TN Division of
Health Care
Finance & Administration

May 31, 2016

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

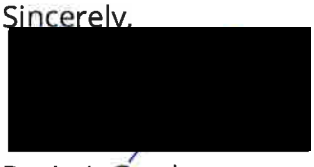
RE: TennCare II, STC 46, Quarterly Progress Report

Dear Ms. Woodard:

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

Please let us know if you have comments or questions.

Sincerely,



Darin J. Gordon
Director, Bureau of TennCare

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

TennCare II

Section 1115 Quarterly Report

(For the period January - March 2016)

Demonstration Year: 14 (7/1/15 - 6/30/16)
Federal Fiscal Quarter: 2/2016 (1/16 - 3/16)
Waiver Quarter: 3/2016 (1/16 - 3/16)

I. Introduction

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

TennCare contracts with several Managed Care Contractors (MCCs) to provide services to over 1.5 million enrollees. During this quarter, these entities included Managed Care Organizations (MCOs) for medical, behavioral, and certain Long-Term Services and Supports (LTSS), a Dental Benefits Manager (DBM) for dental services, and a Pharmacy Benefits Manager (PBM) for pharmacy services.

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

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

Table 1
Key Dates of Approval/Operation in the Quarter

Date	Action	STC #
January and February 2016	The Monthly Call was not held.	45
1/6/16	CMS sent the State a letter confirming that its application to renew the TennCare Demonstration included the necessary elements and was therefore complete.	
1/25/16	The State sent the CMS Project Officer a courtesy copy of SPA TN-16-0001, which concerns families' Medicaid eligibility under Transitional Medical Assistance.	7
2/2/16	CMS issued written approval of Amendments 27 and 28. Included with the approval were revised versions of the Waiver List, Expenditure Authorities, and STCs.	
2/22/16	The State sent CMS a letter accepting the approval of Amendments 27 and 28. The letter also outlined technical corrections to be made to the waiver materials that had accompanied CMS' approval.	
2/29/16	The State submitted the Quarterly Progress Report for the October-December 2015 quarter to CMS.	46

[1] The STC numbering system used throughout this Quarterly Progress Report is the one introduced in the waiver materials that accompanied the approval of Demonstration Amendments 27 and 28 on February 2, 2016.

Date	Action	STC #
3/3/16	The State sent CMS additional technical corrections to the waiver materials that had accompanied CMS' approval of Amendments 27 and 28.	
3/4/16	The State submitted two documents to CMS: a study of the State's eligibility and enrollment systems (conducted by Manatt, Phelps & Phillips) and a study of uncompensated care costs for the uninsured in Tennessee (conducted by Public Consulting Group).	69, 70
3/17/16	The State notified the public of its intent to submit Demonstration Amendment 30 to CMS. Amendment 30 outlined program reductions that would be necessary if the Tennessee General Assembly did not renew the annual hospital assessment fee.	15
3/17/16	CMS approved MCO Contract Amendment 3 and TennCare Select Contract Amendment 38.	41
3/22/16	The CMS Project Officer requested that the Monthly Call for March be moved to April.	45
3/22/16	In reference to the State's application to renew the TennCare Demonstration, CMS shared with the State a policy outline that would inform discussions of budget neutrality.	

II. Enrollment and Benefits Information

Information about enrollment by category is presented in Table 2.

Table 2
Enrollment Counts for the January – March 2016 Quarter
Compared to the Previous Two Quarters

Demonstration Populations	Total Number of TennCare Enrollees		
	Jul – Sept 2015	Oct – Dec 2015	Jan – Mar 2016
EG1 Disabled, Type 1 State Plan eligibles	142,205	142,136	143,752
EG9 H-Disabled, Type 2 Demonstration Population	306	282	258
EG2 Over 65, Type 1 State Plan eligibles	197	141	206
EG10 H-Over 65, Type 2 Demonstration Population	39	44	38
EG3 Children, Type 1 State Plan eligibles	749,605	759,289	773,217

Demonstration Populations	Total Number of TennCare Enrollees		
	Jul – Sept 2015	Oct – Dec 2015	Jan – Mar 2016
EG4 Adults, Type 1 State Plan eligibles	413,342	428,937	448,332
EG5 Duals, Type 1 State Plan eligibles and EG11 H-Duals 65, Type 2 Demonstration Population	143,895	145,490	147,871
EG6E Expan Adult, Type 3 Demonstration Population	814	793	780
EG7E Expan Child, Type 3 Demonstration Population	63	61	55
EG8, Med Exp Child, Type 2 Demonstration Population, Optional Targeted Low Income Children funded by Title XIX	0	0	0
Med Exp Child, Title XXI Demonstration Population	18,894	18,734	18,634
EG12E Carryover, Type 3, Demonstration Population	3,792	3,531	3,223
TOTAL*	1,473,142	1,499,438	1,536,366

*** 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 nearly 80 percent of TennCare enrollees appearing in one of these categories.

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

Table 3
TennCare Managed Care Contractors as of March 31, 2016

Managed Care Organizations	Amerigroup BlueCare[2] UnitedHealthcare Community Plan[3] TennCare Select[4]
Pharmacy Benefits Manager	Magellan Health Services

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

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

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

Dental Benefits Manager	DentaQuest

Three proposed amendments to the TennCare Demonstration were in various stages of development during the quarter.

Demonstration Amendment 27: Employment and Community First CHOICES. On June 23, 2015, following an in-depth eighteen-month stakeholder input process with individuals with intellectual and developmental disabilities and their families and providers, and more than a year of discussion with CMS on a Concept Paper, TennCare submitted Amendment 27. Amendment 27 concerns a new program named Employment and Community First (ECF) CHOICES, which would—according to the text of the proposal—implement "an integrated managed long-term services and supports (MLTSS) program that is specifically geared toward promoting and supporting integrated, competitive employment and independent, integrated community living as the first and preferred option for individuals with intellectual and developmental disabilities (I/DD)."

As the January-March 2016 quarter began, negotiations regarding Amendment 27 were ongoing. The TennCare Bureau supplied CMS detailed definitions of the services to be provided under ECF CHOICES and answered all questions posed by the federal agency. In addition, the parties collaborated in drafting a set of STCs for the TennCare Demonstration, defining the manner in which ECF CHOICES would operate within TennCare's managed care system. This process culminated on February 2, 2016, when CMS issued written approval of Amendment 27. Accompanying the approval letter were amended versions of the Waiver List, Expenditure Authorities, and STCs comprising TennCare's Demonstration Agreement with CMS. On February 22, 2016, the Bureau sent CMS a letter accepting the revised materials but identifying a set of technical corrections to be made.

