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 29, 2014

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 45, Quarterly Progress Report

Dear Ms. Woodard:

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

Included in Table 2 ("Enrollment Counts for the April – June 2014 Quarter Compared to the Previous Two Quarters") is the enrollment data for the January – March 2014 quarter that was being corrected at the time the previous Quarterly Progress Report was submitted.

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 2014)

Demonstration Year: 12 (7/1/13 - 6/30/14)
Federal Fiscal Quarter: 3/2014 (4/14 - 6/14)
Waiver Quarter: 4/2014 (4/14 - 6/14)

I. Introduction

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

TennCare contracts with several Managed Care Contractors (MCCs) to provide services to about 1.2 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 #
4/17/14	In reference to Amendment 20, the State sent CMS a letter 1) accepting the STCs, waivers, and expenditure authorities that CMS had provided and 2) proposing technical corrections to these materials.	
4/22/14	The CMS Project Officer cancelled the Monthly Call scheduled for 4/24/14.	44
4/25/14	Following the renewal of the hospital assessment fee during the Tennessee legislative session, the State withdrew Demonstration Amendment 21. (Amendment 21 had outlined program reductions that would have been necessary if the assessment fee were not renewed.)	
4/25/14	CMS sent the State comments about its proposal for evaluating uncompensated care costs for the uninsured.	69
5/8/14	The State submitted Demonstration Amendment 22 to CMS. Amendment 22 proposed to implement the maximum medical copayment amounts allowable under federal law and regulation; to impose a limit on the number of diapers furnished on an outpatient basis to an adult enrollee; and to make two technical corrections to the STCs.	6, 7
5/14/14	CMS communicated to the State that the component of Amendment 22 pertaining to diapers should be addressed	

Date	Action	STC #
	through an amendment to Tennessee's Medicaid State Plan instead of through a demonstration amendment.	
5/19/14	The State participated in a call with CMS to discuss the State's proposal for evaluating uncompensated care costs for the uninsured.	69
5/21/14	The CMS Project Officer cancelled the Monthly Call scheduled for 5/22/14.	44
5/30/14	The State submitted the Quarterly Progress Report for the January-March 2014 quarter to CMS.	45
6/2/14	The State sent CMS a concept paper about the renewal and redesign of TennCare's LTSS delivery system for individuals with intellectual and developmental disabilities.	
6/3/14	With regard to Amendment 22, CMS sent the State questions about its proposal for tracking and documenting enrollee cost sharing.	
6/10/14	The State submitted responses to CMS's questions about enrollee cost sharing.	
6/19/14	The State submitted to CMS a revised version of the State's proposal for evaluating uncompensated care costs for the uninsured.	69
6/23/14	The State submitted point-in-time and annual aggregate data about the CHOICES program to CMS.	43.d.iii.
6/26/14	In lieu of the Monthly Call, an informal call between the State and CMS was held.	44

II. Enrollment and Benefits Information

Information about enrollment by category is presented in Table 2.

Table 2
Enrollment Counts for the April – June 2014 Quarter
Compared to the Previous Two Quarters

Demonstration Populations	Total Number of TennCare Enrollees		
	Oct – Dec 2013[1]	Jan – Mar 2014	Apr – Jun 2014
EG1 Disabled, Type 1 State Plan eligibles	137,992	135,814	134,896

[1] A quality review of enrollment data for the October-December 2013 quarter revealed an error in categorization, namely that SSI-eligible individuals had been counted in EG12E. This issue has been corrected in the data presented here.

Demonstration Populations	Total Number of TennCare Enrollees		
	Oct – Dec 2013[1]	Jan – Mar 2014	Apr – Jun 2014
EG9 H-Disabled, Type 2 Demonstration Population	316	275	291
EG2 Over 65, Type 1 State Plan eligibles	52	19	24
EG10 H-Over 65, Type 2 Demonstration Population	0	0	0
EG3 Children, Type 1 State Plan eligibles	662,566	655,192	667,448
EG4 Adults, Type 1 State Plan eligibles	292,704	298,598	316,441
EG5 Duals, Type 1 State Plan eligibles and EG11 H-Duals 65, Type 2 Demonstration Population	134,248	130,793	130,810
EG6E Expan Adult, Type 3 Demonstration Population	1,439	1,131	1,134
EG7E Expan Child, Type 3 Demonstration Population	157	64	64
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	20,873	19,553	19,523
EG12E Carryover, Type 3, Demonstration Population	6,247	6,621	6,960
TOTAL*	1,256,594	1,248,060	1,277,591

*** 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, 2014

	West Tennessee	Middle Tennessee	East Tennessee
Managed Care Organizations	BlueCare[2] UnitedHealthcare Community Plan[3] TennCare Select[4]	Amerigroup UnitedHealthcare Community Plan TennCare Select	BlueCare UnitedHealthcare Community Plan TennCare Select
Pharmacy Benefits Manager	Magellan Health Services		
Dental Benefits Manager	DentaQuest		

Possible Changes to TennCare Benefits ("Demonstration Amendment 21"). On January 27, 2014, the Bureau of TennCare submitted Demonstration Amendment 21 to CMS. Amendment 21 repeated several changes proposed in each of the last four years that were made unnecessary each time by the Tennessee General Assembly's passage or renewal of a one-year hospital assessment fee. Changes to the TennCare benefit package for adults that would have been necessary if the fee had not been renewed in 2014 were:

- Elimination of physical therapy, speech therapy, and occupational therapy for all adults; and
- Benefit limits on certain hospital services, lab and X-ray services, and health practitioners' office visits for non-pregnant adults and non-institutionalized adults.

