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

May 31, 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 January-March 2013 quarter. This report is being submitted in accordance with STC #47.

Please let us know if you have comments or questions.

Sincerely,

[redacted]

Darin J. Gordon
Director, Bureau of TennCare

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

TennCare II

Section 1115 Quarterly Report

(For the period January - March 2013)

Demonstration Year: 11 (7/1/12 - 6/30/13)
Federal Fiscal Quarter: 2/2013 (1/13 - 3/13)
Waiver Quarter: 3/2013 (1/13 - 3/13)

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), if applicable.

Table 1
Key Dates of Approval/Operation in the Quarter

Date	Action	STC #
1/8/13	After receiving new trend rates in the extension approval materials that CMS had sent the State on 12/31/12, the State asked for an explanation of these new rates. The CMS Project Officer responded that the new rates had been calculated on the basis of the President's budget projections for health care cost inflation.	
1/15/13	In response to a question from CMS on 12/22/12, the State submitted new "with waiver" budget projections for the extension of the TennCare Demonstration that had been calculated using the trend rates of the current waiver.	
1/31/13	The State acknowledged and accepted CMS's award of a three-year extension of the TennCare demonstration, from July 1, 2013, through June 30, 2016. The State submitted proposed technical corrections to CMS.	
2/4/13	The State submitted Demonstration Amendment 17 to CMS. Amendment 17 outlined program reductions that would be necessary effective July 1, 2013, if the hospital assessment fee were not renewed during the legislative session.	7.a.
2/8/13	The CMS Project Officer sent revisions to Tennessee's budget neutrality projections for the upcoming extension	

Date	Action	STC #
	period. (See 1/15/13.) The revisions included changes to the "without waiver" trend rates to the President's Budget projections for health care cost inflation.	
2/28/13	The Monthly Call was held.	46
2/28/13	The State submitted the Quarterly Progress Report for the October-December 2012 quarter to CMS.	47
3/7/13	The State submitted Demonstration Amendment 18 to CMS. Amendment 18 proposed to allow coverage of Assisted Community Living Facility (ACLF) services under special circumstances for individuals in CHOICES 3.	7.a., 7.c.
3/27/13	The State sent the CMS Project Officer a courtesy copy of SPA 13-001, dealing with enhanced payment rates for primary care physicians during a two-year period lasting from January 1, 2013, through December 31, 2014.	7.d.

II. Enrollment and Benefits Information

Information about enrollment by category is presented in Table 2.

Table 2
Enrollment Counts for the January - March 2013 Quarter
Compared to the Previous Two Quarters

Demonstration Populations	Total Number of TennCare Enrollees		
	July – Sept 2012	Oct – Dec 2012	Jan – Mar 2013
EG1 Disabled, Type 1 State Plan eligibles	137,701	136,384	135,215
EG1 Disabled and EG9 H-Disabled, Type 2 Demonstration Population	309	369	339
EG2 Over 65, Type 1 State Plan eligibles	39	50	50
EG2 Over 65 and EG10 H-Over 65, Type 2 Demonstration Population	0	0	0
EG3 Children, Type 1 State Plan eligibles	695,237	700,828	696,874
EG4 Adults, Type 1 State Plan eligibles	281,982	285,536	276,834

Demonstration Populations	Total Number of TennCare Enrollees		
	July – Sept 2012	Oct – Dec 2012	Jan – Mar 2013
EG4 Adults, Type 2 Demonstration Population[1]	0	0	0
EG5 Duals, Type 1 State Plan eligibles and EG11 H-Duals 65, Type 2 Demonstration Population	143,001	140,887	136,225
EG6E Expan Adult, Type 3 Demonstration Population	1,724	1,638	1,473
EG7E Expan Child, Type 3, Demonstration Population	255	247	177
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	20,120	21,153	19,165
EG12E Carryover, Type 3, Demonstration Population	Not available	2,594	5,753
TOTAL *	1,280,368	1,289,686	1,272,105

*** 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 March 31, 2013

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

[1] 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.

[2] BlueCare is operated by Volunteer State Health Plan, Inc. (VSHP), which is an independent licensee of the BlueCross BlueShield Association and a licensed HMO affiliate of its parent company, BlueCross BlueShield of Tennessee.

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

	West Tennessee	Middle Tennessee	East Tennessee
	TennCare Select[4]	TennCare Select	TennCare Select
Pharmacy Benefits Manager	Catamaran[5]		
Dental Benefits Manager	TennDent[6]		

Standard Spend Down. The TennCare Standard Spend Down (SSD) eligibility category opened to new enrollment for the sixth time on March 21, 2013 (following previous periods of open enrollment on October 4, 2010, February 22, 2011, September 12, 2011, February 21, 2012, and September 13, 2012). SSD is available through an amendment to the TennCare Demonstration and is designed to serve a limited number of persons who are not otherwise eligible for Medicaid but who are aged, blind, disabled, or the caretaker relative of a Medicaid-eligible child and who 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.