With federal approval of the ECF CHOICES program secured, TennCare spent much of the January-March quarter making preparations for implementation. These efforts included developing amendments to managed care contracts, finalizing program requirements, beginning to build provider networks, and making systems changes. Readiness activities will continue during the April-June 2016 quarter.

Demonstration Amendment 28: Closure of Standard Spend Down Category. TennCare submitted Amendment 28 to CMS on October 8, 2015. Amendment 28 would close a TennCare eligibility category called "Standard Spend Down" (or "SSD"), which provides coverage to approximately 800 individuals who are not otherwise eligible for Medicaid but 1) are aged, blind, disabled, or the caretaker relative of a Medicaid-eligible child and 2) have enough unreimbursed medical bills to allow them to "spend down" to the Medically Needy Income Standard, a very low threshold. New enrollment in the category has been closed since 2013, and TennCare anticipates that many of the remaining enrollees may be eligible for health coverage through either Medicare or the Health Insurance Marketplace established by the Affordable Care Act.

CMS approved Amendment 28 on February 2, 2016. Current SSD enrollees will remain eligible in that category until they are due for redetermination. As part of the redetermination process, TennCare will review SSD enrollees for eligibility in all open categories of TennCare coverage. Any individual found to qualify in another category will be transferred with no interruption in coverage. Individuals who do not qualify in another category will be disenrolled from TennCare and referred to Medicare and/or the Health Insurance Marketplace.

Demonstration Amendment 30: Program Modifications. During the January-March 2016 quarter, TennCare notified the public of another amendment to be submitted to CMS. Amendment 30 outlines program changes proposed in previous years that were made unnecessary each time by the Tennessee General Assembly's passage or renewal of a one-year hospital assessment fee. Changes to the TennCare benefit package for non-exempt adults that would be necessary if the fee were not renewed in 2016 are as follows:

- A combined annual limit of eight days per person for inpatient hospital and inpatient psychiatric hospital services;
- An annual limit on non-emergency outpatient hospital visits of eight occasions per person;
- A combined annual limit on health care practitioners' office visits of eight occasions per person;
- An annual limit on lab and X-ray services of eight occasions per person; and
- Elimination of coverage for occupational therapy, speech therapy, and physical therapy.

The Bureau opened its public notice and comment period regarding Amendment 30 on March 17, 2016. By the conclusion of the January-March quarter no comments had been received. TennCare leadership decided that, if the General Assembly were to renew the hospital assessment fee by the end of the comment period (or soon thereafter), Amendment 30 would not be submitted to CMS.

Cost Sharing Compliance Plan. In its April 18, 2012, letter approving the Bureau of TennCare's cost sharing compliance plan for the TennCare Standard population, CMS stipulated that "each Quarterly Report . . . must include a report on whether any families have contacted the State to document having reached their aggregate cap, and how these situations were resolved." During the January-March 2016 quarter, the Bureau received no notifications that a family with members enrolled in TennCare Standard had met its cost sharing limit. It should be noted that this is the thirteenth consecutive quarter since the plan was implemented in which no notifications have been received.

III. Innovative Activities to Assure Access

Early and Periodic Screening, Diagnosis and Treatment (EPSDT). EPSDT, or "TennCare Kids," outreach is a significant area of interest for TennCare. The TennCare Bureau maintains a contract with the Tennessee Department of Health (TDH) to conduct a community outreach program for the purpose of educating families on EPSDT benefits and encouraging them to use those benefits, particularly preventive exams.

Table 4 summarizes the community outreach activity during this quarter and the previous two quarters. Quarterly variations in the categories presented here are usually the result of the following factors:

- Seasonal events. Each year, National Children's Dental Health Month in February, back-to-school events in August, and Child Health Week in October all have a profound influence on the focus and direction of outreach efforts during their respective quarters. TDH's communications strategy for each is based on an evaluation of past successes and current opportunities. During one round of Dental Health Month, for instance, TDH employed scrolling billboards prominently, whereas the strategy for Child Health Week eight months later placed greater emphasis on radio and television broadcasts and magazine articles.
- Collaborative partners. A variety of TDH's activities are dependent on the opportunities offered by other State agencies and by entities within the community. For example, publication of articles in newsletters and magazines is usually possible only when local media outlets offer space in their periodicals at no charge. Similarly, TDH's ability to educate the public through television and radio broadcasts is tied to the availability of open timeslots in those platforms. Even certain types of telephone outreach require input from other sources: calls to families to reinforce the importance of dental checkups (detailed in Table 4), for instance, are possible only because of referrals from the School-Based Dental Prevention Program (SBDPP).

Table 4
Tennessee Department of Health
Community Outreach Activity for EPSDT
January – March 2016 Compared to the Previous Two Quarters

Activities	Jul – Sept 2015	Oct – Dec 2015	Jan – Mar 2016
Number of outreach activities/events	3,649	3,141	3,127
Number of people made contact with (mostly face to face at outreach events)	203,202	188,186	138,556[5]
Number of educational materials distributed	218,290	180,304	143,622

[5] Lower turnout at community outreach events during the January-March 2016 quarter is attributable in part to inclement weather during the first two months of the year. This decrease in participation, in turn, helps explain the reduced number of educational materials distributed during the same quarter.