Because of the General Assembly's passage of a one-year extension of the hospital assessment fee on April 14, 2014, the Bureau submitted a letter to CMS on April 25, 2014, withdrawing Amendment 21.

Proposal Concerning Copayments and Benefit Limits ("Demonstration Amendment 22"). On May 8, 2014, TennCare submitted Demonstration Amendment 22 to CMS. Amendment 22 proposed two modifications to the TennCare program:

[2] BlueCare is operated by Volunteer State Health Plan, Inc. (VSHP), which is an independent licensee of the BlueCross BlueShield Association and a licensed HMO affiliate of its parent company, BlueCross BlueShield of Tennessee.
[3] UnitedHealthcare Community Plan, formerly known as "AmeriChoice," is operated by UnitedHealthcare Plan of the River Valley, Inc.
[4] TennCare Select is operated by Volunteer State Health Plan, Inc. (VSHP).

- Implementation of the maximum copayment amounts allowable under federal regulations.
- Imposition of a limit of 200 diapers per month for adults age 21 and older when the diapers are furnished on an outpatient basis and for medical reasons.

With respect to the copayments portion of the proposal, the State requested relief from two specific regulations.

- First, the regulations require that the total amount of copayments charged to enrollees not exceed 5 percent of household income, figured on a monthly or quarterly basis. The Bureau asked that the 5 percent aggregate limit be applied on an annual basis instead, since this would enable low income individuals to reach the limit early and be exempt from any further cost-sharing for the remainder of the year. Such an arrangement would also be more like the annual "Out of Pocket Maximum" that commercial insurance companies apply.
- Second, the State has concluded that the amount of IT development that would be required both by the State and by the managed care contractors to build a system that could collect real-time information across managed care entities about copays charged and that could quickly and accurately identify when an enrollee had reached his aggregate cap would be extraordinary. Diverting resources to this activity and away from other important IT challenges—such as completing the development of the Tennessee Eligibility Determination System (TEDS)—seems both unwise and inefficient. TennCare sought permission to assign the responsibility for tracking copayments to enrollees, who have a financial incentive to document the fulfillment of their cost-sharing obligations.

As of the end of the April-June 2014 quarter, the Bureau decided to address the issue of coverage of adult diapers by directing the Managed Care Organizations (MCOs) to increase utilization review activities for requests for adult diapers that exceed 200 per enrollee per month.

Benefits for Pregnant Women During a Period of Presumptive Eligibility ("Demonstration Amendment 23"). On June 26, 2014, the Bureau notified the public of another proposal to be submitted to CMS. Demonstration Amendment 23 deals with the benefits a pregnant woman may receive from TennCare during a period of "presumptive eligibility," which is a period of temporary eligibility granted to certain groups of pregnant women who would likely qualify for TennCare coverage but who have not yet completed an application. Most members of this population are "presumptives" for only a few short weeks before becoming fully TennCare eligible. Traditionally, the Bureau has offered a complete package of benefits to a presumptively eligible pregnant woman to promote the health of her unborn child. This position is consistent with the statement in STC 28.f. that, where pregnant and post-partum women are concerned, the State considers all Medicaid benefits to be pregnancy-related. CMS has advised the State to amend the TennCare Demonstration to allow coverage of non-

ambulatory services (such as inpatient hospitalizations) for pregnant women during periods of presumptive eligibility to continue TennCare's longstanding practice.

Cost Sharing Compliance Plan. In its April 18, 2012, letter approving the Bureau'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 2014 quarter, the Bureau received no notifications that a family with members enrolled in TennCare Standard had met its cost sharing limit. It should be noted that this is the sixth 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 "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. Quarterly variations in the categories presented here are usually the result of the following factors:

- Seasonal events. National Children's Dental Health Month in February, back-to-school events in August, and Child Health Week in October all have a profound influence on the focus and direction of outreach efforts during their respective quarters. DOH's communications strategy for each is based on an evaluation of past successes and current opportunities. During the 2013 round of Dental Health Month, for instance, DOH 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 DOH'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, DOH'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
Department of Health
Community Outreach Activity for EPSDT
April – June 2014 Compared to the Previous Two Quarters

Activities	Oct – Dec 2013	Jan – Mar 2014	Apr – Jun 2014
Number of outreach activities/events	4,663	3,096	2,789
Number of people made contact with (mostly face to face at outreach events)	158,790	123,317	135,734
Number of educational materials distributed	190,540	139,549	159,052
Number of coalitions/advisory board meetings attended or conducted	54	53	46
Number of attendees at coalitions/advisory board meetings	801	824	675
Number of educational preventive health radio/TV broadcasts	16,367	11,362	19,658
Number of educational preventive health newsletter/magazine articles	141	99[5]	143
Number of educational preventive health billboards, scrolling billboards and bulletin boards	51,142	57,634	7,002[6]
Number of presentations made to enrollees/professional staff who work with enrollees	222	139	116
Number of individuals attending presentations	8,505	7,096	3,736
Number of attempted telephone calls regarding the importance of dental checkups	491	403	408
Number (approx) of completed telephone calls regarding the importance of immunizations and dental checkups	260	144	199
Number of attempted home visits (educational materials left with these families)	16,259	16,626	17,534
Number of home visits completed	7,888	8,763	7,609

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.

[5] This total was previously reported as 117 but has been revised based on additional information from DOH.
[6] For the April-June 2014 quarter, DOH changed its methodology for measuring use of scrolling billboards: rather than counting the number of times TENNderCare messages flashed or scrolled on a particular billboard, the total number of billboards was used.