Each open enrollment period for SSD is facilitated through a dedicated, toll-free telephone line staffed by representatives of Tennessee's Department of Human Services (DHS). An individual who is interested in enrolling in the program contacts the call center and answers questions designed to ensure that he does not already have TennCare coverage. Callers who are found not to be enrolled are mailed an application that must be completed and returned within 30 days.

On March 21, 2013, DHS received 2,500 calls—the limit established by the State to ensure timely processing of applications—in 45 minutes. Because of a technical problem with the phone system, however, the application limit was raised to include individuals who had not reached a DHS representative but whose phone numbers had nonetheless been automatically recorded by the system. Updated statistics on the number of applications received and the number of individuals enrolled in the SSD program will be included in the next Quarterly Progress Report.

Possible Changes to TennCare Benefits ("Amendment 17"). Following the provision of public notice in December 2012, TennCare submitted Demonstration Amendment 17 to CMS on February 4, 2013. Amendment 17 repeats several changes proposed in each of the last three years that were made unnecessary each time by the Tennessee General Assembly's passage of a one-year Enhanced Coverage Fee. Changes to the TennCare benefit package for adults that

[4] TennCare Select is operated by Volunteer State Health Plan, Inc. (VSHP).
[5] Catamaran previously operated on behalf of TennCare as SXC Health Solutions Corp.
[6] TennDent is operated by Delta Dental.

would be necessary if the one-year Enhanced Coverage Fee were not renewed this year are as follows:

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

As of the end of the quarter, the General Assembly had not yet renewed the Enhanced Coverage Fee.

Additional Benefit for Individuals at Risk of Institutional Placement ("Amendment 18"). On March 7, 2013, the Bureau of TennCare submitted Demonstration Amendment 18 to CMS. The purpose of Amendment 18 is to expand the availability of Assisted Care Living Facility (or "ACLF") services within CHOICES, TennCare's program of long-term services and supports (LTSS) for individuals who are elderly or who have physical disabilities.

An ACLF is a home-like setting—licensed by the Tennessee Department of Health—in which residents receive an array of services to assist with their activities of daily living. Examples of ACLF services include daily meals, homemaker services (such as sweeping, laundry, and washing dishes), and medication oversight. Currently, the ACLF benefit is available only to members of CHOICES Group 2, the portion of the CHOICES population that meets the medical criteria for placement in a Nursing Facility (NF) but that receives Home and Community Based Services (HCBS) as a safe and cost-effective alternative to institutional care.

Amendment 18 proposes to extend coverage of ACLF services to certain members of CHOICES Group 3, which consists of individuals who, in the absence of HCBS, would be "at risk" for placement in a NF. To ensure that LTSS expenditures for each individual remain unaffected, moreover, the benefit will be covered only when the cost of ACLF services would not exceed the amount otherwise spent on HCBS for the individual.

Additional information about Amendment 18 may be found on TennCare's website at http://www.tn.gov/tenncare/pol-notice2.shtml.

Co-Payments for Covered Generic Medications ("Amendment 19"). On March 25, 2013, the Bureau notified the public of another proposal to be submitted to CMS. Demonstration Amendment 19 would allow a $1.50 co-payment for covered generic medications to be charged to certain groups of TennCare enrollees. This co-payment would not apply to outpatient drugs provided in an emergency situation, family planning services and supplies, and preventive services, and would not be charged to such categories of enrollees as children in TennCare Medicaid, institutionalized adults, pregnant women, and adults who are receiving hospice services.

The request contained in Amendment 19 is an item recommended by TennCare for inclusion in its Fiscal Year 2014 budget.[7] Although the General Assembly had not—as of the end of the quarter—acted on this recommendation, the Bureau had to submit its request to CMS at this time to be able to implement the provision by October 1.

TennCare estimates that implementation of Amendment 19 would reduce State expenditures by $2,112,300 (and total expenditures by $6,122,600) during Fiscal Year 2014. The full text of the March 25 notice is available online at http://www.tn.gov/tenncare/pol-notice3.shtml.

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 January-March 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.

[7] See Page 5 of the "Health Care Finance and Administration FY 2014 Budget Presentation" document located on TennCare's website at http://www.tn.gov/tenncare/forms/HCFAbudgetFY14.pdf.

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

Activities	July – Sept 2012	Oct – Dec 2012[8]	Jan – Mar 2013
Number of educational materials distributed	204,277	245,215	224,703
Number of outreach activities/events	3,444	3,154	3,224
Number of people made contact with (mostly face to face at outreach events)	167,903	193,100	161,455
Number of coalitions/advisory board meetings presided over[9]	26	38	72
Number of attendees at coalitions/advisory board meetings	287	562	1,158[10]
Number of educational preventive health radio/TV broadcasts[11]	8,994	13,618	12,791
Number of educational preventive health newsletter/magazine articles[12]	151	166	94
Number of educational preventive health billboards, scrolling billboards and bulletin boards	3,238	5,916	33,205[13]
Number of presentations made to enrollees/professional staff who work with enrollees	323	520	508
Number of individuals attending presentations	6,831	12,317	13,265

[8] Child Health Week, which ran from October 1-7, 2012, accounted for several of the statistical fluctuations evident in the October-December 2012 quarter. The distribution of educational materials, the number of radio and television broadcasts, the use of billboard and bulletin board advertising, and the level of presentation attendance all surged as a result of the annual event.

