TN Division of
Health Care
Finance & Administration

November 30, 2016

Ms. Jessica Woodard
TennCare Project Officer
Division of State Demonstrations & Waivers
Center for Medicaid and CHIP Services
Centers for Medicare and Medicaid 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 July – September 2016 quarter. This report is being submitted in accordance with STC 46 of the TennCare Demonstration.

Please let us know if you have comments or questions.

Sincerely,

[redacted]

Wendy Long, M.D.
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 July - September 2016)

Demonstration Year: 15 (7/1/16 - 6/30/17)
Federal Fiscal Quarter: 4/2016 (7/16 - 9/16)
Waiver Quarter: 1/2017 (7/16 - 9/16)

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.

The Bureau of TennCare contracts with several Managed Care Contractors (MCCs) to provide services to nearly 1.6 million enrollees. During this quarter, these entities included Managed Care Organizations (MCOs) for medical, behavioral, and certain Long-Term Services and Supports (LTSS), a Dental Benefits Manager (DBM) for dental services, and a Pharmacy Benefits Manager (PBM) for pharmacy services.

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

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

Table 1
Key Dates of Approval/Operation in the Quarter

Date	Action	STC #
Throughout the July-September 2016 quarter	The State and CMS continued negotiations on priorities established by CMS for Tennessee's application to renew the TennCare Demonstration. Much of this work focused on drafting mutually agreeable versions of the STCs that would govern the Demonstration through June 30, 2021.	
7/28/16	The Monthly Call for July was held.	45
8/17/16	The State received CMS approval for MCO Contract Amendment 4 and TennCare Select Contract Amendment 39.	41
8/23/16	The Monthly Call for August was held.	45
8/29/16	CMS issued a letter approving the continued operation of the TennCare demonstration under the existing terms and conditions through September 30, 2016.	
8/31/16	The State submitted the Quarterly Progress Report for the April-June 2016 quarter to CMS.	46
9/22/16	The Monthly Call for September was held.	45
9/28/16	The State submitted point-in-time and annual aggregate data about the CHOICES program to CMS.	44.d.
9/29/16	The State submitted to CMS a report summarizing the 2016 results of the annual beneficiary survey.	48
9/30/16	CMS issued a letter approving the continued operation of	

Date	Action	STC #
	the TennCare demonstration under the existing terms and conditions through October 31, 2016.	

II. Enrollment and Benefits Information

Information about enrollment by category is presented in Table 2.

Table 2
Enrollment Counts for the July – September 2016 Quarter
Compared to the Previous Two Quarters

Demonstration Populations	Total Number of TennCare Enrollees		
	Jan – Mar 2016	Apr – Jun 2016	Jul – Sept 2016
EG1 Disabled, Type 1 State Plan eligibles	143,752	145,195	146,317
EG9 H-Disabled, Type 2 Demonstration Population	258	247	242
EG2 Over 65, Type 1 State Plan eligibles	206	235	182
EG10 H-Over 65, Type 2 Demonstration Population	38	36	48
EG3 Children, Type 1 State Plan eligibles	773,217	782,727	793,980
EG4 Adults, Type 1 State Plan eligibles	448,332	462,175	477,014
EG5 Duals, Type 1 State Plan eligibles and EG11 H-Duals 65, Type 2 Demonstration Population	147,871	149,707	151,725
EG6E Expan Adult, Type 3 Demonstration Population	780	757	734
EG7E Expan Child, Type 3 Demonstration Population	55	40	53
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	18,634	18,515	18,157
EG12E Carryover, Type 3, Demonstration Population	3,223	2,904	2,624
TOTAL*	1,536,366	1,562,538	1,591,076

*** 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 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 September 30, 2016

Managed Care Organizations	Amerigroup BlueCare[1] UnitedHealthcare Community Plan[2] TennCare Select[3]
Pharmacy Benefits Manager	Magellan Health Services
Dental Benefits Manager	DentaQuest

Tennessee Eligibility Determination System. Tennessee Eligibility Determination System (or "TEDS") is the name of the system that will be used by the State to process applications and identify persons who are eligible for TennCare and CoverKids.

Instead of consolidating all aspects of the project under one vendor, the Bureau opted to procure three separate contracts to address the following functions:

- Technical advisory services;
- Strategic Program Management Office (SPMO) services; and
- Systems integration services.

By the end of Calendar Year 2015, two of the three contracts had been awarded and implemented. KPMG, LLP successfully bid on the technical advisory services contract, which went into effect on September 1, 2015. The contract for SPMO services was awarded to Public Consulting Group, Inc. and took effect on November 1, 2015.

During the July-September 2016 quarter, the State announced that the third and final contract for systems integration services—which contained a start date of October 1, 2016—had been awarded to Deloitte Consulting, LLP. Deloitte's primary responsibility will be to design, develop, implement, maintain, and operate a rules-based Medicaid eligibility determination system. The

[1] 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.
[2] UnitedHealthcare Community Plan is operated by UnitedHealthcare Plan of the River Valley, Inc.
[3] TennCare Select is operated by VSHP.

system in question will perform a variety of vital eligibility functions for the TennCare program, including—but not limited to—making eligibility determinations and redeterminations automatically; receiving application data; interfacing with federal data sources (such as the Federally Facilitated Marketplace and the Internal Revenue Service); and mailing notices and letters to enrollees.