Activities	Jul – Sept 2015	Oct – Dec 2015	Jan – Mar 2016
Number of coalitions/advisory board meetings attended or conducted	85	68	88
Number of attendees at coalitions/advisory board meetings	1,471	1,121	1,637
Number of educational preventive health radio/TV broadcasts	962	1,067	1,264
Number of educational preventive health newsletter/magazine articles	29	45	64
Number of educational preventive health billboards, scrolling billboards and bulletin boards	5,804	5,807	7,194
Number of presentations made to enrollees/professional staff who work with enrollees	118	129	134
Number of individuals attending presentations	4,370	3,699	4,786
Number of completed telephone calls regarding the importance of dental checkups	66	305	368
Number of home visits completed	23	30	196

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

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

Activities	Jul – Sept 2015	Oct – Dec 2015	Jan – Mar 2016
Number of enrollees reached	23,944	23,913	21,137
Number of enrollees who were assisted in scheduling an EPSDT exam for their children	766	723	637
Number of enrollees who were assisted in arranging for transportation	19	37	16

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

	Jul – Sept 2015	Oct – Dec 2015	Jan – Mar 2016
No. of encounters received by TennCare (initial submission)	16,066,893	15,597,491	17,161,264[6]
No. of encounters rejected by Edifecs upon initial submission	11,183	19,529	71,521
Percentage of encounters that were compliant with State standards (including HIPAA) upon initial submission	99.96%	99.87%	99.58%

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

A. CHOICES

As required by STC 32.d., the State offers the following table delineating CHOICES enrollment as of the end of the quarter, as well as information about the number of available reserve slots.

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

Table 7
TennCare CHOICES Enrollment and Reserve Slots
for January – March 2016 Compared to the Previous Two Quarters

	Statewide Enrollment Targets and Reserve Capacity[7]	Enrollment and Reserve Slots Being Held as of the End of Each Quarter		
		Jul – Sept 2015	Oct – Dec 2015	Jan – Mar 2016
CHOICES 1	Not applicable	17,169	17,202	17,136
CHOICES 2	12,500	8,455	8,588	8,744
CHOICES 3 (including Interim CHOICES 3)	To Be Determined	4,690	4,376	4,052
Total CHOICES	Not applicable	30,314	30,166	29,932
Reserve capacity	300	300	300	300

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

Data and trends of the designated CHOICES data elements: STC 44.d. requires the State to submit to CMS periodic statistical reports about the use of LTSS by TennCare enrollees. Nine separate reports—spanning the period of August 2011 through August 2015—had been submitted by the conclusion of the January-March 2016 quarter.

Taken together, the reports depict a program evolving according to the characteristics of LTSS recipients, with institutional care available to individuals with the highest acuity of need, and Home and Community-Based Services (HCBS) available to individuals whose needs can be safely and effectively met at home or in other non-institutional settings. Point-in-time data revealed declining use of NF services over time, with placement in institutional settings decreasing from 21,530 individuals on June 30, 2011, to 17,069 individuals on June 30, 2015. The aggregate number of TennCare enrollees accessing HCBS, by comparison, grew from 6,226 in the twelve-month period preceding CHOICES implementation in Middle Tennessee to 16,112 after CHOICES had been in place for four full fiscal years. This trend was mirrored in point-in-time data as well: on the day prior to CHOICES implementation, 4,861 individuals were using HCBS, but the number had grown to 13,240 by June 30, 2015. This information is summarized in Table 8.

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

Table 8
Changes in Use of HCBS by Persons Who Are Elderly or Disabled (E/D) Before and After CHOICES Implementation

Annual Aggregate Data			Point-in-Time Data		
No. of TennCare enrollees accessing HCBS (E/D), 3/1/09 – 2/28/10	No. of TennCare enrollees accessing HCBS (E/D), 7/1/13 – 6/30/14	Percent increase over a four-year period	No. of TennCare enrollees accessing HCBS (E/D) on the day prior to CHOICES implementa-tion	No. of TennCare enrollees accessing HCBS (E/D) on 6/30/15	Percent increase from the day prior to CHOICES implementa-tion to 6/30/15
6,226	16,112	159%	4,861[8]	13,240	172%

Enrollment of select members of the CHOICES population in Groups 1 and 2: STC 46.f. requires the State to provide "enrollment reports for individuals who would otherwise be eligible for Interim CHOICES 3 but who meet the modified institutional level of care, and whether CHOICES 1 or CHOICES 2 was selected by the individual." The population of LTSS recipients described in this passage, then, consists of individuals who have been approved for Nursing Facility Level of Care in CHOICES 1 (NF) or CHOICES 2 (HCBS) despite having been assigned a score of less than 9 on the TennCare Nursing Facility Level of Care Acuity Scale. Each approval is based on a determination by TennCare that the applicant does not qualify for enrollment in Interim CHOICES 3. Such a determination would be made when the necessary intervention and supervision needed by the applicant could not be safely provided within the array of services and supports that would be available if the applicant were enrolled in Interim CHOICES 3, including—

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

During the period from January 1, 2016, through March 31, 2016, NF PreAdmission Evaluations (PAEs) were approved for 286 individuals with acuity scores lower than 9, and 147 of these individuals were subsequently enrolled in CHOICES 1 during the measurement period. Reasons that the remaining individuals were approved for—but not yet enrolled in—CHOICES 1 include:

[8] The total of 4,861 comprises 1,479 individuals receiving HCBS (E/D) in Middle Tennessee on February 28, 2010 (the day prior to CHOICES implementation in that region), and 3,382 individuals receiving HCBS (E/D) in East and West Tennessee on July 31, 2010 (the day prior to CHOICES implementation in those regions).

- Pending notification by Nursing Facilities of the exhaustion of other sources of reimbursement (e.g., Medicare, other insurance, or private payment);
- Medicaid financial eligibility determination pending; and
- Failure of the individual to meet Medicaid financial eligibility requirements.

In the same reporting period, HCBS PAEs were approved for 189 individuals with acuity scores lower than 9, and 151 of the individuals were subsequently enrolled in CHOICES 2. The remaining applicants did not meet Medicaid financial eligibility requirements or otherwise failed to qualify for, or proceed with, enrollment in CHOICES 2.

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

Table 9
TennCare CHOICES Transition Allowances
for January – March 2016 Compared to the Previous Two Quarters

	Frequency and Use of Transition Allowances					
	Jul – Sept 2015		Oct – Dec 2015		Jan – Mar 2016	
Grand Region	# Distributed	Total Amount	# Distributed	Total Amount	# Distributed	Total Amount
East	13	$19,431	20	$20,435	15	$13,891
Middle	9	$6,009	14	$13,089	12	$14,015
West	12	$8,256	15	$15,179	11	$10,033
Statewide Total	34	$33,696	49	$48,703	38	$37,939

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

Claims Payment Analysis. The prompt pay requirements of T.C.A. § 56-32-126(b) mandate that each Managed Care Organization (MCO) ensure that 90 percent of clean claims for payment for services delivered to a TennCare enrollee are paid within 30 calendar days of the receipt of such claims and that 99.5 percent of all provider claims are processed within 60 calendar days of receipt. TennCare's contract with its Dental Benefits Manager (DBM) requires the DBM to process claims in accordance with this statutory standard as well. TennCare's contract with its Pharmacy Benefits Manager (PBM) requires the PBM to pay 100 percent of all clean claims submitted by pharmacy providers within 15 calendar days of receipt.

