269

IX. Consumer Issues

Eligibility Appeals. TennCare eligibility appeals are handled by the Tennessee Department of Human Services. Table 12 presents a summary of the number and types of eligibility appeals handled during the quarter, compared to the previous two quarters.

Table 12
Eligibility Appeals Handled by the Department of Human Services
During the April – June 2012 Quarter, Compared to the Previous Two Quarters

	Oct – Dec 2011	Jan – Mar 2012	Apr – Jun 2012
TennCare Medicaid			
No. of appeals received	3,311	3,971	3,589
No. of appeals resolved or withdrawn	2,002	1,906	1,532
No. of appeals taken to hearing	1,563	1,636	1,370
No. of appeals that did not involve a valid factual dispute	1,657	1,550	1,590
Appeals previously heard that were decided in the State's favor	1,063	1,044	928
Appeals previously heard that were decided in the appellant's favor	143	107	87
TennCare Standard			
No. of appeals received	246	228	125
No. of appeals resolved or withdrawn	127	114	48
No. of appeals taken to hearing	186	111	60
No. of appeals that did not involve a valid factual dispute	79	82	47

	Oct – Dec 2011	Jan – Mar 2012	Apr – Jun 2012
Appeals previously heard that were decided in the State's favor	77	71	45
Appeals previously heard that were decided in the appellant's favor	10	18	6

Medical Service Appeals. Medical service appeals are handled by the Bureau of TennCare. Table 13 below presents a summary of the medical service appeals handled during the quarter, compared to the previous two quarters.

Table 13
Medical Service Appeals Handled by the Bureau of TennCare
During the April – June 2012 Quarter, Compared to the Previous Two Quarters

	Oct – Dec 2011	Jan – Mar 2012	Apr – Jun 2012
No. of appeals received	1,393	1,254	1,145
No. of appeals resolved	1,373	1,350	1,203
• Resolved at the MCC level	577	504	511
• Resolved at the TSU level	247	214	193
• Resolved at the LSU level	549	632	499
No. of appeals that did not involve a valid factual dispute	330	270	278
No. of directives issued	245	198	172
No. of appeals taken to hearing	549	632	499
No. of appeals that were withdrawn by the enrollee at or prior to the hearing	195	248	181
Appeals that went to hearing and were decided in the State's favor	112	144	123
Appeals that went to hearing and were decided in the appellant's favor	32	27	15

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.

Long-Term Services and Supports 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.

Table 14
Long-Term Services and Supports Appeals for April – June 2012
Compared to the Previous Two Quarters

	Oct – Dec 2011	Jan – Mar 2012	Apr – Jun 2012
No. of appeals of PAE denials	87	95	116
No. of appeals of PASRR determinations	1	6	5
No. of appeals of denial of enrollment into CHOICES	17	15	23
No. of appeals of involuntary disenrollment from CHOICES	8	10	6
No. of appeals of denial of Consumer Direction	0	0	0
No. of appeals of involuntary withdrawal of Consumer Direction	0	0	1
No. of appeals withdrawn prior to hearing*	--	3	1
No. of appeals dismissed at hearing*	--	10	17
No. of appeals that went to hearing and were decided in the State's favor	4	1	23[23]
No. of appeals that went to hearing and were decided in the appellant's favor	0	0	2

* These categories were not tracked until the January-March 2012 quarter.

[23] The substantial increase in the number of appeals resolved in favor of the State is attributable to the fact that several cases continued in previous quarters were finally heard and decided this quarter.

X. Quality Assurance/Monitoring Activity

Disease Management (DM). MCOs are required to have the following ten DM programs.

- Asthma
- Bipolar Disorder
- Chronic Obstructive Pulmonary Disease (COPD)
- Congestive Heart Failure (CHF)
- Coronary Artery Disease (CAD)
- Diabetes
- Major Depression
- Maternity Management
- Obesity
- Schizophrenia

The focus of DM programs is on preventing worsening of and complications from these diseases. DM programs educate members in order to increase their understanding of their condition(s) and the factors that affect their health status, as well as to empower members to be more effective in self-care and management of their health. Information on enrollment in DM is provided in Table 15. Figures for the period of April through June, 2012, will be provided in the next Quarterly Progress Report.

