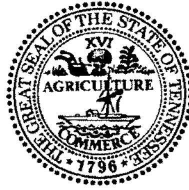

STATE OF TENNESSEE
DEPARTMENT OF FINANCE AND ADMINISTRATION
DIVISION OF HEALTH CARE FINANCE AND ADMINISTRATION
BUREAU OF TENNCARE
310 Great Circle Road
NASHVILLE, TENNESSEE 37243

November 27, 2013

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

RE: TennCare II, STC 45, Quarterly Progress Report

Dear Ms. Woodard:

Enclosed please find the Quarterly Progress Report for the July-September 2013 quarter. This report is being submitted in accordance with STC 45.

Please let us know if you have comments or questions.

Sincerely,

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 2013)

Demonstration Year: 12 (7/1/13 - 6/30/14)
Federal Fiscal Quarter: 4/2013 (7/13 - 9/13)
Waiver Quarter: 1/2014 (7/13 - 9/13)

I. Introduction

The goal of the TennCare Demonstration is to show that careful use of a managed care approach can enable the State to 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 #
7/16/13	CMS provided written approval of Demonstration Amendment 19, the State's proposal to add a $1.50 co-pay on generic prescription drugs for TennCare Medicaid and TennCare Standard enrollees who already had a $3.00 co-pay on brand name prescription drugs. The approval was accompanied by an updated version of the Demonstration agreement between CMS and TennCare.	
7/22/13	The Monthly Call scheduled for July 25, 2013, was cancelled by the CMS Project Officer.	44
8/1/13	CMS provided written approval of Tennessee's revised State Medicaid Health Information Technology Plan, a document outlining the manner in which Electronic Health Record (or "EHR") incentive payments are to be administered over a five-year period.	
8/6/13	The State submitted point in time and annual aggregate data about the CHOICES program to CMS.	43.d.iii.
8/8/13	CMS provided written approval of MCO contract amendments 12, 15, and 32.	
8/9/13	The State notified CMS by letter of its acceptance of the revised STCs associated with the approval of Demonstration Amendment 19.	
8/20/13	The Monthly Call scheduled for August 22, 2013, was	44

Date	Action	STC #
	cancelled by the CMS Project Officer.	
8/21/13	The State submitted its 1115 Demonstration Transition Plan to CMS.	
8/21/13	CMS provided written approval of the State's Medicaid Eligibility Quality Control (MEQC) Pilot Project for the period of October 2012 through September 2013.	23
8/30/13	The State submitted the Quarterly Progress Report for the April-June 2013 quarter to CMS.	45
9/4/13	The State sent CMS an updated version of the Operational Protocol.	Section XIV
9/11/13	The State sent the CMS Project Officer a courtesy copy of State Plan Amendment (SPA) 13-002, a companion to Demonstration Amendment 19. SPA 13-002 proposed a $1.50 co-pay on generic prescription drugs for adult TennCare Medicaid enrollees who already had a $3.00 co-pay on brand name prescription drugs.	7
9/23/13	A conference call between the State and CMS was held to discuss the State's 1115 Demonstration Transition Plan.	
9/25/13	The Monthly Call scheduled for September 26, 2013, was cancelled by the CMS Project Officer.	44
9/30/13	The State submitted the 2013 Beneficiary Survey report to CMS.	47

II. Enrollment and Benefits Information

Information about enrollment by category is presented in Table 2.

Table 2
Enrollment Counts for the July - September 2013 Quarter
Compared to the Previous Two Quarters

Demonstration Populations	Total Number of TennCare Enrollees		
	Jan – Mar 2013	**Apr – Jun 2013**	**Jul – Sept 2013**
EG1 Disabled, Type 1 State Plan eligibles	135,215	133,692	132,328
EG9 H-Disabled, Type 2 Demonstration Population	339	351	345
EG2 Over 65, Type 1 State Plan eligibles	50	37	49
EG10 H-Over 65, Type 2 Demonstration Population	0	0	0

Demonstration Populations	Total Number of TennCare Enrollees		
	Jan – Mar 2013	Apr – Jun 2013	Jul – Sept 2013
EG3 Children, Type 1 State Plan eligibles	696,874	658,669[1]	665,660
EG4 Adults, Type 1 State Plan eligibles	276,834	289,416	301,287
EG4 Adults, Type 2 Demonstration Population[2]	0	0	N/A
EG5 Duals, Type 1 State Plan eligibles and EG11 H-Duals 65, Type 2 Demonstration Population	136,225	133,701	133,146
EG6E Expan Adult, Type 3 Demonstration Population	1,473	1,630	1,558
EG7E Expan Child, Type 3 Demonstration Population	177	151	156
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	19,165	19,309	20,588
EG12E Carryover, Type 3, Demonstration Population	5,753	6,067	7,494
TOTAL*	1,272,105	1,243,023	1,262,611

