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

November 30, 2012

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 July-September 2012 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 July - September 2012)

Demonstration Year: 11 (7/1/12 - 6/30/13)
Federal Fiscal Quarter: 4/2012 (7/12 - 9/12)
Waiver Quarter: 1/2013 (7/12 - 9/12)

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 #
7/1/12	The provisions of Waiver Amendment 14—increasing the Enrollment Target for CHOICES Group 2, opening Interim CHOICES Group 3, and adding a sixth item to the list of factors that are not considered "hardships" in granting requests for changes in MCO assignment—went into effect.	7, 18, 21, and 34
7/1/12	Changes to CHOICES benefits described in Attachment D of the STCs—specifically, the blending of homemaker services into the personal care and attendant care benefits—went into effect.	7, 30, 34, and Attachment D
7/5/12	The State and CMS held the monthly call that had been postponed from June 2012.	46
7/10/12	The State accepted the STCs, Waiver List, and Expenditure Authorities associated with CMS's approval of Waiver Amendments 14 and 16 on 6/15/12. A short list of technical corrections was submitted to CMS.	
7/16/12	CMS issued a letter acknowledging receipt of the State's 6/29/12 application to extend the TennCare II Waiver and confirming its completeness.	
7/17/12	The State submitted the following signed contract amendments to CMS: Amendment 9 to the East/West	45.a.

Date	Action	STC #
	Tennessee Contractor Risk Agreement (CRA), Amendment 12 to the Middle Tennessee CRA, and Amendment 28 to the TennCare Select contract.	
7/26/12	The State and CMS held the monthly call.	46
7/27/12	The State submitted both the Medicaid Eligibility Quality Control (MEQC) Report for Federal Fiscal Year (FFY) 2011 and the MEQC Review Plan for FFY 2013 to CMS.	25
8/1/12	The State submitted the "2012 Quality Assessment and Performance Improvement Strategy and Quality Strategy: Annual Update Report" to CMS.	45.c.
8/3/12	Several CMS staff persons contacted TennCare Director Darin Gordon regarding the State's application to extend the TennCare II Waiver. Issues discussed included the abbreviated approval schedule associated with an 1115(f) extension, as well as the possibility of a six-month extension (instead of one lasting three years) to accommodate the expansion population in 2014.	
8/9/12	The State and CMS held the first bi-weekly conference call to discuss the State's application to extend the TennCare II Waiver. (Bi-weekly calls are being scheduled in addition to the regular monthly calls required by STC 46.) As a follow-up to the 8/3/12 call, the State expressed its preference for a three-year extension that enables the State to amend the Waiver if it should decide to add the expansion population at any time after 1/1/14.	
8/9/12	The State proposed additional technical corrections to the STCs beyond the list submitted on 7/10/12.	
8/13/12	CMS approved Amendment 9 to the East/West Tennessee CRA, Amendment 12 to the Middle Tennessee CRA, and Amendment 28 to the TennCare Select contract.	
8/13/12	CMS issued a letter acknowledging that the State's application to extend the TennCare II Waiver had been submitted timely and declaring CMS's intention to review the Special Terms and Conditions of the current demonstration project.	
8/22/12	At CMS's request, the State submitted reworked enrollment and member month data that had been due with the Quarterly Progress Report for the January-March 2012 quarter.	47, 51, and 54
8/23/12	The State and CMS held the monthly call. Seven questions related to the current approval materials were discussed.	46
8/30/12	The State submitted the Quarterly Progress Report for the	47

Date	Action	STC #
	April-June 2012 quarter.	
9/7/12	The State submitted Amendment 29 to the TennCare Select contract to CMS for review and approval.	45.a.
9/13/12	The State and CMS held a bi-weekly conference call to discuss the State's application to extend the TennCare II Waiver.	
9/13/12	The Standard Spend Down eligibility category opened to new enrollment for the fifth time.	21.a. and Section XIII, Part III
9/14/12	The State transmitted the results of the annual Beneficiary Survey to CMS.	49
9/18/12	The State submitted a revised version of the TennCare Operational Protocol to CMS.	Section XIV
9/27/12	The State submitted its CHOICES Baseline Data Summary—including updated Point in Time statistics for Data Element A ("numbers of persons actively receiving HCBS and numbers of persons actively receiving NF services")—to CMS.	45.d.
9/27/12	CMS issued a letter announcing the start of a 30-day negotiation period concerning the State's application to extend the TennCare II Waiver.	
9/27/12	CMS cancelled the monthly call for September.	46

II. Enrollment and Benefits Information

Information about enrollment by category is presented in Table 2.

Table 2
Enrollment Counts for the July - September 2012 Quarter
Compared to the Previous Two Quarters

Demonstration Populations	Total Number of TennCare Enrollees		
	Jan – Mar 2012	Apr – June 2012	July – Sept 2012
EG1 Disabled, Type 1 State Plan eligibles	129,409	127,642	129,816
EG1 Disabled and EG9 H-Disabled, Type 2 Demonstration Population	4,277	4,345	4,171
EG2 Over 65, Type 1 State Plan eligibles	320	515	132

Demonstration Populations	Total Number of TennCare Enrollees		
	Jan – Mar 2012	Apr – June 2012	July – Sept 2012
EG2 Over 65 and EG10 H-Over 65, Type 2 Demonstration Population	32	35	37
EG3 Children, Type 1 State Plan eligibles	666,187	664,693	667,807
EG4 Adults, Type 1 State Plan eligibles	302,808	300,751	305,779
EG4 Adults, Type 2 Demonstration Population	0	0	0
EG5 Duals, Type 1 State Plan eligibles and EG11 H-Duals 65, Type 2 Demonstration Population[1]	146,345	143,087	144,007
EG6E Expan Adult, Type 3 Demonstration Population	1,187	1,086	1,263
EG7E Expan Child, Type 3, Demonstration Population[2]	2,355	2,163	2,683
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	18,591	17,332	19,797
EG12E Carryover, Type 3, Demonstration Population[3]	N/A	N/A	325
TOTAL *	1,271,511	1,261,649	1,275,817

*** 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.

[1] The EG11 H-Duals category did not open until July 1, 2012; therefore, its presence is not visible statistically until the July-September 2012 quarter. (Only 4 of the 144,007 individuals in this cell of the table are EG11 H-Duals.)

[2] This category includes individuals eligible under presumptive categories (exceeding 185% of FPL and under age 19).

