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

August 30, 2013

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

RE: TennCare II, STC 47, Quarterly Progress Report

Dear Ms. Woodard:

Enclosed please find the Quarterly Progress Report for the April-June 2013 quarter. This report is being submitted in accordance with STC 47 of the Demonstration agreement that was in place throughout the April-June 2013 quarter.

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 2013)

Demonstration Year: 11 (7/1/12 - 6/30/13)
Federal Fiscal Quarter: 3/2013 (4/13 - 6/13)
Waiver Quarter: 4/2013 (4/13 - 6/13)

I. Introduction

The goal of the TennCare Demonstration is to show that careful use of a managed care approach can enable the State to enroll a certain number of people who are not otherwise eligible for Medicaid and to deliver quality care to all enrollees, without spending more than would have been spent had the State continued its Medicaid program.

TennCare contracts with several Managed Care Contractors (MCCs) to provide services to about 1.2 million enrollees. During this quarter, these entities included Managed Care Organizations (MCOs) for medical, behavioral, and certain long-term services and supports, a Dental Benefits Manager (DBM) for dental services, and a Pharmacy Benefits Manager (PBM) for pharmacy services.

There are two major components of TennCare. "TennCare Medicaid" serves Medicaid eligibles, and "TennCare Standard" serves persons in the demonstration population.

The key dates of approval/operation in this quarter are as follows, together with the corresponding Special Terms and Conditions (STCs)[1], if applicable.

Table 1
Key Dates of Approval/Operation in the Quarter

Date	Action	STC #
4/4/13	The Monthly Call originally scheduled for March was held.	46
4/25/13	The Monthly Call was held.	46
4/26/13	Following the renewal of the hospital assessment fee during the Tennessee legislative session, the State withdrew Demonstration Amendment 17. (Amendment 17 had outlined program reductions that would have been necessary if the assessment fee were not renewed.)	
4/26/13	The State submitted Demonstration Amendment 19 to CMS. Amendment 19 proposed the addition of a $1.50 co-pay on generic prescription drugs for TennCare Medicaid and TennCare Standard enrollees who currently have a $3.00 co-pay on brand name prescription drugs.	
4/30/13	CMS sent the State a list of Federal Review Team questions concerning Demonstration Amendment 18, which proposed coverage of Assisted Care Living Facility (ACLF) services under special circumstances for individuals in CHOICES 3.	
5/13/13	The State submitted responses to the Federal Review Team	

[1] All STC references in this Quarterly Progress Report are to those in effect during the April-June 2013 quarter, and not to those that took effect on July 1, 2013, as part of TennCare's new Demonstration Approval Period.

Date	Action	STC #
	questions concerning Amendment 18.	
5/20/13	CMS sent the State follow-up questions concerning Amendment 18.	
5/23/13	The Monthly Call was cancelled.	46
5/31/13	The State submitted the Quarterly Progress Report for the January-March 2013 quarter to CMS.	47
6/4/13	CMS sent the State proposed modifications to the STCs that would effectuate the approval of Amendment 18.	
6/5/13	In response to a suggestion from the CMS Project Officer that activity on Amendment 19 could be suspended until a "simplified process for amendments" had been introduced, the State urged against such a course, noting that it would disrupt a beneficiary notice planned for August 2013.[2]	
6/7/13	CMS provided final approval for technical corrections submitted by the State in response to the December 31, 2012, approval of the Demonstration renewal.	
6/13/13	The State offered alternative language for some of the proposed STC modifications related to Amendment 18.	
6/26/13	The State submitted point in time and annual aggregate data about the CHOICES program to CMS.	45.d.iii.
6/27/13	CMS provided written approval of MCO contract amendments 11, 14, and 31.	
6/27/13	The Monthly Call was cancelled.	46
6/28/13	CMS provided written approval of the State's Pharmacy Benefits Management Contract and Dental Benefits Management Contract.	

II. Enrollment and Benefits Information

Information about enrollment by category is presented in Table 2.

[2] According to Section XIII, Part II, of the STCs, beneficiaries must be notified at least 30 days in advance of any program changes that might be adverse to them. Since the imposition of a new co-pay is considered an adverse action, enrollees must receive notification no later than September 1 of a co-pay scheduled to take effect on October 1. The process of preparing, proofreading, testing, printing, stuffing, and mailing notices to the entire TennCare population is a time-consuming one, usually requiring several weeks and occasionally more than one vendor.

Table 2
Enrollment Counts for the April - June 2013 Quarter
Compared to the Previous Two Quarters

Demonstration Populations	Total Number of TennCare Enrollees		
	Oct – Dec 2012	Jan – Mar 2013	Apr – June 2013
EG1 Disabled, Type 1 State Plan eligibles	136,384	135,215	133,692
EG1 Disabled and EG9 H-Disabled, Type 2 Demonstration Population	369	339	351
EG2 Over 65, Type 1 State Plan eligibles	50	50	37
EG2 Over 65 and EG10 H-Over 65, Type 2 Demonstration Population	0	0	0
EG3 Children, Type 1 State Plan eligibles	700,828	696,874	658,669[3]
EG4 Adults, Type 1 State Plan eligibles	285,536	276,834	289,416
EG4 Adults, Type 2 Demonstration Population[4]	0	0	0
EG5 Duals, Type 1 State Plan eligibles and EG11 H-Duals 65, Type 2 Demonstration Population	140,887	136,225	133,701
EG6E Expan Adult, Type 3 Demonstration Population	1,638	1,473	1,630
EG7E Expan Child, Type 3, Demonstration Population	247	177	151
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	21,153	19,165	19,309
EG12E Carryover, Type 3, Demonstration Population	2,594	5,753	6,067

[3] Although STC 55.a.(iii) defines EG3 Children as "age 18 or younger," some 19-year-olds were erroneously placed in this category in previous quarters. Correction of the mistake accounts for a slightly smaller population of EG3 Children during the April-June 2013 quarter (and a modest rise in the population of EG4 Adults).

[4] This eligibility group—individuals between 19 and 64 years old who are medically needy rollovers—contains no members and will not have any in the future. This category has been removed from the STCs to take effect on July 1, 2013.