*** Unique member counts for reporting quarter, with at least 1 day of eligibility. To avoid duplication, the member counts are based on the last eligibility group (EG) of the quarter.**

The majority of TennCare's enrollment continues to be categorized as Type 1 EG3 children and Type 1 EG4 adults, with just over three in four TennCare enrollees appearing in one of these categories.

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

[1] Although STC 53.a.iii. defines EG3 Children as "age 18 or younger," some 19-year-olds were erroneously placed in this category until the mistake was detected during the April-June 2013 quarter. Correction of the mistake accounts for a slightly smaller population of EG3 Children (and a modest rise in the population of EG4 Adults) in comparison to the January-March 2013 quarter.

[2] This eligibility group—individuals between 19 and 64 years old who are medically needy rollovers—no longer exists and was removed from the STCs that took effect on July 1, 2013. The row for Type 2 EG4 Adults will not appear in future editions of the "Enrollment Counts" table.

Table 3
TennCare Managed Care Contractors as of September 30, 2013

	West Tennessee	Middle Tennessee	East Tennessee
Managed Care Organizations	BlueCare[3] UnitedHealthcare Community Plan[4] TennCare Select[5]	Amerigroup UnitedHealthcare Community Plan TennCare Select	BlueCare UnitedHealthcare Community Plan TennCare Select
Pharmacy Benefits Manager	Magellan Health Services		
Dental Benefits Manager	TennDent[6]		

Co-Payment for Generic Medications (Demonstration Amendment 19 and State Plan Amendment 13-002). On April 26, 2013, the Bureau of TennCare submitted Demonstration Amendment 19 to CMS. Amendment 19 proposed a $1.50 co-payment for covered generic medications to be charged to those TennCare enrollees who already had a $3.00 co-pay on brand name drugs. CMS approved the proposal on July 16, 2013, for implementation on October 1, 2013. TennCare then submitted a corresponding amendment of Tennessee's Medicaid State Plan—designated 13-002—on September 11, 2013, and negotiations concerning the State Plan Amendment had commenced by the conclusion of the July-September quarter.

Request for Qualifications for Member Service Call Center. The Affordable Care Act redefined the manner in which eligibility for Medicaid and the Children's Health Insurance Program (CHIP) would be determined. In preparation for bringing together the eligibility determination functions for TennCare and CoverKids (the State's CHIP), the State issued a Request for Qualifications (RFQ) for a Member Service Call Center on August 9, 2013.

The primary purpose of the call center—as defined in the "Scope of Services" portion of the RFQ document—is to assist callers who are "seeking and providing information regarding participation in TennCare and CHIP." Functions falling within this description include assistance

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[3] 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.
[4] UnitedHealthcare Community Plan, formerly known as "AmeriChoice," is operated by UnitedHealthcare Plan of the River Valley, Inc.
[5] TennCare Select is operated by Volunteer State Health Plan, Inc. (VSHP).
[6] TennDent is operated by Delta Dental. As of the end of the July-September 2013 quarter, DentaQuest USA Insurance Company was scheduled to replace TennDent as TennCare's Dental Benefits Manager on October 1, 2013.

with applications and eligibility redeterminations, collecting verifications and documents needed to demonstrate program eligibility, and providing an avenue through which eligibility appeals may be filed.[7] The call center is to begin operations on January 1, 2014, and will be available 12 hours a day (14 hours a day during certain designated periods), 6 days a week.

The deadline for submission of a proposal to TennCare was September 16, 2013—and, as of the end of the July-September quarter—the successful bidder was to be revealed on October 2, 2013.

Cost Sharing Compliance Plan. In its April 18, 2012 letter approving the Bureau's cost sharing compliance plan for the TennCare Standard population, CMS stipulated that "each Quarterly Report . . . must include a report on whether any families have contacted the State to document having reached their aggregate cap, and how these situations were resolved." In preparation for implementation of the compliance plan on January 1, 2013, TennCare notified Standard members during November 2012 of—

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

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

III. Innovative Activities to Assure Access

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

[7] The State retains the option to add aspects of the medical appeals process to the call center's responsibilities at a later point.