Table 5
Department of Health
TENNderCare Call Center Activity
April – June 2014 Compared to the
Previous Two Quarters

Activities	Oct – Dec 2013	Jan – Mar 2014	Apr – Jun 2014[7]
Number of families reached	42,869	41,470	26,791
Number of families who were assisted in scheduling an EPSDT exam for their children	2,518	2,219	907
Number of families who were assisted in arranging for transportation	169	53	15

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 2014 Quarter, and Percentage that Passed Systems Edits, Compared to the Previous Two Quarters

	Oct – Dec 2013	Jan – Mar 2014	Apr – Jun 2014
No. of encounters received by TennCare (initial submission)	11,854,350	14,755,963[8]	12,854,531
No. of encounters rejected by Edifecs upon initial submission	21,434	19,323	25,686
Percentage of encounters that were compliant with State standards (including HIPAA) upon initial submission	99.82%	99.87%	99.80%

[7] Call Center totals for the April-June 2014 quarter were lower than those for the two preceding quarters as a result of systems issues that TennCare is resolving with its contractor.

[8] Encounter totals grew during the January-March 2014 quarter as the result of Magellan Health Services' reprocessing of claims pertaining to certain generic drugs.

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 2014 Compared to the Previous Two Quarters

	Statewide Enrollment Targets and Reserve Capacity[9]	Enrollment and Reserve Slots Being Held as of the End of Each Quarter		
		Oct – Dec 2013	Jan – Mar 2014	Apr – Jun 2014
CHOICES 1	Not applicable	18,969	18,462	18,018
CHOICES 2	12,500	9,164	8,802	8,729
Interim CHOICES 3	Not applicable	4,018	4,014	4,321
Total CHOICES	Not applicable	32,151	31,278	31,068
Reserve capacity	300	300	300	300

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

Data and trends of the designated CHOICES data elements: STC 43.d. requires the State to submit to CMS periodic statistical reports about the use of LTSS by TennCare enrollees. Six separate reports—from August 2011, June 2012, September 2012, June 2013, November 2013,[10] and June 2014—had been submitted by the conclusion of the April-June 2014 quarter.

Taken together, the reports depict a program moving toward a system that offers more choices to persons requiring LTSS: institutional care to individuals with the highest acuity of need, and Home and Community Based Services (HCBS) for individuals whose needs can be safely and effectively met at home or in other non-institutional settings. Point in time data revealed relatively consistent use of NF services over time, with institutional care reaching 21,530 enrollees on June 30, 2011, 20,968 enrollees on June 30, 2012, and 19,415 enrollees on June 30, 2013. The aggregate number of TennCare enrollees accessing HCBS, by comparison, grew from 6,226 in the twelve-month period preceding CHOICES implementation to 9,789 once

[9] Of the three active CHOICES groups, only CHOICES 2 has an enrollment target.
[10] The November 2013 report was ready for submission on August 6, 2013, but a clerical error resulted in the resubmission of the June 2013 report instead.

CHOICES had been in place for a year, then to 12,862 at the two-year mark, and finally to 15,311 after three 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 8,543 on June 30, 2011, then to 10,482 on June 30, 2012, and finally to 12,559 on June 30, 2013.

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

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

During the period from April 1, 2014, through June 30, 2014, NF PreAdmission Evaluations were approved for 107 individuals with acuity scores lower than 9, and 54 of these individuals were subsequently enrolled in CHOICES 1. 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 PreAdmission Evaluations were approved for 19 individuals with acuity scores lower than 9, and 17 of the individuals were subsequently enrolled in CHOICES Group 2. The remaining individuals 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 8.

Table 8
TennCare CHOICES Transition Allowances
for April – June 2014 Compared to the Previous Two Quarters

Grand Region	Frequency and Use of Transition Allowances					
	Oct – Dec 2013		Jan – Mar 2014		Apr – Jun 2014	
	# Distributed	Total Amount	# Distributed	Total Amount	# Distributed	Total Amount
East	11	$14,820	4	$2,555	5	$2,885
Middle	2	$2,945	1	$45	2	$1,599
West	13	$15,734	6	$9,036	7	$8,065
Statewide Total	26	$33,499	11	$11,636	14	$12,549

B. Concept Paper Regarding Long-Term Services and Supports

Currently, TennCare and the Tennessee Department of Intellectual and Developmental Disabilities (DIDD) deliver Home and Community Based Services (HCBS) to individuals with intellectual disabilities through three Section 1915(c)[11] Waiver programs:

- The Statewide Waiver, which serves more than 6,500 people;
- The Arlington Waiver, which serves nearly 300 people; and
- The Self-Determination Waiver, which serves more than 1,100 people.

With the Statewide Waiver and the Arlington Waiver scheduled to expire on December 31, 2014, TennCare and DIDD initiated a fresh examination of the system of HCBS for TennCare members with intellectual and other kinds of developmental disabilities to determine where meaningful improvements could be made. Meetings held in late 2013 and early 2014 with consumers and their family members, people who are not receiving services currently and their family members, HCBS providers, and advocacy groups yielded substantial feedback about the most effective ways to renew existing 1915(c) Waivers and to introduce new program designs.