Demonstration Populations	Total Number of TennCare Enrollees		
	Oct – Dec 2012	Jan – Mar 2013	Apr – June 2013
TOTAL*	1,289,686	1,272,105	1,243,023

*** 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, 2013

	West Tennessee	Middle Tennessee	East Tennessee
Managed Care Organizations	BlueCare[5]	Amerigroup	BlueCare
	UnitedHealthcare Community Plan[6]	UnitedHealthcare Community Plan	UnitedHealthcare Community Plan
	TennCare Select[7]	TennCare Select	TennCare Select
Pharmacy Benefits Manager	Magellan Health Services		
Dental Benefits Manager	TennDent[8]		

Update on Standard Spend Down Enrollment. Standard Spend Down (SSD) is an eligibility category available through an amendment to the TennCare Demonstration[9] and is designed to serve a limited number of Tennesseans who are not otherwise eligible for Medicaid and who Meet the following criteria:

- They are aged, blind, disabled, or the caretaker relative of a Medicaid-eligible child, and

[5] 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.

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

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

[8] TennDent is operated by Delta Dental.

[9] See Expenditure Authority 7.b. and Special Term and Condition 21.a. of the TennCare Demonstration whose approval period ended on June 30, 2013.

- They have enough unreimbursed medical bills to allow them to "spend down" their income to a low level known as the Medically Needy Income Standard (MNIS). The MNIS for a family of three in Tennessee is $317 per month.

As noted in TennCare's previous Quarterly Progress Report to CMS, SSD opened to new enrollment for the sixth time on March 21, 2013; the proximity of that date to the end of the January-March quarter, however, meant that no applications had been received or individuals enrolled in the program in time to be included in the previous Quarterly Progress Report. As of June 21, 2013, however, a total of 2,495 applications had been received, 506 of which had been approved, 1,271 of which had been denied, and 718 of which were still pending.

Possible Changes to TennCare Benefits ("Amendment 17"). On February 4, 2013, TennCare submitted Demonstration Amendment 17 to CMS. Amendment 17 repeated several changes proposed in each of the last three years that were made unnecessary each time by the Tennessee General Assembly's renewal of a one-year Enhanced Coverage Fee. Specifically, the measure provided for the elimination of physical therapy, speech therapy, and occupational therapy for adults and the institution of benefit limits on certain hospital services, lab and X-ray services, and health practitioners' office visits for non-pregnant and non-institutionalized adults. In April 2013, the General Assembly passed the Annual Coverage Assessment Act of 2013, rendering the benefit modifications unnecessary. As a result, TennCare notified CMS by letter dated April 26, 2013, of its decision to withdraw Amendment 17.

Additional Benefit for Individuals at Risk of Institutional Placement ("Amendment 18"). On March 7, 2013, TennCare proposed to add Assisted Care Living Facility (ACLF) services for individuals in CHOICES 3 when certain criteria (including cost neutrality) were met. CHOICES 3 is the group of individuals who do not meet the Level of Care criteria for Nursing Facility (NF) services, but who have been found to be at risk for institutionalization. ACLF services are already available for persons in CHOICES 2, which consists of enrollees who meet the NF Level of Care criteria but who receive Home and Community Based Services as a safe and cost-effective alternative to institutional care. CMS proposed modifications to the TennCare Demonstration that would require the State to abide by Home and Community Based Services regulations that have not yet been published in their final form. The State was reluctant to commit to abide by regulations not yet seen; the regulations could cause the State to reassess its position on implementing Amendment 18. Therefore, the State requested that the amendment be pended until the final regulations are published.

Co-Payments for Covered Generic Medications ("Amendment 19"). On April 26, 2013, the Bureau submitted Demonstration Amendment 19 to CMS. Amendment 19 would allow a $1.50 co-payment for covered generic medications to be charged to those TennCare enrollees who now have a $3.00 co-pay on brand name drugs.

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." In preparation for implementation of the compliance plan on January 1, 2013, TennCare notified Standard members during November 2012 of—

- The amount of their quarterly family co-payment limit;
- Their responsibility for documenting any co-payment charges incurred during a particular quarter; and
- Their responsibility for notifying the TennCare Solutions Unit (via a toll-free telephone number) upon the fulfillment of their quarterly cost sharing obligations.

During the April-June 2013 quarter, the Bureau received no notifications that a family with members enrolled in TennCare Standard had met its cost sharing limit.

III. Innovative Activities to Assure Access

Early Periodic Screening, Diagnosis and Treatment (EPSDT). EPSDT, or "TENNderCare," outreach is a significant area of interest for TennCare. The TennCare Bureau maintains a contract with the Tennessee Department of Health (DOH) to conduct a community outreach program for the purpose of educating families on EPSDT benefits and encouraging them to use those benefits, particularly preventive exams. Table 4 summarizes the community outreach activity during this quarter and the previous two quarters.

Table 4
Department of Health
Community Outreach Activity for EPSDT
April – June 2013 Compared to the Previous Two Quarters

Activities	Oct – Dec 2012	Jan – Mar 2013	Apr – June 2013[10]
Number of educational materials distributed	245,215	224,703	218,717
Number of outreach activities/events	3,154	3,224	3,492
Number of people made contact with (mostly face to face at outreach events)	193,100	161,455	171,107
Number of coalitions/advisory board meetings presided over[11]	38	72	61
Number of attendees at coalitions/advisory board meetings	562	1,158[12]	855

[10] A notable statistical decrease in several categories of outreach activity occurred during the April-June 2013 quarter, which lacked a galvanizing event comparable to those from the two preceding quarters (i.e., Child Health Week in October 2012 and Dental Health Month in February 2013).

[11] Participation in coalitions and advisory board meetings varies on a quarterly basis depending on the number of collaborative meetings scheduled by DOH, as well as the number of such meetings that TENNderCare staff are invited to attend.

[12] The number of attendees at coalitions and advisory board meetings was higher than normal during the January-March 2013 quarter because a larger number of such meetings were held.

Activities	Oct – Dec 2012	Jan – Mar 2013	Apr – June 2013[10]
Number of educational preventive health radio/TV broadcasts[13]	13,618	12,791	9,199
Number of educational preventive health newsletter/magazine articles[14]	166	94	19
Number of educational preventive health billboards, scrolling billboards and bulletin boards	5,916	33,205[15]	41,297[16]
Number of presentations made to enrollees/professional staff who work with enrollees	520	508	375
Number of individuals attending presentations	12,317	13,265	9,442
Number of attempted telephone calls regarding the importance of immunizations and dental checkups[17]	102	391[18]	503
Number (approx) of completed telephone calls regarding the importance of immunizations and dental checkups	44	166	208
Number of attempted home visits (educational materials left with these families)	17,263	15,720	14,499
Number of home visits completed	7,974	7,418	7,401
Number of outreach events directed to the homeless[19]	52	47	37

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

[14] The number of articles varies from quarter to quarter according to two principal factors: the opportunities for no-cost publication made available by local media outlets and the number of requests from external stakeholders for such articles.