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

Activities	Jan – Mar 2013	Apr – Jun 2013	Jul – Sept 2013
Number of educational materials distributed	224,703	218,717	209,598
Number of outreach activities/events	3,224	3,492	3,967
Number of people made contact with (mostly face to face at outreach events)	161,455	171,107	190,429
Number of coalitions/advisory board meetings attended or conducted[8]	72	61	91
Number of attendees at coalitions/advisory board meetings[9]	1,158	855	610
Number of educational preventive health radio/TV broadcasts[10]	12,791	9,199	9,075
Number of educational preventive health newsletter/magazine articles[11]	94	19	120[12]
Number of educational preventive health billboards, scrolling billboards and bulletin boards	33,205	41,297	16,858[13]
Number of presentations made to enrollees/professional staff who work with enrollees	508	375	221[14]
Number of individuals attending presentations	13,265	9,442	5,457

[8] Participation in coalitions and advisory board meetings varies on a quarterly basis depending on the number of collaborative meetings scheduled by DOH, the number of such meetings that TENNderCare staff are invited to attend, and the presence of any special events (e.g., back-to-school events in August and Child Health Week in October) associated with a particular quarter.

[9] Attendance at coalitions and advisory board meetings varies for a variety of reasons beyond DOH's control, not least of which is the calling of such meetings by community partners rather than by TENNderCare community outreach staff.

[10] 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.

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

[12] The number of articles was especially high during the July-September 2013 quarter as a result of back-to-school promotion efforts.

[13] Despite the notable decrease in the use of billboards and bulletin boards during the July-September 2013 quarter, TENNderCare staff (especially in the East Tennessee, Mid-Cumberland, South Central, and Upper Cumberland regions) continue to develop relationships with community partners who agree to display EPSDT-related messages on billboards, bulletin boards, and websites.

[14] Presentations to enrollees and professional staff fell in the July-September 2013 quarter, as available resources were channeled, instead, into meetings with school-age children and adolescents at school-based events.

Activities	Jan – Mar 2013	Apr – Jun 2013	Jul – Sept 2013
Number of attempted telephone calls regarding the importance of immunizations and dental checkups[15]	391	503	252
Number (approx) of completed telephone calls regarding the importance of immunizations and dental checkups	166	208	105
Number of attempted home visits (educational materials left with these families)	15,720	14,499	17,039
Number of home visits completed	7,418	7,401	8,848
Number of outreach events directed to the homeless[16]	47	37	45

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 2013 Compared to the Previous Two Quarters

Activities	Jan – Mar 2013	Apr – Jun 2013	Jul – Sept 2013
Number of families reached	48,590	45,236	49,490
Number of families who were assisted in scheduling an EPSDT exam for their children	3,975	3,646	3,803
Number of families who were assisted in arranging for transportation	188	118	145

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

[15] Quarterly variations in this category are attributable to the number of referrals made by the School-based Dental Prevention Program and the federally funded Women, Infants, and Children program.
[16] Many homeless individuals are transient, and the number of contacts fluctuates depending on the number of referrals from the agencies accessed by homeless individuals.

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

	Jan – Mar 2013	Apr – Jun 2013	Jul – Sept 2013
No. of encounters received by TennCare (initial submission)	6,667,160[17]	7,691,163	7,964,941
No. of encounters rejected by Edifecs upon initial submission	92,562	34,340	90,108
Percentage of encounters that were compliant with State standards (including HIPAA) upon initial submission	98.61%	99.54%	98.87%[18]

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

A. CHOICES

The Long-Term Care Community CHOICES Act of 2008 provided the framework that allowed the State to restructure its Long-Term Services and Supports (LTSS) delivery system, and the two-phased implementation of CHOICES was complete in August 2010. A primary aim of the CHOICES program is to increase the home and community based services (HCBS) options that are available to meet the needs of adults who are elderly or who have physical disabilities and who require Nursing Facility (NF) level of care. Fulfillment of this goal is proceeding apace, as the percentage of individuals receiving LTSS in the community has increased from 17 percent of the LTSS population when CHOICES began to just over 40 percent by the conclusion of September 2013.

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.

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

[18] The percentage of compliant encounters was slightly lower during the July-September 2013 quarter due in part to the normal transition issues that accompany the introduction of a new Pharmacy Benefits Manager.