[9] 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.

[10] The number of attendees at coalitions and advisory board meetings was higher than in the previous two quarters because the number of such meetings increased to 72.

[11] 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.

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

[13] 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).

Activities	July – Sept 2012	Oct – Dec 2012[8]	Jan – Mar 2013
Number of attempted telephone calls regarding the importance of immunizations and dental checkups[14]	169	102	391[15]
Number (approx) of completed telephone calls regarding the importance of immunizations and dental checkups	83	44	166
Number of attempted home visits (educational materials left with these families)	18,161	17,263	15,720
Number of home visits completed	8,760	7,974	7,418
Number of outreach events directed to the homeless[16]	51	52	47

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
January - March 2013 Compared to the
Previous Two Quarters

Activities	July – Sept 2012	Oct – Dec 2012	Jan – Mar 2013
Number of families reached	51,181	49,233	48,590
Number of families who were assisted in scheduling an EPSDT exam for their children	3,113	3,477	3,975
Number of families who were assisted in arranging for transportation	146	255	188

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

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

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

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

	July – Sept 2012	Oct – Dec 2012[17]	Jan – Mar 2013
No. of encounters received by TennCare (initial submission)	10,146,567	8,079,096	6,667,160[18]
No. of encounters rejected by Edifecs upon initial submission	214,186[19]	21,430	92,562
Percentage of encounters that were compliant with State standards (including HIPAA) upon initial submission	97.89%	99.73%	98.61%

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

[17] Both the number of encounters received by TennCare and the number of encounters rejected by Edifecs during the October-December 2012 quarter were low in comparison to totals from preceding quarters. From April through November of 2012, TennCare's MCOs were engaged in a mandatory reprocessing of claims to adjust reimbursement of providers retroactively. The bulk of this effort occurred prior to the October-December quarter, with September 2012 as the month with the single highest reprocessing volume.

[18] 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 with the assistance of—the holidays in November and December.

[19] Rejections were unusually high during the July-September 2012 quarter as the result of errors in three files containing 169,000 encounter claims. Although the files were corrected and successfully resubmitted, the percentage of compliant claims fell by nearly two points this quarter as a result of the original submission.

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 38 percent by the conclusion of March 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 January – March 2013 Compared to the Previous Two Quarters

	Statewide Enrollment Targets and Reserve Capacity[20]	**Enrollment and Reserve Slots Being Held as of the End of Each Quarter**		
		July – Sept 2012	**Oct – Dec 2012**	**Jan – Mar 2013**
CHOICES 1	Not applicable	20,761	20,500	19,644
CHOICES 2	11,000	10,352	10,189	9,830
Interim CHOICES 3	Not applicable	1,366	1,894	2,370
Total CHOICES	Not applicable	32,479	32,583	31,844
Reserve capacity	300	300	300	300

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 "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. The reporting period for STC 47.f. begins on July 1, 2012, when the "modified institutional level of care" went into effect. This data, which appears below in Table 8, will be submitted on a quarterly basis after this initial report.

[20] Only CHOICES 2 has an enrollment target.

Table 8
Enrollment of Individuals Who Would Otherwise Be Eligible for Interim CHOICES 3 But Who Met the Modified Level of Care, July 1, 2012, through March 31, 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
641	461	180

Frequency and use of MCO-distributed transition allowances (CHOICES approval letter dated February 26, 2010): The allocation of CHOICES transition allowance funds is detailed in Table 9.

Table 9
TennCare CHOICES Transition Allowances
for January – March 2013 Compared to the Previous Two Quarters

	Frequency and Use of Transition Allowances[21]					
	July – Sept 2012		Oct – Dec 2012		Jan – Mar 2013[22]	
Grand Region	# Distributed	Total Amount	# Distributed	Total Amount	# Distributed	Total Amount
East	17	$25,899.64	24	$33,215.27	15	$18,063.42
Middle	11	$14,535.66	16	$18,735.69	5	$2,442.00
West	16	$29,570.36	13	$18,591.81	12	$12,110.57
Statewide Total	44	$70,005.66	53	$70,542.77	32	$32,615.99

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

[21] 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.

[22] It is not unusual for the number of transition allowances—and the total amount of transition allowance funding distributed—to decline in the January-March quarter. The October-December quarter typically sees more individuals transitioned from institutions to the community, as families strive to bring members home for the holidays. A lull in such activity at the beginning of the Calendar Year, therefore, is to be expected.

Pharmacy Benefits Manager (PBM) requires the PBM to pay 100 percent of all clean claims submitted by pharmacy providers within 10 calendar days of receipt.

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

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

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

During this quarter, the MCOs submitted their National Association of Insurance Commissioners (NAIC) Annual Financial Statements. As of December 31, 2012, TennCare MCOs reported net worth as indicated in the table below.[23]

Table 10
Net Worth Reported by MCOs as of December 31, 2012

	Net Worth Requirement	Reported Net Worth	Excess/ (Deficiency)
Amerigroup Tennessee	$17,328,549	$106,079,845	$88,751,296
UnitedHealthcare Plan of the River Valley (UnitedHealthcare	$64,481,178	$441,221,776	$376,740,598

[23] 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.