[15] Several circumstances coincided during the January-March 2013 quarter to drive up the use of billboards and bulletin boards. First, a variety of community partners (including schools, boards of education, mental health agencies, and local businesses and organizations) posted on their websites either a message about TENNderCare or a link to the Bureau's TENNderCare website. Second, scrolling billboards were used much more prominently in the Anderson, Morgan, and Roane counties to promote TENNderCare checkups. Third, the Upper Cumberland Region used scrolling billboards to encourage both TENNderCare checkups and dental checkups (the latter of which gained prominence during February, which was Dental Health Month).

[16] The success achieved with billboards and bulletin boards during the January-March quarter prompted even more emphasis on this mode of communication in the East Tennessee Region during the April-June quarter.

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

[18] The number of attempted—and completed—phone calls during the January-March 2013 quarter outpaced the totals for the preceding quarter in part because calls concerning dental checkups were added to this category for the first time.

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

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.

Table 5
Department of Health
TENNderCare Call Center Activity
April – June 2013 Compared to the
Previous Two Quarters

Activities	Oct – Dec 2012	Jan – Mar 2013	Apr – June 2013
Number of families reached	49,233	48,590	45,236
Number of families who were assisted in scheduling an EPSDT exam for their children	3,477	3,975	3,646
Number of families who were assisted in arranging for transportation	255	188	118

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 2013 Quarter, and Percentage that Passed Systems Edits, Compared to the Previous Two Quarters

	Oct – Dec 2012	Jan – Mar 2013	Apr – June 2013
No. of encounters received by TennCare (initial submission)	8,079,096	6,667,160[20]	7,691,163
No. of encounters rejected by Edifecs upon initial submission	21,430	92,562	34,340
Percentage of encounters that were	99.73%	98.61%	99.54%

[20] The total of encounter claims received by TennCare tends to dip during the January-March quarter, as many enrollees prefer to schedule medical appointments in advance of—or even during—the holidays in November and December.

	Oct – Dec 2012	Jan – Mar 2013	Apr – June 2013
compliant with State standards (including HIPAA) upon initial submission			

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

A. CHOICES

The Long-Term Care Community CHOICES Act of 2008 provided the framework that allowed the State to restructure its Long-Term Services and Supports (LTSS) delivery system, and the two-phased implementation of CHOICES was complete in August 2010. A primary aim of the CHOICES program is to increase the home and community based services (HCBS) options that are available to meet the needs of adults who are elderly or who have physical disabilities and who require Nursing Facility (NF) level of care. Fulfillment of this goal is proceeding apace, as the percentage of individuals receiving LTSS in the community has increased from 17 percent of the LTSS population when CHOICES began to just over 39 percent by the conclusion of June 2013.

As required by STC 34.e., 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 2013 Compared to the Previous Two Quarters

	Statewide Enrollment Targets and Reserve Capacity[21]	Enrollment and Reserve Slots Being Held as of the End of Each Quarter		
		Oct – Dec 2012	Jan – Mar 2013	Apr – June 2013
CHOICES 1	Not applicable	20,500	19,644	19,415
CHOICES 2	11,000	10,189	9,830	9,612
Interim CHOICES 3	Not applicable	1,894	2,370	2,947
Total CHOICES	Not applicable	32,583	31,844	31,974
Reserve capacity	300	300	300	300

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

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

Enrollment of select members of the CHOICES population in Groups 1 and 2: STC 47.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 long-term services and supports 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 (Home and Community Based Services) despite having been assigned a score of less than 9 on the TennCare Nursing Facility Level of Care Acuity Scale. Relevant enrollment data for the April-June 2013 quarter appears in Table 8.

Table 8
Enrollment of Individuals Who Would Otherwise Be Eligible for Interim CHOICES 3 But Who Met the Modified Level of Care, April – June 2013

No. of Individuals who would otherwise be eligible for Interim CHOICES 3 but who meet the modified level of care	No. who chose CHOICES 1	No. who chose CHOICES 2	No. who are not enrolled in CHOICES 1 or CHOICES 2
176	119	20	37[22]

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.

[22] Of the 176 individuals who met the modified Level of Care requirements during the April-June 2013 quarter, 37 had not been enrolled in either CHOICES 1 or CHOICES 2 by June 30. Reasons for this include ongoing use of reimbursement sources other than TennCare (e.g., Medicare, other insurance, or private payment), failure to meet Medicaid financial eligibility requirements, and failure to proceed with enrollment in CHOICES.

Table 9
TennCare CHOICES Transition Allowances
for April – June 2013 Compared to the Previous Two Quarters

	Frequency and Use of Transition Allowances[23]					
	Oct – Dec 2012[24]		Jan – Mar 2013		Apr – June 2013	
Grand Region	# Distributed	Total Amount	# Distributed	Total Amount	# Distributed	Total Amount
East	24	$33,215	15	$18,063	20	$21,677
Middle	16	$18,736	5	$2,442	7	$5,744
West	13	$18,592	12	$12,111	11	$9,408
Statewide Total	53	$70,543	32	$32,616	38	$36,829

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

Claims Payment Analysis. The prompt pay requirements of T.C.A. § 56-32-126(b) mandate that each Managed Care Organization (MCO) ensure that 90 percent of clean claims for payment for services delivered to a TennCare enrollee are paid within 30 calendar days of the receipt of such claims and that 99.5 percent of all provider claims are processed within 60 calendar days of receipt. TennCare's contract with its Dental Benefits Manager (DBM) requires the DBM to process claims in accordance with this statutory standard as well. TennCare's contract with its Pharmacy Benefits Manager (PBM) requires the PBM to pay 100 percent of all clean claims submitted by pharmacy providers within 10 calendar days of receipt.

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

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

[24] It is not unusual for the number of transition allowances—and the total amount of transition allowance funding distributed—to rise in the October-December quarter, when families transfer members from institutional settings to home and community based living arrangements in time for the holidays.