Drawing heavily on these suggestions, TennCare and DIDD published a joint proposal—entitled Renewal and Redesign of Tennessee's Long-Term Services and Supports Delivery System for Individuals with Intellectual Disabilities: A Concept Paper for Stakeholder Review and Input—on May 30, 2014. The document, which is available on TennCare's website at http://www.tn.gov/tenncare/forms/ConceptPaper.pdf and which was sent to CMS on June 2, 2014, outlines a plan for renewing the Statewide Waiver and the Arlington Waiver with essential

[11] Section 1915(c) of the Social Security Act is the provision of federal law that authorizes Medicaid programs to cover HCBS for individuals with intellectual disabilities.

amendments,[12] and for launching a new program of managed LTSS to be called *Employment and Community First CHOICES*. The stated goal of *Employment and Community First CHOICES* is "promoting and supporting integrated, competitive employment and independent living as the first and preferred option for all individuals with intellectual and developmental disabilities."[13]

In June 2014, representatives of TennCare and DIDD hosted a series of Community Meetings in all three regions of the state to share information and accept comments about the Concept Paper. Members of the public who could not attend one of the Community Meetings were invited to share their thoughts online by June 30, 2014. Feedback received will be incorporated into the formal proposals submitted to CMS later this year.

C. Financial Monitoring by the Tennessee Department of Commerce and Insurance

Claims Payment Analysis. The prompt pay requirements of T.C.A. § 56-32-126(b) mandate that each Managed Care Organization (MCO) ensure that 90 percent of clean claims for payment for services delivered to a TennCare enrollee are paid within 30 calendar days of the receipt of such claims and that 99.5 percent of all provider claims are processed within 60 calendar days of receipt. TennCare's contract with its Dental Benefits Manager (DBM) requires the DBM to process claims in accordance with this statutory standard as well. TennCare's contract with its Pharmacy Benefits Manager (PBM) requires the PBM to pay 100 percent of all clean claims submitted by pharmacy providers within 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

[12] The Concept Paper proposes corresponding amendments to the Self-Determination Waiver, even though it does not expire as soon as the Statewide and Arlington Waivers.
[13] Concept Paper, Page 2.

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 2014 Financial Statements. As of March 31, 2014, TennCare MCOs reported net worth as indicated in the table below.[14]

Table 9
Net Worth Reported by MCOs as of March 31, 2014

	Net Worth Requirement	Reported Net Worth	Excess/ (Deficiency)
Amerigroup Tennessee	$17,550,992	$104,253,521	$86,702,529
UnitedHealthcare Plan of the River Valley (UnitedHealthcare Community Plan)	$64,885,278	$486,138,826	$421,253,548
Volunteer State Health Plan (BlueCare & TennCare Select)	$34,942,038	$270,769,113	$235,827,075

All TennCare MCOs met their minimum net worth requirements as of March 31, 2014.

D. Managed Care Organization (MCO) Contracts

After issuing a Request for Proposals (RFP) for three MCOs to furnish managed care services to the TennCare population, the Bureau announced on December 16, 2013, that successful bids had been submitted by Amerigroup, BlueCare, and UnitedHealthcare, the companies already comprising TennCare's managed care network. The new contracts require delivery of physical health services, behavioral health services, and LTSS in all three of Tennessee's grand regions. Each of the previous contracts, by contrast, was limited to two plans per grand region.

During the April-June 2014 quarter, TennCare continued its collaboration with the three contractors to ensure a seamless transition to the statewide service delivery model on January 1, 2015. The Bureau and the MCOs participated in a joint conference call on May 16, 2014, to discuss such issues as innovations that the MCOs will be required to implement, a list of key dates and milestones, and an upcoming desk review of the MCOs' policies and procedures. By

[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.

the conclusion of the call, participants recognized the potential value of additional one-on-one sessions between TennCare and each contractor. Therefore, on June 13, 2014, the Bureau hosted meetings with the MCOs individually, focusing on overall readiness plans as well as the need to accommodate implementation plans developed by each TennCare Business Section.

Another topic addressed during the April-June 2014 quarter was the transfer of portions of the enrollee population from one health plan to another on January 1, 2015, and on April 1, 2015. This reassignment will affect approximately one-third of TennCare's members, with certain segments of the population—such as residents of Intermediate Care Facilities for Individuals with Intellectual Disabilities and members of a household who are assigned to the same MCO—exempted from reassignment. In addition, wherever possible, an individual dually eligible for Medicare and TennCare will be assigned to a single contractor that can serve simultaneously as a Medicare Dual Eligible Special Needs Plan (D-SNP) and TennCare MCO.

E. Electronic Health Record Incentive Program

The Electronic Health Record (EHR) Incentive Program is a partnership between federal and state governments that grew out of the Health Information Technology for Economic and Clinical Health (HITECH) Act. The purpose of the program is to provide financial incentives to Medicaid providers[15] 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 program's administrative costs.

Currently, Medicaid providers may qualify for three 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 payments to providers who continue to demonstrate meaningful use.

EHR payments made by TennCare during the April-June 2014 quarter as compared with payments made throughout the life of the program appear in the table below:

[15] 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 10
EHR Payments
Quarterly and Cumulative

Payment Type	No. of Providers Paid During the Quarter	Quarterly Amount Paid (Apr-Jun 2014)	Cumulative Amount Paid To Date
First-year payments	274[16]	$6,390,184	$141,515,874
Second-year payments	347	$3,518,252	$39,526,706
Third-year payments	201	$3,403,436	$4,107,967

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

- Participation throughout the quarter in five Southeast Regional Collaboration for HIT/HIE (SERCH) calls;
- Telephone assistance throughout the quarter for eligible professionals attesting to Meaningful Use;
- Hosting webinars on April 22, May 22, May 29, and June 9;
- Involvement in the virtual eHealth Summit sponsored by CMS on May 19, 2014;
- Responding to more than 500 inquiries submitted to the EHR Meaningful Use email box;
- Monthly newsletters distributed by the Bureau's EHR ListServ; and
- A quarterly reminder issued through the Provider Incentive Payment Program ("PIPP") system to Tennessee providers who had registered at the federal level but who have not registered or attested at the state level.

