TN Division of Health Care Finance & Administration

August 31, 2016

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

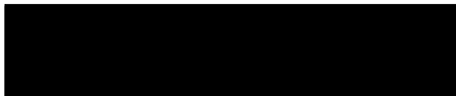
RE: TennCare II, STC 46, Quarterly Progress Report

Dear Ms. Woodard:

Enclosed please find the Quarterly Progress Report for the April – June 2016 quarter. This report is being submitted in accordance with STC 46.

Please let us know if you have comments or questions.

Sincerely,



Wendy Long, M.D.
Director, Bureau of TennCare

cc: 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

Bureau of TennCare • 310 Great Circle Road • Nashville, TN 37243
Tel: 615-507-6480 • tn.gov/tenncare

TennCare II

Section 1115 Quarterly Report

(For the period April - June 2016)

Demonstration Year: 14 (7/1/15 - 6/30/16)
Federal Fiscal Quarter: 3/2016 (4/16 - 6/16)
Waiver Quarter: 4/2016 (4/16 - 6/16)

I. Introduction

The goal of the TennCare Demonstration is to show that careful use of a managed care approach can enable the State to deliver quality care to all enrollees without spending more than would have been spent had the State continued its Medicaid program.

The Bureau of TennCare contracts with several Managed Care Contractors (MCCs) to provide services to over 1.5 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 April-June 2016 quarter	CMS identified priorities related to Tennessee’s application to renew the TennCare Demonstration (referred to simply as “renewal application” elsewhere in this table), as well as questions tied to each priority. The State, in turn, supplied written responses—and, where needed, data reports—in response to the questions.	
4/1/16	The rescheduled Monthly Call for March was held.	45
4/8/16	In response to the State’s 2/22/16 request, CMS issued technical corrections to the 1115 waiver document that had accompanied approval of Demonstration Amendments 27 and 28.	
4/28/16	In lieu of a formal Monthly Call, the CMS Project Officer communicated a tentative schedule of conference calls to address priorities related to the renewal application.	
4/29/2016	The State sent information to CMS about the enrollment targets to be used in the Employment and Community First CHOICES program.	33.d.ii.

Date	Action	STC #
5/5/16	The State submitted MCO Contract Amendment 4 and TennCare Select Contract Amendment 39 to CMS for review. In addition, the State received an amended approval letter from CMS regarding MCO Contract Amendment 3 and TennCare Select Contract Amendment 38.	41
5/17/16	The State sent the CMS Project Officer a courtesy copy of State Plan Amendment TN-16-0002, which authorizes the eligibility and enrollment administrative contractor for Tennessee's CHIP program to make presumptive eligibility determinations for pregnant women.	7
5/26/16	The Monthly Call for May was held.	45
5/31/16	The State submitted the Quarterly Progress Report for the January-March 2016 quarter to CMS.	46
6/1/2016	The State sent CMS information about the criteria to be used to reserve slots in the Employment and Community First CHOICES program.	33.d.iv.
6/23/16	The Monthly Call for June was held.	45
6/27/16	The State submitted point-in-time and annual aggregate data about the CHOICES program to CMS.	44.d.
6/30/2016	The State submitted to CMS a revised quality improvement strategy. The quality improvement strategy had been revised to address the implementation of Employment and Community First CHOICES.	44.c.
6/30/2016	CMS issued a letter approving the continued operation of the TennCare demonstration under the existing terms and conditions through August 31, 2016.	

II. Enrollment and Benefits Information

Information about enrollment by category is presented in Table 2.

Table 2
Enrollment Counts for the April – June 2016 Quarter
Compared to the Previous Two Quarters

Demonstration Populations	Total Number of TennCare Enrollees		
	Oct – Dec 2015	Jan – Mar 2016	Apr – Jun 2016
EG1 Disabled, Type 1 State Plan eligibles	142,136	143,752	145,195
EG9 H-Disabled, Type 2 Demonstration Population	282	258	247

Demonstration Populations	Total Number of TennCare Enrollees		
	Oct – Dec 2015	**Jan – Mar 2016**	**Apr – Jun 2016**
EG2 Over 65, Type 1 State Plan eligibles	141	206	235
EG10 H-Over 65, Type 2 Demonstration Population	44	38	36
EG3 Children, Type 1 State Plan eligibles	759,289	773,217	782,727
EG4 Adults, Type 1 State Plan eligibles	428,937	448,332	462,175
EG5 Duals, Type 1 State Plan eligibles and EG11 H-Duals 65, Type 2 Demonstration Population	145,490	147,871	149,707
EG6E Expan Adult, Type 3 Demonstration Population	793	780	757
EG7E Expan Child, Type 3 Demonstration Population	61	55	40
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	18,734	18,634	18,515
EG12E Carryover, Type 3, Demonstration Population	3,531	3,223	2,904
TOTAL*	1,499,438	1,536,366	1,562,538

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

The majority of TennCare's enrollment continues to be categorized as Type 1 EG3 children and Type 1 EG4 adults, with 80 percent of TennCare enrollees appearing in one of these categories.

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

Table 3
TennCare Managed Care Contractors as of June 30, 2016

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

Employment and Community First CHOICES. Employment and Community First CHOICES is the first managed long-term services and supports program in the nation that is focused on promoting and supporting integrated, competitive employment and independent community living as the first and preferred option for people with intellectual and other types of developmental disabilities.

Employment and Community First CHOICES offers three different benefit packages:

- Essential Family Supports for families caring for a loved one with an intellectual or developmental disability;
- Essential Supports for Employment and Independent Living for adults with an intellectual or developmental disability who are transitioning out of school or who need support to achieve employment and independent living goals; and
- Comprehensive Supports for Employment and Community Living for adults with an intellectual or developmental disability who have more intense needs and require more comprehensive supports to achieve their employment and community living goals.