Table 15
DM Program Enrollment, January - March 2012
Compared to the Previous Two Quarters[24]

DM Program	July – Sept 2011		Oct – Dec 2011		Jan – Mar 2012	
	Non-CHOICES Members	CHOICES Members	Non-CHOICES Members	CHOICES Members[25]	Non-CHOICES Members[26]	CHOICES Members[27]
Asthma	121,697	272	120,443	191	109,494	31
Bipolar	24,033	161	26,090	125	21,579	17
Chronic Obstructive Pulmonary Disease	8,896	1,494	9,086	407	3,712	55
Congestive Heart Failure	4,274	1,491	4,300	504	1,616	189
Coronary Artery Disease	8,392	882	8,681	266	4,978	55
Diabetes	26,716	2,768	26,341	1,082	16,501	524
HIV[28]	268	4	250	5	254	6
Hypertension[29]	4,415	33	3,708	126	4,255	133
Major Depression	54,013	460	56,975	248	51,622	49
Maternity	17,488	0	15,720	0	15,853	0
Multiple	25,139	204	23,515	173	48,050[30]	279

[24] The numbers in this table reflect DM enrollment at the end of the quarter and are not unduplicated: a person enrolled in two different MCOs during the reporting period could be counted in a particular DM program twice. In addition, some persons may be enrolled in more than one DM program. Nonetheless, as described in Footnote 26, efforts to reduce statistical duplication are underway.

[25] CHOICES members' enrollment in several DM programs appears to have declined during the October-December quarter. This statistical fluctuation is the result of a reporting error by UnitedHealthcare Community Plan: in previous quarters, the managed care organization had counted all CHOICES members eligible for DM, when only CHOICES members receiving DM interventions should have been counted.

[26] Lower numbers in several DM categories for non-CHOICES members during the January-March 2012 quarter do not reflect an actual decrease in enrollment; rather, they represent less duplication. Instead of counting one individual who suffers from both asthma and hypertension in both categories, for instance, the MCOs have begun counting such individuals in the "multiple conditions" category, a move that explains the doubling of the "multiple conditions" population this quarter. (Until 2012, MCOs' use of the "multiple conditions" designation varied: UnitedHealthcare Community Plan, for instance, had never previously assigned members to this category.)

[27] Continued declines in the enrollment of CHOICES members in DM programs during the January-March 2012 quarter are the result of protocols that were introduced at the end of 2011 but that did not begin to have an effect until 2012. These protocols include removing CHOICES 1 (Nursing Facility) members who have been determined incapable of DM participation and allowing CHOICES 2 (HCBS) members to opt out of DM enrollment.

[28] A DM program for HIV is not a requirement, but AmeriGroup has chosen to have a program for this condition.

[29] A DM program for Hypertension is not a requirement, but AmeriGroup has chosen to have a program for this condition.

[30] The dramatic rise in enrollment in the "multiple conditions" category is explained in Footnote 26.

DM Program	July – Sept 2011		Oct – Dec 2011		Jan – Mar 2012	
	Non-CHOICES Members	CHOICES Members	Non-CHOICES Members	CHOICES Members[25]	Non-CHOICES Members[26]	CHOICES Members[27]
Conditions						
Obesity	32,620	335	33,911	204	23,270	14
Other[31]	8,476	373	20,356[32]	268	19,133	288
Schizophrenia	7,255	165	7,328	66	6,098	53
Total DM Enrollment	**343,682**	**8,642**	**356,704**	**3,665**	**326,415**	**1,693**
Total CHOICES and Non-CHOICES DM Enrollment	**352,324**		**360,369**		**328,108**	

Provider Data Validation Report. During April 2012, TennCare's External Quality Review Organization (EQRO), Qsource, published the results of its quarterly provider data validation survey. Qsource took a sample of provider data files from TennCare's MCCs[33] 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 children under age 21
- Services to adults 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 health plans' accuracy rates have maintained a high level," especially in the categories of "active contract status with

[31] Other conditions for which AmeriGroup has chosen to establish DM programs include transplants, End Stage Renal Disease, etc.

[32] The substantial increase in enrollment of non-CHOICES members in the "Other" category is attributable to two factors. First, the DM program converted its data registry from Access/SQL to CareCompass; as a result, the extraction of population-level data changed within the new reporting environment. Second, more non-CHOICES members were passively enrolled into DM, both through the distribution of Program Enrollment Packages, and through a higher volume of calls made by the Eliza automated phone system.

[33] TennCare's pharmacy benefits manager (PBM) was not included in the survey.

MCC" (98.1 percent accuracy), "provider credentialed specialty / behavioral health service code" (97.8 percent accuracy), "availability of routine care services" (97.5 percent accuracy), "primary care services" (99.0 percent accuracy), and "prenatal care services" (99.5 percent accuracy). Furthermore, the MCCs' overall accuracy rate improved in eight of the ten categories addressed by the survey.