If an MCO does not comply with the prompt pay requirements based on the total claims processed in a month, TDCI has the statutory authority to levy an administrative penalty of $10,000 for each month of non-compliance after the first instance of non-compliance was reported to the plan. The TennCare Bureau can also assess liquidated damages pursuant to the terms of the TennCare Contract. If the DBM and PBM do not meet their contractual prompt pay requirements, only the TennCare Bureau can assess applicable liquidated damages against these entities.

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

During this quarter, the MCOs submitted their National Association of Insurance Commissioners (NAIC) First Quarter 2013 Financial Statements. As of March 31, 2013, TennCare MCOs reported net worth as indicated in the table below.[25]

Table 10
Net Worth Reported by MCOs as of March 31, 2013

	Net Worth Requirement	Reported Net Worth	Excess/ (Deficiency)
Amerigroup Tennessee	$17,323,202	$112,170,452	$94,847,250
UnitedHealthcare Plan of the River Valley (UnitedHealthcare Community Plan)	$64,481,178	$477,995,733	$413,514,555
Volunteer State Health Plan (BlueCare & TennCare Select)	$35,639,453	$221,816,720	$186,177,267

All TennCare MCOs met their minimum net worth requirements as of March 31, 2013.

C. *John B.* Case

The *John B.* lawsuit addressed the adequacy of services provided by TennCare to children under the age of 21. *John B*. was a consent decree filed in 1998 that had been the subject of ongoing litigation since 2000. In February 2012, District Judge Thomas A. Wiseman, Jr. ruled in favor of the State by dismissing the case on the grounds that TennCare had successfully established compliance with "all the binding provisions of the Consent Decree."[26] This decision was upheld

[25] 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.

[26] John B. v. Emkes. U.S. District Court for the Middle District of Tennessee at Nashville. Order, pages 1-2. February 14, 2012.

unanimously by a three-judge panel of the United States Court of Appeals for the Sixth Circuit on March 14, 2013.

Although the Plaintiffs in the suit had the option of pursuing the matter to the United States Supreme Court, the June 12 deadline for filing an appeal of the Sixth Circuit's ruling passed without incident. The Plaintiffs' decision not to take further action leaves Judge Wiseman's order vacating the consent decree undisturbed. As a result, the litigation has concluded.

D. Higher Reimbursement for Primary Care

One provision of the Affordable Care Act (ACA) with which all Medicaid programs must comply is an enhanced reimbursement rate for certain providers delivering primary care services during Calendar Years 2013 and 2014. Section 1202 of ACA, entitled "Payments to Primary Care Physicians," requires Medicaid agencies to pay certain primary care providers for identified primary care services at a rate no lower than the one at which primary care physicians are reimbursed under Medicare Part B, the "Medical Insurance" portion of Medicare that covers outpatient care. Medicaid providers eligible for the higher levels of reimbursement are those whose primary specialty falls within one of the following categories:

- Family medicine
- General internal medicine
- Pediatric medicine
- Related subspecialties

The Bureau of TennCare submitted a State Plan Amendment outlining its compliance with Section 1202 of ACA to CMS on March 27, 2013. Following a two-month period of negotiations, CMS approved the Amendment on May 29, 2013. While eligible claims could not be paid at the enhanced rate until CMS had issued its approval, retroactive reimbursement will occur automatically, requiring no further action by providers on claims that have already been submitted. TennCare Managed Care Organizations (MCOs), furthermore, will begin to pay primary care providers the higher rate for current dates of service beginning on August 1, 2013.

E. Awarding of Dental Benefits Management Contract

Following a competitive bidding process in which four companies submitted proposals, TennCare named DentaQuest USA Insurance Company as its new Dental Benefits Manager (DBM) on April 24, 2013. DentaQuest was awarded a three-year contract (containing options for two one-year extensions) that will begin—following a five-month period of "readiness review"—on October 1, 2013. While all previous contracts between TennCare and its DBMs were "Administrative Services Only" (or "ASO") contracts, the contract executed by the parties in May is a partial risk-bearing contract.

Although DentaQuest's responsibilities will include building an adequate network of dentists and administering dental benefits for more than 750,000 children enrolled in TennCare, the

company's experience managing dental benefits for more than 16 million recipients in 26 states is a positive indication of the company's ability to succeed with projects of similar scope. Additional information is available on TennCare's website at http://news.tn.gov/node/10664.

F. Completion of Pharmacy Benefits Management Transition

On June 1, 2013, Magellan Health Services assumed full responsibilities as TennCare's Pharmacy Benefits Manager (PBM), a role previously held by Catamaran. To minimize disruption in the transition from one PBM to another, Magellan had engaged in six months of preparation before beginning to pay claims in June. This period of infrastructure development had included such tasks as establishing a pharmacy network, building a claims processing system, creating a call center and website to assist patients and providers, and contracting with drug manufacturers for supplemental rebates. TennCare's contract with Magellan lasts through May 31, 2016, and contains options for two one-year extensions.

Before being named TennCare's PBM, Magellan had managed pharmacy benefits for more than eight million individuals. From June 1 through June 30, 2013 (the company's first full month of operations for the Bureau), Magellan paid 932,777 claims, a volume in line with typical TennCare pharmacy claims activity. Although typical transition difficulties arose during June, the Bureau worked closely with the PBM to clarify expectations and to devise solutions as appropriate.

G. Electronic Health Record Incentive Program

The Electronic Health Record (EHR) Incentive Program is a partnership between federal and state governments that grew out of the Health Information Technology for Economic and Clinical Health (HITECH) Act. The purpose of the program, as its name suggests, is to provide financial incentives to Medicaid providers[27] 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 two types of payments:

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

[27] 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).

days in Fiscal Year 2012 (for eligible hospitals) or Calendar Year 2012 (for eligible professionals).