This tiered benefit structure based on the needs of people supported and their families, with appropriate cost caps and expenditure controls, will help TennCare to begin serving people with intellectual disabilities in Tennessee more cost-effectively, allowing more Tennesseans who need these services to receive them. This includes people currently on the waiting list for services and people with other kinds of developmental disabilities.

After a year and a half of intensive work with stakeholders, TennCare submitted a formal proposal for Employment and Community First CHOICES to CMS in June 2015, and CMS ultimately approved the proposal in February 2016. With federal approval secured and implementation activities well underway, the Bureau devoted several additional months to

[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).

readiness, ensuring that the implementation scheduled for July 1, 2016, would proceed as seamlessly as possible. During the April-June 2016 quarter, these preparations included provider training and outreach activities, as well as readiness review tasks related to TennCare's MCOs, including desk deliverables, systems testing, and systems-related demonstrations. By the conclusion of the quarter, final preparations were complete, and the MCOs had been cleared to proceed with program implementation.

As importantly, during the quarter, the Tennessee General Assembly approved funding to serve up to 1,700 people in the first year, offering long needed supports to many Tennesseans with intellectual and developmental disabilities and their families.

Tennessee Eligibility Determination System. Tennessee Eligibility Determination System (or "TEDS") is the name of the system that will be used by the State to process applications and identify persons who are eligible for TennCare and CoverKids.

Instead of consolidating all aspects of the project under one vendor, the State opted to procure three separate contracts to address the following functions:

- Technical advisory services;
- Strategic Program Management Office (SPMO) services; and
- Systems integration services.

By the end of Calendar Year 2015, two of the three contracts had been awarded and implemented. KPMG, LLP successfully bid on the technical advisory services contract, which went into effect on September 1, 2015. The contract for SPMO services was awarded to Public Consulting Group, Inc. and took effect on November 1, 2015.

During the April-June 2016 quarter, procurement of the third contract for systems integration services neared completion. The State issued a Request for Qualifications on April 1, 2016, and, by the end of the quarter, responses from vendors had been received and evaluated. As of June 30, 2016, the State planned to announce the successful bidder in July.

Demonstration Amendment 30: Program Modifications. During March and April 2016, TennCare held a public notice and comment period concerning a demonstration amendment that was being developed. Amendment 30 was based on demonstration amendments from prior years that outlined program reductions to be made if the Tennessee General Assembly did not pass or renew a one-year hospital assessment fee. The reductions contemplated in Amendment 30 included limits on inpatient hospital services, outpatient hospital visits, health care practitioners' office visits, and lab and X-ray services, as well as the elimination of certain kinds of therapy.

By the time the public notice period concluded on April 18, 2016, the State had received two sets of comments, each of which expressed concern about the impact that the potential reductions could have on TennCare enrollees (especially those with serious and/or chronic

conditions). As was the case in previous years, however, the General Assembly renewed the hospital assessment fee, thereby eliminating the need for Amendment 30 to be submitted to CMS.

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 April-June 2016 quarter, the State received no notifications that a family with members enrolled in TennCare Standard had met its cost sharing limit. It should be noted that this is the fourteenth consecutive quarter since the plan was implemented in which no notifications have been received.

III. Innovative Activities to Assure Access

Early and Periodic Screening, Diagnosis and Treatment (EPSDT). EPSDT, or "TennCare Kids," outreach is a significant area of interest for TennCare. 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. Each year, National Children's Dental Health Month in February, back-to-school events in August, and Child Health Week in October all have an 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 one 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
April – June 2016 Compared to the Previous Two Quarters

Activities	Oct – Dec 2015	Jan – Mar 2016	Apr – Jun 2016
Number of outreach activities/events	3,141	3,127	3,111
Number of people made contact with (mostly face to face at outreach events)	188,186	138,556[4]	155,997
Number of educational materials distributed	180,304	143,622	122,159
Number of coalitions/advisory board meetings attended or conducted	68	88	94
Number of attendees at coalitions/advisory board meetings	1,121	1,637	1,731
Number of educational preventive health radio/TV broadcasts	1,067	1,264	1,042
Number of educational preventive health newsletter/magazine articles	45	64	39
Number of educational preventive health billboards, scrolling billboards and bulletin boards	5,807	7,194	6,162
Number of presentations made to enrollees/professional staff who work with enrollees	129	134	101
Number of individuals attending presentations	3,699	4,786	2,078
Number of completed telephone calls regarding the importance of dental checkups	305	368	490
Number of home visits completed	30	196	363

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

[4] Lower turnout at community outreach events during the January-March 2016 quarter is attributable in part to inclement weather during the first two months of the year.

Table 5
Tennessee Department of Health
TennCare Kids Call Center Activity
April – June 2016 Compared to the
Previous Two Quarters

Activities	Oct – Dec 2015	Jan – Mar 2016	Apr – Jun 2016
Number of enrollees reached	23,913	21,137	22,295
Number of enrollees who were assisted in scheduling an EPSDT exam for their children	723	637	784
Number of enrollees who were assisted in arranging for transportation	37	16	29

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 2016 Quarter, and Percentage that Passed Systems Edits, Compared to the Previous Two Quarters

	Oct – Dec 2015	Jan – Mar 2016	Apr – Jun 2016
No. of encounters received by TennCare (initial submission)	15,597,491	17,161,264[5]	16,181,311
No. of encounters rejected by Edifecs upon initial submission	19,529	71,521	11,689
Percentage of encounters that were compliant with State standards (including HIPAA) upon initial submission	99.87%	99.58%	99.93%

[5] During the January-March 2016 quarter, two sets of encounter data were reprocessed: Amerigroup resubmitted transportation claims that had originally been denied instead of being paid at $0, and UnitedHealthcare resubmitted claims involving an incorrect billing provider. These reprocessing projects help explain the higher volume of encounters during the quarter.