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 "open/closed to new patients," which demonstrated only 92.2 percent accuracy), TennCare required each of its MCCs to submit Corrective Action Plans by June 5. The Bureau had received, reviewed, and accepted all of the plans by June 7.

XI. Demonstration Evaluation

On October 31, 2011, the State submitted the Draft Annual Report as required by STC #48. Part V of that report provided the progress to date on the performance measures that were outlined in the approved Evaluation Design. It is the State's intention to update the performance measures in each Annual Report.

In addition, 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.

XII. Essential Access Hospital Pool[34]

A. Safety Net Hospitals

Regional Medical Center (The MED)
Erlanger Medical Center
Vanderbilt University Hospital
University of Tennessee Memorial Hospital
Johnson City Medical Center Hospital
Metro Nashville General Hospital

B. Children's Hospitals

LeBonheur Children's Medical Center

[34] 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.

East Tennessee Children's Hospital

C. Free Standing Psychiatric Hospitals

Pathways of Tennessee
Ridgeview Psychiatric Hospital and Center
Community Behavioral Health

D. Other Acute Care Hospitals

Jackson - Madison County General Hospital
Methodist Healthcare - South
Parkridge Medical Center (with Parkridge Valley Psych)
Parkwest Medical Center (with Peninsula Psych)
Methodist University Healthcare
Saint Jude Children's Research Hospital
Centennial Medical Center
Saint Francis Hospital
Delta Medical Center
University Medical Center
Skyline Medical Center (with Skyline Madison)
Wellmont Holston Valley Medical Center
Maury Regional Hospital
Mercy Medical Center
Fort Sanders Regional Medical Center
Middle Tennessee Medical Center
Methodist Healthcare – North
Gateway Medical Center
Cookeville Regional Medical Center
Baptist Hospital
Wellmont Bristol Regional Medical Center
Skyridge Medical Center
Baptist Memorial Hospital for Women
Parkridge East Hospital
Morristown - Hamblen Healthcare System
NorthCrest Medical Center
Summit Medical Center
Regional Hospital of Jackson
LeConte Medical Center
Sweetwater Hospital Association
Sumner Regional Medical Center
StoneCrest Medical Center
Baptist Hospital of Cocke County
Dyersburg Regional Medical Center

Methodist Medical Center of Oak Ridge
Southern Hills Medical Center
Baptist Memorial Hospital – Tipton
Horizon Medical Center
Blount Memorial Hospital
United Regional Medical Center
Saint Mary's Medical Center of Campbell County
Takoma Regional Hospital
Harton Regional Medical Center
Jellico Community Hospital
Hendersonville Medical Center
Sycamore Shoals Hospital
Athens Regional Medical Center
Lakeway Regional Hospital
Hardin Medical Center
Heritage Medical Center
Henry County Medical Center
Indian Path Medical Center
Crockett Hospital
Saint Mary's Jefferson Memorial Hospital
River Park Hospital
Humboldt General Hospital
Southern Tennessee Medical Center
Grandview Medical Center
Bolivar General Hospital
Claiborne County Hospital
Lincoln Medical Center
Wellmont Hawkins County Memorial Hospital
Baptist Memorial Hospital – Union City
Jamestown Regional Medical Center
Roane Medical Center
Hillside Hospital
Skyridge Medical Center – West
Riverview Regional Medical Center – North
Livingston Regional Hospital
Volunteer Community Hospital
Methodist Healthcare – Fayette
McKenzie Regional Hospital
Wayne Medical Center
McNairy Regional Hospital
Henderson County Community Hospital
Haywood Park Community Hospital
Baptist Memorial Hospital – Huntingdon
Erlanger East Hospital

Gibson General Hospital
Johnson City Specialty Hospital
White County Community Hospital
Decatur County General Hospital
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 hospitals are as 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

Macon County General Hospital
Three Rivers Hospital
Baptist-Hickman Community Hospital

Trousdale Medical Center
Johnson County Community Hospital
Erlanger-Bledsoe Medical
Riverview Regional Medical Center-South
Medical Center of Manchester
Marshall Medical Center
Rhea Medical Center
Patient's Choice Medical Center of Erin (formerly Trinity Hospital)
Wellmont Hancock County Hospital
Centennial Medical Center of Ashland City
Copper Basin Medical CT Copperhill
Camden General Hospital
Baptist Memorial Hospital-Lauderdale
Scott County Hospital

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Date Submitted to CMS: August 30, 2012