	Net Worth Requirement	Reported Net Worth	Excess/ (Deficiency)
Community Plan)			
Volunteer State Health Plan (BlueCare & TennCare Select)	$35,639,453	$217,716,730	$182,077,277

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

C. *John B.* Case

The *John B.* lawsuit addresses the adequacy of services provided by TennCare to children under the age of 21. *John B*. was a consent decree filed in 1998 that has 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."[24] In response, the Plaintiffs filed a Notice of Appeal with the United States Court of Appeals for the Sixth Circuit on March 9, 2012.

A three-judge panel of the Sixth Circuit heard oral arguments on the appeal on October 5, 2012. Plaintiffs and Defendants subsequently filed supplemental briefs on the subject of TennCare's periodicity schedule, a timeline identifying the points in a child enrollee's life when the State must provide health screenings.[25]

On March 14, 2013, the Sixth Circuit issued a unanimous opinion upholding Judge Wiseman's decision to dismiss the *John B.* case. The 27-page ruling examined all of the arguments advanced by the Plaintiffs in their March 2012 appeal and classified each as either a "misstate[ment of] the bases of the [district] court's decision" or "simply meritless."[26] Acknowledging that Judge Wiseman had made one technical error with regard to the denominator used in calculating the screening ratio, the mistake was ultimately found to be "harmless" because TennCare had achieved full compliance with relevant federal law.[27] The concluding passage of the decision offered a definitive consideration of all of these matters:

> The district court's handling of this case after our remand last year was exemplary. The court conducted an exhaustive evidentiary hearing, reviewed 345 pages of proposed findings of fact and conclusions of law from the parties, and familiarized itself with thousands of pages of evidence already in the record. And on the basis of all of that evidence, the court found, in a thorough and carefully reasoned opinion, that TennCare had vastly improved its delivery of

[24] John B. v. Emkes. U.S. District Court for the Middle District of Tennessee at Nashville. Order, pages 1-2. February 14, 2012.
[25] TennCare's periodicity schedule is available online at http://www.tn.gov/tenncare/tenndercare/screeningsched.shtml.
[26] John B. v. Emkes. U.S. Court of Appeals for the Sixth Circuit. Opinion, page 2. March 14, 2013.
[27] Ibid, page 23.

> services to enrollees, and indeed become a national leader in its compliance with the Medicaid statute. The court's conclusions were sound. Its judgment is affirmed.[28]

The full text of the Sixth Circuit's opinion is available online at http://www.ca6.uscourts.gov/opinions.pdf/13a0068p-06.pdf.

D. Electronic Health Record Incentive Program

The Electronic Health Record (EHR) Incentive Program is a partnership between federal and state governments that grew out of the Health Information Technology for Economic and Clinical Health (HITECH) Act. The purpose of the program, as its name suggests, is to provide financial incentives to Medicaid providers[29] 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 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 January-March 2013 quarter as compared with payments made throughout the life of the program appear in the table below:

[28] Ibid, page 27.

[29] 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 11
EHR First-Year and Second-Year Payments
Quarterly and Cumulative

Payment Type	Number of Providers	Quarterly Amount Paid (Oct-Dec 2012)	Cumulative Amount Paid To Date
First-year payments	330 providers (151 physicians, 122 nurse practitioners, 45 dentists, 6 hospitals, 4 physician assistants, and 2 certified nurse midwives)	$9,864,032.00	$109,836,694.97
Second-year payments	119 providers (68 physicians, 42 nurse practitioners, and 9 hospitals)	$7,244,664.00	$15,171,033.00

Outreach activities conducted during the quarter included:

- Presentation on February 19 to representatives of the Internal Health Council, a planning group dedicated to health information technology issues with members from a dozen State agencies;
- Posting an online video entitled "Three Common Challenges to Achieving State 1 Meaningful Use"—available at http://www.tn.gov/tenncare/mu_prep.shtml—on February 13;
- Posting an online video entitled "Timelines for the 2011 Cohort"[30]—available at http://www.tn.gov/tenncare/mu_2011timeline.shtml—on March 12;
- 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.

This robust promotion of the EHR program will continue during the April-June 2013 quarter in a variety of venues, including the Fifth Annual CMS Multi-State Medicaid HITECH Conference, monthly meetings of the Internal Health Council, and provider meetings and open houses hosted by TennCare's MCOs.

Finally, based on clarification from CMS that the denominator for patient volume calculation should include total patient encounters (paid and unpaid), TennCare made adjustments on a prospective basis beginning in February 2013. If the Bureau is required to apply the new

[30] The "2011 Cohort" refers to the group of eligible professionals who attested to adoption, implementation, or upgrade of certified EHR technology and who earned a first-year incentive payment for Calendar Year 2011.

guidance retrospectively, some providers who were previously determined to be eligible may subsequently be determined ineligible. While considerable flexibility has been given to states in an effort to minimize the likelihood that this will occur, TennCare continues to have serious concerns regarding a CMS directive that would require providers to re-assess patient volume and the potential for provider recoupments. The Bureau remains hopeful that a resolution can be reached that will prevent the need for repeat audits and the possibility that providers will have to refund payments.