First-year and second-year EHR payments made by TennCare during the April-June 2013 quarter as compared with payments made throughout the life of the program appear in the table below:

Table 11
EHR First-Year and Second-Year Payments
Quarterly and Cumulative

Payment Type	Number of Providers	Quarterly Amount Paid (Apr-Jun 2013)	Cumulative Amount Paid To Date
First-year payments	363 providers (165 physicians, 126 nurse practitioners, 58 dentists, 10 hospitals, 3 physician assistants, and 1 certified nurse midwife)	$14,639,292	$124,475,987
Second-year payments	161 providers (105 physicians[28], 42 nurse practitioners, 10 hospitals, 2 physician assistants, and 2 certified nurse midwives)	$5,931,875	$21,102,908

EHR-related outreach activities conducted during the quarter included:

- Participation in the United Healthcare Provider Information Fair, an event held in Nashville on May 6, 2013, that attracted attendance of approximately 130 providers;
- Presentation to 30 staff members of tnREC (Tennessee's regional extension center for health information technology) on May 14, 2013;
- Coordination with managed care organizations and other insurance companies at the Tennessee Medical Association Workshop Planning Meeting held in Nashville on May 15, 2013;
- Attendance at the Fifth Annual CMS Multi-State Medicaid HITECH Conference held in Bethesda, Maryland, from May 21 through May 23, 2013;
- Presentation to 20 members of the Internal Health Council—a State planning group and "guide for the State's policies, priorities and programs related to HIE [Health

[28] This total includes a variety of physicians in categories that had not previously qualified for second-year payments, including ophthalmology, neurology, gastroenterology, and oncology.

Information Exchange] and health IT [Information Technology]"[29]—at a meeting held in Nashville on June 18, 2013;

- The deployment of two new tools through TennCare's online provider portal: 1) a confidential summary of each provider's history within the EHR program (including program year and payment year, date, and amount) and 2) meaningful use attestations that may be downloaded by providers or accessed through the aforementioned histories;
- 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 not at the state level.

Other projects in development include videos to assist providers with the EHR program,[30] and preparations for the third-year attestations that will begin for Eligible Hospitals in October 2013 and for Eligible Professionals in January 2014.

H. New General Counsel

On April 4, 2013, John G. (Gabe) Roberts joined TennCare and the Health Care Finance and Administration (HCFA) staff as General Counsel.

Mr. Roberts, who is originally from Jackson, Mississippi, graduated from the University of Mississippi's E. H. Patterson School of Accountancy and Vanderbilt University Law School. He is a licensed Certified Public Accountant and, prior to attending law school, worked in the Memphis, Tennessee, office of Ernst & Young as an auditor of both publicly traded and privately held Tennessee companies.

Mr. Roberts comes to HCFA from the Nashville, Tennessee, law firm Sherrard & Roe, where his primary practice areas included general corporate law, mergers and acquisitions, and private equity investment transactions. While at Sherrard & Roe, his business law practice intersected regularly with the health care industry and regulatory environment. His unique perspective borne by the diversity of his professional experiences is one of the factors that make him well suited for this position.

[29] See Page 12 of the "State Medicaid Health IT Plan" document for Tennessee, which is available online at http://www.tn.gov/tenncare/forms/TNSMHP.pdf.

[30] Two such videos are already available: "Three Common Challenges to Achieving Stage 1 Meaningful Use" is located at http://www.tn.gov/tenncare/mu_prep.shtml, and "Timelines for the 2011 Cohort" is located at http://www.tn.gov/tenncare/mu_2011timeline.shtml.

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

Considered in isolation, the Tennessee economy appeared to be regressing during the April-June 2013 quarter. Although total state and local revenue collections in April and May 2013 were higher than those for the same months of 2012, June 2013 was the first month since June 2010 to generate fewer revenues than the corresponding month of the preceding year.[31] Even more troubling, perhaps, was the direction of the Tennessee unemployment rate, which ticked upward each month of the quarter, rising from 7.9 percent in March to 8.0 percent in April, 8.3 percent in May, and 8.5 percent in June.[32] In all three months, Tennessee's unemployment rate exceeded not only the national unemployment rate for the same months, but also the state unemployment rate for the corresponding months of 2012.

Nonetheless, according to a report published by the University of Tennessee's Center for Business and Economic Research (CBER) in June 2013, this economic downturn was to be expected and, more importantly, will be replaced by positive growth by the end of the calendar year. The study attributes Tennessee's temporary setback to problems afflicting the United States economy as a whole, including "the global slowdown in economic activity, reduced federal government spending from sequestration and reduced consumer spending arising from the elimination of the payroll tax holiday."[33] Report author Matthew N. Murray identifies "a revival in the national and state residential housing markets" as a key factor in reestablishing growth, returning Tennessee employment levels to pre-recession highs, and achieving economic gains through at least 2015.[34]

Furthermore, there was good news about jobs during the April-June 2013 quarter to offset the state's unemployment figures. On April 15, German manufacturing company HP Pelzer Automotive Systems Inc. publicized plans to invest $28 million in the construction of a plant in Athens, Tennessee, that would employ 200 workers upon opening later this year.[35] Eastman Chemical Company made a similar announcement on May 29, pledging $1.6 billion to upgrade a facility in Kingsport, Tennessee, thereby adding 300 jobs to the economy over the next seven

[31] The Department of Revenue's collections summaries are available online at http://www.state.tn.us/revenue/statistics/summaries.shtml.

[32] Details of Tennessee's unemployment rate are available on the Department of Labor and Workforce Development's website at https://news.tn.gov/taxonomy/term/32.

[33] Murray, M., "Tennessee Business and Economic Outlook: The State's Economic Outlook, Spring 2013," p. 7. Center for Business and Economic Research, University of Tennessee. The report is located online at http://cber.bus.utk.edu/tefs/spr13.pdf.

[34] Ibid, pp. 7-8 and 12.

[35] "HP Pelzer Plans $28M Auto Parts Factory in Athens." *Knoxville News Sentinel* 15 Apr. 2013. http://www.knoxnews.com/news/2013/apr/15/hp-pelzer-plans-28m-auto-parts-factory-in-02/.

years.[36] These developments (and others like them) suggest that the revitalization of the state's economy forecasted by CBER is on a firm foundation.

VIII. Member Month Reporting

Tables 12 and 13 below present the member month reporting by eligibility group for each month in the quarter.

Table 12
Member Month Reporting for Use in Budget Neutrality Calculations
April - June 2013

Eligibility Group	April 2013	May 2013	June 2013	Sum for Quarter Ending 6/30/13
EG1 Disabled, Type 1 State Plan eligibles	132,548	131,047	129,552	393,147
EG1 Disabled, Type 2 Demonstration Population[37]	N/A	N/A	N/A	N/A
EG9 H-Disabled, Type 2 Demonstration Population	319	322	346	987
EG2 Over 65, Type 1 State Plan eligibles	25	29	25	79
EG2 Over 65, Type 2 Demonstration Population[38]	N/A	N/A	N/A	N/A
EG10 H-Over 65, Type 2 Demonstration Population	0	0	0	0
EG3 Children, Type 1 State Plan eligibles	642,664	642,215	638,661	1,923,540
EG4 Adults, Type 1 State Plan eligibles	276,534	276,940	275,179	828,653
EG4 Adults, Type 2 Demonstration Population[39]	0	0	0	0

[36] "Eastman Chemical Co. to Add 300 Jobs, Invest $1.6 billion." *Bristol Herald Courier* 29 May 2013. http://www.tricities.com/news/local/article_23460c52-c8b8-11e2-80a8-0019bb30f31a.html.