As the July-September 2016 quarter came to a close, TennCare and Deloitte were planning a series of sessions to define in detail the requirements for the eligibility determination system, to be followed by sessions concerning the design of the system.

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 July-September 2016 quarter, the State 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 fifteenth 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 factors such as:

- 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 an 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
July – September 2016 Compared to the Previous Two Quarters

Activities	Jan – Mar 2016	Apr – Jun 2016	Jul – Sept 2016
Number of outreach activities/events	3,127	3,111	2,736
Number of people made contact with (mostly face to face at outreach events)	138,556	155,997	157,141
Number of educational materials distributed	143,622	122,159	123,675
Number of coalitions/advisory board meetings attended or conducted	88	94	127
Number of attendees at coalitions/advisory board meetings	1,637	1,731	1,805
Number of educational preventive health radio/TV broadcasts	1,264	1,042	738
Number of educational preventive health newsletter/magazine articles	64	39	37
Number of educational preventive health billboards, scrolling billboards and bulletin boards	7,194	6,162	3,283
Number of presentations made to enrollees/professional staff who work with enrollees	134	101	120
Number of individuals attending presentations	4,786	2,078	1,871
Number of completed telephone calls regarding the importance of dental checkups	368	490	130
Number of home visits completed	196	363	243

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
July – September 2016 Compared to the
Previous Two Quarters

Activities	Jan – Mar 2016	Apr – Jun 2016	Jul – Sept 2016
Number of enrollees reached	21,137	22,295	13,449
Number of enrollees who were assisted in scheduling an EPSDT exam for their children	637	850[4]	539
Number of enrollees who were assisted in arranging for transportation	16	29	40

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

	Jan – Mar 2016	Apr – Jun 2016	Jul – Sept 2016
No. of encounters received by TennCare (initial submission)	17,161,264	16,181,311	15,657,014
No. of encounters rejected by Edifecs upon initial submission	71,521	11,689	35,809
Percentage of encounters that were compliant with State standards (including HIPAA) upon initial submission	99.58%	99.93%	99.77%

[4] This number was erroneously reported as 784 in TennCare's previous Quarterly Progress Report.

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

A. CHOICES

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

Table 7
CHOICES Enrollment and Reserve Slots
for July – September 2016 Compared to the Previous Two Quarters

	Statewide Enrollment Targets and Reserve Capacity[5]	Enrollment and Reserve Slots Being Held as of the End of Each Quarter		
		Jan – Mar 2016	Apr – Jun 2016	Jul – Sept 2016
CHOICES 1	Not applicable	17,136	17,141	17,211
CHOICES 2	12,500	8,744	8,857	9,017
CHOICES 3 (including Interim CHOICES 3)	To Be Determined	4,052	3,797	3,619
Total CHOICES	Not applicable	29,932	29,795	29,847
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. Eleven separate reports—spanning the period of August 2011 through September 2016—had been submitted by the conclusion of the July-September 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 Nursing Facility (NF) services over time, with placement in institutional settings decreasing from 21,530 individuals on June 30, 2011, to 17,141 individuals on June 30, 2016. This downward trend was even more pronounced for new LTSS recipients, 81 percent of whom

[5] 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.

had been admitted to NFs in the year prior to implementation of the CHOICES program, as compared with 49 percent admitted to NFs in the fifth year of CHOICES.

By contrast, appropriate use of HCBS by TennCare enrollees grew significantly during these years. The aggregate number of members accessing HCBS increased from 6,226 in the twelve-month period preceding CHOICES implementation in Middle Tennessee to 16,454 after CHOICES had been in place for five 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 12,654 by June 30, 2016. This information is summarized in Table 8.

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), 7/1/14 – 6/30/15	Percent increase over a five-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 6/30/16	Percent increase from the day prior to CHOICES implementa-tion to 6/30/16
6,226	16,454	164%	4,861[6]	12,654	160%

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—

[6] 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).

- 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 July 1, 2016, through September 30, 2016, NF PreAdmission Evaluations (PAEs) were approved for 318 individuals with acuity scores lower than 9, and 200 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:

- 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 198 individuals with acuity scores lower than 9, and 142 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.[7]

Table 9
CHOICES Transition Allowances
for July – September 2016 Compared to the Previous Two Quarters

	Frequency and Use of Transition Allowances					
	Jan – Mar 2016		Apr – Jun 2016		Jul – Sept 2016	
Grand Region	# Distributed	Total Amount	# Distributed	Total Amount	# Distributed	Total Amount
East	15	$13,891	18	$18,429	23	$27,295
Middle	12	$14,015	12	$18,326	33	$43,579
West	11	$10,033	18	$19,275	19	$17,788
Statewide Total	38	$37,939	48	$56,030	75	$88,662

[7] MCOs may provide transition allowances as a cost-effective alternative (CEA) to continued institutional care for CHOICES members. Transition allowances are not available as a CEA in the Employment and Community First CHOICES program (discussed in greater detail below).