The MCOs, the DBM, and the PBM are required to submit monthly claims data files of all TennCare claims processed to the Tennessee Department of Commerce and Insurance (TDCI) for verification of statutory and contractual prompt pay compliance. The plans are required to separate their claims data by claims processor (e.g., MCO, vision benefits manager, etc.). Furthermore, the MCOs are required to identify separately non-emergency transportation

(NEMT) claims in the data files. Finally, the MCOs are required to submit separate claims data files representing a subset of electronically submitted NF and applicable HCBS claims for CHOICES enrollees. TDCI then performs an analysis and reports the results of the prompt pay analyses by NEMT and CHOICES claim types, by claims processor, and by total claims processed for the month.

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

Net Worth and Company Action Level Requirements. According to Tennessee's "Health Maintenance Organization Act of 1986" statute (T.C.A. § 56-32-101 *et seq.*), the minimum net worth requirement for each TennCare MCO is calculated based on premium revenue for the most recent calendar year, as well as any TennCare payments made to the MCO that are not reported as premium revenue.

During the January-March 2016 quarter, the MCOs submitted their National Association of Insurance Commissioners (NAIC) Annual Financial Statements. As of December 31, 2015, TennCare MCOs reported net worth as indicated in the table below.[9]

Table 10
Net Worth Reported by MCOs as of December 31, 2015

	Net Worth Requirement	Reported Net Worth	Excess/ (Deficiency)
Amerigroup Tennessee	$29,016,782	$169,567,033	$140,550,251
UnitedHealthcare Plan of the River Valley (UnitedHealthcare Community Plan)	$55,361,026	$423,305,536	$367,944,510
Volunteer State Health Plan (BlueCare & TennCare Select)	$43,251,806	$330,831,416	$287,579,610

During the January-March 2016 quarter, the MCOs were also required to comply with Tennessee's "Risk-Based Capital for Health Organizations" statute (T.C.A. § 56-46-201 *et seq.*).

[9] The "Net Worth Requirement" and "Reported Net Worth" figures in the table are based on the MCOs' company-wide operations, not merely their TennCare operations. Amerigroup and Volunteer State Health Plan, for instance, operate Medicare Advantage Plans, while UnitedHealthcare has several lines of business in Illinois, Iowa, Virginia, and Tennessee.

Risk-based capital (RBC) involves a method of calculating the minimum amount of capital necessary for a health entity to support its overall business operations depending on its size and risk profile. A health entity with a higher amount of risk is required to hold a higher amount of capital. The RBC statute gives TDCI the authority and mandate to use preventive and corrective measures that vary depending on the amount of capital deficiency indicated by the RBC calculations. A "Company Action Level" deficiency (defined at T.C.A. § 56-46-203(a)) would require the submission of a plan to correct the entity's capital deficiency.

The following table compares the MCOs' net worth to the Company Action Level requirements as of December 31, 2015:

Table 11
Company Action Level Reported by MCOs as of December 31, 2015

	Company Action Level Requirement	Reported Net Worth	Excess/ (Deficiency)
Amerigroup Tennessee	$104,759,436	$169,567,033	$64,807,597
UnitedHealthcare Plan of the River Valley (UnitedHealthcare Community Plan)	$189,545,450	$423,305,536	$233,760,086
Volunteer State Health Plan (BlueCare & TennCare Select)	$133,523,082	$330,831,416	$197,308,334

All TennCare MCOs far exceeded their minimum net worth requirements and Company Action Level requirements as of December 31, 2015.

C. Departure of TennCare Director

On March 30, 2016, Tennessee Governor Bill Haslam announced that TennCare Director and Deputy Commissioner of Health Care Finance and Administration Darin Gordon would enter the private sector at the end of June. Having taken on his role in 2006, Mr. Gordon is not only the longest serving TennCare director in state history but also the longest serving Medicaid director in the country.

During his tenure, TennCare gained national recognition as a model of an innovative Medicaid managed care program. Mr. Gordon led TennCare to maintain the lowest cost trend in its history, make significant improvements in a substantial number of quality measures, and gain national recognition for innovations in managed care and payment and delivery system reform. His contributions extend beyond Tennessee, as evidenced by his service as president of the National Association of Medicaid Directors.

Mr. Gordon started his career in Tennessee state government as an intern for the Senate Finance Committee in 1996, and he has more than eighteen years of experience in public health

care finance and management. Prior to 2006, he held key executive management positions within TennCare, first as the Director of Managed Care Programs and subsequently as Chief Financial Officer. Mr. Gordon's last day with TennCare will be June 30. Until that time, he will continue to work on TennCare's renewal application (discussed in greater detail below) and help facilitate the transition to new leadership.

D. Application to Renew the TennCare Demonstration

As detailed in the Bureau's previous Quarterly Progress Report, an application to renew the TennCare Demonstration was submitted to CMS on December 22, 2015. The current approval period ends on June 30, 2016, and the State is seeking a renewal of the Demonstration through June 30, 2021.

The extension application requests only one change to the Demonstration: that the waiver of retroactive eligibility currently scheduled to expire on June 30, 2016, be extended throughout the next approval period. CMS published the document for a federal comment period lasting from January 7 through February 6, 2016. Following the conclusion of the federal comment period, CMS communicated a preliminary list of topics for future discussion with the State. Negotiations on points identified are expected to progress throughout the April-June 2016 quarter.

E. Payment Reform

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

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

Two of the most important strategies being used to reform health care payment approaches are primary care transformation and episodes of care:

- Primary care transformation focuses on the role of the primary care provider in promoting the delivery of preventive services and managing chronic illnesses over time. The Initiative is developing an aligned model for multi-payer Patient Centered Medical Homes (PCMHs), Health Homes for TennCare members with Serious and Persistent Mental Illness, and a shared care coordination tool that includes hospital and Emergency Department admission, discharge, and transfer alerts for attributed providers.