[3] This category did not open until July 1, 2012; consequently, there are no enrollment figures for the January-March and April-June 2012 quarters. The enrollment count of 325 for the July-September 2012 quarter represents the number of TennCare members enrolled in the PACE program during that period rather than a fully updated accounting of the Carryover Groups for CHOICES 1, CHOICES 2, and PACE.

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 September 30, 2012

	West Tennessee	Middle Tennessee	East Tennessee
Managed Care Organizations	BlueCare[4] UnitedHealthcare Community Plan[5] TennCare Select[6]	Amerigroup UnitedHealthcare Community Plan TennCare Select	BlueCare UnitedHealthcare Community Plan TennCare Select
Pharmacy Benefits Manager	SXC Health Solutions Corp.		
Dental Benefits Manager	TennDent[7]		

Standard Spend Down. The TennCare Standard Spend Down (SSD) eligibility category opened to new enrollment for the fifth time on September 13, 2012 (following previous periods of open enrollment on October 4, 2010, February 22, 2011, September 12, 2011, and February 21, 2012). SSD is available through an amendment to the TennCare Waiver[8] 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.

During the open enrollment period, the Department of Human Services (DHS) received 2,731 calls in less than one hour. As a result, 2,626 callers not already covered by TennCare were invited to apply for SSD. As of the end of the quarter, the announced deadline for submitting an application was October 31, 2012.

[4] 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.
[5] UnitedHealthcare Community Plan, formerly known as "AmeriChoice," is operated by UnitedHealthcare Plan of the River Valley, Inc.
[6] TennCare Select is operated by Volunteer State Health Plan, Inc. (VSHP).
[7] TennDent is operated by Delta Dental.
[8] See Expenditure Authority 7.b.ii and Special Term and Condition #21.a of the TennCare Waiver, a copy of which is available online at http://www.tn.gov/tenncare/forms/tenncarewaiver.pdf.

III. Innovative Activities to Assure Access

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

Table 4
Department of Health
Community Outreach Activity for EPSDT
July – September 2012 Compared to the Previous Two Quarters

Activities	Jan – Mar 2012	Apr – June 2012	July – Sept 2012
Number of educational materials distributed	200,969	212,881	204,277
Number of outreach activities/events	4,453	3,746	3,444
Number of people made contact with (mostly face to face at outreach events)	132,157	147,939	167,903
Number of coalitions/advisory board meetings presided over	32	24	26
Number of attendees at coalitions/advisory board meetings	417	419	287
Number of educational preventive health radio/TV broadcasts[9]	11,131	12,807	8,994
Number of educational preventive health newsletter/magazine articles[10]	116	119	151
Number of educational preventive health billboards, scrolling billboards and bulletin boards	3,884	4,056	3,328
Number of presentations made to enrollees/professional staff who work with enrollees	530	339	323
Number of individuals attending presentations	11,554	8,402	6,831
Number of immunization reminder telephone calls made to households[11]	93	224	169
Number (approx) of completed telephone calls re: importance of immunizations	46	79	83

[9] 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.
[10] The number of such articles varies from quarter to quarter according to the opportunities for no-cost publication made available by local media outlets.
[11] Quarterly variations in this category are attributable to the number of referrals made by the federally funded Women, Infants, and Children program.

Activities	Jan – Mar 2012	Apr – June 2012	July – Sept 2012
Number of attempted home visits (educational materials left with these families)	16,471	15,418	18,161
Number of home visits completed	8,455	8,204	8,760
Number of outreach activities to the homeless[12]	52 events	57 events	51 events

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
July - September 2012 Compared to the
Previous Two Quarters

Activities	Jan – Mar 2012	Apr – June 2012	July – Sept 2012
Number of families reached	53,524	48,714	51,181
Number of families who were assisted in scheduling an EPSDT exam for their children	2,386	2,916	3,113
Number of families who were assisted in arranging for transportation	123	130	146

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.

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

Table 6
Number of Initial Encounters Received by TennCare During the July – September 2012 Quarter, and Percentage that Passed Systems Edits, Compared to the Previous Two Quarters

	Jan – Mar 2012	Apr – June 2012	July – Sept 2012
No. of encounters received by TennCare (initial submission)	14,511,650[13]	11,466,818	10,146,567
No. of encounters rejected by Edifecs upon initial submission	44,313	57,371	214,186[14]
Percentage of encounters that were compliant with State standards (including HIPAA) upon initial submission	99.69%	99.50%	97.89%

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 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 options that are available to meet the needs of adults who are elderly or who have physical disabilities and who require Nursing Facility care. Fulfillment of this goal is proceeding apace, as the percentage of individuals receiving long-term services and supports in the community has increased from 17 percent of the LTSS population when CHOICES began to just over 36 percent by the conclusion of September 2012.

The following table delineates CHOICES enrollment in Tennessee as of the end of the quarter. The table also provides reserve slot information per STC #34.e.iii.(A).

[13] The number of encounter claims received by TennCare was higher than normal during the January-March 2012 quarter because of a reprocessing effort undertaken by UnitedHealthcare. Extraction errors by the MCO in reference to 837 Institutional (also known as "837I") claims necessitated the reprocessing, which consisted of voiding erroneous encounters and resubmitting corrected encounters.

[14] Rejections rose substantially 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.

Table 7
TennCare CHOICES Enrollment and Reserve Slots
for July – September 2012 Compared to the Previous Two Quarters

	Statewide Enrollment Targets and Reserve Capacity	Enrollment and Reserve Slots Being Held as of the End of Each Quarter		
		Jan – Mar 2012	Apr – June 2012	July – Sept 2012
CHOICES 1	Not applicable[15]	20,904	20,966	20,761
CHOICES 2	11,000	10,440	10,482	10,352
Interim CHOICES 3[16]	Not applicable	Not applicable	Not applicable	1,366
Total CHOICES	Not applicable	31,344	31,448	32,479
Reserve capacity	300	300	300	300

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

Data and trends of the designated CHOICES data elements: STC #45.d. requires the State to submit to CMS periodic statistical reports about the use of Long-Term Services and Supports (LTSS) within the TennCare program. Each report includes nine categories of data (or "data elements"), which—taken together—provide a comparison between the use of Nursing Facility care and the use of Home and Community Based Services (HCBS) by TennCare enrollees. Three such reports have been submitted to CMS so far:

- On August 31, 2011, the State provided a statistical portrait of LTSS utilization before the CHOICES program was implemented in 2010.
- On June 28, 2012, the State submitted a side-by-side comparison of the pre-CHOICES utilization data with a year's worth of post-implementation data.
- On September 27, 2012, the State offered updated Point in Time statistics concerning persons actively receiving HCBS and persons actively receiving NF services.