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 April – June 2016 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		
		Oct – Dec 2015	Jan – Mar 2016	Apr – Jun 2016
CHOICES 1	Not applicable	17,202	17,136	17,141
CHOICES 2	12,500	8,588	8,744	8,857
CHOICES 3 (including Interim CHOICES 3)	To Be Determined	4,376	4,052	3,797
Total CHOICES	Not applicable	30,166	29,932	29,795
Reserve capacity	300	300	300	300

The CMS letter approving CHOICES implementation in Middle Tennessee dated February 26, 2010, and STCs 44 and 46 require specific monitoring and reporting activities that include:

Data and trends of the designated CHOICES data elements: STC 44.d. requires the State to submit to CMS periodic statistical reports about the use of LTSS by TennCare enrollees. Ten separate reports—spanning the period of August 2011 through June 2016—had been submitted by the conclusion of the April-June 2016 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 17,069 individuals on June 30, 2015. This downward trend was even more pronounced for new LTSS recipients, 81 percent of whom had been

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

admitted to NFs in the year prior to implementation of the CHOICES program, as compared with 49 percent admitted to NFs in the fifth year of CHOICES.

By contrast, appropriate use of HCBS by TennCare enrollees grew significantly during these years. The aggregate number of members accessing HCBS increased from 6,226 in the twelve-month period preceding CHOICES implementation in Middle Tennessee to 16,454 after CHOICES had been in place for five 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 13,240 by June 30, 2015. 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), 7/1/14 – 6/30/15	Percent increase over a five-year period	No. of TennCare enrollees accessing HCBS (E/D) on the day prior to CHOICES implementation	No. of TennCare enrollees accessing HCBS (E/D) on 6/30/15	Percent increase from the day prior to CHOICES implementation to 6/30/15
6,226	16,454	164%	4,861[7]	13,240	172%

Enrollment of select members of the CHOICES population in Groups 1 and 2: STC 46.f. requires the State to provide "enrollment reports for individuals who would otherwise be eligible for Interim CHOICES 3 but who 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—

[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).

- 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 April 1, 2016, through June 30, 2016, NF PreAdmission Evaluations (PAEs) were approved for 270 individuals with acuity scores lower than 9, and 160 of these individuals were subsequently enrolled in CHOICES 1 during the measurement period. Reasons that the remaining individuals were approved for—but not yet enrolled in—CHOICES 1 include:

- 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 PAEs were approved for 250 individuals with acuity scores lower than 9, and 177 of the individuals were subsequently enrolled in CHOICES 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.

Table 9
TennCare CHOICES Transition Allowances
for April – June 2016 Compared to the Previous Two Quarters

	Frequency and Use of Transition Allowances					
	Oct – Dec 2015		**Jan – Mar 2016**		**Apr – Jun 2016**	
Grand Region	# Distributed	Total Amount	# Distributed	Total Amount	# Distributed	Total Amount
East	20	$20,435	15	$13,891	18	$18,429
Middle	14	$13,089	12	$14,015	12	$18,326
West	15	$15,179	11	$10,033	18	$19,275
Statewide Total	49	$48,703	38	$37,939	48	$56,030

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 15 calendar days of receipt.

The MCOs, the DBM, and the PBM are required to submit monthly claims data files of all TennCare claims processed to the Tennessee Department of Commerce and Insurance (TDCI) for verification of statutory and contractual prompt pay compliance. The plans are required to separate their claims data by claims processor (e.g., MCO, vision benefits manager, etc.). Furthermore, the MCOs are required to identify separately non-emergency transportation (NEMT) claims in the data files. Finally, the MCOs are required to submit separate claims data files representing a subset of electronically submitted NF and applicable HCBS claims for CHOICES enrollees. TDCI then performs an analysis and reports the results of the prompt pay analyses by NEMT and CHOICES claim types, by claims processor, and by total claims processed for the month.

If an MCO does not comply with the prompt pay requirements based on the total claims processed in a month, TDCI has the statutory authority to levy an administrative penalty of $10,000 for each month of non-compliance after the first instance of non-compliance was reported to the plan. 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 and Company Action Level Requirements. According to Tennessee's "Health Maintenance Organization Act of 1986" statute (T.C.A. § 56-32-101 *et seq.*), the minimum net worth requirement for each TennCare MCO is calculated based on premium revenue reported on the National Association of Insurance Commissioners (NAIC) Annual Financial Statement for the most recent calendar year, as well as any TennCare payments made to the MCO that are not reported as premium revenue.

During the April-June 2016 quarter, the MCOs submitted their National Association of Insurance Commissioners (NAIC) Annual Financial Statements. As of March 31, 2016, TennCare MCOs reported net worth as indicated in the table below.[8]

---

[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.

Table 10
Net Worth Reported by MCOs as of March 31, 2016

	Net Worth Requirement	Reported Net Worth	Excess/ (Deficiency)
Amerigroup Tennessee	$29,016,782	$153,385,375	$124,368,593
UnitedHealthcare Plan of the River Valley (UnitedHealthcare Community Plan)	$55,361,026	$419,602,706	$364,241,680
Volunteer State Health Plan (BlueCare & TennCare Select)	$43,251,806	$346,137,825	$302,886,019

During the April-June 2016 quarter, the MCOs were also required to comply with Tennessee's "Risk-Based Capital for Health Organizations" statute (T.C.A. § 56-46-201 *et seq.*). Risk-based capital (RBC) involves a method of calculating the minimum amount of capital necessary for a health entity to support its overall business operations depending on its size and risk profile. A health entity with a higher amount of risk is required to hold a higher amount of capital. The RBC statute gives TDCI the authority and mandate to use preventive and corrective measures that vary depending on the amount of capital deficiency indicated by the RBC calculations. A "Company Action Level" deficiency (defined at T.C.A. § 56-46-203(a)) would require the submission of a plan to correct the entity's capital deficiency.