E. Request for Proposals for Dental Benefits Management

With less than six months remaining until the contract between TennCare and its current dental benefits manager (DBM) Delta Dental of Tennessee[31] expires on September 30, 2013, the State issued a request for proposals (RFP) for dental administrative and management services on February 1, 2013.

According to the "Scope of Services" portion of the RFP document (available online at http://tn.gov/generalserv/cpo/sourcing_sub/documents/31865-00355.pdf), actual delivery of services would begin on October 1, 2013, but would be preceded by a five-month period of "readiness review." All previous contracts between TennCare and Dental Benefits Managers have been "Administrative Services Only" (or "ASO") contracts. This contract will be a partial risk-bearing contract.

As of the end of the January-March 2013 quarter, the deadline for submission of a proposal to TennCare was April 2, 2013, and the successful bidder was to be revealed on April 24, 2013.

F. New Chief Medical Officer

On January 28, 2013, Vaughn Frigon, M.D. joined TennCare's Executive Staff in the role of Chief Medical Officer. He fills the position left vacant when Dr. Wendy Long assumed a dual role as TennCare's Deputy Director and Chief of Staff.

Dr. Frigon, who is originally from Virginia, graduated from the United States Military Academy at West Point and served in the United States Army Infantry as a platoon leader during the first Persian Gulf War. After attending medical school at the University of Tennessee's College of Medicine in Memphis, he completed both an Orthopedic Surgery residency at Tulane University, and the Health Care MBA program at Vanderbilt University's Owen Graduate School of Management.

Dr. Frigon is board certified by the American Board of Orthopaedic Surgery and has practiced orthopedics for 12 years. He has also worked as the Lead Medical Director for the Unum Insurance Company in Chattanooga for the last five years. The diversity of his professional experience—military service, providing care in rural communities with significant Medicaid

[31] Delta Dental delivers services to TennCare enrollees under the program name "TennDent."

populations, helping manage a corporate insurance program—should be a valuable asset for TennCare.

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

Several developments from the January-March 2013 quarter suggest that the Tennessee economy is moving in a positive direction. According to data compiled by the Tennessee Department of Revenue, revenue collections for all three months of the quarter were higher than those for the same months of 2012.[32] State and local collections during March 2013 provided particularly good news: while total revenues exceeded those from March 2012 by more than $24 million (a 2.3 percent improvement), state revenues alone exceeded expectations by roughly $33 million.[33]

Grounds for cautious optimism were boosted even further by the news that Tennessee exports had thrived in 2012, establishing new records for the state. Statistics from the International Trade Administration, a bureau within the United States Department of Commerce, indicate that Tennessee exported a total of $31.1 billion worth of merchandise overseas in 2012, with particularly robust trade activity occurring in Canada, Mexico, China, Japan, and Belgium.[34] This figure represents a 4 percent improvement over the 2011 total of $30 billion and is indicative of the state's growing prominence within the context of American commercial efforts abroad: Tennessee is now ranked 15th among all states with regard to exports.[35]

Not all news from the quarter, however, was quite so heartening. The state's unemployment rate ticked upward each month, rising from 7.6 percent in December to 7.7 percent in January, 7.8 percent in February, and 7.9 percent in March. While the rates for January and February 2013 were lower than those for the corresponding months of 2012, the level of unemployment in March 2013 was identical to that of March 2012.[36] The juxtaposition of disappointing unemployment data with encouraging statistics regarding revenues and exports supports a

[32] The Department of Revenue's collections summaries are located online at http://www.state.tn.us/revenue/statistics/summaries.shtml.
[33] "Tennessee Revenue Collections Exceed Expectations." *Memphis Business Journal* 9 Apr. 2013. http://www.bizjournals.com/memphis/blog/morning_call/2013/04/tennessee-revenue-collections-exceed.html.
[34] The International Trade Administration's profile of Tennessee's export activity may be found online at http://www.trade.gov/mas/ian/statereports/states/tn.pdf.
[35] "Tennessee Exports Grow to Record Level." *Knoxville News Sentinel* 5 Mar 2013. http://www.knoxnews.com/news/2013/mar/05/tennessee-exports-grow/.
[36] 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.

projection made by the University of Tennessee's Center for Business and Economic Research earlier this year: Tennessee growth is likely to be "modest" in 2013 but "stronger" in 2014.[37]

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
January - March 2013

Eligibility Group	January 2013	February 2013	March 2013	Sum for Quarter Ending 3/31/13
EG1 Disabled, Type 1 State Plan eligibles	134,066	132,658	131,272	397,996
EG1 Disabled, Type 2 Demonstration Population[38]	N/A	N/A	N/A	N/A
EG9 H-Disabled, Type 2 Demonstration Population	313	311	333	957
EG2 Over 65, Type 1 State Plan eligibles	31	28	28	87
EG2 Over 65, Type 2 Demonstration Population[39]	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	678,454	664,894	662,255	2,005,603
EG4 Adults, Type 1 State Plan eligibles	265,268	256,309	254,655	776,232
EG4 Adults, Type 2 Demonstration Population[40]	0	0	0	0

[37] Murray, M., "An Economic Report to the Governor of the State of Tennessee: The State's Economic Outlook, January 2013," p. 30. Center for Business and Economic Research, University of Tennessee. The report is available online at http://cber.bus.utk.edu/erg/erg2013.pdf.