These reports indicate not only that CHOICES is providing the full spectrum of services required by one of the most vulnerable TennCare populations, but also that the services are successfully reaching the individuals for whom they were designed. The number of TennCare enrollees accessing HCBS, for instance, grew from 6,226 in the twelve-month period preceding CHOICES implementation to 9,789 once CHOICES had been in place for a year. Program snapshots

[15] Only CHOICES 2 has an enrollment target.
[16] The Interim CHOICES 3 category approved by CMS as part of Waiver Amendment 14 did not open until July 1, 2012.

comprising the Point in Time data mirrored the trends of the aggregate data. On the day before CHOICES was implemented, the number of individuals using HCBS was 4,861. This number had grown to 8,543 on June 30, 2011, and still further to 10,482 on June 30, 2012. Nursing Facility services, furthermore, remained available to the enrollees with the highest acuity of need, as the number of individuals receiving such care totaled 21,530 on June 30, 2011, and 20,968 on June 30, 2012.

Although the evolution of TennCare's LTSS program depicted in these numbers (and in Table 7) is a gradual one, the State continues to capitalize on innovative opportunities for expanding options, as demonstrated by the opening of Interim CHOICES 3 on July 1, 2012, and the progress of the "Money Follows the Person" (or "MFP") program.

Frequency and use of MCO-distributed transition allowances (CHOICES approval letter dated February 26, 2010): The allocation of CHOICES transition allowance funds is detailed in Table 8.

Table 8
TennCare CHOICES Transition Allowances
for July – September 2012 Compared to the Previous Two Quarters

	Frequency and Use of Transition Allowances[17]					
	Jan – Mar 2012		**Apr – June 2012**		**July – Sept 2012**	
Grand Region	# Distributed	Total Amount	# Distributed	Total Amount	# Distributed	Total Amount
East	7	$10,429.00	13	$18,249.75	17	$25,899.64
Middle	8	$11,798.00	18	$22,148.59	11	$14,535.66
West	7	$10,341.00	11	$13,651.47	16	$29,570.36
Statewide Total	22	$32,568.00	42	$54,049.81	44	$70,005.66

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

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

[17] 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.

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) Second Quarter 2012 Financial Statement. As of June 30, 2012, TennCare MCOs reported net worth as indicated in the table below.[18]

Table 9
Net Worth Reported by MCOs as of June 30, 2012

	Net Worth Requirement	Reported Net Worth	Excess/ (Deficiency)
Amerigroup Tennessee	$17,551,988	$94,570,941	$77,018,953
UnitedHealthcare Plan of the River Valley (UnitedHealthcare Community Plan)	$62,651,284	$481,256,798	$418,605,514
Volunteer State Health Plan (BlueCare & TennCare Select)	$34,832,427	$196,627,600	$161,795,173

[18] 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.

All TennCare MCOs met their minimum net worth requirements as of June 30, 2012.

C. Application to Renew the TennCare Waiver

Unlike traditional fee-for-service Medicaid programs, TennCare is a demonstration project. In exchange for a waiver of certain federal statutes and regulations governing Medicaid, TennCare "demonstrates" the principle that a managed care approach to health care can extend coverage to people who would not otherwise be eligible for Medicaid without increasing expenditures or diminishing the quality of care. One limitation imposed on demonstration projects, however, is that they may operate only for finite periods of time (referred to as "approval periods") before having to be renewed.

Although the TennCare Demonstration does not expire until June 30, 2013, the Bureau filed its renewal application with the Centers for Medicare and Medicaid Services (CMS) on June 29, 2012, to comply with provisions in federal regulation and the Waiver requiring submission a year in advance.[19] The Bureau requested a three-year extension, through June 30, 2016. CMS is currently reviewing the extension request in light of federal changes that are scheduled to take place under the Affordable Care Act on January 1, 2014.

D. Annual Beneficiary Survey

On September 14, 2012, in compliance with STC 49 of the TennCare Waiver, TennCare submitted the results of the annual Beneficiary Survey to CMS.

The Beneficiary Survey (entitled *The Impact of TennCare: A Survey of Recipients, 2012*, but occasionally referred to as the "Patient Satisfaction Survey") records the impressions of Tennessee citizens—TennCare enrollees, individuals with private insurance, and uninsured individuals alike—on the quality of the health care they receive. The survey of 5,000 households has been conducted by the University of Tennessee's Center for Business and Economic Research (CBER) since 1993 and, as a result, provides a valuable perspective on how Tennesseans have viewed health care issues and the TennCare program over time.

Although the findings of a single survey must be viewed in context of long-term trends, several results from 2012 are noteworthy:

- The estimated number of "uninsured" Tennesseans (577,813) is at its lowest point since 2008.
- The percentage of respondents classifying themselves as "uninsured" (9.2 percent) is at its lowest point since 2005.

[19] See 42 C.F.R. § 431.412(c) and Special Term and Condition #8 of the TennCare Waiver.

- 93 percent of respondents covered by TennCare expressed satisfaction with the quality of care they had received. This level of satisfaction is one of the highest in the program's history.
- The vast majority of respondents covered by TennCare report that they seek initial medical care for themselves (89 percent) and for their children (97 percent) at a doctor's office or clinic instead of at the hospital. These figures are significant because seeking initial medical care at the emergency room (in the absence of an emergency) is clearly less cost-effective than seeking this care at a doctor's office or clinic.

Such statistics illustrate the report's concluding observation that "TennCare continues to receive positive feedback from its recipients, indicating the program is providing medical care in a satisfactory manner and up to the expectations of those it serves."

CBER published the Beneficiary Survey report in September 2012. It may be viewed online at http://cber.bus.utk.edu/tncare/tncare12.pdf.

E. Electronic Health Record Incentive Program

The Electronic Health Record (EHR) Incentive Program is a partnership between federal and state governments that grew out of the Health Information Technology for Economic and Clinical Health (HITECH) Act. The purpose of the program, as its name suggests, is to provide financial incentives to Medicaid providers[20] to replace outdated, often paper-based approaches to medical record-keeping with an electronic system that meets 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 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 July-September 2012 quarter as compared with payments made throughout the life of the program appear in the table below:

[20] CMS allows two types of providers to participate in the Medicaid EHR Incentive Program: medical professionals (physicians, nurse practitioners, certified nurse midwives, dentists, and certain kinds of physician assistants) and hospitals (acute care hospitals, critical access hospitals, and children's hospitals).