- Episodes of care focuses on the health care delivered in association with acute health care events, such as a surgical procedure or an inpatient hospitalization. Episodes encompass care delivered by multiple providers in relation to a specific health care event. Each episode has a principal accountable provider (or "quarterback") who leads and coordinates the team of care providers and helps drive improvement through various activities including, but not limited to, care coordination, early intervention, and patient education.

Both of these strategies have benefitted from the input of Technical Advisory Groups (TAGs) composed of subject matter experts. TAG recommendations span a variety of topics, including the patient journey and care pathways, the definition of the principal accountable provider (i.e., the quarterback), any aspects of care delivery unique to Tennessee, the components of the episode of care, and appropriate quality measures.

During the January-March 2016 quarter, the State and participating insurance companies worked to implement TAG recommendations concerning the PCMH program. TAG recommendations related to the fifth set ("Wave 5") of episodes of care are expected in early summer 2016. The Wave 5 episodes are Breast Cancer Mastectomy, Breast Cancer Medical Treatment, Breast Biopsy, Tonsillectomy, Otitis, Anxiety, and Chronic Depression.

F. Electronic Health Record Incentive Program

The Electronic Health Record (EHR) Incentive Program is a partnership between federal and state governments that grew out of the Health Information Technology for Economic and Clinical Health (HITECH) Act. The purpose of the program is to provide financial incentives to Medicaid providers[10] to replace outdated, often paper-based approaches to medical record-keeping with electronic systems that meet rigorous certification criteria and that can improve health care delivery and quality. The federal government provides 100 percent of the funding for the incentive payments and 90 percent of the administrative costs.

Currently, Medicaid providers may qualify for the following types of payments:

- First-year payments to providers (eligible hospitals or practitioners) who either—
    - Adopt, implement, or upgrade to certified EHR technology capable of meeting "meaningful use" in accordance with CMS standards, or
    - Achieve meaningful use of certified EHR technology for any period of 90 consecutive days;
- Second-year payments to providers who have received first-year payments and who achieved meaningful use for a subsequent period of 90 consecutive days;

[10] 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).

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

With CMS approval, TennCare issues incentive payments to eligible hospitals over a three-year period, while eligible practitioners must attest over a six-year period.

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

Table 12
EHR Payments
Quarterly and Cumulative

Payment Type	No. of Providers Paid During the Quarter	Quarterly Amount Paid (Jan-Mar 2016)	Cumulative Amount Paid To Date
First-year payments	299[11]	$7,086,203	$164,214,386
Second-year payments	14	$963,935	$51,150,193
Third-year payments	52	$6,374,511	$23,336,549
Fourth-year payments	38	$311,668	$1,705,673
Fifth-year payments	17	$144,500	$144,500

The Bureau's technical assistance activities, outreach efforts, and other EHR-related projects intensified during the quarter. This increase, which coincided with newly implemented "Modified Stage 2" meaningful use measures, included:

- Acceptance of meaningful use attestations involving Modified Stage 2 measures beginning on January 12, 2016;
- Conducting seven onsite visits to physician offices;
- Holding 82 technical assistance calls;
- Responding to 640 emails received in the EHR meaningful use mailbox;
- Participation throughout the quarter in several Southeast Regional Collaboration for HIT/HIE (SERCH) calls;
- Monthly newsletters and occasional alerts distributed by the Bureau's EHR ListServ; and
- A quarterly reminder to Tennessee providers who had registered at the federal level but who have not registered or attested at the state level.

TennCare continues to schedule EHR workshops with a variety of provider organizations to maintain the momentum of the program. Events planned for the spring of 2016, for instance, include participation in the statewide meeting of the Tennessee Medical Association. The Bureau is also making every effort to alert eligible professionals and eligible hospitals that 2016

[11] Of the 299 providers receiving first-year payments in the January-March 2016 quarter, 1 earned the incentive by successfully attesting to meaningful use of EHR technology in the first year of participation in the program.

is the last year in which they may enroll in the EHR program and begin attesting (as specified by the HITECH Act).

G. Award for General Counsel

On January 26, 2016, The Nashville Business Journal announced the winners of its annual "40 Under 40" distinction, which celebrates 40 professionals under the age of 40 for their excellence in business as well as contributions to their Middle Tennessee communities. TennCare General Counsel John G. (Gabe) Roberts was one of the individuals honored.

Mr. Roberts is a licensed Certified Public Accountant who worked in the Memphis office of Ernst & Young as an auditor of publicly traded and privately held Tennessee companies. After graduating from Vanderbilt University Law School, Mr. Roberts practiced law at the Nashville firm of Sherrard & Roe, where his business law practice intersected regularly with the health care industry and regulatory environment. He joined TennCare as its General Counsel in April 2013.

VI. Action Plans for Addressing Any Issues Identified

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

VII. Financial/Budget Neutrality Development Issues

Revenue collections were mixed—though mostly positive—during the January-March 2016 quarter. In two of the three months, total state and local revenue collections were higher than during the corresponding months of 2015, with a four percent improvement in February and a sixteen percent improvement in March. In January 2016, however, revenue collections were three percent lower than in January 2015.[12]

Employment prospects demonstrated positive and steady progress throughout the quarter. The unemployment rate fell from 5.4 percent in January to 4.9 percent in February and then to 4.5 percent in March. These figures represent an improvement on the results from one year ago, when the Tennessee unemployment rate exceeded six percent in all three months of the quarter. Furthermore, Tennessee reversed the gap between the state and national unemployment rates this quarter: Tennessee's unemployment rate was 0.5 percent higher than the national rate in January but was 0.5 percent lower than the national rate in March.[13]

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

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

VIII. Member Month Reporting

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

Table 13
Member Month Reporting for Use in Budget Neutrality Calculations
January – March 2016

Eligibility Group	January 2016	February 2016	March 2016	Sum for Quarter Ending 3/31/16
Medicaid eligibles (Type 1)				
EG1 Disabled, Type 1 State Plan eligibles	144,395	143,815	143,112	431,322
EG2 Over 65, Type 1 State Plan eligibles	130	162	191	483
EG3 Children, Type 1 State Plan eligibles	764,369	767,722	769,343	2,301,434
EG4 Adults, Type 1 State Plan eligibles	436,992	441,733	446,498	1,325,223
EG5 Duals, Type 1 State Plan eligibles	139,098	139,459	139,837	418,394
Demonstration eligibles (Type 2)				
EG8 Med Exp Child, Type 2 Demonstration Population, Optional Targeted Low Income Children funded by Title XIX	0	0	0	0
EG9 H-Disabled, Type 2 Demonstration Population	261	258	251	770
EG10 H-Over 65, Type 2 Demonstration Population	34	36	35	105
EG11 H-Duals, Type 2 Demonstration Population	6,020	5,993	6,020	18,033
TOTAL	1,491,299	1,499,178	1,505,287	4,495,764