Table 7
TennCare CHOICES Enrollment and Reserve Slots
for July – September 2013 Compared to the Previous Two Quarters

	Statewide Enrollment Targets and Reserve Capacity[19]	Enrollment and Reserve Slots Being Held as of the End of Each Quarter		
		Jan – Mar 2013	Apr – Jun 2013	Jul – Sept 2013
CHOICES 1	Not applicable	19,644	19,415	19,115
CHOICES 2	12,500	9,830	9,612	9,388
Interim CHOICES 3	Not applicable	2,370	2,947	3,572
Total CHOICES	Not applicable	31,844	31,974	32,075
Reserve capacity	300	300	300	300

The CMS letter approving CHOICES implementation in Middle Tennessee dated February 26, 2010, and STCs 43 and 45 require specific monitoring and reporting activities that include:

Data and trends of the designated CHOICES data elements: STC 43.d. requires the State to submit to CMS periodic statistical reports about the use of LTSS by TennCare enrollees. Four separate reports—from August 2011, June 2012, September 2012, and June 2013—had been submitted by the conclusion of the July-September 2013 quarter.[20]

Taken together, the reports depict a program in balance, one that offers institutional care to individuals with the highest acuity of need, as well as HCBS for individuals whose needs can be safely and effectively met at home or in other non-institutional settings. Point in time data revealed relatively consistent use of NF services over time, with 21,530 people receiving institutional care on June 30, 2011, and 20,968 people receiving it on June 30, 2012. The aggregate number of TennCare enrollees accessing HCBS, by comparison, grew from 6,226 in the twelve-month period preceding CHOICES implementation to 9,789 once CHOICES had been in place for a year, and then to 12,862 at the two-year mark. 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 8,543 on June 30, 2011, and then to 10,482 on June 30, 2012.

Enrollment of select members of the CHOICES population in Groups 1 and 2: STC 45.f. requires the State to provide "quarterly enrollment reports for individuals that would otherwise be eligible for *Interim* CHOICES 3 but meet the modified institutional level of care, and whether

[19] Of the three active CHOICES groups, only CHOICES 2 has an enrollment target.
[20] A fifth report was submitted on August 6, 2013, but the data was identical with that submitted on June 26, 2013. A corrected version of the report was subsequently planned for the October-December 2013 quarter.

CHOICES 1 or CHOICES 2 was selected by the individual." The population of long-term services and supports recipients described in this passage, then, consists of individuals who have been approved for Nursing Facility Level of Care in CHOICES 1 (NF) or CHOICES 2 (HCBS) despite having been assigned a score of less than 9 on the TennCare Nursing Facility Level of Care Acuity Scale. Relevant enrollment data for the July-September 2013 quarter appears in Table 8.

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

No. of Individuals who would otherwise be eligible for Interim CHOICES 3 but who meet the modified level of care	No. who chose CHOICES 1	No. who chose CHOICES 2	No. whose choice has not been finalized
113	71	10	32[21]

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. A notable decline in the number of transition allowances and the amount of money distributed is evident in the July-September 2013 quarter. This development is the result of a variety of elements affecting the MCOs' ability to transition CHOICES members from nursing facilities to the community, including housing barriers, lack of natural support within the community, and the Level of Care (LOC) changes implemented on July 1, 2012. The purpose of the LOC changes is to target NF services to individuals with higher acuity of need, while continuing to make HCBS more broadly available, including to persons who do not meet the higher LOC criteria. As a result, the State has achieved a nearly 20 percent diversion of all NF applicants to more cost-effective and integrated community-based care. While this was the intended outcome, its realization means that persons admitted to NFs have more acute needs and may also have fewer (or no) natural supports available to them in the community, giving rise to additional challenges in transitioning such individuals back to community-based settings.

[21] Of the 113 individuals who met the modified Level of Care requirements during the July-September 2013 quarter, 32 had not been enrolled in either CHOICES 1 or CHOICES 2 by September 30. Reasons for this include ongoing use of reimbursement sources other than TennCare (e.g., Medicare, other insurance, or private payment), failure to meet Medicaid financial eligibility requirements, and failure to proceed with enrollment in CHOICES.