The following table compares the MCOs' net worth to the Company Action Level requirements as of March 31, 2016:

Table 11
Company Action Level Reported by MCOs as of March 31, 2016

	Company Action Level Requirement	Reported Net Worth	Excess/ (Deficiency)
Amerigroup Tennessee	$104,759,436	$153,385,375	$48,625,939
UnitedHealthcare Plan of the River Valley (UnitedHealthcare Community Plan)	$189,545,450	$419,602,706	$230,057,256
Volunteer State Health Plan (BlueCare & TennCare Select)	$133,523,082	$346,137,825	$212,614,743

All TennCare MCOs far exceeded their minimum net worth requirements and Company Action Level requirements as of March 31, 2016.

C. Naming of New TennCare Director

As detailed in TennCare's previous Quarterly Progress Report to CMS, Darin Gordon decided to step down from his roles as TennCare Director and Deputy Commissioner of Health Care Finance and Administration (HCFA) at the end of June. On April 6, 2016, Tennessee Governor Bill Haslam announced that Dr. Wendy Long would succeed Mr. Gordon in both of these roles beginning on July 1.

Dr. Long's experience in public sector healthcare is extensive. Prior to her tenure at TennCare, she held a variety of positions of increasing responsibility within the Tennessee Department of Health, including Assistant Commissioner and Medical Director for the Bureau of Health Services. Dr. Long has also served in several key roles at TennCare and HCFA, including Interim TennCare Director (from March 1998 to January 1999), Medical Director, Chief Medical Officer, and—since 2013—Deputy Director and Chief of Staff. In the role of Deputy Director, she has provided leadership in all areas of operation, including oversight of contracts between TennCare and its network of Managed Care Contractors.

Dr. Long received her undergraduate and medical degrees from the Ohio State University and completed a preventive medicine residency and Master of Public Health program at the University of South Carolina.

D. Application to Renew the TennCare Demonstration

On December 22, 2015, the Bureau submitted an application to renew the TennCare Demonstration to the Centers for Medicare and Medicaid Services (CMS). The application requested that the approval period for the Demonstration—which was scheduled to end on June 30, 2016—be extended through June 30, 2021.

Throughout the April-June 2016 quarter, the State and CMS negotiated the terms of a renewal. The State requested no substantive changes to the TennCare Demonstration; however, CMS identified a number of topics it wished to discuss, including supplemental pool payments to Tennessee hospitals and the methodology by which the TennCare program remains "budget-neutral" (i.e., does not spend more than would be expended to operate Tennessee's Medicaid program in the absence of the Demonstration). While considerable progress was made in these negotiations, the State and CMS ultimately determined that more time was needed to come to final agreement and complete the approval process. The parties therefore agreed to a temporary extension of the Demonstration through August 31, 2016. The purpose of the two-month extension is to allow for further discussion of any remaining issues with the hope of finalizing the Special Terms and Conditions (STCs) that will govern the operations of the TennCare program during the next approval period.

E. Payment Reform

In February 2013, Governor Haslam launched Tennessee's Health Care Innovation Initiative to change the way that health care is paid for in Tennessee. The desired direction is to move from paying for volume to paying for value by rewarding health care providers for high-quality and efficient treatment of medical conditions, and to help in maintaining people's health over time.

The Tennessee Health Care Innovation Initiative is located in HCFA, the agency in which TennCare is located as well. Although the Initiative's goals transcend Medicaid, there is much emphasis on Medicaid and TennCare as playing a pivotal role in meeting these goals. All of TennCare's providers are included in the Initiative.

Two strategies being used to reform health care payment approaches are Tennessee Health Link and episodes of care:

- As part of the State's strategy to transform primary care, Tennessee Health Link is working with providers to improve integrated and value-based behavioral and primary care services for people with significant behavioral health needs. These TennCare members have higher rates of asthma, congestive heart failure, chronic obstructive pulmonary disease (COPD), coronary artery disease, diabetes, hypertension, and stroke. Furthermore, on average, a TennCare member with significant behavioral health needs uses the Emergency Department (ED) more than twice as often as a TennCare member who does not have these needs. The State will leverage an enhanced federal match to offer value-based payments for care coordination and case management for two years, coupled with provider training and capacity building, and quarterly cost and quality reporting. While TennCare has already taken significant steps to integrate behavioral health and primary care within the services delivered by the MCOs, the implementation of Tennessee Health Link will help providers integrate care and build their practices' capacity to transition to value-based payment and delivery.
- Episodes of care focuses on health care delivered in acute health care events, such as a surgical procedure or an inpatient hospitalization. Episodes encompass care delivered by multiple providers in relation to a specific health care event. Each episode has a principal accountable provider (or "quarterback") who is in the best position to influence the cost and quality of the episode. Episodes of care are implemented in groups or—in the terminology of the program—"waves." The fifth wave ("Wave 5") is the most recent.

Both of these strategies have benefitted from the input of Technical Advisory Groups (TAGs) composed of subject matter experts. TAG recommendations related to Tennessee Health Link span a variety of topics, including member identification criteria, physical and behavioral quality measures, eligibility, workforce and personnel qualifications, primary care physician (PCP) collaboration, patient engagement, staffing roles and ratios, provider reporting, and training curriculum and support. TAG recommendations concerning episodes of care are similarly comprehensive, addressing such topics as the patient journey and care pathways, the definition

of the principal accountable provider (i.e., the quarterback), any aspects of care delivery unique to Tennessee, the components of the episode of care, and appropriate quality measures.