Table 10
EHR First-Year and Second-Year Payments
Quarterly and Cumulative

Payment Type	Number of Providers	Quarterly Amount Paid (July-Sept 2012)	Cumulative Amount Paid To Date
First-year payments	246 providers (155 physicians, 56 nurse practitioners, 20 dentists, 7 certified nurse midwives, 6 hospitals, and 2 physician assistants)	$11,516,941.00	$94,140,059.97
Second-year payments	80 providers (44 physicians, 32 nurse practitioners, and 4 hospitals	$1,558,165.00	$2,104,863.00

Outreach efforts conducted during the quarter included the mailing of individualized inquiries to nearly 400 providers in two categories: those who had completed TennCare's EHR registration process but had not attested to meeting applicable criteria, and those who had completed CMS's EHR registration process but had not logged into TennCare's Provider Incentive Payment Program (PIPP) web portal for more than 90 days. That these providers had demonstrated interest in the program without actually earning payments made them ideal targets for renewed contact.

Other outreach activities included:

- Co-hosting an attestation webinar with Qualifacts Systems, Inc. on July 16;
- Making a presentation at the TennCare Dental Advisory Committee Meeting on August 31;
- Participating in Tennessee Medical Association workshops in six different cities during September; and
- Addressing payment and meaningful use issues at the September 11 meeting between TennCare and the Tennessee Chapter of the American Academy of Pediatrics.

Such activities complement TennCare's considerable online resources devoted to these subjects, some facets of which are a dedicated webpage (located at http://www.tn.gov/tenncare/ehr_intro.shtml) and newsletters distributed by the Bureau's EHR ListServ.

F. Request for Proposals for Pharmacy Benefits Management

With less than a year remaining until the contract between TennCare and pharmacy benefits manager (PBM) SXC Health Solutions[21] expires on May 31, 2013, the State issued a request for proposals (RFP) for a new pharmacy benefits manager on August 3, 2012.

According to the "Scope of Services" portion of the RFP document (available online at http://tn.gov/generalserv/purchasing/ocr/documents/31865-00346_001.pdf), actual delivery of services would begin on June 1, 2013, but would be preceded by a six-month period of "readiness review" to ensure proper benefits implementation, so that no disruptions of service occur. Responsibilities of the PBM include:

- Design, implementation, and operation of an online system of claims management, adjudication, and payment;
- Management of TennCare's Preferred Drug List;
- Reviewing enrollees' patterns of prescription drug use and providers' prescribing habits for possible fraud, abuse, and/or waste;
- Operation of a Prior Authorization Review Unit to review and adjudicate requests for non-preferred drugs and requests for preferred drugs that do not conform to established guidelines;
- Operation of a Pharmacy Help Desk that responds to pharmacies' questions concerning systems and claims issues; and
- Furnishing an adequate network of retail, specialty, and long-term care pharmacies throughout the state.

Comments and questions from potential bidders occupy 26 pages of the RFP document, suggesting that interest in the contract with TennCare is substantial. As of the conclusion of the quarter, the deadline for submission of a proposal was October 15, 2012.

G. Name Change for Pharmacy Benefits Manager

Following the completion of its merger with Catalyst Health Solutions on July 2, 2012, TennCare Pharmacy Benefits Manager (PBM) SXC Health Solutions announced on July 10 that the company's name had changed to Catamaran. Although SXC's acquisition of Catalyst made Catamaran the nation's fourth largest PBM by prescription volume, the effect of the merger on TennCare enrollees is expected to be minimal: neither the Bureau's coverage of prescription drugs nor the network of pharmacies serving the TennCare population has been affected. While the "TennCare Pharmacy Program" website (located at https://tnm.rxportal.sxc.com/rxclaim/portal/preLogin) now displays the Catamaran insignia and includes provider notices reflecting the name change, member materials will not bear the company's new name until January 2013. A notice mailed to all enrollees on September 28,

[21] SXC recently changed its name to "Catamaran." Additional information about this development appears in the next update (entitled "Name Change for Pharmacy Benefits Manager").

2012, summarizes this development and informs recipients that they will receive a new pharmacy card.

H. Recognition of TennCare

In August 2012, Mercy Children's Clinic, a non-profit provider of medical care to disadvantaged children in Williamson County, honored TennCare with a Certificate of Recognition. The award commends the Bureau's "outstanding dedication in collaborative partnership to provide health care services to the underserved in Tennessee." TennCare Medical Director Jeanne James accepted the certificate on behalf of the Bureau.

The stated mission of Mercy Children's Clinic, which has treated patients since 1999, is to "reflect the love and compassion of Jesus Christ by providing healthcare services to all children and support to their families."[22]

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

The July-September 2012 quarter was a study in contrasts with regard to Tennessee's economy. If the State's fiscal health were measured by revenue collections alone, Tennessee's outlook would be very positive. Statistics published by the Tennessee Department of Revenue showed that collections for all three months of the quarter were higher than those for the same months of 2011.[23] September 2012 was especially robust, with total State revenues exceeding those from September 2011 by nearly $65 million, a 6.4 percent improvement.

With respect to the unemployment rate, there was an increase to 8.4 percent in the third quarter.[24] Dr. David Penn, the Director of Middle Tennessee State University's Business and Economic Research Center, attributed this development to the ongoing difficulties in Europe: "Much of [Tennessee's] growth in manufacturing and business related to manufacturing have

[22] See the organization's "Mission/History" page, which is located online at http://mercytn.org/about-us-our-missionhistory/.

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

[24] 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 and at http://www.jobs4tn.gov/analyzer/searchAnalyzer.asp?cat=HST_EMP_WAGE_LAB_FORCE&session=LABFORCE&subsession=99&time=&geo=&currsubsessavail=&incsource=&blnStart=True.

had to do with exports, over the last 10 years or so anyway. As the markets—especially European markets—shrink, then demand for our exports drops."[25]

Nonetheless, grounds for cautious optimism remain. According to a report published by the University of Tennessee's Center for Business and Economic Research, one of the main obstacles to the State's recovery may be resolved in the near future: "A return to growth in the European Union, which is expected next year, will help lift the global economy and foster an improved outlook for exports from the U.S. and Tennessee."[26] The report concludes that this development—coupled with anticipated gains in the housing and light vehicle sectors of the economy—could revitalize growth within the State as soon as 2014.