Table 9
TennCare CHOICES Transition Allowances
for July – September 2013 Compared to the Previous Two Quarters

	Frequency and Use of Transition Allowances					
	Jan – Mar 2013		**Apr – Jun 2013**		**Jul – Sept 2013**	
Grand Region	# Distributed	Total Amount	# Distributed	Total Amount	# Distributed	Total Amount
East	15	$18,063	20	$21,677	13	$12,340
Middle	5	$2,442	7	$5,744	4	$2,874
West	12	$12,111	11	$9,408	8	$8,353
Statewide Total	32	$32,616	38	$36,829	25	$23,567

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

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

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

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 2013 Financial Statements. As of June 30, 2013, TennCare MCOs reported net worth as indicated in the table below.[22]

Table 10
Net Worth Reported by MCOs as of June 30, 2013

	Net Worth Requirement	Reported Net Worth	Excess/ (Deficiency)
Amerigroup Tennessee	$17,323,202	$95,170,439	$77,847,237
UnitedHealthcare Plan of the River Valley (UnitedHealthcare Community Plan)	$64,481,178	$466,783,297	$402,302,119
Volunteer State Health Plan (BlueCare & TennCare Select)	$35,639,453	$233,142,540	$197,503,087

All TennCare MCOs met their minimum net worth requirements as of June 30, 2013.

C. Notifications to TennCare Enrollees

On September 1, 2013, TennCare mailed the entire enrollee population[23] a notice informing them of their right to file an appeal when medical care is denied, delayed, or suspended. The notice, which is issued annually, identifies the circumstances under which appeals may be filed, the duties imposed on TennCare and its Managed Care Contractors (MCCs) when requests for medical care are made, and the timeframes within which appeals must be processed. To ensure the accessibility of the notice content to audiences with varying needs, a Spanish language version was printed on the reverse side, and an explanatory cover letter provided toll-free telephone numbers through which individuals with mental illness, hearing problems, or speech problems could seek assistance.

[22] 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.

[23] The notice was sent to all individuals enrolled in TennCare as of July 29, 2013, but not to Medicare beneficiaries who are ineligible for TennCare but receive cost-sharing and premium assistance from the program, or illegal/undocumented aliens whose emergency services are paid for by TennCare.

The summary of appeal rights was accompanied by other notices applicable to the recipient's age group. These supplements included:

- A statement for all enrollees of TennCare's revised privacy practices (which had been modified in accordance with stricter federal privacy laws that were to take effect on September 23, 2013);
- A notice to enrollee children under age 21 that their TennDent dental plan would be replaced by DentaQuest on October 1, 2013;
- Notification to enrollee children under age 21 that certain children enrolled in TennCare Standard would have a $1.50 co-pay on covered generic medications beginning on October 1, 2013; and
- A summary of certain benefit clarifications for enrollee adults age 21 and over.

By enclosing these supplemental notices with the summary of appeal rights, the Bureau eliminated the costs and administrative burden associated with multiple mailings.

D. Electronic Health Record Incentive Program

The Electronic Health Record (EHR) Incentive Program is a partnership between federal and state governments that grew out of the Health Information Technology for Economic and Clinical Health (HITECH) Act. The purpose of the program, as its name suggests, is to provide financial incentives to Medicaid providers[24] to replace outdated, often paper-based approaches to medical record-keeping with electronic systems that meet rigorous certification criteria and that can improve health care delivery and quality. The federal government provides 100 percent of the funding for the incentive payments and 90 percent of the program's administrative costs.

Currently, Medicaid providers may qualify for two types of payments:

- First-year payments to providers who adopted, implemented, or upgraded to certified EHR technology capable of meeting "meaningful use" (i.e., use that is measurable in both quantity and quality) standards; and
- Second-year payments to providers who earned first-year payments in calendar year 2011 or 2012 (or alternately demonstrated meaningful use in their first attestation) and who achieved meaningful use of EHR technology for any period of 90 consecutive days in Fiscal Year 2013 (for eligible hospitals) or Calendar Year 2013 (for eligible professionals).

[24] 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).

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

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

Payment Type	Number of Providers	Quarterly Amount Paid (Jul-Sept 2013)	Cumulative Amount Paid To Date
First-year payments	106 providers (43 physicians, 26 nurse practitioners, 32 dentists, 3 hospitals, 1 physician assistant, and 1 certified nurse midwife)	$4,950,092	$129,426,079
Second-year payments	61 providers (43 physicians, 14 nurse practitioners, 3 hospitals, and 1 physician assistant)	$1,909,044	$23,011,952

EHR-related outreach activities conducted during the quarter included:

- Posting of nine audio-enhanced PowerPoint presentations—four for Eligible Professionals, two for Eligible Hospitals, and three for both groups—on TennCare's dedicated EHR webpage at http://www.tn.gov/tenncare/ehr_page6.shtml[25];
- Monthly newsletters distributed by the Bureau's EHR ListServ; and
- A quarterly reminder issued through the Provider Incentive Payment Program ("PIPP") system to Tennessee providers who had registered at the federal level but who have not registered or attested at the state level.