During the April-June 2016 quarter, implementation efforts related to payment reform proceeded as planned. The State and participating insurance companies continued their work related to episodes of care. Furthermore, in preparation for the implementation of Tennessee Health Link, the State held a public notice and comment period about the new program in June. By the conclusion of the quarter, no comments had been received.

F. 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, fourth-year, and fifth-year payments to providers who continue to demonstrate meaningful use.

Eligible practitioners who successfully attest may receive incentive payments in up to six program years. With CMS approval, TennCare chose to divide the full amount of incentive payments available to eligible hospitals among three program years. Eligible hospitals must continue to attest annually beyond the three years of payments in order to avoid Medicare payment adjustments.

EHR payments made by TennCare during the April-June 2016 quarter as compared with payments made throughout the life of the program appear in the table below:

[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).

Table 12
EHR Payments
Quarterly and Cumulative

Payment Type	No. of Providers Paid During the Quarter	Quarterly Amount Paid (Apr-Jun 2016)	Cumulative Amount Paid To Date
First-year payments	207[10]	$3,199,262	$167,413,648
Second-year payments	82	$2,162,404	$53,312,597
Third-year payments	82	$1,621,542	$25,285,091
Fourth-year payments	96	$810,334	$2,516,007
Fifth-year payments	56	$476,000	$620,500

The Bureau's technical assistance activities, outreach efforts, and other EHR-related projects remained robust during the quarter, due in part to recently implemented "Modified Stage 2" meaningful use measures. These activities included the following:

- Evaluation of more than 1,000 meaningful use attestations;
- Holding 72 technical assistance calls;
- Responding to 778 emails received in the EHR meaningful use mailbox;
- Attendance at the "MedTenn 2016" convention, a statewide meeting of physicians and medical professionals sponsored by the Tennessee Medical Association;
- Attendance at regional workshops hosted by Amerigroup and UnitedHealthcare Community Plan;
- Participation throughout the quarter in several Southeast Regional Collaboration for HIT/HIE (SERCH) calls;
- Monthly newsletters and occasional alerts distributed by the Bureau's EHR ListServ; and
- A quarterly reminder 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. The Bureau is also making every effort to alert eligible professionals and eligible hospitals that 2016 is the last year in which they may enroll in the EHR program and begin attesting (as specified by the HITECH Act).

G. *Wilson v. Gordon*

Wilson v. Gordon is a class action lawsuit filed against TennCare by the Tennessee Justice Center, the Southern Poverty Law Center, and the National Health Law Program. The suit alleges federal noncompliance in the Medicaid application and appeals process TennCare has been using since implementation of the Affordable Care Act.

---

[10] Of the 207 providers receiving first-year payments in the April-June 2016 quarter, 10 earned their incentives by successfully attesting to meaningful use of EHR technology in their first year of participation in the program.

Two separate courts have heard arguments in the case. One is the U.S. District Court for the Middle District of Tennessee, where Plaintiffs originally filed suit in July 2014. The District Court granted class action status to the case and issued a preliminary injunction requiring the State to provide an opportunity for a fair hearing on any delayed adjudications of applications for TennCare coverage. TennCare took immediate action to comply with these rulings but also filed an appeal of the preliminary injunction with a second court, the U.S. Court of Appeals for the Sixth Circuit in Cincinnati.

On May 23, 2016, a three-judge panel for the Sixth Circuit affirmed the District Court's decision to issue a preliminary injunction. The panel majority's opinion held that the actions taken by the State to address the needs of the named plaintiffs in the suit did not render the case moot and, therefore, that the preliminary injunction was properly issued. The dissenting opinion reached a very different conclusion, noting, "The plaintiffs asked and now have received. Because the plaintiffs received all of their requested injunctive relief before class certification, the case is moot."

On June 6, 2016, the State responded to the ruling by filing a petition for rehearing en banc with the Sixth Circuit. If granted, the petition would allow the State's appeal to be heard by all of the Sixth Circuit judges instead of by a small panel. The rehearing request is based on the premise that the three-judge panel reached a determination at odds with relevant decisions issued by other courts, including other circuit courts (the Fourth, Fifth, and Eighth Circuits) and the Supreme Court. As of the end of the April-June 2016 quarter, the Plaintiffs' response to the State's petition was expected to be filed in July.

VI. Action Plans for Addressing Any Issues Identified

TennCare continues to comply with orders issued in the *Wilson v. Gordon* court action.

VII. Financial/Budget Neutrality Development Issues

Revenue collections showed strength throughout the April-June 2016 quarter. In all three months, total state and local revenue collections were higher than during the corresponding months of 2015, with a six percent improvement in April, a five percent improvement in May, and a five percent improvement in June.[11]

Employment prospects were similarly robust. The unemployment rate fell from 4.3 percent in April to 4.1 percent in May and June. These figures were a marked contrast to the results from a year ago, when the Tennessee unemployment rate hovered near six percent in all three

[11] The Department of Revenue's collection summaries are available online at https://www.tn.gov/revenue/article/revenue-collections-summaries.

months of the quarter. In addition, Tennessee outperformed the nation as a whole in the arena of jobs: Tennessee's unemployment rate was more than a half percentage point lower than the national rate in April, May, and June.[12]

VIII. Member Month Reporting

Tables 13 and 14 below present the member month reporting by eligibility group for each month in the quarter.