Attachment A

Budget Neutrality Calculations for the Quarter

Actual TennCare Budget Neutrality (April - June 2012)

I. The Extension of the Baseline

Baseline PMPM

	FY 2012 PMPM
1-Disabled (can be any ages)	$1,432.78
2-Child <=18	$428.37
3-Adult >= 65	$951.45
4-Adult <= 64	$826.25
Duals (17)	$604.23

Actual Member months of Groups I and II

1-Disabled (can be any ages)	377,881
2-Child <=18	1,947,492
3-Adult >= 65	1,040
4-Adult <= 64	849,195
Duals (17)	419,213
Total	3,594,821

Ceiling without DSH

	Baseline * MM
1-Disabled (can be any ages)	$541,421,214
2-Child <=18	$834,250,952
3-Adult >= 65	$989,510
4-Adult <= 64	$701,648,173
17s	$253,301,866
Total	$2,331,611,714

DSH

DSH Adjustment (Quarterly)	$115,999,213

Total Ceiling

Budget Neutrality Cap	
Total w/DSH Adj.	$2,447,610,927

II. Actual Expenditures

Group 1 and 2

1-Disabled (can be any ages)	$ 477,907,331
2-Child <=18	$ 408,539,962
3-Adult >= 65	$ 4,780,062
4-Adult <= 64	$ 309,936,096

Duals (17)	$	390,651,451
Total		**1,591,814,902**

Group 3

1-Disabled (can be any ages)	$	59,036,458
2-Child <=18	$	1,146,460
3-Adult >= 65	$	-
4-Adult <= 64	$	2,023,711
Duals (17)	$	-
Total		**62,206,628**

Pool Payments and Admin

Total Pool Payments		**196,040,547**

Admin	**$**	**137,981,917**

Quarterly Drug Rebates		($136,826,163)
Quarterly Premium Collections		($485,713)
Total Net Quarterly Expenditures	**$**	**2,125,355,870**

III. Surplus/(Deficit)

	$322,255,057
Federal Share	**$213,848,456**

HCI Result	MM201204	MM201205	MM201206
EG1-TYPE1 (disabled, type1 state plan eligibles)	126,320	125,760	124,788
EG1-TYPE2 (disabled, type2 transition group)	66	69	73
EG2-TYPE1 (over 65, type1 state plan eligibles)	259	308	406
EG2-TYPE2 (over 65, type2 state plan eligibles)			
EG3-TYPE1 (children, type1 state plan eligibles)	661,996	651,490	650,143
Med Exp Child (Title XXI Demo Pop; EG3-Type2)			
EG4-TYPE1 (adults, type1 State plan eligibles)	286,140	283,969	283,197
EG4-TYPE2 (adults, type2 demonstration pop)	504	494	510
EG5-TYPE1 (duals, state plan eligibles)	140,679	139,678	138,352
EG6E-TYPE3 (Expan adult, type3 demonstration pop)	1,087	1,018	977
EG7E-TYPE3 (Expan child, type3 demonstration pop)	1,970	2,011	1,939
EG8-TYPE2 (emd exp child) ~ SCHIP	16,323	16,932	15,967
EG9 H-Disabled (TYPE 2 Eligibles)	4,249	4,235	4,258
EG10 H	28	31	35
Unknown			
Total	**1,239,621**	**1,225,995**	**1,220,645**

HCI Result	MM201204	MM201205	MM201206
EG1-TYPE1 (disabled, type1 state plan eligibles)	126,604	126,106	125,171
EG1-TYPE2 (disabled, type2 transition group)	0	0	0
EG2-TYPE1 (over 65, type1 state plan eligibles)	262	314	464
EG2-TYPE2 (over 65, type2 state plan eligibles)			
EG3-TYPE1 (children, type1 state plan eligibles)	649,331	649,216	648,945
Med Exp Child (Title XXI Demo Pop; EG3-Type2)			
EG4-TYPE1 (adults, type1 State plan eligibles)	283,192	283,241	282,762
EG4-TYPE2 (adults, type2 demonstration pop)	0	0	0
EG5-TYPE1 (duals, state plan eligibles)	140,792	139,939	138,482
EG6E-TYPE3 (Expan adult, type3 demonstration pop)	1,082	1,017	976
EG7E-TYPE3 (Expan child, type3 demonstration pop)	2,039	2,060	2,015
EG8-TYPE2 (emd exp child)	16,051	16,679	15,889
EG9 H-Disabled (TYPE 2 Eligibles)	4,222	4,218	4,235
EG10 H	28	31	35
Unknown			
Total	1,223,575	1,222,790	1,218,939