Notable EHR-related events planned for the remainder of Calendar Year 2013 include six meetings between TennCare and the Tennessee Medical Association, a variety of meetings with tnREC (Tennessee's regional extension center for health information technology), and Bureau participation in the Tennessee Academy of Family Physicians Conference.

[25] Two additional PowerPoint presentations on TennCare's EHR webpage—entitled "Common Challenges to Achieving Stage 1 Meaningful Use" and "Timelines for 2011 Cohort"—had been posted prior to the July-September quarter.

E. New Pharmacy Leadership

On July 22, 2013, Dr. Rusty Hailey joined the TennCare program in the position of Chief Pharmacy Officer.

Dr. Hailey, who succeeds Bryan Leibowitz as head of the Pharmacy Division, earned a bachelor's degree in Pharmacy from the University of Mississippi (Oxford and Jackson, MS) and his Doctorate of Pharmacy from Rio Grande College of Pharmacy (Albuquerque, NM), as well as a Master of Business Administration degree from St. Joseph's University (Philadelphia, PA). He pursued his academic interests further by serving on the editorial advisory boards of peer-reviewed journals *Pharmacy & Therapeutics* and *Formulary*, as well as on advisory boards for the University of Mississippi's School of Pharmacy and Belmont University's College of Pharmacy.

Two aspects of Dr. Hailey's distinguished career will be especially useful in guiding TennCare's pharmacy program in the years ahead. First, his extensive leadership experience over a 20-year period—established in such roles as President of Pharmacy Operations and Senior Vice President of Cigna HealthSpring, Chief Pharmacy Officer and Senior Vice President of Coventry Health Care, and Executive Vice President of Coventry Pharmaceutical Management Services—qualifies Dr. Hailey to serve in the position of Pharmacy Director. Second, the managed care approach to health care that defines the TennCare program is very familiar to Dr. Hailey, who was both a Fellow and the President of the Academy of Managed Care Pharmacy, and who served as President of the Foundation of Managed Care Pharmacy.

F. Quality Oversight Awards

As part of its joint meeting with the Bureau's Managed Care Contractors on September 11, 2013, TennCare's Division of Quality Oversight presented its third annual awards for "outstanding performance [by] contracted Managed Care Companies who showed a commitment to quality in various areas that are monitored by TennCare."

Nominations and awards were based on recommendations from TennCare's Quality Oversight staff, TennCare's Medical Director, and the MCCs themselves. While some honors—such as "2013 Highest Annual Quality Survey Score Award" and "2012 Highest NCQA-Ranked TennCare Health Plan Award"—recognized MCCs, others—like "Population Health Workgroup Award" and "CHOICES 'Above and Beyond' Award"—were bestowed on individual MCC staff members. The "Best All Around Award", which acknowledges exceptional performance across a broad spectrum of measures (including accuracy of reporting, integration of care, and adherence to TennCare guidance), was presented to BlueCare.

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 Tennessee economy presented mixed news during the July-September 2013 quarter. Although total state and local revenue collections in July and August 2013 were higher than those for the same months of 2012 (4.44 percent higher in July, in fact), September 2013 yielded slightly lower collections than had been obtained during the corresponding month of the preceding year.[26] The Tennessee unemployment rate remained stagnant, furthermore, charting at 8.5 percent in July and August, and 8.4 percent in September.[27] In all three months, Tennessee's unemployment rate exceeded the national unemployment rate by more than one full percentage point, and matched or exceeded the state unemployment rate for the corresponding months of 2012.

On the other hand, according to a report published by the University of Tennessee's Center for Business and Economic Research (CBER) in September 2013, the Tennessee employment prospects for the next two years are more encouraging. Classifying the current jobs situation in Tennessee as "dismal," report author Matthew N. Murray anticipates a gradual reversal of this state of affairs, predicting a decline in the unemployment rate to 7.6 percent in 2014, and further still to 7.0 percent in 2015.[28] Complementing these trends, according to Murray, will be improvements in nonfarm and manufacturing employment, income growth, and taxable sales.[29]

Other announcements made during the July-September 2013 quarter that bode well for Tennessee's ongoing recovery from the Great Recession include:

- *Area Development Magazine* rated Tennessee number seven in its list of "Top States for Doing Business 2013" because of the state's prominence in manufacturing, low debt ratio, and transportation infrastructure.[30]

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

[27] 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.