VIII. Member Month Reporting

Tables 10 and 11 below present the member month reporting by eligibility group for each month in the quarter.

Table 11
Member Month Reporting for Use in Budget Neutrality Calculations
July - September 2012

Eligibility Group	July 2012	August 2012	September 2012	Sum for Quarter Ending 9/30/12
EG1 Disabled, Type 1 State Plan eligibles	127,803	127,527	126,957	382,287
EG1 Disabled, Type 2 Demonstration Population	0	0	0	0
EG9 H-Disabled, Type 2 Demonstration Population	4,201	4,153	4,092	12,446
EG2 Over 65, Type 1 State Plan eligibles	103	102	114	319
EG2 Over 65, Type 2 Demonstration Population	0	0	0	0
EG10 H-Over 65, Type 2 Demonstration Population	34	36	35	105
EG3 Children, Type 1 State Plan	648,785	652,021	652,564	1,953,370

[25] As quoted in Blake Farmer's "August Makes Four Months of Rising Unemployment," published by Nashville Public Radio on September 20, 2012, and available online at http://wpln.org/?p=41376.
[26] Murray, M., "Tennessee Business and Economic Outlook: The State's Economic Outlook Fall 2012," p. 7. Center for Business and Economic Research, University of Tennessee. The report is available online at http://cber.bus.utk.edu/tefs/fall12.pdf.

Eligibility Group	July 2012	August 2012	September 2012	Sum for Quarter Ending 9/30/12
eligibles				
EG4 Adults, Type 1 State Plan eligibles	282,595	284,265	284,886	851,746
EG4 Adults, Type 2 Demonstration Population	0	0	0	0
EG5 Duals, Type 1 State Plan eligibles	141,809	141,196	140,155	423,160
EG11 H-Duals, Type 2 Demonstration Population	4	2	2	8
EG8 Med Exp Child, Type 2 Demonstration Population, Optional Targeted Low Income Children funded by Title XIX	0	0	0	0
TOTAL	1,205,334	1,209,302	1,208,805	3,623,441

- **Rounding may cause a discrepancy between the sum of the quarterly averages and their respective totals.**

Table 12
Member Month Reporting Not Used in Budget Neutrality Calculations
July - September 2012

Eligibility Group	July 2012	August 2012	September 2012	Sum for Quarter Ending 9/30/12
EG6E Expan Adult, Type 3, Demonstration Population	1,206	1,203	1,189	3,598
EG7E Expan Child, Type 3, Demonstration Population	2,641	2,632	2,624	7,897
Med Exp Child, Title XXI Demonstration Population	17,888	18,812	19,054	55,754
EG12E Carryover, Type 3, Demonstration Population	320	317	316	953
TOTAL	22,055	22,964	23,183	68,202

IX. Consumer Issues

Eligibility Appeals. TennCare eligibility appeals are handled by the Tennessee Department of Human Services. Table 12 presents a summary of the number and types of eligibility appeals handled during the quarter, compared to the previous two quarters.

Table 13
Eligibility Appeals Handled by the Department of Human Services
During the July – September 2012 Quarter, Compared to the Previous Two Quarters

	Jan – Mar 2012	Apr – June 2012	July – Sept 2012
TennCare Medicaid			
No. of appeals received	3,971	3,589	3,551
No. of appeals resolved or withdrawn	1,906	1,532	1,331
No. of appeals taken to hearing	1,636	1,370	1,098
No. of appeals that did not involve a valid factual dispute	1,550	1,590	1,818
Appeals previously heard that were decided in the State's favor	1,044	928	731
Appeals previously heard that were decided in the appellant's favor	107	87	69
TennCare Standard			
No. of appeals received	228	125	108
No. of appeals resolved or withdrawn	114	48	41
No. of appeals taken to hearing	111	60	25
No. of appeals that did not involve a valid factual dispute	82	47	55
Appeals previously heard that were decided in the State's favor	71	45	22
Appeals previously heard that were decided in the appellant's favor	18	6	0

Medical Service Appeals. Medical service appeals are handled by the Bureau of TennCare. Table 13 below presents a summary of the medical service appeals handled during the quarter, compared to the previous two quarters.

Table 14
Medical Service Appeals Handled by the Bureau of TennCare
During the July – September 2012 Quarter, Compared to the Previous Two Quarters

	Jan – Mar 2012	Apr – June 2012	July – Sept 2012
No. of appeals received	1,254	1,145	1,256
No. of appeals resolved	1,350	1,203	1,119
• Resolved at the MCC level	504	511	483
• Resolved at the TSU level	214	193	188
• Resolved at the LSU level	632	499	448
No. of appeals that did not involve a valid	270	278	292

	Jan – Mar 2012	Apr – June 2012	July – Sept 2012
factual dispute			
No. of directives issued	198	172	152
No. of appeals taken to hearing	632	499	448
No. of appeals that were withdrawn by the enrollee at or prior to the hearing	248	181	139
Appeals that went to hearing and were decided in the State's favor	144	123	113
Appeals that went to hearing and were decided in the appellant's favor	27	15	13

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.

Long-Term Services and Supports Appeals. In the CMS letter approving CHOICES implementation in Middle Tennessee dated February 26, 2010, the Bureau was asked to monitor and provide information on CHOICES-specific appeals. In the approval letter sent to the State on August 3, 2010, CMS said that they looked forward to "continuing our collaboration with the State for monitoring the CHOICES Program through sharing of standardized reports, monthly Demonstration monitoring calls, and the Quarterly and Annual Reports." The following table provides information regarding certain appeals administered by the Long-Term Services and Supports Division for the quarter, compared to the previous two quarters.

Table 15
Long-Term Services and Supports Appeals for July – September 2012
Compared to the Previous Two Quarters

	Jan – Mar 2012	Apr – June 2012	July – Sept 2012
No. of appeals of PreAdmission Evaluation (PAE) denials	95	116	302[27]
No. of appeals of PASRR determinations	6	5	4
No. of appeals of denial of enrollment into CHOICES	15	23	13
No. of appeals of involuntary disenrollment from CHOICES	10	6	5
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 withdrawn prior to hearing	3	1	8
No. of appeals dismissed at hearing	10	17	7
No. of appeals that went to hearing and were decided in the State's favor	1	23[28]	3
No. of appeals that went to hearing and were decided in the appellant's favor	0	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

[27] The number of appeals related to PAE denials rose during the July-September 2012 quarter because of the enhanced Level of Care requirements introduced on July 1, 2012.