A significant priority for TennCare staff in the coming months is scheduling EHR workshops with a variety of provider organizations to maintain the momentum of the program.

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

Although total state and local revenue collections were 4.25 percent higher in April 2014 than they had been a year previously, revenues in May and June 2014 fell in comparison to the

[16] Of the 274 providers receiving first-year payments in the April-June 2014 quarter, 13 earned their incentives by successfully attesting to meaningful use of EHR technology in their first year of participation in the program.

corresponding months of 2013.[17] In the arena of jobs, the unemployment rate fell to 6.3 percent in April 2014, marking the eighth straight month in which the rate had declined. Although unemployment proceeded to tick upward to 6.4 percent in May and again to 6.6 percent in June, the rate nonetheless remained lower in all three months of the April-June 2014 quarter than in any month of the January-March 2014 quarter. Furthermore, Tennessee's unemployment levels were comparable to the national average, with no more than a 0.5 percent difference between the two in any month of the quarter.[18]

VIII. Member Month Reporting

Tables 11 and 12 below present the member month reporting by eligibility group for each month in the quarter.

Table 11
Member Month Reporting for Use in Budget Neutrality Calculations
April – June 2014

Eligibility Group	April 2014	May 2014	June 2014	Sum for Quarter Ending 6/30/14
Medicaid eligibles (Type 1)				
EG1 Disabled, Type 1 State Plan eligibles	134,381	134,177	133,709	402,267
EG2 Over 65, Type 1 State Plan eligibles	20	22	24	66
EG3 Children, Type 1 State Plan eligibles	659,728	663,040	666,410	1,989,178
EG4 Adults, Type 1 State Plan eligibles	305,095	310,223	315,813	931,131
EG5 Duals, Type 1 State Plan eligibles	123,183	123,199	123,214	369,596
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

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

Eligibility Group	April 2014	May 2014	June 2014	Sum for Quarter Ending 6/30/14
EG9 H-Disabled, Type 2 Demonstration Population	265	276	283	824
EG10 H-Over 65, Type 2 Demonstration Population	0	0	0	0
EG11 H-Duals, Type 2 Demonstration Population	5,300	5,250	5,351	15,901
TOTAL	1,227,972	1,236,187	1,244,804	3,708,963

Table 12
Member Month Reporting Not Used in Budget Neutrality Calculations
April – June 2014

Eligibility Group	April 2014	May 2014	June 2014	Sum for Quarter Ending 6/30/14
EG6E Expan Adult, Type 3, Demonstration Population	1,107	1,119	1,125	3,351
EG7E Expan Child, Type 3, Demonstration Population	64	64	64	192
Med Exp Child, Title XXI Demonstration Population	19,475	19,514	19,501	58,490
EG12E Carryover, Type 3, Demonstration Population	6,606	6,729	6,819	20,154
TOTAL	27,252	27,426	27,509	82,187

IX. Consumer Issues

Eligibility Appeals. Tennessee is currently a "determination" state, meaning that MAGI-based eligibility decisions are made by the Federally-Facilitated Marketplace (FFM) rather than by the State.

When the FFM denies an application, it has the responsibility of providing the applicant with an appeal of its decision; current regulations give the applicant a choice, if he would prefer that the State hear his appeal. The State's ability to process an appeal, however, is dependent upon its having access to the information that the FFM used to deny the application. The FFM has so far been unable to provide the State with this information. Therefore, as communicated to the FFM by letter dated March 7, 2014, the State is currently sending all MAGI-based appeals it receives to the FFM to process.

On June 30, 2014, CMS initiated a call with the State regarding the handling of FFM appeals. CMS outlined its plans to reach out to those appellants who had indicated they wanted the State to handle their appeals and offer to conduct the appeal if the appellant was agreeable. The names of persons whom CMS was unable to reach would be sent to the State, along with the names of persons who indicated they still wanted the State to handle their appeals. CMS indicated that it would soon forward information on the FFM's denial of applications that the State could use in handling the appeals. CMS also indicated that the State would soon receive the agreement with OMEA (the Office of Medicaid Eligibility Appeals) that the State had been awaiting. Finally, CMS offered to send the State a "companion letter" to accompany the approval of proposed State Plan Amendment 13-0001 that would explain why the State had been unable to comply with the October 1, 2013, requirement that it handle appeals when requested to do so by the appellant. The State requested that CMS send some sample files to the State so that the State could begin setting up its processes, and CMS was agreeable. As of this writing, the State is still waiting on CMS to provide each of the items outlined above.

Eligibility appeals concerning non-MAGI eligibility categories continued to be processed by the Tennessee Department of Human Services during this quarter. Table 13 presents a summary of the number and types of eligibility appeals handled during the quarter, compared to the previous two quarters. The steady decline in the number of appeals over the last three quarters coincides with the suspension of "termination of enrollment" notices that began in December 2013.