[28] Murray, M., "Tennessee Business and Economic Outlook: The State's Economic Outlook, Fall 2013, p. 6. Center for Business and Economic Research, University of Tennessee. The report is located at http://cber.bus.utk.edu/tefs/fall13.pdf.

[29] Ibid, pp. 7-8.

[30] "Top States for Doing Business 2013: Texas on Top….Again." *Area Development* Q3/Summer 2013. http://www.areadevelopment.com/Top-States-for-Doing-Business/Q3-2013/survey-results-state-analysis-888237.shtml.

- $103 million will be invested in the Jack Daniel Distillery, meaning that 94 new full-time positions will be added over the course of the next five years.[31]
- A Kroger Marketplace providing 165 new jobs will open in Oak Ridge, TN, in July 2014.[32]

The impact of these plans, while not immediate, points to the emerging economic recovery in Tennessee as described by Professor Murray.

VIII. Member Month Reporting

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

Table 12
Member Month Reporting for Use in Budget Neutrality Calculations
July – September 2013

Eligibility Group	July 2013	August 2013	September 2013	Sum for Quarter Ending 9/30/13
Medicaid eligibles (Type 1)				
EG1 Disabled, Type 1 State Plan eligibles	132,142	131,371	129,967	393,480
EG2 Over 65, Type 1 State Plan eligibles	32	36	33	101
EG3 Children, Type 1 State Plan eligibles	651,624	647,009	643,559	1,942,192
EG4 Adults, Type 1 State Plan eligibles	283,882	276,348	275,112	835,342
EG5 Duals, Type 1 State Plan eligibles	124,007	123,548	122,779	370,334
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	306	313	331	950

[31] "Jack Daniel Expanding Operations in Lynchburg." *TNReport* 22 Aug 2013. http://tnreport.com/2013/08/22/jack-daniel-expanding-operations-in-lynchburg/.
[32] "New Oak Ridge Grocery Will Produce 165 New Jobs." *Knoxville News Sentinel* 22 Aug. 2013. http://www.knoxnews.com/news/2013/aug/22/new-oak-ridge-grocery-will-produce-165-new-jobs/.

Eligibility Group	July 2013	August 2013	September 2013	Sum for Quarter Ending 9/30/13
EG10 H-Over 65, Type 2 Demonstration Population	0	0	0	0
EG11 H-Duals, Type 2 Demonstration Population	5,814	5,946	6,098	17,858
TOTAL	1,197,807	1,184,571	1,177,879	3,560,257

Table 13
Member Month Reporting Not Used in Budget Neutrality Calculations
July – September 2013

Eligibility Group	July 2013	August 2013	September 2013	Sum for Quarter Ending 9/30/13
EG6E Expan Adult, Type 3, Demonstration Population	1,522	1,492	1,487	4,501
EG7E Expan Child, Type 3, Demonstration Population	152	151	144	447
Med Exp Child, Title XXI Demonstration Population	19,170	19,483	19,432	58,085
EG12E Carryover, Type 3, Demonstration Population	7,492	7,397	7,319	22,208
TOTAL	28,336	28,523	28,382	85,241

IX. Consumer Issues

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

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

	Jan – Mar 2013	Apr – Jun 2013	Jul – Sept 2013
TennCare Medicaid			
No. of appeals received	3,051	3,598	3,582
No. of appeals resolved or withdrawn	1,277	1,535	1,525
No. of appeals taken to hearing	1,235	1,755	1,774
No. of appeals that did not involve a valid	1,096	1,728	1,201

	Jan – Mar 2013	Apr – Jun 2013	Jul – Sept 2013
factual dispute			
Appeals previously heard that were decided in the State's favor	802	1,145	1,225
Appeals previously heard that were decided in the appellant's favor	88	152	116
TennCare Standard			
No. of appeals received	109	101	125
No. of appeals resolved or withdrawn	54	45	27
No. of appeals taken to hearing	50	52	56
No. of appeals that did not involve a valid factual dispute	27	44	31
Appeals previously heard that were decided in the State's favor	31	40	32
Appeals previously heard that were decided in the appellant's favor	7	5	4