[28] The substantial increase in the number of appeals resolved in favor of the State during the April-June 2012 quarter is attributable to the fact that several cases continued in previous quarters were finally heard and decided during this period.

- 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 15. Figures for the period of July through September, 2012, will be provided in the next Quarterly Progress Report.

Table 16
DM Program Enrollment, April - June 2012
Compared to the Previous Two Quarters[29]

DM Program	Oct – Dec 2011		Jan – Mar 2012		Apr – June 2012	
	Non-CHOICES Members	CHOICES Members	Non-CHOICES Members[30]	CHOICES Members[31]	Non-CHOICES Members	CHOICES Members
Asthma	120,443	191	109,494	31	110,366	24
Bipolar	26,090	125	21,579	17	22,045	12
Chronic Obstructive Pulmonary Disease	9,086	407	3,712	55	3,636	57
Congestive Heart Failure	4,300	504	1,616	189	1,546	177
Coronary Artery Disease	8,681	266	4,978	55	4,962	48
Diabetes	26,341	1,082	16,501	524	15,865	481
HIV[32]	250	5	254	6	245	6

[29] 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. Nonetheless, as described in Footnote 30, efforts to reduce statistical duplication are underway.

[30] Lower numbers in several DM categories for non-CHOICES members during the January-March 2012 quarter do not reflect an actual decrease in enrollment; rather, they represent less duplication. Instead of counting one individual who suffers from both asthma and hypertension in both categories, for instance, the MCOs have begun counting such individuals in the "multiple conditions" category, a move that explains the doubling of the "multiple conditions" population this quarter. (Until 2012, MCOs' use of the "multiple conditions" designation varied: UnitedHealthcare Community Plan, for instance, had never previously assigned members to this category.)

[31] Continued declines in the enrollment of CHOICES members in DM programs during the January-March 2012 quarter are the result of protocols that were introduced at the end of 2011 but that did not begin to have an effect until 2012. These protocols include removing CHOICES 1 (Nursing Facility) members who have been determined incapable of DM participation and allowing CHOICES 2 (HCBS) members to opt out of DM enrollment.

[32] A DM program for HIV is not a requirement, but Amerigroup has chosen to have a program for this condition.

DM Program	Oct – Dec 2011		Jan – Mar 2012		Apr – June 2012	
	Non-CHOICES Members	CHOICES Members	Non-CHOICES Members[30]	CHOICES Members[31]	Non-CHOICES Members	CHOICES Members
Hypertension[33]	3,708	126	4,255	133	4,124	136
Major Depression	56,975	248	51,622	49	52,501	60
Maternity	15,720	0	15,853	0	16,414	0
Multiple Conditions	23,515	173	48,050[34]	279	50,258	264
Obesity	33,911	204	23,270	14	24,994	9
Other[35]	20,356	268	19,133	288	17,310	270
Schizophrenia	7,328	66	6,098	53	6,138	30
Total DM Enrollment	**356,704**	**3,665**	**326,415**	**1,693**	**330,404**	**1,574**
Total CHOICES and Non-CHOICES DM Enrollment	**360,369**		**328,108**		**331,978**	

Quality Improvement Strategy. As required by federal law,[36] federal regulation,[37] and the State's Waiver agreement with CMS,[38] TennCare has developed a strategy for evaluating and improving the quality and accessibility of care offered to enrollees through the managed care network. The Bureau submitted its annual update of the strategy—entitled "2012 Quality Assessment and Performance Improvement Strategy and Quality Strategy: Annual Update Report"—to CMS on August 1, 2012. In addition to laying out the measures of quality assurance already in place, the report outlines TennCare's goals and objectives for the year ahead. Although CMS had not completed its review of the report by the conclusion of the July-September quarter, last year's approved strategy remains available online at http://www.tn.gov/tenncare/forms/qualitystrategy2011.pdf.

Report on Pay-for-Performance Initiatives. During this quarter, a report was prepared on MCO pay-for-performance quality incentives. Table 16 shows the plans that met criteria for quality incentive payments in 2012.

[33] A DM program for Hypertension is not a requirement, but Amerigroup has chosen to have a program for this condition.
[34] The dramatic rise in enrollment in the "multiple conditions" category is explained in Footnote 30.
[35] Other conditions for which Amerigroup has chosen to establish DM programs include Transplants, End Stage Renal Disease, etc.
[36] 42 U.S.C. § 1396u-2(c)(1)(A)
[37] 42 C.F.R. § 438.202
[38] Special Term and Condition #45(c) of the TennCare Waiver, a link to which appears in Footnote 8.

Table 17
MCOs Meeting the Criteria for Quality Incentive Payments in 2012

MCO	Measures	Baseline (2011) Results	2012 Results	Change Required for Incentive	Change Achieved
Amerigroup	Adolescent Well-Care Visits	47.69%	53.72%	6.00%	6.03%
BlueCare West	HbA1C Control (poor > 9.0%)	48.28%	56.84%	6.00%	8.56%
UnitedHealthcare East	HbA1C Control (poor > 9.0%)	48.85%	58.42%	6.00%	9.57%
	HbA1C Testing	77.58%	84.36%	4.00%	6.78%
UnitedHealthcare Middle	HbA1C Control (poor > 9.0%)	45.77%	51.79%	6.00%	6.02%
	HbA1C Testing	75.00%	81.15%	4.00%	6.15%
UnitedHealthcare West	Follow-up After Hospitalization for Mental Illness: 7-day*	42.13%	67.58%	6.00%	25.45%
	Follow-up After Hospitalization for Mental Illness: 30-day*	63.46%	78.90%	5.00%	15.44%

***To be eligible for an incentive payment in either of these categories, the MCO must demonstrate sufficient improvement in both categories.**

Provider Data Validation Report. During September 2012, TennCare's External Quality Review Organization (EQRO), Qsource, published the results of its quarterly provider data validation survey. Qsource took a sample of provider data files from TennCare's MCCs[39] 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

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

The validity of such information is one measure of providers' availability and accessibility to TennCare enrollees. Qsource's report concluded that "[o]verall, the MCCs' accuracy rates have maintained a high level," especially in the categories of "active contract status with MCC" (97.4 percent accuracy), "provider credentialed specialty / behavioral health service code" (97.6 percent accuracy), "availability of urgent care services" (96.0 percent accuracy), "primary care services" (99.1 percent accuracy), and "prenatal care services" (99.5 percent accuracy).