Table 13
Member Month Reporting for Use in Budget Neutrality Calculations
April – June 2016

Eligibility Group	April 2016	May 2016	June 2016	Sum for Quarter Ending 6/30/16
Medicaid eligibles (Type 1)				
EG1 Disabled, Type 1 State Plan eligibles	145,647	145,159	144,490	435,296
EG2 Over 65, Type 1 State Plan eligibles	113	144	218	475
EG3 Children, Type 1 State Plan eligibles	774,176	776,829	777,598	2,328,603
EG4 Adults, Type 1 State Plan eligibles	451,172	455,388	459,703	1,366,263
EG5 Duals, Type 1 State Plan eligibles	140,808	141,148	141,506	423,462
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	232	243	244	719
EG10 H-Over 65, Type 2 Demonstration Population	28	30	36	94
EG11 H-Duals, Type 2 Demonstration Population	6,000	6,013	6,032	18,045

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

Eligibility Group	April 2016	May 2016	June 2016	Sum for Quarter Ending 6/30/16
TOTAL	1,518,176	1,524,954	1,529,827	4,572,957

Table 14
Member Month Reporting Not Used in Budget Neutrality Calculations
April – June 2016

Eligibility Group	April 2016	May 2016	June 2016	Sum for Quarter Ending 6/30/16
EG6E Expan Adult, Type 3, Demonstration Population	759	754	749	2,262
EG7E Expan Child, Type 3, Demonstration Population	40	40	40	120
Med Exp Child, Title XXI Demonstration Population	18,526	18,481	18,455	55,462
EG12E Carryover, Type 3, Demonstration Population	2,974	2,906	2,862	8,742
TOTAL	22,299	22,181	22,106	66,586

IX. Consumer Issues

Eligibility Appeals. TennCare eligibility appeals are handled by the Bureau of TennCare. Table 15 presents a summary of eligibility appeal activity during the quarter, compared to the previous two quarters.

Table 15
Eligibility Appeals for April – June 2016
Compared to the Previous Two Quarters

	Oct – Dec 2015	Jan – Mar 2016	Apr – Jun 2016
No. of appeals received	4,794	5,889	6,371
No. of appeals resolved or withdrawn	3,487	2,556	2,729
No. of appeals taken to hearing	1,380	2,617	3,231
No. of hearings resolved in favor of appellant	210	342	322

Medical Service Appeals. Medical service appeals are handled by the Bureau of TennCare. Table 16 below presents a summary of the medical service appeals handled during the quarter, compared to the previous two quarters.

Table 16
Medical Service Appeals for April – June 2016
Compared to the Previous Two Quarters

	Oct – Dec 2015	Jan – Mar 2016	Apr – Jun 2016
No. of appeals received	2,188	2,064	2,163
No. of appeals resolved	2,285	2,033	2,029
• Resolved at the MCC level	972	828	854
• Resolved at the TSU level	209	177	178
• Resolved at the LSU level	1,104	1,028	997
No. of appeals that did not involve a valid factual dispute	264	261	204
No. of directives issued	315	295	281
No. of appeals taken to hearing	1,104	1,028	997
No. of appeals that were withdrawn by the enrollee at or prior to the hearing	333	342	319
Appeals that went to hearing and were decided in the State's favor	355	346	337
Appeals that went to hearing and were decided in the appellant's favor	43	48	41

By way of explanation:

- The "MCC" level is the level of the Managed Care Contractors. MCCs sometimes reverse their decisions or develop new recommendations for addressing an issue after reviewing an appeal.

- The "TSU" level is the TennCare Solutions Unit. The TSU 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.

Table 17
Long-Term Services and Supports Appeals for April – June 2016
Compared to the Previous Two Quarters

	Oct – Dec 2015	Jan – Mar 2016	Apr – Jun 2016
No. of appeals received	258	230	214
No. of appeals resolved or withdrawn	142	118	105
No. of appeals set for hearing	78	80	88
No. of hearings resolved in favor of appellant	1	2	1

X. Quality Assurance/Monitoring Activity

Population Health. "Population Health" (PH) is TennCare's model of targeted health care interventions. Key benefits of PH 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 January-March 2016 quarter is provided in Table 18. Data for the period of April through June 2016 will be provided in the next Quarterly Progress Report.

Table 18
Population Health Data*, January – March 2016

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	762,417
Level 1: low or moderate risk	Maternity Program	Engage pregnant women in timely prenatal care and deliver a healthy, term infant without complications	16,251
	Health Risk Management	Prevent, reduce, or delay exacerbation and complications of a condition or health risk behavior	662,674
	Care Coordination	Assure that members receive the services they need to reduce the risk of an adverse health outcome	28,996
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	5,468
	High Risk Pregnancy Management	Engage pregnant women in timely prenatal care and deliver a healthy, term infant without complications	1,868
	Complex Case Management	Move members to optimal levels of health and well-being through timely coordination of quality services and self-management support	1,057
Total PH Enrollment			**1,478,731**

*** 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. TennCare's External Quality Review Organization (EQRO), Qsource, published the results of its provider data validation survey for the January-March 2016 quarter. Qsource took a sample of provider data files from TennCare's MCCs[13] and reviewed each for accuracy in the following categories:

- Contract status with MCC
- Provider address

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

- 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" (97.6 percent accuracy), "provider credentialed specialty / behavioral health service code" (95.2 percent accuracy), "routine care services" (95.5 percent accuracy), "urgent care services" (97.4 percent accuracy), "primary care services" (99.1 percent accuracy), and "prenatal care services" (99.6 percent accuracy).

Because the MCOs' transition to a statewide service delivery model occurred relatively recently, progress in accuracy rates is currently being measured on a quarter-to-quarter basis. Compared with the period of October-December 2015, the MCCs—according to the report—"have maintained relatively high accuracy rates this quarter." Nonetheless, to ensure ongoing improvement in all ten categories of the survey, TennCare required each of its MCCs to submit a Corrective Action Plan no later than June 6, 2016. The Bureau, in turn, had received, reviewed, and accepted all of the plans by June 10, 2016. Results for the April-June 2016 quarter will be discussed in the next Quarterly Progress Report.