Table 14
Member Month Reporting Not Used in Budget Neutrality Calculations
January – March 2016

Eligibility Group	January 2016	February 2016	March 2016	Sum for Quarter Ending 3/31/16
EG6E Expan Adult, Type 3, Demonstration Population	781	777	774	2,332
EG7E Expan Child, Type 3, Demonstration Population	57	56	56	169
Med Exp Child, Title XXI Demonstration Population	18,671	18,630	18,591	55,892
EG12E Carryover, Type 3, Demonstration Population	3,302	3,196	3,162	9,660
TOTAL	22,811	22,659	22,583	68,053

IX. Consumer Issues

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

Table 15
Eligibility Appeals for January – March 2016
Compared to the Previous Two Quarters

	Jul – Sept 2015	Oct – Dec 2015	Jan – Mar 2016
No. of appeals received	4,382	4,794	5,889
No. of appeals resolved or withdrawn	3,205	3,487	2,556
No. of appeals taken to hearing	1,966	1,380	2,617
No. of hearings resolved in favor of appellant[14]		210	342

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

[14] This category of eligibility appeals data has been added at CMS's request. The State is furnishing data not only for the current quarter but for one previous quarter as well (for purposes of comparison).

Table 16
Medical Service Appeals for January – March 2016
Compared to the Previous Two Quarters

	Jul – Sept 2015	Oct – Dec 2015	Jan – Mar 2016
No. of appeals received	2,149	2,188	2,064
No. of appeals resolved	1,800	2,285	2,033
• Resolved at the MCC level	795	972	828
• Resolved at the TSU level	132	209	177
• Resolved at the LSU level	873	1,104	1,028
No. of appeals that did not involve a valid factual dispute	235	264	261
No. of directives issued	201	315	295
No. of appeals taken to hearing	873	1,104	1,028
No. of appeals that were withdrawn by the enrollee at or prior to the hearing	293	333	342
Appeals that went to hearing and were decided in the State's favor	293	355	346
Appeals that went to hearing and were decided in the appellant's favor	28	43	48

By way of explanation:

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

- The "TSU" level is the TennCare Solutions Unit. The TSU might overturn the decision of the MCC and issue a directive requiring the MCC to approve provision of the service under appeal. Alternatively, if, following review, TennCare agrees with the MCC's decision, the appeal typically proceeds to TennCare's Legal Solutions Unit (LSU), where it is scheduled for administrative hearing before an Administrative Law Judge.

- The "LSU" level is the Legal Solutions Unit. This unit ensures that enrollees receive those procedural rights to which they are entitled under the law. LSU represents TennCare and its MCCs at administrative hearings and takes those steps necessary to ensure that such appeals come to a timely resolution.

LTSS Appeals. In the CMS letter approving CHOICES implementation in Middle Tennessee dated February 26, 2010, the Bureau was asked to monitor and provide information on CHOICES-specific appeals. In the approval letter sent to the State on August 3, 2010, CMS said that they looked forward to "continuing our collaboration with the State for monitoring the

CHOICES Program through sharing of standardized reports, monthly Demonstration monitoring calls, and the Quarterly and Annual Reports." The following table provides information regarding certain appeals administered by the Long-Term Services and Supports Division for the quarter, compared to the previous two quarters.

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

	Jul – Sept 2015	Oct – Dec 2015	Jan – Mar 2016
No. of appeals received	297	258	230
No. of appeals resolved or withdrawn	147	142	118
No. of appeals set for hearing	72	78	80
No. of hearings resolved in favor of appellant[15]		1	2

X. Quality Assurance/Monitoring Activity

Population Health. "Population Health" (PH) is TennCare's model of targeted health care interventions. Key benefits of PH include—

- Selection of a much larger portion of the TennCare population than had been attempted previously;
- Identification of risky behaviors likely to lead to disease in the future (such as poor eating habits, physical inactivity, and drug use);
- Assistance to enrollees in discontinuing such activities; and
- Interventions to assist enrollees who already have a complex chronic condition.

Enrollees are assigned to one of three levels of health risk and one of seven programs for reducing risk. Information on the risk levels addressed by PH, the manner in which these risks are addressed, and the total number of unique members enrolled in PH at the conclusion of the October-December 2015 quarter is provided in Table 18. Data for the period of January through March 2016 will be provided in the next Quarterly Progress Report.

[15] This category of LTSS appeals data has been added at CMS's request. The State is furnishing data not only for the current quarter but for one previous quarter as well (for purposes of comparison).

Table 18
Population Health Data*, October – December 2015

Risk Level	Intervention Type	Intervention Goal(s)	Number of Unique Members at End of Quarter
Level 0: no identified risk	Wellness Program	Keep members healthy as long as possible	772,628
Level 1: low or moderate risk	Maternity Program	Engage pregnant women in timely prenatal care and deliver a healthy, term infant without complications	16,703
	Health Risk Management	Prevent, reduce, or delay exacerbation and complications of a condition or health risk behavior	619,908
	Care Coordination	Assure that members receive the services they need to reduce the risk of an adverse health outcome	26,657
Level 2: high risk	Chronic Care Management	Provide intense self-management education and support to members with multiple chronic conditions to improve their quality of life, health status, and use of services	5,426
	High Risk Pregnancy Management	Engage pregnant women in timely prenatal care and deliver a healthy, term infant without complications	2,201
	Complex Case Management	Move members to optimal levels of health and well-being through timely coordination of quality services and self-management support	918
Total PH Enrollment			**1,444,441**

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

Provider Data Validation Report. In January 2016, TennCare's External Quality Review Organization (EQRO), Qsource, published the results of its provider data validation survey for the October-December 2015 quarter. Qsource took a sample of provider data files from TennCare's MCCs[16] and reviewed each for accuracy in the following categories:

- Contract status with MCC
- Provider address

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

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

The validity of such information is one measure of providers' availability and accessibility to TennCare enrollees. Qsource's report concluded that "[o]verall, the MCCs' accuracy rates have maintained a high level," especially in the categories of "active contract status with MCC" (98.1 percent accuracy), "provider credentialed specialty / behavioral health service code" (96.2 percent accuracy), "routine care services" (96.5 percent accuracy), "urgent care services" (97.0 percent accuracy), "primary care services" (99.5 percent accuracy), and "prenatal care services" (99.7 percent accuracy).