Table 13
Eligibility Appeals Handled by the Department of Human Services
During the April – June 2014 Quarter, Compared to the Previous Two Quarters

	Oct – Dec 2013	Jan – Mar 2014	Apr – Jun 2014
TennCare Medicaid			
No. of appeals received	3,222	1,466	496
No. of appeals resolved or withdrawn	1,568	1,084	323
No. of appeals taken to hearing	1,718	623	102
No. of appeals that did not involve a valid factual dispute	955	718	296
Appeals previously heard that were decided in the State's favor	1,064	594	66
Appeals previously heard that were decided in the appellant's favor	179	124	16
TennCare Standard			
No. of appeals received	106	11	3
No. of appeals resolved or withdrawn	33	10	3
No. of appeals taken to hearing	74	28	1
No. of appeals that did not involve a valid	25	19	1

	Oct – Dec 2013	Jan – Mar 2014	Apr – Jun 2014
factual dispute			
Appeals previously heard that were decided in the State's favor	48	23	0
Appeals previously heard that were decided in the appellant's favor	5	2	0

Medical Service Appeals. Medical service appeals are handled by the Bureau of TennCare. Table 14 below presents a summary of the medical service appeals handled during the quarter, compared to the previous two quarters.

Table 14
Medical Service Appeals Handled by the Bureau of TennCare
During the April – June 2014 Quarter, Compared to the Previous Two Quarters

	Oct – Dec 2013	Jan – Mar 2014	Apr – Jun 2014[19]
No. of appeals received	924	901	1,602
No. of appeals resolved	961	829	1,384
• Resolved at the MCC level	301	274	704
• Resolved at the TSU level	115	108	100
• Resolved at the LSU level	545	447	580
No. of appeals that did not involve a valid factual dispute	275	227	276
No. of directives issued	178	163	169
No. of appeals taken to hearing	545	447	580
No. of appeals that were withdrawn by the enrollee at or prior to the hearing	172	157	212
Appeals that went to hearing and were decided in the State's favor	170	123	149
Appeals that went to hearing and were decided in the appellant's favor	17	22	31

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.

[19] The increase in medical service appeals that is observable in the current quarter has been attributed largely to an increase in dental appeals, which in turn is attributed in part to outreach conducted by TennCare in partnership with the Tennessee Dental Association on the subject of how participating providers should properly file appeals on behalf of TennCare enrollees.

- 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 15
Long-Term Services and Supports Appeals for April – June 2014
Compared to the Previous Two Quarters

	Oct – Dec 2013	Jan – Mar 2014	Apr – Jun 2014
No. of appeals of PreAdmission Evaluation (PAE) denials	447	326	302
No. of appeals of PASRR determinations	3	5	5
No. of appeals of denial for enrollment into CHOICES	7	8	11
No. of appeals of involuntary disenrollment from CHOICES	4	5	4
No. of appeals of denial of Consumer Direction	0	1	1
No. of appeals of involuntary withdrawal of Consumer Direction	0	0	0
No. of appeals of involuntary disenrollment from an HCBS waiver for individuals with intellectual disabilities	0	0	1
No. of appeals resolved in appellant's favor prior to hearing	143	156	159

	Oct – Dec 2013	Jan – Mar 2014	Apr – Jun 2014
No. of appeals withdrawn prior to hearing	9	27	23
No. of appeals dismissed at hearing	55	86	72
No. of appeals continued at hearing	33	5	11
No. of appeals that went to hearing and were decided in the State's favor	36	50	26
No. of appeals that went to hearing and were decided in the appellant's favor	4	10	6

X. Quality Assurance/Monitoring Activity

Population Health. "Population Health" (PH) is the model of targeted health care interventions implemented by TennCare in the months leading up to—and culminating on—July 1, 2013. Advantages of PH 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 2014 quarter is provided in Table 16. Data for the period of April through June 2014 will be provided in the next Quarterly Progress Report.

Table 16
Population Health Data*, January – March 2014

Risk Level	Intervention Type	Intervention Goal(s)	Number of Unique Members at End of Quarter
Level 0: no identified risk	Wellness Program	Keep members healthy as long as possible	660,083
Level 1: low or moderate risk	Maternity Program	Engage pregnant women in timely prenatal care and deliver a healthy,	10,579

Risk Level	Intervention Type	Intervention Goal(s)	Number of Unique Members at End of Quarter
		term infant without complications	
	Health Risk Management	Prevent, reduce, or delay exacerbation and complications of a condition or health risk behavior	511,547
	Care Coordination	Assure that members receive the services they need to reduce the risk of an adverse health outcome	12,899
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	7,386
	High Risk Pregnancy Management	Engage pregnant women in timely prenatal care and deliver a healthy, term infant without complications	4,453
	Complex Case Management	Move members to optimal levels of health and well-being through timely coordination of quality services and self-management support	976
Total PH Enrollment			**1,207,923**

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

Provider Data Validation Report. In April 2014, TennCare's External Quality Review Organization (EQRO), Qsource, published the results of its provider data validation survey for the January-March 2014 quarter. Qsource took a sample of provider data files from TennCare's MCCs[20] and reviewed each for accuracy in the following categories:

- Contract status with MCC
- Provider address
- Provider credentialed specialty / behavioral health service code
- Open / closed to new patients
- Services to patients under age 21
- Services to patients age 21 or older
- Primary care services
- Prenatal care services
- Availability of routine care services

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

- Availability of urgent care services

The validity of such information is one measure of providers' availability and accessibility to TennCare enrollees. Qsource's report concluded that "[o]verall, the MCCs' accuracy rates have maintained a high level," especially in the categories of "active contract status with MCC" (98.3 percent accuracy), "provider credentialed specialty / behavioral health service code" (97.9 percent accuracy), "primary care services" (99.1 percent accuracy), and "prenatal care services" (99.5 percent accuracy).