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

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

[40] 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.

Eligibility Group	January 2013	February 2013	March 2013	Sum for Quarter Ending 3/31/13
EG5 Duals, Type 1 State Plan eligibles	128,181	126,504	125,793	380,478
EG11 H-Duals, Type 2 Demonstration Population	5,898	5,939	6,052	17,889
EG8 Med Exp Child, Type 2 Demonstration Population, Optional Targeted Low Income Children funded by Title XIX	0	0	0	0
TOTAL	1,212,211	1,186,643	1,180,388	3,579,242

Table 13
Member Month Reporting Not Used in Budget Neutrality Calculations
January - March 2013

Eligibility Group	January 2013	February 2013	March 2013	Sum for Quarter Ending 3/31/13
EG6E Expan Adult, Type 3, Demonstration Population	1,342	1,289	1,397	4,028
EG7E Expan Child, Type 3, Demonstration Population	182	173	154	509
Med Exp Child, Title XXI Demonstration Population	20,166	20,408	20,009	60,583
EG12E Carryover, Type 3, Demonstration Population	5,753	5,704	5,640	17,097
TOTAL	27,443	27,574	27,200	82,217

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 January – March 2013 Quarter, Compared to the Previous Two Quarters

	July – Sept 2012	Oct – Dec 2012	Jan – Mar 2013
TennCare Medicaid			
No. of appeals received	3,551	3,552	3,051
No. of appeals resolved or withdrawn	1,331	1,327	1,277
No. of appeals taken to hearing	1,098	938	1,235
No. of appeals that did not involve a valid factual dispute	1,818	1,365	1,096
Appeals previously heard that were decided in the State's favor	731	579	802
Appeals previously heard that were decided in the appellant's favor	69	68	88
TennCare Standard			
No. of appeals received	108	104	109
No. of appeals resolved or withdrawn	41	36	54
No. of appeals taken to hearing	25	40	50
No. of appeals that did not involve a valid factual dispute	55	21	27
Appeals previously heard that were decided in the State's favor	22	30	31
Appeals previously heard that were decided in the appellant's favor	0	2	7

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 January – March 2013 Quarter, Compared to the Previous Two Quarters

	July – Sept 2012	Oct – Dec 2012	Jan – Mar 2013
No. of appeals received	1,256	1,339	1,309
No. of appeals resolved	1,119	1,330	1,309
• Resolved at the MCC level	483	557	581
• Resolved at the TSU level	188	205	182
• Resolved at the LSU level	448	568	546
No. of appeals that did not involve a valid	292	295	313

	July – Sept 2012	Oct – Dec 2012	Jan – Mar 2013
factual dispute			
No. of directives issued	152	171	160
No. of appeals taken to hearing	448	568	546
No. of appeals that were withdrawn by the enrollee at or prior to the hearing	139	183	185
Appeals that went to hearing and were decided in the State's favor	113	144	142
Appeals that went to hearing and were decided in the appellant's favor	13	13	25

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 January – March 2013
Compared to the Previous Two Quarters

	July – Sept 2012	Oct – Dec 2012	Jan – Mar 2013
No. of appeals of PreAdmission Evaluation (PAE) denials	302	257	322
No. of appeals of PASRR determinations	4	1	4
No. of appeals of denial for enrollment into CHOICES	13	16	8
No. of appeals of involuntary disenrollment from CHOICES	5	4	7
No. of appeals of denial of Consumer Direction	0	0	0
No. of appeals of involuntary withdrawal of Consumer Direction	0	1	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	148	130	156
No. of appeals withdrawn prior to hearing	8	7	2
No. of appeals dismissed at hearing	7	14	41
No. of appeals continued at hearing	8	9	5
No. of appeals that went to hearing and were decided in the State's favor	3	6	11
No. of appeals that went to hearing and were decided in the appellant's favor	1	2	1

X. Quality Assurance/Monitoring Activity

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

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

- Maternity Management
- Obesity
- Schizophrenia

The focus of DM programs is on preventing worsening of and complications from these diseases. DM programs educate members in order to increase their understanding of their condition(s) and the factors that affect their health status, as well as to empower members to be more effective in self-care and management of their health. Information on enrollment in DM is provided in Table 17. Figures for the period of January through March, 2013, will be provided in the next Quarterly Progress Report.