[37] This eligibility group was valid only for the reporting of enrollment and member months prior to July 1, 2010. See STC 55.b.(iv).

[38] This eligibility group was valid only for the reporting of enrollment and member months prior to July 1, 2010. See STC 55.b.(vi).

[39] This eligibility group—individuals between 19 and 64 years old who are medically needy rollovers—contains no members and will not have any in the future. This category has been removed from the STCs to take effect on July 1, 2013.

Eligibility Group	April 2013	May 2013	June 2013	Sum for Quarter Ending 6/30/13
EG5 Duals, Type 1 State Plan eligibles	125,866	124,710	124,003	374,579
EG11 H-Duals, Type 2 Demonstration Population	6,042	6,160	6,266	18,468
EG8 Med Exp Child, Type 2 Demonstration Population, Optional Targeted Low Income Children funded by Title XIX	0	0	0	0
TOTAL	1,183,998	1,181,423	1,174,032	3,539,453

Table 13
Member Month Reporting Not Used in Budget Neutrality Calculations
April - June 2013

Eligibility Group	April 2013	May 2013	June 2013	Sum for Quarter Ending 6/30/13
EG6E Expan Adult, Type 3, Demonstration Population	1,630	1,542	1,490	4,662
EG7E Expan Child, Type 3, Demonstration Population	158	147	132	437
Med Exp Child, Title XXI Demonstration Population	20,043	20,274	19,756	60,073
EG12E Carryover, Type 3, Demonstration Population	6,066	5,994	5,936	17,996
TOTAL	27,897	27,957	27,314	83,168

IX. Consumer Issues

Eligibility Appeals. TennCare eligibility appeals are handled by the Tennessee Department of Human Services. Table 14 presents a summary of the number and types of eligibility appeals handled during the quarter, compared to the previous two quarters.

Table 14
Eligibility Appeals Handled by the Department of Human Services
During the April – June 2013 Quarter, Compared to the Previous Two Quarters

	Oct – Dec 2012	Jan – Mar 2013	Apr – June 2013
TennCare Medicaid			
No. of appeals received	3,552	3,051	3,598
No. of appeals resolved or withdrawn	1,327	1,277	1,535
No. of appeals taken to hearing	938	1,235	1,755
No. of appeals that did not involve a valid factual dispute	1,365	1,096	1,728
Appeals previously heard that were decided in the State's favor	579	802	1,145
Appeals previously heard that were decided in the appellant's favor	68	88	152
TennCare Standard			
No. of appeals received	104	109	101
No. of appeals resolved or withdrawn	36	54	45
No. of appeals taken to hearing	40	50	52
No. of appeals that did not involve a valid factual dispute	21	27	44
Appeals previously heard that were decided in the State's favor	30	31	40
Appeals previously heard that were decided in the appellant's favor	2	7	5

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

Table 15
Medical Service Appeals Handled by the Bureau of TennCare
During the April – June 2013 Quarter, Compared to the Previous Two Quarters

	Oct – Dec 2012	Jan – Mar 2013	Apr – June 2013
No. of appeals received	1,339	1,309	1,072
No. of appeals resolved	1,330	1,309	1,170
• Resolved at the MCC level	557	581	499
• Resolved at the TSU level	205	182	163
• Resolved at the LSU level	568	546	508
No. of appeals that did not involve a valid	295	313	339

	Oct – Dec 2012	Jan – Mar 2013	Apr – June 2013
factual dispute			
No. of directives issued	171	160	162
No. of appeals taken to hearing	568	546	508
No. of appeals that were withdrawn by the enrollee at or prior to the hearing	183	185	184
Appeals that went to hearing and were decided in the State's favor	144	142	129
Appeals that went to hearing and were decided in the appellant's favor	13	25	17

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 16
Long-Term Services and Supports Appeals for April – June 2013
Compared to the Previous Two Quarters

	Oct – Dec 2012	Jan – Mar 2013	Apr – June 2013
No. of appeals of PreAdmission Evaluation (PAE) denials	257	322	450
No. of appeals of PASRR determinations	1	4	5
No. of appeals of denial for enrollment into CHOICES	16	8	6
No. of appeals of involuntary disenrollment from CHOICES	4	7	5
No. of appeals of denial of Consumer Direction	0	0	0
No. of appeals of involuntary withdrawal of Consumer Direction	1	0	1
No. of appeals of involuntary disenrollment from an HCBS waiver for individuals with intellectual disabilities	0	1	2
No. of appeals resolved in appellant's favor prior to hearing	130	156	148
No. of appeals withdrawn prior to hearing	7	2	4
No. of appeals dismissed at hearing	14	41	39
No. of appeals continued at hearing	9	5	13
No. of appeals that went to hearing and were decided in the State's favor	6	11	27
No. of appeals that went to hearing and were decided in the appellant's favor	2	1	2

X. Quality Assurance/Monitoring Activity

Transition from Disease Management to Population Health. As noted in each of the last two Quarterly Progress Reports, TennCare has been preparing to phase out its "Disease Management" (DM) model of targeted health care interventions in favor of a new model referred to as "Population Health" (PH). Whereas DM aimed to prevent the worsening of chronic conditions that had already developed, PH is more proactive in that it targets a much larger portion of the TennCare population, identifies risky behaviors likely to lead to disease in the future (such as poor eating habits, physical inactivity, and drug use), and assists enrollees in discontinuing such activities. PH retains interventions, furthermore, to assist enrollees who already have a complex chronic condition.

The transition of DM members to PH began on January 1, 2013. As of the end of the April-June 2013 quarter, full implementation of the program—meaning assignment of members to one of three levels of health risk and one of seven programs for reducing risk—was to begin on July 1, 2013. Information on the risk levels addressed by PH, the manner in which these risks are addressed, and the transition of DM members to PH during the January-March 2013 quarter is provided in Table 17. Data for the period of April through June, 2013, will be provided in the next Quarterly Progress Report.