B. Employment and Community First CHOICES

Designed in partnership with people with intellectual and developmental disabilities, their families, advocates, and other stakeholders, Employment and Community First (ECF) CHOICES is the first managed LTSS program in the nation that is focused on promoting and supporting integrated, competitive employment and independent community living as the first and preferred option for people with intellectual and other types of developmental disabilities.

The need for ECF CHOICES arose from a variety of challenges impacting the service delivery system for individuals with intellectual and developmental disabilities, including the disproportionately high cost in Tennessee of providing HCBS to individuals with intellectual disabilities; a substantial waiting list for such services; a lack of HCBS options for individuals with developmental disabilities but not intellectual disabilities; and a significant gap between the number of people with intellectual disabilities who want to work and those who are actually working.

ECF CHOICES was designed to address these issues in a number of ways. ECF CHOICES offers three different benefit packages:

- Essential Family Supports for families caring for a loved one with an intellectual or developmental disability;
- Essential Supports for Employment and Independent Living for adults with an intellectual or developmental disability who are transitioning out of school or who need support to achieve employment and independent living goals; and
- Comprehensive Supports for Employment and Community Living for adults with an intellectual or developmental disability who have more intense needs and require more comprehensive supports to achieve their employment and community living goals.

This tiered benefit structure, which is based on the needs of people supported and their families, with appropriate cost caps and expenditure controls, helped TennCare begin serving people with intellectual disabilities in Tennessee more cost-effectively, allowing more Tennesseans who need these services to receive them. This includes people with intellectual disabilities on a waiting list for services and people with other kinds of developmental disabilities. In addition, the unique array of employment services and supports in ECF CHOICES helps to create a pathway to employment, even for individuals with significant disabilities, resulting in improved employment, better health and quality of life outcomes, and reduced reliance on public benefits. An employment-informed choice process further helps to ensure that people do not dismiss employment as a real option because they lack complete information and a vision of how employment could be possible for them.

After intensive preparations by TennCare (including working extensively with stakeholders, securing federal approval, building provider networks, amending managed care contracts, and making systems changes), the Tennessee General Assembly approved funding to serve up to 1,700 people in the first year of the program. Implementation of ECF CHOICES began on July 1,

2016, and—by the conclusion of the July-September quarter—240 individuals had been successfully enrolled in the program. TennCare monitored the rollout of the program carefully and determined that provider networks were more than adequate, thereby ensuring that enrollees received ECF CHOICES benefits in a timely and appropriate manner.

As required by STC 33.d., the State offers the following table delineating ECF CHOICES enrollment as of the end of the quarter, as well as information about enrollment targets and the number of available reserve slots.

Table 10
ECF CHOICES Enrollment, Enrollment Targets, and Reserve Slots

	Statewide Enrollment Targets and Reserve Capacity for State Fiscal Year 2017	Enrollment as of September 30, 2016
ECF CHOICES 4	500	71
ECF CHOICES 5	1,000	136
ECF CHOICES 6	200	6
Reserve Capacity	250	27[8]
Total ECF CHOICES	1,700	240

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

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

[8] During the July-September 2016 quarter, 27 of the 250 reserve capacity slots in the ECF CHOICES program were used for individuals meeting specified criteria and determined eligible to enroll. The 27-person total represents 3 individuals enrolled in ECF CHOICES Group 4; 19 individuals enrolled in ECF CHOICES Group 5; and 5 individuals enrolled in ECF CHOICES Group 6.

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 reported on the National Association of Insurance Commissioners (NAIC) Annual Financial Statement 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 July-September 2016 quarter, the MCOs submitted their NAIC Second Quarter 2016 Financial Statements. As of June 30, 2016, TennCare MCOs reported net worth as indicated in the table below.[9]

Table 11
Net Worth Reported by MCOs as of June 30, 2016

	Net Worth Requirement	Reported Net Worth	Excess/ (Deficiency)
Amerigroup Tennessee	$29,016,782	$157,116,550	$128,099,768
UnitedHealthcare Plan of the River Valley (UnitedHealthcare Community Plan)	$55,361,026	$392,773,791	$337,412,765
Volunteer State Health Plan (BlueCare & TennCare Select)	$43,251,806	$368,793,374	$325,541,568

During the July-September 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.*). Risk-based capital (RBC) involves a method of calculating the minimum amount of capital

[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.

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 June 30, 2016:

Table 12
Company Action Level Reported by MCOs as of June 30, 2016

	Company Action Level Requirement	Reported Net Worth	Excess/ (Deficiency)
Amerigroup Tennessee	$104,759,436	$157,116,550	$52,357,114
UnitedHealthcare Plan of the River Valley (UnitedHealthcare Community Plan)	$189,545,450	$392,773,791	$203,228,341
Volunteer State Health Plan (BlueCare & TennCare Select)	$133,523,082	$368,793,374	$235,270,292

All TennCare MCOs far exceeded their minimum net worth requirements and Company Action Level requirements as of June 30, 2016.