Table 17
DM Program Enrollment, October - December 2012
Compared to the Previous Two Quarters[41]

DM Program	Apr – June 2012		July – Sept 2012		Oct – Dec 2012	
	Non-CHOICES Members	CHOICES Members	Non-CHOICES Members	CHOICES Members	Non-CHOICES Members	CHOICES Members
Asthma	110,366	24	110,581	24	109,607	24
Bipolar	22,045	12	22,314	16	22,341	14
Chronic Obstructive Pulmonary Disease	3,636	57	3,468	48	3,406	53
Congestive Heart Failure	1,546	177	1,532	194	1,523	180
Coronary Artery Disease	4,962	48	4,923	50	4,925	51
Diabetes	15,865	481	15,420	537	15,008	505
HIV[42]	245	6	238	8	217	8
Hypertension[43]	4,124	136	3,989	150	3,850	154
Major Depression	52,501	60	56,241	67	56,873	68
Maternity	16,414	0	17,827	1	16,554	1
Multiple Conditions	50,258	264	52,802	367	53,889	274

[41] The numbers in this table reflect DM enrollment at the end of the quarter and are not unduplicated: a person enrolled in two different MCOs during the reporting period could be counted in a particular DM program twice. In addition, some persons may be enrolled in more than one DM program.
[42] A DM program for HIV is not a requirement, but Amerigroup has chosen to have a program for this condition.
[43] A DM program for Hypertension is not a requirement, but Amerigroup has chosen to have a program for this condition.

DM Program	Apr – June 2012		July – Sept 2012		Oct – Dec 2012	
	Non-CHOICES Members	CHOICES Members	Non-CHOICES Members	CHOICES Members	Non-CHOICES Members	CHOICES Members
Obesity	24,994	9	25,155	6	25,416	13
Other[44]	17,310	270	15,702	284	14,178	277
Schizophrenia	6,138	30	6,118	34	5,748	28
Total DM Enrollment	**330,404**	**1,574**	**336,310**	**1,786**	**333,535**	**1,650**
Total CHOICES and Non-CHOICES DM Enrollment	**331,978**		**338,096**		**335,185**	

By July 1, 2013, TennCare's MCOs will have replaced the Disease Management program with a new model referred to as "Population Health". This approach 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. Measures will remain in place, furthermore, to assist enrollees who already have a complex chronic condition. Data for the Population Health program will be forthcoming later in Calendar Year 2013.

Provider Data Validation Report. TennCare's External Quality Review Organization (EQRO), Qsource, published the results of its provider data validation survey for the January-March 2013 quarter. Qsource took a sample of provider data files from TennCare's MCCs[45] and reviewed each for accuracy in the following categories:

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

The validity of such information is one measure of providers' availability and accessibility to TennCare enrollees. Qsource's report concluded that "[o]verall, the MCCs' accuracy rates have

[44] Other conditions for which Amerigroup has chosen to establish DM programs include Transplants, End Stage Renal Disease, etc.

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

maintained a high level," especially in the categories of "active contract status with MCC" (97.3 percent accuracy), "provider credentialed specialty / behavioral health service code" (97.0 percent accuracy), "primary care services" (99.5 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 "open/closed to new patients," which demonstrated only 89.8 percent accuracy), TennCare required each of its MCCs to submit a Corrective Action Plan no later than February 11, 2013. The Bureau, in turn, had received, reviewed, and accepted all of the plans by February 12, 2013.

XI. Demonstration Evaluation

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

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

XII. Essential Access Hospital Pool[46]

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

[46] 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.

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)
Pathways of Tennessee
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
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
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

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Date Submitted to CMS: May 31, 2013

Attachment A

Budget Neutrality Calculations for the Quarter

Actual TennCare Budget Neutrality (Jan - March 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)	400,346
2-Child <=18	2,005,603
3-Adult >= 65	87
4-Adult <= 64	776,232
Duals (17)	397,955
Total	3,580,223

Ceiling without DSH

	Baseline * MM
1-Disabled (can be any ages)	$594,790,049
2-Child <=18	$908,658,495
3-Adult >= 65	$85,018
4-Adult <= 64	$679,140,901
17s	$248,431,368
Total	$2,431,105,831

DSH

DSH Adjustment (Quarterly)	$115,999,213

Total Ceiling

Budget Neutrality Cap	
Total w/DSH Adj.	$2,547,105,045

II. Actual Expenditures

Group 1 and 2

1-Disabled (can be any ages)	$ 537,302,050
2-Child <=18	$ 426,023,404
3-Adult >= 65	$ 170,177
4-Adult <= 64	$ 302,107,866

Duals (17)	$	350,354,755
Total		**1,615,958,253**

Group 3

1-Disabled (can be any ages)	$	-
2-Child <=18	$	12,195,386
3-Adult >= 65	$	70,570,706
4-Adult <= 64	$	2,526,127
Duals (17)	$	-
Total		**85,292,219**

Pool Payments and Admin

Total Pool Payments	**255,887,977**

Admin	**96,351,999**

Quarterly Drug Rebates		$100,495,737
Quarterly Premium Collections		$271
Total Net Quarterly Expenditures	**$**	**1,952,994,440**