Because October-December 2015 was only the fourth quarter in which all of the MCOs delivered services statewide, the results of the survey were not entirely comparable to results achieved by the MCOs during the corresponding quarters of 2014, when accuracy was measured on a regional basis. Compared with the first three quarters of the statewide approach, however, the MCCs—according to the report—"have maintained relatively high accuracy rates this quarter." Nonetheless, to ensure ongoing improvement in all ten categories of the survey, TennCare required each of its MCCs to submit a Corrective Action Plan no later than March 7, 2016. The Bureau, in turn, had received, reviewed, and accepted all of the plans by March 10, 2016. Results for the January-March 2016 quarter will be discussed in the next Quarterly Progress Report.

XI. Demonstration Evaluation

On October 30, 2015, in compliance with STC 47, the State submitted to CMS its Draft Annual Report for Demonstration Year 13. Part V of that report provided the progress to date on the performance measures outlined in the approved Evaluation Design. It is the State's intention to provide updated information on the performance measures in each Annual Report.

Furthermore, on November 18, 2015, the State submitted to CMS its annual update of the strategy to evaluate and improve the quality and accessibility of care offered to enrollees through the managed care network. The document, entitled *2015 Annual Update Report of the 2013 Quality Assessment and Performance Improvement Strategy*, remains available on TennCare's website.

In addition, on December 22, 2015, the State submitted its application to renew the TennCare Demonstration, Part VI of which was an Interim Evaluation Report addressing progress in three areas: 1) medical and behavioral health measures; 2) efficiency, stability, and viability measures; and 3) measures for the TennCare CHOICES program. During subsequent negotiations on the renewal application, CMS expressed interest in revisiting the State's Evaluation Design.

XII. Essential Access Hospital Pool[17]

A. Safety Net Hospitals

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

B. Children's Hospitals

LeBonheur Children's Medical Center
East Tennessee Children's Hospital

C. Free Standing Psychiatric Hospitals

Pathways of Tennessee
Ridgeview Psychiatric Hospital and Center
Rolling Hills Hospital

D. Other Acute Care Hospitals

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

[17] 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.

TriStar Skyline Medical Center (with Madison campus)
Wellmont Holston Valley Medical Center
University Medical Center (with McFarland Psych)
Parkridge East Hospital
Saint Francis Hospital
Saint Thomas Rutherford Hospital
Lincoln Medical Center
Saint Thomas Midtown Hospital
Maury Regional Hospital
Baptist Memorial Hospital for Women
Wellmont Bristol Regional Medical Center
Cookeville Regional Medical Center
Fort Sanders Regional Medical Center
Tennova Healthcare – Physicians Regional Medical Center
Blount Memorial Hospital
Delta Medical Center
TriStar Summit Medical Center
TriStar StoneCrest Medical Center
Skyridge Medical Center
Southern Hills Medical Center
NorthCrest Medical Center
Gateway Medical Center
TriStar Horizon Medical Center
Sumner Regional Medical Center
Morristown – Hamblen Healthcare System
Dyersburg Regional Medical Center
Baptist Memorial Hospital – Tipton
Methodist Medical Center of Oak Ridge
TriStar Hendersonville Medical Center
Jellico Community Hospital
LeConte Medical Center
Harton Regional Medical Center
Takoma Regional Hospital
Tennova Healthcare – LaFollette Medical Center
Grandview Medical Center
Baptist Rehabilitation – Germantown
Skyridge Medical Center – Westside
Southern Tennessee Medical Center
United Regional Medical Center and Medical Center of Manchester
Sycamore Shoals Hospital
Indian Path Medical Center
Lakeway Regional Hospital
Roane Medical Center
Laughlin Memorial Hospital

Starr Regional Medical Center – Athens
Regional Hospital of Jackson
Hardin Medical Center
Crockett Hospital
Henry County Medical Center
Stones River Hospital
Wellmont Hawkins County Memorial Hospital
River Park Hospital
Jamestown Regional Medical Center
Hillside Hospital
Livingston Regional Hospital
Heritage Medical Center
Baptist Memorial Hospital – Union City
McNairy Regional Hospital
Claiborne County Hospital
McKenzie Regional Hospital
Erlanger Health System – East Campus
Henderson County Community Hospital
Volunteer Community Hospital
Wayne Medical Center
DeKalb Community Hospital
Cumberland River Hospital
Decatur County General Hospital
Baptist Memorial Hospital – Huntingdon
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 universities are listed below:

Universities	Hospitals
East Tennessee State University	Mountain State Health Alliance Wellmont ETSU Quillen Mission Hospital

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

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Attachment A

Budget Neutrality Calculations for the Quarter

Actual TennCare Budget Neutrality (January - March 2016)

I. The Extension of the Baseline

Baseline PMPM

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

Actual Member months of Groups I and II

1-Disabled (can be any ages)	432,092
2-Child <=18	2,301,434
3-Adult >= 65	483
4-Adult <= 64	1,325,223
Duals (17)	436,427
Total	4,495,659

Ceiling without DSH

	Baseline * MM
1-Disabled (can be any ages)	$745,268,171
2-Child <=18	$1,152,698,855
3-Adult >= 65	$540,175
4-Adult <= 64	$1,338,393,361
17s	$311,802,167
Total	**$3,548,702,729**

DSH

DSH Adjustment (Quarterly)	$115,999,213

Total Ceiling

Budget Neutrality Cap	
Total w/DSH Adj.	**$3,664,701,942**

II. Actual Expenditures

Group 1 and 2

1-Disabled (can be any ages)	$ 544,105,130
2-Child <=18	$ 473,505,367
3-Adult >= 65	$ 208,674
4-Adult <= 64	$ 459,664,956

Duals (17)	$	348,393,753
Total		**1,825,877,881**

Group 3

1-Disabled (can be any ages)	$	-
2-Child <=18	$	12,910,960
3-Adult >= 65	$	44,526,134
4-Adult <= 64	$	813,293
Duals (17)	$	-
Total		**58,250,388**