While the results were comparable to the overall scores obtained last quarter and one year ago, to ensure improvement in these and other areas (such as "services to patients age 21 or older," which demonstrated only 92.1 percent accuracy), TennCare required each of its MCCs to submit a Corrective Action Plan no later than June 5, 2014. The Bureau, in turn, had received, reviewed, and accepted all of the plans by June 12, 2014. Results for the April-June 2014 quarter will be discussed in the next Quarterly Progress Report.

XI. Demonstration Evaluation

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

In addition, on October 31, 2013, the State submitted the Draft Annual Report as required by STC 46. Part V of that report provided the progress to date on the performance measures that were outlined in the approved Evaluation Design. It is the State's intention to provide updated information on the performance measures in each Annual Report.

XII. Essential Access Hospital Pool[21]

A. Safety Net Hospitals

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

[21] 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.

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 – South
Methodist Healthcare – Memphis Hospitals
Saint Jude Children's Research Hospital
University Medical Center (with McFarland Psych)
Saint Thomas Midtown Hospital
Centennial Medical Center
Physicians Regional Medical Center
Methodist Healthcare – North
Skyline Medical Center (with Madison campus)
Saint Francis Hospital
Saint Thomas Rutherford Hospital
Parkwest Medical Center (with Peninsula Psych)
Wellmont Holston Valley Medical Center
Maury Regional Hospital
Fort Sanders Regional Medical Center
Skyridge Medical Center
Gateway Medical Center
Cookeville Regional Medical Center
Delta Medical Center
Parkridge East Hospital
Methodist Hospital – Germantown
Blount Memorial Hospital
Wellmont Bristol Regional Medical Center
Baptist Memorial Hospital for Women
Haywood Park Community Hospital
NorthCrest Medical Center
Southern Hills Medical Center
LeConte Medical Center

Horizon Medical Center
Sumner Regional Medical Center
Tennova Healthcare – Newport Medical Center
Takoma Regional Hospital
Methodist Medical Center of Oak Ridge
Heritage Medical Center
Baptist Memorial Hospital – Tipton
StoneCrest Medical Center
Summit Medical Center
Tennova Healthcare – LaFollette Medical Center
Dyersburg Regional Medical Center
Morristown – Hamblen Healthcare System
Henry County Medical Center
Sweetwater Hospital Association
Sycamore Shoals Hospital
Harton Regional Medical Center
Grandview Medical Center
Indian Path Medical Center
Regional Hospital of Jackson
Baptist Memorial Hospital – Union City
Lakeway Regional Hospital
Jellico Community Hospital
Wellmont Hawkins County Memorial Hospital
Hardin Medical Center
Crockett Hospital
Athens Regional Medical Center
River Park Hospital
Southern Tennessee Medical Center
Livingston Regional Hospital
Tennova Healthcare – Jefferson Memorial Hospital
Henderson County Community Hospital
McNairy Regional Hospital
Roane Medical Center
Skyridge Medical Center – Westside
Bolivar General Hospital
McKenzie Regional Hospital
Claiborne County Hospital
Hillside Hospital
Volunteer Community Hospital
United Regional Medical Center
Jamestown Regional Medical Center
Wayne Medical Center
Methodist Healthcare – Fayette
Erlanger Health System – East Campus

DeKalb Community Hospital
Baptist Memorial Hospital – Huntingdon
White County Community Hospital
Emerald Hodgson Hospital
Humboldt General Hospital
Gibson General Hospital

XIII. Graduate Medical Education (GME) Hospitals

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

The GME medical schools and their affiliated universities are 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

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

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Date Submitted to CMS: August 29, 2014

Attachment A

Budget Neutrality Calculations for the Quarter

Actual TennCare Budget Neutrality (April - June 2014)

I. The Extension of the Baseline

Baseline PMPM

	SFY 2014 PMPM
1-Disabled (can be any ages)	$1,561.46
2-Child <=18	$468.46
3-Adult >= 65	$1,022.17
4-Adult <= 64	$917.79
Duals (17)	$652.99

Actual Member months of Groups I and II

1-Disabled (can be any ages)	403,091
2-Child <=18	1,989,178
3-Adult >= 65	66
4-Adult <= 64	931,131
Duals (17)	385,497
Total	3,708,963

Ceiling without DSH	**Baseline * MM**
1-Disabled (can be any ages)	$629,410,473
2-Child <=18	$931,850,326
3-Adult >= 65	$67,463
4-Adult <= 64	$854,582,720
17s	$251,725,686
Total	**$2,667,636,668**

DSH	**DSH Adjustment (Quarterly)**	$115,999,213

Total Ceiling	**Budget Neutrality Cap**	
	Total w/DSH Adj.	**$2,783,635,882**

II. Actual Expenditures

Group 1 and 2

1-Disabled (can be any ages)	$ 549,756,386
2-Child <=18	$ 412,691,722
3-Adult >= 65	$ 71,131
4-Adult <= 64	$ 360,060,582

Duals (17)	$	279,978,953
Total		**1,602,558,775**

Group 3

1-Disabled (can be any ages)		
2-Child <=18	$	12,188,483
3-Adult >= 65	$	66,867,618
4-Adult <= 64	$	1,937,110
Duals (17)		
Total		**80,993,210**

Pool Payments and Admin

Total Pool Payments		$214,453,236

Admin	$	129,080,734

Quarterly Drug Rebates	$	120,642,822.00
Quarterly Premium Collections		365
Total Net Quarterly Expenditures	**$**	**1,906,442,768**