D. Beneficiary Survey

Every year since 1993, the Boyd Center for Business and Economic Research (BCBER) at the University of Tennessee in Knoxville has conducted a survey of Tennessee citizens—TennCare enrollees, individuals with private insurance, and uninsured individuals alike—to assess their opinions about health care. Respondents provide feedback on a range of topics, including demographics (age, household income, family size, etc.), perceptions of quality of care received, and behavior relevant to health care (the type of provider from whom an individual is most likely to seek initial care, the frequency with which care is sought, etc.).

BCBER prepared a summary of the results of the most recent survey titled "The Impact of TennCare: A Survey of Recipients, 2016," and the Bureau submitted the document to CMS on September 29, 2016. Although the findings of a single survey must be viewed in context of long-term trends, several results from the report are notable:

- Satisfaction with TennCare remains high. Ninety-two percent of respondents covered by TennCare expressed satisfaction with the quality of care they had received, making

2016 the eighth straight year in which survey respondents have reported satisfaction levels exceeding 90 percent.

- More Tennesseans have health insurance. The percentage of respondents classifying themselves as uninsured fell to 5.5 percent, the lowest level in the 24-year history of the survey. When considered in terms of age, the reported uninsured rate is 6.6 percent for individuals who are age 18 or older, and 1.8 percent for individuals under age 18.
- TennCare families rarely sought initial medical care at hospitals. Ninety-six percent of heads of households with TennCare reported seeking initial medical care for themselves at a doctor's office or clinic, and 98 percent reported doing so for their children. Furthermore, only 3 percent of heads of households with TennCare reported seeking initial medical care for themselves at hospitals, and only 2 percent reported doing so for their children.

The report concludes with this assessment: "TennCare continues to receive positive feedback from its recipients, with 92 percent reporting satisfaction with the program, indicating TennCare is providing medical care in a satisfactory manner and meeting the expectations of those it serves."

E. Application to Renew the TennCare Demonstration

On December 22, 2015, the Bureau submitted to CMS an application to renew the TennCare Demonstration. The application requested that the approval period for the Demonstration—which was scheduled to end on June 30, 2016—be extended through June 30, 2021.

Although the State's renewal request had not sought any substantive changes to the TennCare Demonstration, CMS identified a number of topics it wished to discuss. As detailed in TennCare's previous Quarterly Progress Report, negotiations between the State and CMS on these topics were productive, but the parties agreed to a temporary extension of the Demonstration through August 31, 2016, in an attempt to reach agreement on certain issues that had not been resolved.

Throughout the July-September 2016 quarter, the focal points of discussion were—

- Supplemental pool payments to Tennessee hospitals;
- The methodology by which "budget neutrality" (i.e., not spending more under the TennCare Demonstration than would have been spent in its absence) is calculated;
- Evaluation of the TennCare Demonstration; and
- The period of time enrollees have to transfer from one TennCare health plan to another without having to show cause.

While the parties came closer to agreement on some of these issues, CMS granted two additional temporary extensions of the Demonstration during the reporting period: one through September 30, 2016, and one through October 31, 2016. The additional time afforded

by these extensions was used not only to continue work on the issues identified above, but also to develop and refine drafts of the Waiver List, Expenditure Authorities, and STCs that would govern the TennCare Demonstration through June 30, 2021.

F. Payment Reform

Tennessee's Health Care Innovation Initiative was launched by Governor Bill Haslam in 2013 to change the way that health care is paid for in the state. The desired direction is to move from paying for volume to paying for value by rewarding health care providers for 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 co-located with TennCare in the Tennessee Division of Health Care Finance and Administration (HCFA). Although its goals transcend Medicaid, there is much emphasis on Medicaid and TennCare as playing a pivotal role in meeting the Initiative's goals. All of TennCare's providers are included in the Initiative.

One strategy being used to reform health care payment approaches is episodes of care. Episodes of care focuses on health care delivered in 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 is in the best position to influence the cost and quality of the episode. Episodes of care are implemented in groups or—in the terminology of the program—"waves." The fifth and sixth waves are expected to be implemented in the spring of 2017.

Stakeholder input from Tennessee providers, payers, patients, and employers is central to the design of episodes of care and the other value-based payment strategies that are part of Tennessee's Health Care Innovation Initiative. For each episode, the Initiative organizes Technical Advisory Groups (TAGs) composed of experts in the field to provide clinical feedback on each episode's design. Episode TAG meetings are held in the spring and fall. The fall 2016 TAG meetings began on September 6 but had not concluded by the end of the July-September quarter. The subject of the meetings was Wave 6, which includes episodes for outpatient skin and soft tissue infection, neonatal (multiple), HIV, diabetes acute exacerbation, and pancreatitis.

Annual Feedback Sessions are another opportunity for stakeholders to provide input on existing episodes of care. On July 19, 2016, HCFA staff hosted an event in which providers from across Tennessee convened to discuss strengths and areas of opportunity in the design of episodes in Wave 1 (perinatal, total joint replacement (hip and knee), and asthma acute exacerbation) and Wave 2 (chronic obstructive pulmonary disease acute exacerbation; screening and surveillance colonoscopy; outpatient and non-acute inpatient cholecystectomy; acute percutaneous coronary intervention (PCI), and non-acute PCI). The meetings were held simultaneously in six cities across Tennessee (Chattanooga, Jackson, Johnson City, Knoxville, Nashville, and Memphis) and were connected via videoconference to facilitate attendee participation.