Table 17
Transition of DM Members to PH, January – March 2013

Risk Level	Intervention Type	Intervention Goal(s)	Member Enrollment
Level 0: no identified risk	Wellness Program	Keep members healthy as long as possible	0*
Level 1: low or moderate risk	Maternity Program	Engage pregnant women in timely prenatal care and deliver a healthy, term infant without complications	0**
	Health Risk Management	Prevent, reduce, or delay exacerbation and complications of a condition or health risk behavior	243,214
	Care Coordination	Assure that members receive the services they need to reduce the risk of an adverse health outcome	2,597
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	9,759
	High Risk Pregnancy Management	Engage pregnant women in timely prenatal care and deliver a healthy, term infant without complications	0**
	Complex Case Management	Move members to optimal levels of health and well-being through timely coordination of quality services and self-management support	8,419
Total PH Enrollment			**263,989**

*Enrollment data in Table 17 is limited to individuals transitioned from DM to PH. No individual who had been enrolled in DM could be classified as Level 0 ("no identified risk").

**During the January-March 2013 quarter, individuals enrolled in the "Maternity" DM program remained there instead of being transitioned into PH's "Maternity Program" and/or "High Risk Pregnancy Management."

Provider Data Validation Report. TennCare's External Quality Review Organization (EQRO), Qsource, published the results of its provider data validation survey for the April-June 2013 quarter. Qsource took a sample of provider data files from TennCare's MCCs[40] and reviewed each for accuracy in the following categories:

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

The validity of such information is one measure of providers' availability and accessibility to TennCare enrollees. Qsource's report concluded that "[o]verall, the MCCs' accuracy rates have maintained a high level," especially in the categories of "active contract status with MCC" (97.7 percent accuracy), "provider credentialed specialty / behavioral health service code" (97.1 percent accuracy), "primary care services" (98.7 percent accuracy), and "prenatal care services" (99.1 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 "open/closed to new patients," which demonstrated only 89.7 percent accuracy), TennCare required each of its MCCs to submit a Corrective Action Plan no later than June 5, 2013. The Bureau, in turn, had received, reviewed, and accepted all of the plans by June 10, 2013.

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, 2012, the State submitted the Draft Annual Report as required by STC 48. Part V of that report provided the progress to date on the performance measures that were outlined in the approved Evaluation Design. It is the State's intention to update the performance measures in each Annual Report.

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

XII. Essential Access Hospital Pool[41]

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

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
Baptist Hospital
Parkwest Medical Center (with Peninsula Psych)
Physicians Regional Medical Center
University Medical Center (with McFarland Psych)
Wellmont Holston Valley Medical Center
Saint Francis Hospital
Centennial Medical Center
Skyline Medical Center (with Madison campus)
Maury Regional Hospital
Methodist Healthcare – North
Middle Tennessee Medical Center
Fort Sanders Regional Medical Center

[41] 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.

Delta Medical Center
Cookeville Regional Medical Center
Skyridge Medical Center
Gateway Medical Center
Parkridge East Hospital
Wellmont Bristol Regional Medical Center
Blount Memorial Hospital
Baptist Memorial Hospital for Women
Morristown - Hamblen Healthcare System
Baptist Memorial Hospital – Tipton
Sumner Regional Medical Center
StoneCrest Medical Center
NorthCrest Medical Center
Tennova Healthcare – Newport Medical Center
Horizon Medical Center
LeConte Medical Center
Southern Hills Medical Center
Summit Medical Center
Tennova Healthcare – LaFollette Medical Center
Methodist Medical Center of Oak Ridge
Takoma Regional Hospital
Harton Regional Medical Center
Sweetwater Hospital Association
Henry County Medical Center
Baptist Memorial Hospital – Union City
Dyersburg Regional Medical Center
Humboldt General Hospital
Wellmont Hawkins County Memorial Hospital
United Regional Medical Center
Lakeway Regional Hospital
Jellico Community Hospital
Grandview Medical Center
Skyridge Medical Center – Westside
Indian Path Medical Center
Athens Regional Medical Center
Heritage Medical Center
Regional Hospital of Jackson
Crockett Hospital
River Park Hospital
Lincoln Medical Center
Bolivar General Hospital
Southern Tennessee Medical Center
Sycamore Shoals Hospital
Hardin Medical Center

Livingston Regional Hospital
Wayne Medical Center
Hillside Hospital
Roane Medical Center
Claiborne County Hospital
McKenzie Regional Hospital
McNairy Regional Hospital
Volunteer Community Hospital
Jamestown Regional Medical Center
Gibson General Hospital
Haywood Park Community Hospital
Baptist Memorial Hospital – Huntingdon
Henderson County Community Hospital
Methodist Healthcare – Fayette
DeKalb Community Hospital
Decatur County General Hospital
White County Community Hospital
Emerald Hodgson Hospital

XIII. Graduate Medical Education (GME) Hospitals

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

The GME medical schools and their affiliated hospitals are as listed below:

Universities	Hospitals
East Tennessee State University	Mountain State Health Alliance Wellmont ETSU Quillen Mission Hospital Johnson City Medical Center Johnson City Health Center Woodridge Hospital Holston Valley Medical Center Bristol Regional Medical Center
Meharry Medical College	Metro General Meharry Medical Group

Universities	Hospitals
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
Patients' Choice Medical Center of Erin
Rhea Medical Center
Riverview Regional Medical Center
Scott County Hospital
Three Rivers Hospital
TriStar Ashland City Medical Center
Trousdale Medical Center
Wellmont Hancock County Hospital

State Contact:

Susie Baird
Director of Policy
Bureau of TennCare
310 Great Circle Road
Nashville, TN 37243

Phone: 615-507-6480
Fax: 615-253-2917

Date Submitted to CMS: August 30, 2013

Attachment A

Budget Neutrality Calculations for the Quarter

Actual TennCare Budget Neutrality (April - June 2013)

I. The Extension of the Baseline

Baseline PMPM

	FY 2013 PMPM
1-Disabled (can be any ages)	$1,485.69
2-Child <=18	$453.06
3-Adult >= 65	$977.22
4-Adult <= 64	$874.92
Duals (17)	$624.27

Actual Member months of Groups I and II

1-Disabled (can be any ages)	393,147
2-Child <=18	1,923,540
3-Adult >= 65	79
4-Adult <= 64	828,653
Duals (17)	393,047
Total	3,538,466