While the results were comparable to the overall scores obtained last quarter and one year ago, to ensure improvement in these and other areas (such as "open/closed to new patients," which demonstrated only 91.3 percent accuracy), TennCare planned—as of the conclusion of the quarter—to require each of its MCCs to submit a Corrective Action Plan before the end of Calendar Year 2012.

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[40]

A. Safety Net Hospitals

Regional Medical Center (The MED)
Erlanger Medical Center
Vanderbilt University Hospital
University of Tennessee Memorial Hospital
Johnson City Medical Center Hospital
Metro Nashville General Hospital

[40] Within the four Essential Access Hospital (EAH) groupings (Safety Net Hospitals, Children's Hospitals, Free Standing Psychiatric Hospitals, and Other Acute Care Hospitals), hospitals are arranged—in descending order—according to the amount of compensation each receives from the EAH pool.

B. Children's Hospitals

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

C. Free Standing Psychiatric Hospitals

Pathways of Tennessee
Ridgeview Psychiatric Hospital and Center
Community Behavioral Health

D. Other Acute Care Hospitals

Jackson - Madison County General Hospital
Methodist Healthcare - South
Parkridge Medical Center (with Parkridge Valley Psych)
Parkwest Medical Center (with Peninsula Psych)
Methodist University Healthcare
Saint Jude Children's Research Hospital
Centennial Medical Center
Saint Francis Hospital
Delta Medical Center
University Medical Center
Skyline Medical Center (with Skyline Madison)
Wellmont Holston Valley Medical Center
Maury Regional Hospital
Mercy Medical Center
Fort Sanders Regional Medical Center
Middle Tennessee Medical Center
Methodist Healthcare – North
Gateway Medical Center
Cookeville Regional Medical Center
Baptist Hospital
Wellmont Bristol Regional Medical Center
Skyridge Medical Center
Baptist Memorial Hospital for Women
Parkridge East Hospital
Morristown - Hamblen Healthcare System
NorthCrest Medical Center
Summit Medical Center
Regional Hospital of Jackson
LeConte Medical Center
Sweetwater Hospital Association
Sumner Regional Medical Center

StoneCrest Medical Center
Baptist Hospital of Cocke County
Dyersburg Regional Medical Center
Methodist Medical Center of Oak Ridge
Southern Hills Medical Center
Baptist Memorial Hospital – Tipton
Horizon Medical Center
Blount Memorial Hospital
United Regional Medical Center
Saint Mary's Medical Center of Campbell County
Takoma Regional Hospital
Harton Regional Medical Center
Jellico Community Hospital
Hendersonville Medical Center
Sycamore Shoals Hospital
Athens Regional Medical Center
Lakeway Regional Hospital
Hardin Medical Center
Heritage Medical Center
Henry County Medical Center
Indian Path Medical Center
Crockett Hospital
Saint Mary's Jefferson Memorial Hospital
River Park Hospital
Humboldt General Hospital
Southern Tennessee Medical Center
Grandview Medical Center
Bolivar General Hospital
Claiborne County Hospital
Lincoln Medical Center
Wellmont Hawkins County Memorial Hospital
Baptist Memorial Hospital – Union City
Jamestown Regional Medical Center
Roane Medical Center
Hillside Hospital
Skyridge Medical Center – West
Riverview Regional Medical Center – North
Livingston Regional Hospital
Volunteer Community Hospital
Methodist Healthcare – Fayette
McKenzie Regional Hospital
Wayne Medical Center
McNairy Regional Hospital
Henderson County Community Hospital

Haywood Park Community Hospital
Baptist Memorial Hospital – Huntingdon
Erlanger East Hospital
Gibson General Hospital
Johnson City Specialty Hospital
White County Community Hospital
Decatur County General 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

Macon County General Hospital
Three Rivers Hospital
Baptist-Hickman Community Hospital
Trousdale Medical Center
Johnson County Community Hospital
Erlanger-Bledsoe Medical
Riverview Regional Medical Center-South
Medical Center of Manchester
Marshall Medical Center
Rhea Medical Center
Patient's Choice Medical Center of Erin (formerly Trinity Hospital)
Wellmont Hancock County Hospital
Centennial Medical Center of Ashland City
Copper Basin Medical CT Copperhill
Camden General Hospital
Baptist Memorial Hospital-Lauderdale
Scott County Hospital

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Date Submitted to CMS: November 30, 2012

Attachment A

Budget Neutrality Calculations for the Quarter

Actual TennCare Budget Neutrality (July - Sept 2012)

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)	382,287
2-Child <=18	2,009,124
3-Adult >= 65	1,272
4-Adult <= 64	851,746
Duals (17)	423,160
Total	3,667,589

Ceiling without DSH

	Baseline * MM
1-Disabled (can be any ages)	$567,959,973
2-Child <=18	$910,253,719
3-Adult >= 65	$1,243,024
4-Adult <= 64	$745,209,610
17s	$264,166,093
Total	$2,488,832,420

DSH

DSH Adjustment (Quarterly)	$115,999,213

Total Ceiling

Budget Neutrality Cap	
Total w/DSH Adj.	$2,604,831,633

II. Actual Expenditures

Group 1 and 2

1-Disabled (can be any ages)	$ 487,339,898
2-Child <=18	$ 402,165,166
3-Adult >= 65	$ 2,989,583
4-Adult <= 64	$ 316,008,806

Duals (17)	$	410,906,176
Total		**1,619,409,629**

Group 3

1-Disabled (can be any ages)	$	55,467,796
2-Child <=18	$	418,716
3-Adult >= 65	$	948,193
4-Adult <= 64	$	3,677,072
Duals (17)	$	37,308
Total		**60,549,085**

Pool Payments and Admin

Total Pool Payments		**446,245,879**

Admin	**$**	**143,844,596**

Quarterly Drug Rebates		$75,717,486
Quarterly Premium Collections		$1,098
Total Net Quarterly Expenditures	**$**	**2,194,330,605**