G. Electronic Health Record Incentive Program

The Electronic Health Record (EHR) Incentive Program is a partnership between federal and state governments that grew out of the Health Information Technology for Economic and Clinical Health (HITECH) Act. The purpose of the program 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 funding for 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;
- Third-year, fourth-year, and fifth-year payments to providers who continue to demonstrate meaningful use.

Eligible practitioners who successfully attest may receive incentive payments in up to six program years. With CMS approval, TennCare chose to divide the full amount of incentive payments available to eligible hospitals among three program years. Eligible hospitals must continue to attest annually beyond the three years of payments in order to avoid Medicare payment adjustments.

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

Table 13
EHR Payments
Quarterly and Cumulative

Payment Type	No. of Providers Paid During the Quarter	Quarterly Amount Paid (Jul-Sept 2016)	Cumulative Amount Paid To Date
First-year payments	99[11]	$1,688,202	$169,101,850

[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).

[11] Of the 99 providers receiving first-year payments in the July-September 2016 quarter, 14 earned their incentives by successfully attesting to meaningful use of EHR technology in their first year of participation in the program.

Payment Type	No. of Providers Paid During the Quarter	Quarterly Amount Paid (Jul-Sept 2016)	Cumulative Amount Paid To Date
Second-year payments	184	$1,306,173	$54,618,770
Third-year payments	148	$1,829,702	$27,114,793
Fourth-year payments	120	$1,008,668	$3,524,675
Fifth-year payments	39	$331,500	$952,000

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

- Acceptance of Incentive Year 2016 meaningful use attestations based on Modified Stage 2 measures;
- Holding 48 technical assistance calls;
- Responding to 401 emails received in the EHR meaningful use mailbox;
- Attendance at CMS's 2016 Medicaid HITECH Multi-Regional Conference, held in Chicago, IL, in July;
- 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. In addition, preparations were made to participate in upcoming meetings of the Tennessee Medical Association and in regional workshops hosted by Amerigroup and UnitedHealthcare Community Plan. The Bureau is also making every effort to alert eligible professionals and eligible hospitals that 2016 is the last year in which they may enroll in the EHR program and begin attesting (as specified by the HITECH Act).

H. *Wilson v. Gordon*

Wilson v. Gordon is a class action lawsuit filed against the Bureau of TennCare by the Tennessee Justice Center, the Southern Poverty Law Center, and the National Health Law Program. The suit alleges federal noncompliance in the Medicaid application and appeals process TennCare has been using since implementation of the Affordable Care Act.

Two separate courts have heard arguments in the case. One is the U.S. District Court for the Middle District of Tennessee, where Plaintiffs originally filed suit in July 2014. The District Court granted class action status to the case and issued a preliminary injunction requiring the State to provide an opportunity for a fair hearing on any delayed adjudications of applications for TennCare coverage. TennCare took immediate action to comply with these rulings but also filed an appeal of the preliminary injunction with a second court, the U.S. Court of Appeals for the Sixth Circuit in Cincinnati.

As recounted in TennCare's previous Quarterly Progress Report, a three-judge panel for the Sixth Circuit affirmed the District Court's decision to issue a preliminary injunction. The State, in turn, filed a petition for rehearing en banc, which—if granted—would have allowed the State's appeal to be heard by all of the Sixth Circuit judges instead of by a small panel. On August 1, 2016, however, the petition was denied.

With the State's appeal and petition to the Sixth Circuit having both been adjudicated, activity related to the *Wilson* suit resumed in District Court. On September 16, 2016, the State filed a Motion to Decertify the Class and Dismiss the Case. The basis of the motion was that processes used by TennCare and CMS for Medicaid applications and application appeals in Tennessee had evolved substantially. As a result of this evolution, the Motion contends, there are no remaining members in the Plaintiff class originally certified by the District Court, and any eligibility issues arising in 2016 are completely different from the issues that originally prompted the *Wilson* suit. The District Court has reserved ruling on this motion pending the completion of accelerated discovery in advance of a bench trial in this case that is currently scheduled for March 28, 2017.

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 showed continued vitality throughout the July-September 2016 quarter. In all three months, total state and local revenue collections were higher than during the corresponding months of 2015, with a two percent improvement in July 2016, a five percent improvement in August 2016, and a six percent improvement in September 2016.[12]

Employment prospects in Tennessee presented mixed news during the quarter. The unemployment rate ticked up from 4.3 percent in July to 4.4 percent in August and then to 4.6 percent in September. Despite this modest upward trend, the unemployment figures remained a noticeable improvement on the results from a year ago, when the Tennessee unemployment rate was fixed at 5.6 percent in all three months of the quarter. In addition, Tennessee continued to outperform the nation as a whole during the July-September 2016 quarter: Tennessee's unemployment rate ranged from 0.4 percent to 0.6 percent lower than the national rate.[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 14 and 15 below present the member month reporting by eligibility group for each month in the quarter.