Ceiling without DSH

	Baseline * MM
1-Disabled (can be any ages)	$584,094,566
2-Child <=18	$871,479,032
3-Adult >= 65	$77,200
4-Adult <= 64	$725,005,083
17s	$245,367,451
Total	$2,426,023,333

DSH

DSH Adjustment (Quarterly)	$115,999,213

Total Ceiling

Budget Neutrality Cap	
Total w/DSH Adj.	$2,542,022,546

II. Actual Expenditures

Group 1 and 2

1-Disabled (can be any ages)	$ 500,069,504
2-Child <=18	$ 383,540,110
3-Adult >= 65	$ 223,570
4-Adult <= 64	$ 305,308,323

Duals (17)	$	337,050,956
Total		**1,526,192,463**

Group 3

1-Disabled (can be any ages)	$	-
2-Child <=18	$	10,747,419
3-Adult >= 65	$	76,098,865
4-Adult <= 64	$	2,583,445
Duals (17)	$	-
Total		**89,429,729**

Pool Payments and Admin

Total Pool Payments	**203,596,540**

Admin	**122,903,615**

Quarterly Drug Rebates		$93,174,547
Quarterly Premium Collections		$1,900
Total Net Quarterly Expenditures	**$**	**1,848,945,900**

III. Surplus/(Deficit)

	$693,076,646
Federal Share	**$458,331,586**

HCI Result	MM201304	MM201305	MM201306	TOTAL	HCI ASO	HCI Rx	HCI DTL	HCI MCO CAP (TCS Admin)	TOTAL
EG1-TYPE1 (disabled, type1 state plan eligibles)	132,548	131,047	129,552	393,147	$74,283,622	$79,343,634	$2,036,349	$339,500,666	$495,164,271
EG1-TYPE2 (disabled, type2 transition group)	0	0	0	-					$0
EG2-TYPE1 (over 65, type1 state plan eligibles)	25	29	25	79	$192,000	$3,457	$0	$28,113	$223,570
EG2-TYPE2 (over 65, type2 state plan eligibles)	0	0	0	-					$0
EG3-TYPE1 (children, type1 state plan eligibles)	642,664	642,215	638,661	1,923,540	$14,106,797	$46,303,783	$34,847,070	$288,282,460	$383,540,110
Med Exp Child (Title XXI Demo Pop; EG3-Type2)	20,043	20,274	19,756	60,073	$47,831	$2,659,352	$1,493,977	$6,417,807	$10,618,967
EG4-TYPE1 (adults, type1 State plan eligibles)	276,534	276,940	275,179	828,653	$1,716,681	$43,299,156	$4,137,444	$256,155,042	$305,308,323
EG4-TYPE2 (adults, type2 demonstration pop)	0	0	0	-					$0
EG5-TYPE1 (duals, state plan eligibles)	125,866	124,710	124,003	374,579	$859,196	$688,803	$48,710	$275,075,268	$276,671,977
EG6E-TYPE3 (Expan adult, type3 demonstration pop)	1,630	1,542	1,490	4,662	$252	$482,178	$0	$2,101,015	$2,583,445
EG7E-TYPE3 (Expan child, type3 demonstration pop)	158	147	132	437	$44	$73,761	$7,979	$46,668	$128,452
EG8-TYPE2 (emd exp child)	0	0	0	-					$0
EG9 H-Disabled (TYPE 2 Eligibles)	319	322	346	987	$492	$266,817	$0	$4,637,924	$4,905,233
EG11H, H-Dual	6,042	6,160	6,266	18,468	$1,800	$12,373	$0	$60,364,806	$60,378,979
EG12E, Carryovers	6,066	5,994	5,936	17,996	$0	$1,165,163	$0	$74,933,702	$76,098,865
Total	**1,211,895**	**1,209,380**	**1,201,346**	**3,622,621**	**$91,208,715**	**$174,298,477**	**$42,571,529**	**$1,307,543,471**	**$1,615,622,192**

HCI Result	MM201304	MM201305	MM201306	TOTAL	HCI ASO PMPM	HCI Rx PMPM	HCI DTL PMPM	HCI MCO CAP (TCS Admin)	TOTAL
EG1-TYPE1 (disabled, type1 state plan eligibles)	132,548	131,047	129,552	393,147	$188.95	$201.82	$5.18	$863.55	$1,259.49
EG1-TYPE2 (disabled, type2 transition group)	0	0	0	-					
EG2-TYPE1 (over 65, type1 state plan eligibles)	25	29	25	79	$2,430.38	$43.76	$0.00	$355.86	$2,830.00
EG2-TYPE2 (over 65, type2 state plan eligibles)	0	0	0	-	-	-	-	-	-
EG3-TYPE1 (children, type1 state plan eligibles)	642,664	642,215	638,661	1,923,540	$7.33	$24.07	$18.12	$149.87	$199.39
Med Exp Child (Title XXI Demo Pop; EG3-Type2)	20,043	20,274	19,756	60,073	$0.80	$44.27	$24.87	$106.83	$176.77
EG4-TYPE1 (adults, type1 State plan eligibles)	276,534	276,940	275,179	828,653	$2.07	$52.25	$4.99	$309.12	$368.44
EG4-TYPE2 (adults, type2 demonstration pop)	0	0	0	-					
EG5-TYPE1 (duals, state plan eligibles)	125,866	124,710	124,003	374,579	$2.29	$1.84	$0.13	$734.36	$738.62
EG6E-TYPE3 (Expan adult, type3 demonstration pop)	1,630	1,542	1,490	4,662	$0.05	$103.43	$0.00	$450.67	$554.15
EG7E-TYPE3 (Expan child, type3 demonstration pop)	158	147	132	437	$0.10	$168.79	$18.26	$106.79	$293.94
EG8-TYPE2 (emd exp child)	0	0	0	-					
EG9 H-Disabled (TYPE 2 Eligibles)	319	322	346	987	$0.50	$270.33	$0.00	$4,699.01	$4,969.84
EG11H, H-Dual	6,042	6,160	6,266	18,468	$0.10	$0.67	$0.00	$3,268.62	$3,269.38
EG12E, Carryovers	6,066	5,994	5,936	17,996	$0.00	$64.75	$0.00	$4,163.91	$4,228.65
Total	**1,211,895**	**1,209,380**	**1,201,346**	**3,622,621**	**$25.18**	**$48.11**	**$11.75**	**$360.94**	**$445.98**

* Unknown allocation was performed within the Service category totals.