III. Surplus/(Deficit)

	$594,110,605
Federal Share	**$392,885,343**

HCI Result	MM201301	MM201302	MM201303	TOTAL	HCI ASO Jan - Mar 13	HCI Rx Jan - Mar 13	HCI DTL Jan - Mar 13	HCI MCO CAP (w/o TSL)	TOTAL
EG1-TYPE1 (disabled, type1 state plan eligibles)	134,066	132,658	132,665	399,389	$82,144,797	$89,461,253	$1,804,886	$358,818,642	$532,229,578
EG1-TYPE2 (disabled, type2 transition group)	0	0	0	-					$0
EG2-TYPE1 (over 65, type1 state plan eligibles)	31	28	28	87	$143,756	$2,861	$0	$23,560	$170,177
EG2-TYPE2 (over 65, type2 state plan eligibles)	0	0	0	-					$0
EG3-TYPE1 (children, type1 state plan eligibles)	678,454	664,894	662,255	2,005,603	$11,464,269	$60,767,059	$33,615,973	$320,176,103	$426,023,404
Med Exp Child (Title XXI Demo Pop; EG3-Type2)	20,166	20,408	20,009	60,583	$53,841	$2,990,276	$1,322,161	$7,695,161	$12,061,439
EG4-TYPE1 (adults, type1 State plan eligibles)	265,268	256,309	254,655	776,232	$1,325,374	$45,081,624	$2,050,116	$253,650,752	$302,107,866
EG4-TYPE2 (adults, type2 demonstration pop)	0	0	0	-					$0
EG5-TYPE1 (duals, state plan eligibles)	128,181	126,504	125,793	380,478	$977,639	$832,060	$30,901	$284,180,987	$286,021,587
EG6E-TYPE3 (Expan adult, type3 demonstration pop)	1,342	1,289	1,397	4,028	$0	$472,731	$0	$2,053,396	$2,526,127
EG7E-TYPE3 (Expan child, type3 demonstration pop)	182	173	154	509	$2,330	$50,981	$9,187	$71,449	$133,947
EG8-TYPE2 (emd exp child)	0	0	0	-					$0
EG9 H-Disabled (TYPE 2 Eligibles)	313	311	333	957	$2,674	$272,009	$0	$4,797,789	$5,072,472
EG11H, H-Dual	5,898	5,939	5,640	17,477	$3,251	$12,364	$0	$64,317,553	$64,333,168
Eg12E, Carryovers (PACE, Choices 1, Choices 2)	5,753	5,704	5,640	17,097	$2,429	$1,218,044	$115	$69,350,118	$70,570,706
Total	**1,239,654**	**1,214,217**	**1,208,569**	**3,662,440**	**$96,120,360**	**$201,161,262**	**$38,833,339**	**$1,365,135,510**	**$1,701,250,472**

HCI Result	MM201301	MM201302	MM201303	TOTAL	HCI ASO PMPM	HCI Rx PMPM	HCI DTL PMPM	HCI MCO CAP (w/o TSL)	TOTAL
EG1-TYPE1 (disabled, type1 state plan eligibles)	134,066	132,658	132,665	399,389	$205.68	$224.00	$4.52	$898.42	$1,332.61
EG1-TYPE2 (disabled, type2 transition group)	0	0	0	-					
EG2-TYPE1 (over 65, type1 state plan eligibles)	31	28	28	87	$1,652.37	$32.89	$0.00	$270.80	$1,956.06
EG2-TYPE2 (over 65, type2 state plan eligibles)	0	0	0	-	-	-	-	-	-
EG3-TYPE1 (children, type1 state plan eligibles)	678,454	664,894	662,255	2,005,603	$5.72	$30.30	$16.76	$159.64	$212.42
Med Exp Child (Title XXI Demo Pop; EG3-Type2)	20,166	20,408	20,009	60,583	$0.89	$49.36	$21.82	$127.02	$199.09
EG4-TYPE1 (adults, type1 State plan eligibles)	265,268	256,309	254,655	776,232	$1.71	$58.08	$2.64	$326.77	$389.20
EG4-TYPE2 (adults, type2 demonstration pop)	0	0	0	-					
EG5-TYPE1 (duals, state plan eligibles)	128,181	126,504	125,793	380,478	$2.57	$2.19	$0.08	$746.91	$751.74
EG6E-TYPE3 (Expan adult, type3 demonstration pop)	1,342	1,289	1,397	4,028	$0.00	$117.36	$0.00	$509.78	$627.14
EG7E-TYPE3 (Expan child, type3 demonstration pop)	182	173	154	509	$4.58	$100.16	$18.05	$140.37	$263.16
EG8-TYPE2 (emd exp child)	0	0	0	-					
EG9 H-Disabled (TYPE 2 Eligibles)	313	311	333	957	$2.79	$284.23	$0.00	$5,013.36	$5,300.39
EG11H, H-Dual	5,898	5,939	5,640	17,477	$0.19	$0.71	$0.00	$3,680.13	$3,681.02
Eg12E, Carryovers (PACE, Choices 1, Choices 2)	5,753	5,704	5,640	17,097	$0.14	$71.24	$0.01	$4,056.27	$4,127.67
Total	**1,239,654**	**1,214,217**	**1,208,569**	**3,662,440**	**$26.24**	**$54.93**	**$10.60**	**$372.74**	**$464.51**

* Unknown allocation was performed within the Service category totals.