Table 14
Member Month Reporting for Use in Budget Neutrality Calculations
July – September 2016

Eligibility Group	July 2016	August 2016	September 2016	Sum for Quarter Ending 9/30/16
Medicaid eligibles (Type 1)				
EG1 Disabled, Type 1 State Plan eligibles	146,835	146,428	145,724	438,987
EG2 Over 65, Type 1 State Plan eligibles	137	158	157	452
EG3 Children, Type 1 State Plan eligibles	782,501	787,003	784,952	2,354,456
EG4 Adults, Type 1 State Plan eligibles	464,088	453,274	452,552	1,369,914
EG5 Duals, Type 1 State Plan eligibles	142,870	143,207	143,608	429,685
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	225	235	237	697
EG10 H-Over 65, Type 2 Demonstration Population	35	43	46	124
EG11 H-Duals, Type 2 Demonstration Population	6,073	6,116	6,120	18,309
TOTAL	1,542,764	1,536,464	1,533,396	4,612,624

Table 15
Member Month Reporting Not Used in Budget Neutrality Calculations
July – September 2016

Eligibility Group	July 2016	August 2016	September 2016	Sum for Quarter Ending 9/30/16
EG6E Expan Adult, Type 3, Demonstration Population	741	730	724	2,195
EG7E Expan Child, Type 3, Demonstration Population	53	53	48	154
Med Exp Child, Title XXI Demonstration Population	18,238	17,010	16,530	51,778
EG12E Carryover, Type 3, Demonstration Population	2,686	2,610	2,578	7,874
TOTAL	21,718	20,403	19,880	62,001

IX. Consumer Issues

Eligibility Appeals. TennCare eligibility appeals are handled by the Bureau of TennCare. Table 16 presents a summary of eligibility appeal activity during the quarter, compared to the previous two quarters. It should be noted that appeals (whether related to eligibility, medical services, or LTSS) may be resolved or taken to hearing in a quarter other than the one in which they are initially received by TennCare.

The higher volume of eligibility appeals during the July-September 2016 quarter is attributable to two primary factors. First, implementation of Tennessee's approved redetermination plan has increased annual redeterminations of eligibility. Second, TennCare has recently increased the number of enrollees who are selected on a quarterly basis for failure to report a valid Social Security number in at least twelve months.

Table 16
Eligibility Appeals for July – September 2016
Compared to the Previous Two Quarters

	Jan – Mar 2016	Apr – Jun 2016	Jul – Sept 2016
No. of appeals received	5,889	6,371	18,264
No. of appeals resolved or withdrawn	2,556	2,729	9,621
No. of appeals taken to hearing	2,617	3,231	2,759
No. of hearings resolved in favor of appellant	342	322	263

Medical Service Appeals. Medical service appeals are handled by the Bureau of TennCare. Table 17 below presents a summary of the medical service appeals handled during the quarter, compared to the previous two quarters.

Table 17
Medical Service Appeals for July – September 2016
Compared to the Previous Two Quarters

	Jan – Mar 2016	Apr – Jun 2016	Jul – Sept 2016
No. of appeals received	2,064	2,163	2,115
No. of appeals resolved	2,033	2,029	1,993
• Resolved at the MCC level	828	854	717
• Resolved at the TSU level	177	178	192
• Resolved at the LSU level	1,028	997	1,084
No. of appeals that did not involve a valid factual dispute	261	204	158
No. of directives issued	295	281	301
No. of appeals taken to hearing	1,028	997	1,084
No. of appeals that were withdrawn by the enrollee at or prior to the hearing	342	319	360
Appeals that went to hearing and were decided in the State's favor	346	337	386
Appeals that went to hearing and were decided in the appellant's favor	48	41	28

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. 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 18
Long-Term Services and Supports Appeals for July – September 2016
Compared to the Previous Two Quarters

	Jan – Mar 2016	Apr – Jun 2016	Jul – Sept 2016
No. of appeals received	230	214	210
No. of appeals resolved or withdrawn	118	105	81
No. of appeals set for hearing	80	88	96
No. of hearings resolved in favor of appellant	2	1	3

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 April-June 2016 quarter is provided in Table 19. Data for the period of July through September 2016 will be provided in the next Quarterly Progress Report.

Table 19
Population Health Data*, April – June 2016

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	741,774
Level 1: low or moderate risk	Maternity Program	Engage pregnant women in timely prenatal care and deliver a healthy, term infant without complications	16,532
	Health Risk Management	Prevent, reduce, or delay exacerbation and complications of a condition or health risk behavior	702,770
	Care Coordination	Assure that members receive the services they need to reduce the risk of an adverse health outcome	24,845
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	5,734
	High Risk Pregnancy Management	Engage pregnant women in timely prenatal care and deliver a healthy, term infant without complications	1,768
	Complex Case Management	Move members to optimal levels of health and well-being through timely coordination of quality services and self-management support	1,006
Total PH Enrollment			**1,494,429**

*** 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 July 2016, TennCare's External Quality Review Organization (EQRO), Qsource, published the results of its provider data validation survey for the April-June 2016 quarter. Qsource took a sample of provider data files from TennCare's MCCs[14] and reviewed each for accuracy in the following categories:

- Contract status with MCC
- Provider address

[14] 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 (MCO only)
- Prenatal care services (MCO only)
- Availability of routine care services
- Availability of urgent care services

The validity of such information is one measure of providers' availability and accessibility to TennCare enrollees. Qsource's report concluded that "[o]verall, the MCCs' accuracy rates have maintained a high level," especially in the categories of "active contract status with MCC" (97.7 percent accuracy), "provider credentialed specialty / behavioral health service code" (97.9 percent accuracy), "services to patients under age 21" (96.5 percent accuracy), "services to patients age 21 or older" (95.6 percent accuracy), "primary care services" (98.8 percent accuracy), and "prenatal care services" (99.6 percent accuracy).

Because the MCOs' transition to a statewide service delivery model occurred relatively recently, progress in accuracy rates is currently being measured on a quarter-to-quarter basis. Compared with the period of October-December 2015, 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 September 5, 2016. The Bureau, in turn, had received, reviewed, and accepted all of the plans by September 8, 2016. Results for the July-September 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, titled *2015 Annual Update Report of the 2013 Quality Assessment and Performance Improvement Strategy*, was subsequently expanded to address the new ECF CHOICES program. This revised version of the strategy was submitted to CMS on June 30, 2016.

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.

XII. Essential Access Hospital Pool[15]

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
TriStar Skyline Medical Center (with Madison campus)
Wellmont Holston Valley Medical Center
University Medical Center (with McFarland Psych)
Parkridge East Hospital

[15] 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.

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
Skyridge Medical Center – Westside
Southern Tennessee Regional Health System – Winchester
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
Saint Thomas River Park Hospital
Jamestown Regional Medical Center
Hillside Hospital
Livingston Regional Hospital
Heritage Medical Center
Baptist Memorial Hospital – Union City
Claiborne County Hospital
McKenzie Regional Hospital
Erlanger Health System – East Campus
Henderson County Community Hospital
Volunteer Community Hospital
Wayne Medical Center
DeKalb Community Hospital
McNairy Regional Hospital
Decatur County General Hospital
Baptist Memorial Hospital – Huntingdon
Southern Tennessee Regional Health System – Sewanee

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 Johnson City Medical Center Johnson City Health Center Woodridge Hospital Holston Valley Medical Center Bristol Regional Medical Center
Meharry Medical College	Metro General

Universities	Hospitals
	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 River Hospital
Erlanger Bledsoe Hospital
Johnson County Community Hospital
Lauderdale Community Hospital
Macon County General Hospital
Marshall Medical Center
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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Date Submitted to CMS: November 30, 2016

Attachment A

Budget Neutrality Calculations for the Quarter

Actual TennCare Budget Neutrality (July - September 2016)

I. The Extension of the Baseline

Baseline PMPM

	SFY 2017 PMPM
1-Disabled (can be any ages)	$1,862.93
2-Child <=18	$577.17
3-Adult >= 65	$1,188.25
4-Adult <= 64	$1,106.64
Duals (17)	$774.54

Actual Member months of Groups I and II

1-Disabled (can be any ages)	439,684
2-Child <=18	2,354,456
3-Adult >= 65	452
4-Adult <= 64	1,369,914
Duals (17)	447,994
Total	4,612,500

Ceiling without DSH

	Baseline * MM
1-Disabled (can be any ages)	$819,101,984
2-Child <=18	$1,358,928,813
3-Adult >= 65	$537,091
4-Adult <= 64	$1,515,996,416
17s	$346,988,855
Total	**$4,041,553,160**

DSH

DSH Adjustment (Quarterly)	$115,999,213

Total Ceiling

Budget Neutrality Cap	
Total w/DSH Adj.	**$4,157,552,373**

II. Actual Expenditures

Group 1 and 2

1-Disabled (can be any ages)	$ 536,004,891
2-Child <=18	$ 475,805,159
3-Adult >= 65	$ 428,531
4-Adult <= 64	$ 471,775,109

Duals (17)	$	359,536,977
Total		**1,843,550,667**

Group 3

1-Disabled (can be any ages)	$	-
2-Child <=18	$	11,882,974
3-Adult >= 65	$	36,309,633
4-Adult <= 64	$	704,434
Duals (17)	$	-
Total		**48,897,041**

Pool Payments and Admin

Total Pool Payments	$	341,240,720

Admin	$	82,038,803

Quarterly Drug Rebates	$	(227,436,985)
Quarterly Premium Collections	$	-
Total Net Quarterly Expenditures	**$**	**2,088,290,246**