III. Surplus/(Deficit)

	$877,193,114
Federal Share	**$572,719,384**

HCI Result	MM201404	MM201405	MM201406	TOTAL	HCI ASO	HCI Rx	HCI DTL	HCI MCO CAP (TCS Admin)	UNK Allocation	TOTAL
EG1-TYPE1 (disabled, type1 state plan eligibles)	134,381	134,177	133,709	402,267	$81,286,405	$107,774,311	$1,639,453	$356,091,074	(1,132,897)	$545,658,345
EG1-TYPE2 (disabled, type2 transition group)	0	0	0	-				$0	-	$0
EG2-TYPE1 (over 65, type1 state plan eligibles)	20	22	24	66	$35,878	$4,631	$0	$30,770	(148)	$71,131
EG2-TYPE2 (over 65, type2 state plan eligibles)	0	0	0	-				$0	-	$0
EG3-TYPE1 (children, type1 state plan eligibles)	659,728	663,040	666,410	1,989,178	$12,514,276	$53,952,661	$30,622,505	$316,459,177	(856,897)	$412,691,722
Med Exp Child (Title XXI Demo Pop; EG3-Type2)	19,475	19,514	19,501	58,490	$44,067	$2,966,863	$1,212,965	$7,941,805	(25,213)	$12,140,487
EG4-TYPE1 (adults, type1 State plan eligibles)	305,095	310,223	315,813	931,131	$1,376,123	$58,691,826	$2,619,802	$298,120,329	(747,498)	$360,060,582
EG4-TYPE2 (adults, type2 demonstration pop)	0	0	0	-				$0	-	$0
EG5-TYPE1 (duals, state plan eligibles)	123,183	123,199	123,214	369,596	$911,554	$778,823	$607,011	$232,104,443	(485,677)	$233,916,155
EG6E-TYPE3 (Expan adult, type3 demonstration pc	1,107	1,119	1,125	3,351		$500,782	$4,147	$1,436,202	(4,022)	$1,937,110
EG7E-TYPE3 (Expan child, type3 demonstration pc	64	64	64	192		$19,242	$2,378	$26,475	(100)	$47,996
EG8-TYPE2 (emd exp child)	0	0	0	-				$0	-	$0
EG9 H-Disabled (TYPE 2 Eligibles)	265	276	283	824	$3,386	$212,124	$0	$3,891,040	(8,509)	$4,098,041
EG11H, H-Dual	5,300	5,250	5,351	15,901		$31,827	$9,601	$46,117,018	(95,648)	$46,062,798
EG12E, Carryovers	6,606	6,729	6,819	20,154	$2,182	$197,578	$11,694	$66,794,984	(138,820)	$66,867,618
Total	**1,255,224**	**1,263,613**	**1,272,313**	**3,791,150**	**$96,173,871**	**$225,130,668**	**$36,729,556**	**$1,329,013,318**	**-$3,495,428**	**$1,683,551,985**

HCI Result	MM201404	MM201405	MM201406	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)	134,381	134,177	133,709	402,267	$202.07	$267.92	$4.08	$885.21	-$2.82	$1,356.46
EG1-TYPE2 (disabled, type2 transition group)	0	0	0	-						
EG2-TYPE1 (over 65, type1 state plan eligibles)	20	22	24	66	$543.61	$70.17	$0.00	$466.21	-$2.24	$1,077.74
EG2-TYPE2 (over 65, type2 state plan eligibles)	0	0	0	-	-	-	-	-	-	-
EG3-TYPE1 (children, type1 state plan eligibles)	659,728	663,040	666,410	1,989,178	$6.29	$27.12	$15.39	$159.09	-$0.43	$207.47
Med Exp Child (Title XXI Demo Pop; EG3-Type2)	19,475	19,514	19,501	58,490	$0.75	$50.72	$20.74	$135.78	-$0.43	$207.57
EG4-TYPE1 (adults, type1 State plan eligibles)	305,095	310,223	315,813	931,131	$1.48	$63.03	$2.81	$320.17	-$0.80	$386.69
EG4-TYPE2 (adults, type2 demonstration pop)	0	0	0	-						
EG5-TYPE1 (duals, state plan eligibles)	123,183	123,199	123,214	369,596	$2.47	$2.11	$1.64	$628.00	-$1.31	$632.90
EG6E-TYPE3 (Expan adult, type3 demonstration pc	1,107	1,119	1,125	3,351	$0.00	$149.44	$1.24	$428.59	-$1.20	$578.07
EG7E-TYPE3 (Expan child, type3 demonstration pc	64	64	64	192	$0.00	$100.22	$12.39	$137.89	-$0.52	$249.98
EG8-TYPE2 (emd exp child)	0	0	0	-						
EG9 H-Disabled (TYPE 2 Eligibles)	265	276	283	824	$4.11	$257.43	$0.00	$4,722.14	-$10.33	$4,973.35
EG11H, H-Dual	5,300	5,250	5,351	15,901	$0.00	$2.00	$0.60	$2,900.26	-$6.02	$2,896.85
EG12E, Carryovers	6,606	6,729	6,819	20,154	$0.11	$9.80	$0.58	$3,314.23	-$6.89	$3,317.83
Total	**1,255,224**	**1,263,613**	**1,272,313**	**3,791,150**	**$25.37**	**$59.38**	**$9.69**	**$350.56**	**-$0.92**	**$444.07**

* Unknown allocation was performed within the Service category totals.