III. Surplus/(Deficit)

	$410,501,028
Federal Share	**$271,702,421**

HCI Result	TOTAL	HCI MCO Jul - Sep 12	HCI Rx Jul - Sep 12	HCI DTL Jul - Sep 12	HCI MCO CAP (w/o TSL)	HCI BHO CAP	State-Only Allocation	UNK Allocation	Taxes	Allocation on Differences between DV and HCI-CAP	TOTAL
EG1-TYPE1 (disabled, type1 state plan eligibles)	382,287	$89,522,965.00	$82,514,073.00	$2,341,419.18	**$312,961,441**	$0.00	$ -	$ -	$ -	$ -	$487,339,898
EG1-TYPE2 (disabled, type2 transition group)		$0.00	$0.00	$0.00	**$0**	$0.00	$ -	$ -	$ -	$ -	$0
EG2-TYPE1 (over 65, type1 state plan eligibles)	319	$70,635.00	$23,634.00	$79.00	**$141,997**	$0.00	$ -	$ -	$ -	$ -	$236,345
EG2-TYPE2 (over 65, type2 state plan eligibles)		$0.00	$0.00	$0.00	**$0**	$0.00	$ -	$ -	$ -	$ -	$0
EG3-TYPE1 (children, type1 state plan eligibles)	1,953,370	$11,785,763.00	$51,810,409.00	$38,100,302.37	**$290,496,002**	$0.00	$ -	$ -	$ -	$ -	$392,192,476
Med Exp Child (Title XXI Demo Pop; EG3-Type2)	55,754	$57,415.00	$2,469,098.00	$1,838,579.07	**$5,607,597**	$0.00	$ -	$ -	$ -	$ -	$9,972,689
EG4-TYPE1 (adults, type1 State plan eligibles)	851,746	$2,229,479.00	$47,529,470.00	$5,362,049.25	**$260,887,808**	$0.00	$ -	$ -	$ -	$ -	$316,008,806
EG4-TYPE2 (adults, type2 demonstration pop)		$0.00	$0.00	$0.00	**$0**	$0.00	$ -	$ -	$ -	$ -	$0
EG5-TYPE1 (duals, state plan eligibles)	423,160	$1,630,117.00	$3,386,081.00	$133,101.00	**$405,756,877**	$0.00	$ -	$ -	$ -	$ -	$410,906,176
EG6E-TYPE3 (Expan adult, type3 demonstration pop)	3,598	$121.00	$401,348.00	$2,150.00	**$3,273,453**	$0.00	$ -	$ -	$ -	$ -	$3,677,072
EG7E-TYPE3 (Expan child, type3 demonstration pop)	7,897	$2,982.00	$32,733.00	$40,069.04	**$342,932**	$0.00	$ -	$ -	$ -	$ -	$418,716
EG8-TYPE2 (emd exp child)		$0.00	$0.00	$0.00	**$0**	$0.00					$0
EG9 H-Disabled (TYPE 2 Eligibles)	12,446	$4,723.00	$2,181,357.00	$0.00	**$53,281,716**	$0.00					$55,467,796
EG10 H	105			$0.00	**$948,193**						$948,193
EG11 H	8	$888.00	$69.00	$0.00	**$36,351**						$37,308
EG12	953		$12,634.00	$0.00	**$2,740,604**						$2,753,238
Total	3,691,643	$105,304,200.00	$190,360,906.00	$47,817,748.91	**$1,336,474,971**	$0.00	$ -	$ -	$ -	$ -	**$1,676,219,975**

HCI Result	TOTAL	HCI MCO Jul - Sep 12 PMPM	HCI Rx Jul - Sep 12 PMPM	HCI DTL Jul - Sep 12 PMPM	HCI MCO CAP	HCI BHO CAP	State-Only Allocation	UNK Allocation	Taxes	Allocation on Differences between DV and HCI-CAP	TOTAL
EG1-TYPE1 (disabled, type1 state plan eligibles)	382,287	$78.06	$71.95	$2.04	**$272.89**	$0.00	$0.00	$0.00	$0.00	$0.00	**$424.93**
EG1-TYPE2 (disabled, type2 transition group)											
EG2-TYPE1 (over 65, type1 state plan eligibles)	319	$73.81	$24.70	$0.08	**$148.38**	$0.00	$0.00	$0.00	$0.00	$0.00	**$246.96**
EG2-TYPE2 (over 65, type2 state plan eligibles)		-	-	-	**-**	-	-	-	-	-	**-**
EG3-TYPE1 (children, type1 state plan eligibles)	1,953,370	$2.01	$8.84	$6.50	**$49.57**	$0.00	$0.00	$0.00	$0.00	$0.00	**$66.93**
Med Exp Child (Title XXI Demo Pop; EG3-Type2)	55,754	$0.34	$14.76	$10.99	**$33.53**	$0.00	$0.00	$0.00	$0.00	$0.00	**$59.62**
EG4-TYPE1 (adults, type1 State plan eligibles)	851,746	$0.87	$18.60	$2.10	**$102.10**	$0.00	$0.00	$0.00	$0.00	$0.00	**$123.67**
EG4-TYPE2 (adults, type2 demonstration pop)											
EG5-TYPE1 (duals, state plan eligibles)	423,160	$1.28	$2.67	$0.10	**$319.62**	$0.00	$0.00	$0.00	$0.00	$0.00	**$323.68**
EG6E-TYPE3 (Expan adult, type3 demonstration pop)	3,598	$0.01	$37.18	$0.20	**$303.27**	$0.00	$0.00	$0.00	$0.00	$0.00	**$340.66**
EG7E-TYPE3 (Expan child, type3 demonstration pop)	7,897	$0.13	$1.38	$1.69	**$14.48**	$0.00	$0.00	$0.00	$0.00	$0.00	**$17.67**
EG8-TYPE2 (emd exp child)											
EG9 H-Disabled (TYPE 2 Eligibles)	12,446	$0.13	$58.42	$0.00	**$1,427.01**	$0.00	$0.00	$0.00	$0.00	$0.00	**$1,485.56**
EG10 H	105	$0.00	$0.00	$0.00	**$3,010.14**						**$3,010.14**
EG11 H	8	$37.00	$2.88	$0.00	**$1,514.64**						**$1,554.51**
EG12	953	$0.00	$4.42	$0.00	**$958.59**						**$963.01**
Total	3,691,643	$9.51	$17.19	$4.32	**$120.68**	$0.00	$0.00	$0.00	$0.00	$0.00	**$151.35**