III. Surplus/(Deficit)

	$2,069,262,127
Federal Share	**$1,345,744,624**

HCI Result	MM201607	MM201608	MM201609	TOTAL	HCI ASO	HCI Rx	HCI DTL	HCI MCO CAP (TCS Admin)	UNK Allocation	TOTAL
EG1-TYPE1 (disabled, type1 state plan eligibles)	146,835	146,428	145,724	438,987	$75,307,936	$124,665,425	$1,879,924	$328,837,948	1,199,833	$531,891,066
EG1-TYPE2 (disabled, type2 transition group)	0	0	0	0	$0	$0	$0	$0	-	$0
EG2-TYPE1 (over 65, type1 state plan eligibles)	137	158	157	452	$35,714	$18,674	$0	$373,177	967	$428,531
EG2-TYPE2 (over 65, type2 state plan eligibles)	0	0	0	0	$0	$0	$0	$0	-	$0
EG3-TYPE1 (children, type1 state plan eligibles)	782,501	787,003	784,952	2,354,456	$11,272,797	$64,952,021	$35,580,127	$362,929,973	1,070,240	$475,805,159
Med Exp Child (Title XXI Demo Pop; EG3-Type2)	18,238	17,010	16,530	51,778	$511,169	$2,790,701	$1,074,328	$7,435,588	26,611	$11,838,398
EG4-TYPE1 (adults, type1 State plan eligibles)	464,088	453,274	452,552	1,369,914	$1,480,551	$77,358,319	$2,988,859	$388,886,225	1,061,155	$471,775,109
EG4-TYPE2 (adults, type2 demonstration pop)	0	0	0	0	$0	$0	$0	$0	-	$0
EG5-TYPE1 (duals, state plan eligibles)	142,870	143,207	143,608	429,685	$1,402,694	$1,005,988	$26,930	$291,289,764	662,166	$294,387,542
EG6E-TYPE3 (Expan adult, type3 demonstration pop)	741	730	724	2,195	$0	$110,663	$0	$592,187	1,584	$704,434
EG7E-TYPE3 (Expan child, type3 demonstration pop)	53	53	48	154	$606	$18,047	$4,158	$21,665	100	$44,576
EG8-TYPE2 (med exp child)	0	0	0	0	$0	$0	$0	$0	-	$0
EG9 H-Disabled (TYPE 2 Eligibles)	225	235	237	697	$0	$400,486	$0	$3,704,085	9,253	$4,113,824
EG10 H-Senior	35	43	46	124	$0	$7,106	$0	$676,266		$683,372
EG11H, H-Dual	6,073	6,116	6,120	18,309	$276	$18,726	$0	$64,983,888	146,544	$65,149,434
EG12E, Carryovers	2,686	2,610	2,578	7,874	$0	$125,238	$0	$35,420,895	80,128	$35,626,261
Total	**1,564,482**	**1,556,867**	**1,553,276**	**4,674,625**	**$90,011,746**	**$271,471,393**	**$41,554,326**	**$1,485,151,661**	**$4,258,582**	**$1,892,447,708**

HCI Result	MM201607	MM201608	MM201609	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)	146,835	146,428	145,724	438,987	$171.55	$283.98	$4.28	$749.08	$2.73	$1,211.63
EG1-TYPE2 (disabled, type2 transition group)	0	0	0	-						
EG2-TYPE1 (over 65, type1 state plan eligibles)	137	158	157	452	$79.01	$41.31	$0.00	$825.61	$2.14	$948.08
EG2-TYPE2 (over 65, type2 state plan eligibles)	0	0	0	-	-	-	-	-	-	-
EG3-TYPE1 (children, type1 state plan eligibles)	782,501	787,003	784,952	2,354,456	$4.79	$27.59	$15.11	$154.15	$0.45	$202.09
Med Exp Child (Title XXI Demo Pop; EG3-Type2)	18,238	17,010	16,530	51,778	$9.87	$53.90	$20.75	$143.61	$0.51	$228.64
EG4-TYPE1 (adults, type1 State plan eligibles)	464,088	453,274	452,552	1,369,914	$1.08	$56.47	$2.18	$283.88	$0.77	$344.38
EG4-TYPE2 (adults, type2 demonstration pop)	0	0	0	-						
EG5-TYPE1 (duals, state plan eligibles)	142,870	143,207	143,608	429,685	$3.26	$2.34	$0.06	$677.91	$1.54	$685.12
EG6E-TYPE3 (Expan adult, type3 demonstration pop)	741	730	724	2,195	$0.00	$50.42	$0.00	$269.79	$0.72	$320.93
EG7E-TYPE3 (Expan child, type3 demonstration pop)	53	53	48	154	$3.94	$117.19	$27.00	$140.68	$0.65	$289.46
EG8-TYPE2 (emd exp child)	0	0	0	-						
EG9 H-Disabled (TYPE 2 Eligibles)	225	235	237	697	$0.00	$574.59	$0.00	$5,314.33	$13.28	$5,902.19
EG10 H-Senior	35	43	46	124	$0.00	$57.31	$0.00	$5,453.76	$0.00	
EG11H, H-Dual	6,073	6,116	6,120	18,309	$0.02	$1.02	$0.00	$3,549.29	$8.00	$3,558.33
EG12E, Carryovers	2,686	2,610	2,578	7,874	$0.00	$15.91	$0.00	$4,498.46	$10.18	$4,524.54
Total	**1,564,482**	**1,556,867**	**1,553,276**	**4,674,625**	**$19.26**	**$58.07**	**$8.89**	**$317.70**	**$0.91**	**$404.83**

* Unknown allocation was performed within the Service category totals.