XI. Demonstration Evaluation

On October 30, 2015, in compliance with STC 47, the State submitted to CMS its Draft Annual Report for Demonstration Year 13. 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 18, 2015, the State submitted to CMS 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 *2015 Annual Update Report of the 2013 Quality Assessment and Performance Improvement Strategy*, remains available on TennCare's website.

In addition, on December 22, 2015, the State submitted its application to renew the TennCare Demonstration, 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) measures for the TennCare CHOICES program.

XII. Essential Access Hospital Pool[14]

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

D. Other Acute Care Hospitals

Parkridge Medical Center (with Parkridge Valley Psych)
Jackson – Madison County General Hospital
Methodist Healthcare – Memphis Hospitals
Saint Jude Children's Research Hospital
Methodist Healthcare – South
Parkwest Medical Center (with Peninsula Psych)
Methodist Healthcare – North
TriStar Centennial Medical Center
TriStar Skyline Medical Center (with Madison campus)
Wellmont Holston Valley Medical Center
University Medical Center (with McFarland Psych)
Parkridge East Hospital

[14] 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.

Saint Francis Hospital
Saint Thomas Rutherford Hospital
Lincoln Medical Center
Saint Thomas Midtown Hospital
Maury Regional Hospital
Baptist Memorial Hospital for Women
Wellmont Bristol Regional Medical Center
Cookeville Regional Medical Center
Fort Sanders Regional Medical Center
Tennova Healthcare – Physicians Regional Medical Center
Blount Memorial Hospital
Delta Medical Center
TriStar Summit Medical Center
TriStar StoneCrest Medical Center
Skyridge Medical Center
Southern Hills Medical Center
NorthCrest Medical Center
Gateway Medical Center
TriStar Horizon Medical Center
Sumner Regional Medical Center
Morristown – Hamblen Healthcare System
Dyersburg Regional Medical Center
Baptist Memorial Hospital – Tipton
Methodist Medical Center of Oak Ridge
TriStar Hendersonville Medical Center
Jellico Community Hospital
LeConte Medical Center
Harton Regional Medical Center
Takoma Regional Hospital
Tennova Healthcare – LaFollette Medical Center
Grandview Medical Center
Skyridge Medical Center – Westside
Southern Tennessee Regional Health System – Winchester
United Regional Medical Center and Medical Center of Manchester
Sycamore Shoals Hospital
Indian Path Medical Center
Lakeway Regional Hospital
Roane Medical Center
Laughlin Memorial Hospital
Starr Regional Medical Center – Athens
Regional Hospital of Jackson
Hardin Medical Center
Crockett Hospital
Henry County Medical Center

Stones River Hospital
Wellmont Hawkins County Memorial Hospital
Saint Thomas River Park Hospital
Jamestown Regional Medical Center
Hillside Hospital
Livingston Regional Hospital
Heritage Medical Center
Baptist Memorial Hospital – Union City
McNairy Regional Hospital
Claiborne County Hospital
McKenzie Regional Hospital
Erlanger Health System – East Campus
Henderson County Community Hospital
Volunteer Community Hospital
Wayne Medical Center
DeKalb Community Hospital
Decatur County General Hospital
Baptist Memorial Hospital – Huntingdon
Southern Tennessee Regional Health System – Sewanee

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

Universities	Hospitals
	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
Cumberland Medical Center
Erlanger Bledsoe Hospital
Johnson County Community Hospital
Lauderdale Community Hospital
Macon County General Hospital
Marshall Medical Center
Pioneer Community Hospital of Scott
Rhea Medical Center
Riverview Regional Medical Center
Saint Thomas Hickman Hospital
Three Rivers Hospital
TriStar Ashland City Medical Center
Trousdale Medical Center
Wellmont Hancock County Hospital

State Contact:

Aaron Butler
Director of Policy
Bureau of TennCare
310 Great Circle Road
Nashville, TN 37243
Phone: 615-507-6448
Fax: 615-253-2917

Date Submitted to CMS: August 31, 2016

Attachment A

Budget Neutrality Calculations for the Quarter

Actual TennCare Budget Neutrality (April - June 2016)

I. The Extension of the Baseline

Baseline PMPM

	SFY 2016 PMPM
1-Disabled (can be any ages)	$1,724.79
2-Child <=18	$500.86
3-Adult >= 65	$1,118.37
4-Adult <= 64	$1,009.94
Duals (17)	$714.44

Actual Member months of Groups I and II

1-Disabled (can be any ages)	436,015
2-Child <=18	2,328,603
3-Adult >= 65	475
4-Adult <= 64	1,366,263
Duals (17)	441,507
Total	4,572,863

Ceiling without DSH

	Baseline * MM
1-Disabled (can be any ages)	$752,034,524
2-Child <=18	$1,166,306,751
3-Adult >= 65	$531,228
4-Adult <= 64	$1,379,841,225
17s	$315,431,537
Total	**$3,614,145,266**

DSH

DSH Adjustment (Quarterly)	$115,999,213

Total Ceiling

Budget Neutrality Cap	
Total w/DSH Adj.	**$3,730,144,479**

II. Actual Expenditures

Group 1 and 2

1-Disabled (can be any ages)	$ 544,979,189
2-Child <=18	$ 474,240,050
3-Adult >= 65	$ 180,257
4-Adult <= 64	$ 473,722,293

Duals (17)	$	351,122,047
Total		**1,844,243,835**

Group 3

1-Disabled (can be any ages)	$	-
2-Child <=18	$	12,596,477
3-Adult >= 65	$	39,300,534
4-Adult <= 64	$	760,828
Duals (17)	$	-
Total		**52,657,838**

Pool Payments and Admin

Total Pool Payments	$	315,340,540

Admin	$	145,758,482

Quarterly Drug Rebates	$	(182,001,817)
Quarterly Premium Collections	$	-
Total Net Quarterly Expenditures	**$**	**2,175,998,879**