Adjusted TOTALs after Exclusion of EG6 Type 3, EG7 Type 3, EG3 Title 21

TOTAL	**1,236,564**	**1,222,966**	**1,217,729**
TOTAL	**1,220,454**	**1,219,713**	**1,215,948**

According to Waiver: The Budget Neutrality Calculation excludes: EG6 Type 3, EG7 Type 3, EG3 Title 21

TOTAL	Dental	RX	ASO	MCO Cap
376,868	2,135,561	$86,100,851	$88,933,390	$ 299,574,782
208				
973		$86,062	4,179	$ 1,693,753
-				$ 2,963,078
1,963,629	33,956,724	$56,065,313	$61,639,952	$ 288,015,132
-				
853,306	4,479,651	$48,944,324	$343,119	$ 258,509,609
1,508	9,222			
418,709	55,577	3,720,331	$1,297,269	$ 382,937,745
3,082		$306,222		$ 1,703,522
5,920	135,252	$544,782	$321	$ 593,444
49,222	1,108,823	$1,990,270	$24,349	$ 4,831,359
12,742		$2,267,804	$129	$ 56,361,081
94		$5,056		
				$ 11,055,468
3,686,261	**41,880,810**	**$200,025,960**	**$152,242,708**	**$ 1,391,090,108**

TOTAL	Dental	RX	Fee for Service, Dental, ASO	MCO Cap
377,881	$1.89	$76.15	$78.66	$264.97
-	$0.00	$0.00	$0.00	$0.00
1,040	$0.00	$29.48	$1.43	$580.25
-	-	-	-	-
1,947,492	$5.76	$9.52	$10.46	$48.89
-	$0.00	$0.00	$0.00	$0.00
849,195	$1.75	$19.12	$0.13	$100.98
-	$2.04	$0.00	$0.00	$0.00
419,213	$0.04	$2.96	$1.03	$304.86
3,075	$0.00	$33.12	$0.00	$184.24
6,114	$7.62	$30.67	$0.02	$33.41
48,619	$7.51	$13.48	$0.16	$32.72
12,675	$0.00	$59.33	$0.00	$1,474.42
94				
	$0.00	$0.00	$0.00	$0.00
3,665,304	$3.79	$18.09	$13.77	$125.79

1693753

3,677,259		**199,174,955**	**152,242,387**	**1,388,793,142**
3,656,115			**$13.88**	**$126.62**

UNK Allocation	Taxes	Allocation on Differences between DV and HCI-CAP	TOTAL
$ 3,298,308.07	$ -	$ -	**$477,907,331.31**
$ -	$ -	$ -	**$0.00**
$ 12,397.91	$ -	$ -	**$1,796,391.91**
$ 20,591.99	$ -	$ -	**$2,983,669.99**
$ 2,819,564.73	$ -	$ -	**$408,539,961.73**
$ -	$ -	$ -	**$0.00**
$ 2,139,043.83	$ -	$ -	**$309,936,095.83**
$ -	$ -	$ -	**$0.00**
$ 2,696,106.02	$ -	$ -	**$390,651,451.02**
$ 13,966.77	$ -	$ -	**$2,023,711.07**
$ 7,912.36	$ -	$ -	**$1,146,459.55**
$ 47,576.31	0	0	**$6,893,554.65**
$ 407,443.90			**$59,036,457.72**
$ -			
$ 11,055,468.00	$ -	$ -	**$1,660,915,084.79**

UNK Allocation	Taxes	Allocation on Differences between DV and HCI-CAP	TOTAL
$2.92	$0.00	$0.00	**$422.70**
$0.00	$0.00	$0.00	**$0.00**
$4.25	$0.00	$0.00	**$615.41**
-	-	-	**-**
$0.48	$0.00	$0.00	**$69.35**
$0.00	$0.00	$0.00	**$0.00**
$0.84	$0.00	$0.00	**$121.07**
$0.00	$0.00	$0.00	**$0.00**
$2.15	$0.00	$0.00	**$311.00**
$1.51	$0.00	$0.00	**$218.87**
$0.45	$0.00	$0.00	**$64.55**
$0.32	$0.00	$0.00	**$46.68**
$10.66	$0.00	$0.00	**$1,544.41**
$0.00	$0.00	$0.00	**$0.00**
$1.00	$0.00	$0.00	**$150.19**

11,033,589	**-**	**-**	**1,657,744,914**
$1.01	**$0.00**	**$0.00**	**$151.14**