Pool Payments and Admin

Total Pool Payments		167,263,608

Admin	$	126,759,887

Quarterly Drug Rebates	$	(151,326,116)
Quarterly Premium Collections	$	-
Total Net Quarterly Expenditures	**$**	**2,026,825,648**

III. Surplus/(Deficit)

	$1,637,876,294
Federal Share	**$1,065,192,848**

HCI Result	MM201601	MM201602	MM201603	TOTAL	HCI ASO	HCI Rx	HCI DTL	HCI MCO CAP (TCS Admin)	UNK Allocation	TOTAL
EG1-TYPE1 (disabled, type1 state plan eligibles)	144,395	143,815	143,112	431,322	$75,588,035	$135,132,359	$1,741,429	$328,600,992	(1,219,706)	$539,843,109
EG1-TYPE2 (disabled, type2 transition group)	0	0	0	0	$0	$0	$0	$0	-	$0
EG2-TYPE1 (over 65, type1 state plan eligibles)	130	162	191	483	$7,155	$28,405	$0	$173,508	(394)	$208,674
EG2-TYPE2 (over 65, type2 state plan eligibles)	0	0	0	0	$0	$0	$0	$0	-	$0
EG3-TYPE1 (children, type1 state plan eligibles)	764,369	767,722	769,343	2,301,434	$11,875,494	$75,569,667	$32,735,660	$354,397,621	(1,073,074)	$473,505,367
Med Exp Child (Title XXI Demo Pop; EG3-Type2)	18,671	18,630	18,591	55,892	$582,302	$3,256,836	$1,080,310	$7,970,889	(28,840)	$12,861,496
EG4-TYPE1 (adults, type1 State plan eligibles)	436,992	441,733	446,498	1,325,223	$1,630,860	$79,147,738	$2,965,688	$376,967,090	(1,046,420)	$459,664,956
EG4-TYPE2 (adults, type2 demonstration pop)	0	0	0	0	$0	$0	$0	$0	-	$0
EG5-TYPE1 (duals, state plan eligibles)	139,098	139,459	139,837	418,394	$1,201,629	$1,266,660	$940,876	$286,338,831	(655,567)	$289,092,430
EG6E-TYPE3 (Expan adult, type3 demonstration pop)	781	777	774	2,332	$0	$151,196	$5,234	$658,682	(1,818)	$813,293
EG7E-TYPE3 (Expan child, type3 demonstration pop)	57	56	56	169	$754	$23,310	$2,165	$23,344	(110)	$49,464
EG8-TYPE2 (med exp child)	0	0	0	0	$0	$0	$0	$0	-	$0
EG9 H-Disabled (TYPE 2 Eligibles)	261	258	251	770	$0	$322,378	$6,154	$3,948,199	(14,711)	$4,262,020
EG10 H-Senior	34	36	35	105	$0	$8,424	$0	$573,841		$582,265
EG11H, H-Dual	6,020	5,993	6,020	18,033	$1,542	$13,040	$9,711	$59,407,582	(130,553)	$59,301,323
EG12E, Carryovers	3,302	3,196	3,162	9,660	$0	$142,170	$11,453	$43,886,363	(96,117)	$43,943,870
Total	**1,514,110**	**1,521,837**	**1,527,870**	**4,563,817**	**$90,887,771**	**$295,062,182**	**$39,498,681**	**$1,462,946,943**	**-$4,267,309**	**$1,884,128,269**

HCI Result	MM201601	MM201602	MM201603	TOTAL	HCI ASO PMPM	HCI Rx PMPM	HCI DTL PMPM	HCI MCO CAP (TCS Admin)	UNK Allocation	TOTAL
EG1-TYPE1 (disabled, type1 state plan eligibles)	144,395	143,815	143,112	431,322	$175.25	$313.30	$4.04	$761.85	-$2.83	$1,251.60
EG1-TYPE2 (disabled, type2 transition group)	0	0	0	-						
EG2-TYPE1 (over 65, type1 state plan eligibles)	130	162	191	483	$14.81	$58.81	$0.00	$359.23	-$0.82	$432.04
EG2-TYPE2 (over 65, type2 state plan eligibles)	0	0	0	-	-	-	-	-	-	-
EG3-TYPE1 (children, type1 state plan eligibles)	764,369	767,722	769,343	2,301,434	$5.16	$32.84	$14.22	$153.99	-$0.47	$205.74
Med Exp Child (Title XXI Demo Pop; EG3-Type2)	18,671	18,630	18,591	55,892	$10.42	$58.27	$19.33	$142.61	-$0.52	$230.11
EG4-TYPE1 (adults, type1 State plan eligibles)	436,992	441,733	446,498	1,325,223	$1.23	$59.72	$2.24	$284.46	-$0.79	$346.86
EG4-TYPE2 (adults, type2 demonstration pop)	0	0	0	-						
EG5-TYPE1 (duals, state plan eligibles)	139,098	139,459	139,837	418,394	$2.87	$3.03	$2.25	$684.38	-$1.57	$690.96
EG6E-TYPE3 (Expan adult, type3 demonstration pop)	781	777	774	2,332	$0.00	$64.84	$2.24	$282.45	-$0.78	$348.75
EG7E-TYPE3 (Expan child, type3 demonstration pop)	57	56	56	169	$4.46	$137.93	$12.81	$138.13	-$0.65	$292.69
EG8-TYPE2 (emd exp child)	0	0	0	-						
EG9 H-Disabled (TYPE 2 Eligibles)	261	258	251	770	$0.00	$418.67	$7.99	$5,127.53	-$19.10	$5,535.09
EG10 H-Senior	34	36	35	105	$0.00	$80.23	$0.00	$5,465.15	$0.00	
EG11H, H-Dual	6,020	5,993	6,020	18,033	$0.09	$0.72	$0.54	$3,294.38	-$7.24	$3,288.49
EG12E, Carryovers	3,302	3,196	3,162	9,660	$0.00	$14.72	$1.19	$4,543.10	-$9.95	$4,549.05
Total	**1,514,110**	**1,521,837**	**1,527,870**	**4,563,817**	**$19.91**	**$64.65**	**$8.65**	**$320.55**	**-$0.94**	**$412.84**

* Unknown allocation was performed within the Service category totals.