III. Surplus/(Deficit)

III. Surplus/(Deficit)	**$1,554,145,600**
Federal Share	**$1,010,738,591**

HCI Result	MM201604	MM201605	MM201606	TOTAL	HCI ASO	HCI Rx	HCI DTL	HCI MCO CAP (TCS Admin)	UNK Allocation	TOTAL
EG1-TYPE1 (disabled, type1 state plan eligibles)	145,647	145,159	144,490	435,296	$76,568,176	$131,456,795	$1,834,698	$332,312,747	(1,219,706)	$540,952,710
EG1-TYPE2 (disabled, type2 transition group)	0	0	0	0	$0	$0	$0	$0	-	$0
EG2-TYPE1 (over 65, type1 state plan eligibles)	113	144	218	475	$28,044	$18,990	$0	$133,616	(394)	$180,257
EG2-TYPE2 (over 65, type2 state plan eligibles)	0	0	0	0	$0	$0	$0	$0	-	$0
EG3-TYPE1 (children, type1 state plan eligibles)	774,176	776,829	777,598	2,328,603	$10,984,980	$68,617,872	$34,184,679	$361,525,592	(1,073,074)	$474,240,050
Med Exp Child (Title XXI Demo Pop; EG3-Type2)	18,526	18,481	18,455	55,462	$597,520	$3,064,004	$1,109,495	$7,813,835	(28,840)	$12,556,014
EG4-TYPE1 (adults, type1 State plan eligibles)	451,172	455,388	459,703	1,366,263	$1,576,996	$80,383,826	$3,078,759	$389,729,131	(1,046,420)	$473,722,293
EG4-TYPE2 (adults, type2 demonstration pop)	0	0	0	0	$0	$0	$0	$0	-	$0
EG5-TYPE1 (duals, state plan eligibles)	140,808	141,148	141,506	423,462	$1,245,445	$1,344,792	$25,769	$287,176,148	(655,567)	$289,136,587
EG6E-TYPE3 (Expan adult, type3 demonstration pop)	759	754	749	2,262	$0	$143,710		$618,936	(1,818)	$760,828
EG7E-TYPE3 (Expan child, type3 demonstration pop)	40	40	40	120	$1,143	$20,424	$2,120	$16,885	(110)	$40,463
EG8-TYPE2 (med exp child)	0	0	0	0	$0	$0	$0	$0	-	$0
EG9 H-Disabled (TYPE 2 Eligibles)	232	243	244	719	$0	$293,526	$0	$3,747,663	(14,711)	$4,026,478
EG10 H-Senior	28	30	36	94	$0	$9,031	$0	$524,002		$533,033
EG11H, H-Dual	6,000	6,013	6,032	18,045	$3,171	$11,328	$0	$62,101,514	(130,553)	$61,985,460
EG12E, Carryovers	2,974	2,906	2,862	8,742	$0	$129,600	$0	$38,734,017	(96,117)	$38,767,500
Total	**1,540,475**	**1,547,135**	**1,551,933**	**4,639,543**	**$91,005,477**	**$285,493,899**	**$40,235,521**	**$1,484,434,086**	**-$4,267,309**	**$1,896,901,674**

HCI Result	MM201604	MM201605	MM201606	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)	145,647	145,159	144,490	435,296	$175.90	$301.99	$4.21	$763.42	-$2.80	$1,242.72
EG1-TYPE2 (disabled, type2 transition group)	0	0	0	-						
EG2-TYPE1 (over 65, type1 state plan eligibles)	113	144	218	475	$59.04	$39.98	$0.00	$281.30	-$0.83	$379.49
EG2-TYPE2 (over 65, type2 state plan eligibles)	0	0	0	-	-	-	-	-	-	-
EG3-TYPE1 (children, type1 state plan eligibles)	774,176	776,829	777,598	2,328,603	$4.72	$29.47	$14.68	$155.25	-$0.46	$203.66
Med Exp Child (Title XXI Demo Pop; EG3-Type2)	18,526	18,481	18,455	55,462	$10.77	$55.25	$20.00	$140.89	-$0.52	$226.39
EG4-TYPE1 (adults, type1 State plan eligibles)	451,172	455,388	459,703	1,366,263	$1.15	$58.83	$2.25	$285.25	-$0.77	$346.73
EG4-TYPE2 (adults, type2 demonstration pop)	0	0	0	-						
EG5-TYPE1 (duals, state plan eligibles)	140,808	141,148	141,506	423,462	$2.94	$3.18	$0.06	$678.16	-$1.55	$682.79
EG6E-TYPE3 (Expan adult, type3 demonstration pop)	759	754	749	2,262	$0.00	$63.53	$0.00	$273.62	-$0.80	$336.35
EG7E-TYPE3 (Expan child, type3 demonstration pop)	40	40	40	120	$9.53	$170.20	$17.67	$140.71	-$0.92	$337.19
EG8-TYPE2 (emd exp child)	0	0	0	-						
EG9 H-Disabled (TYPE 2 Eligibles)	232	243	244	719	$0.00	$408.24	$0.00	$5,212.33	-$20.46	$5,600.11
EG10 H-Senior	28	30	36	94	$0.00	$96.07	$0.00	$5,574.49	$0.00	
EG11H, H-Dual	6,000	6,013	6,032	18,045	$0.18	$0.63	$0.00	$3,441.48	-$7.23	$3,435.05
EG12E, Carryovers	2,974	2,906	2,862	8,742	$0.00	$14.83	$0.00	$4,430.80	-$10.99	$4,434.63
Total	**1,540,475**	**1,547,135**	**1,551,933**	**4,639,543**	**$19.62**	**$61.53**	**$8.67**	**$319.95**	**-$0.92**	**$408.86**

* Unknown allocation was performed within the Service category totals.