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

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

	Jan – Mar 2013	Apr – Jun 2013	Jul – Sept 2013
No. of appeals received[33]	1,309	1,072	880
No. of appeals resolved • Resolved at the MCC level • Resolved at the TSU level • Resolved at the LSU level	1,309 581 182 546	1,170 499 163 508	771 195 93 483
No. of appeals that did not involve a valid factual dispute	313	339	531
No. of directives issued	160	162	148
No. of appeals taken to hearing	546	508	483
No. of appeals that were withdrawn by the enrollee at or prior to the hearing	185	184	165

[33] Transition issues associated with the introduction of Magellan Health Services as TennCare's new Pharmacy Benefits Manager on June 1, 2013, helps explain the steady decline in the number of medical service appeals during the April-June and July-September quarters.

	Jan – Mar 2013	Apr – Jun 2013	Jul – Sept 2013
Appeals that went to hearing and were decided in the State's favor	142	129	144
Appeals that went to hearing and were decided in the appellant's favor	25	17	16

By way of explanation:

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

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

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

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

Table 16
Long-Term Services and Supports Appeals for July – September 2013
Compared to the Previous Two Quarters

	Jan – Mar 2013	Apr – Jun 2013	Jul – Sept 2013
No. of appeals of PreAdmission Evaluation (PAE) denials	322	450	402
No. of appeals of PASRR determinations	4	5	3

	Jan – Mar 2013	Apr – Jun 2013	Jul – Sept 2013
No. of appeals of denial for enrollment into CHOICES	8	6	12
No. of appeals of involuntary disenrollment from CHOICES	7	5	4
No. of appeals of denial of Consumer Direction	0	0	1
No. of appeals of involuntary withdrawal of Consumer Direction	0	1	0
No. of appeals of involuntary disenrollment from an HCBS waiver for individuals with intellectual disabilities	1	2	0
No. of appeals resolved in appellant's favor prior to hearing	156	148	124
No. of appeals withdrawn prior to hearing	2	4	7
No. of appeals dismissed at hearing	41	39	34
No. of appeals continued at hearing	5	13	9
No. of appeals that went to hearing and were decided in the State's favor	11	27	21
No. of appeals that went to hearing and were decided in the appellant's favor	1	2	7

X. Quality Assurance/Monitoring Activity

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

The transition of DM members to PH began on January 1, 2013. Full implementation of the program—meaning assignment of members to one of three levels of health risk and one of seven programs for reducing risk—was complete as of July 1, 2013. Information on the risk levels addressed by PH, the manner in which these risks are addressed, and the total number of members identified for placement in PH by the conclusion of the April-June 2013 quarter is

provided in Table 17. Data for the period of July through September, 2013, will be provided in the next Quarterly Progress Report.

Table 17
Stratification of Population Health Enrollees, April-June 2013

Risk Level	Intervention Type	Intervention Goal(s)	Member Identification[34]
Level 0: no identified risk	Wellness Program	Keep members healthy as long as possible	494,319
Level 1: low or moderate risk	Maternity Program	Engage pregnant women in timely prenatal care and deliver a healthy, term infant without complications	13,410
	Health Risk Management	Prevent, reduce, or delay exacerbation and complications of a condition or health risk behavior	528,313
	Care Coordination	Assure that members receive the services they need to reduce the risk of an adverse health outcome	8,627
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	13,010
	High Risk Pregnancy Management	Engage pregnant women in timely prenatal care and deliver a healthy, term infant without complications	2,781
	Complex Case Management	Move members to optimal levels of health and well-being through timely coordination of quality services and self-management support	8,845
Total PH Enrollment			**1,069,305**

Report on Pay-for-Performance Incentives. During this quarter, a report was prepared on MCO pay-for-performance quality incentives. Table 18 shows the plans that met criteria for quality incentive payments in 2013.

[34] The data in the "Member Identification" column of Table 17 was gathered before full implementation of PH on July 1, 2013. Prior to the July-September 2013 quarter, MCOs interpreted TennCare's requests for PH information in different ways, leading to inconsistency in the collection and submission of such data. Consequently, the Bureau developed a revised "Population Health Quarterly" template to standardize the process, the results of which will be displayed in the next Quarterly Progress Report.

Table 18
MCOs Meeting the Criteria for Quality Incentive Payments in 2013

MCO	Measures	Baseline (2012) Results	2013 Results	Change Required for Incentive	Change Achieved
UnitedHealthcare East	Controlling High Blood Pressure	52.07%	60.73%	6.00%	8.66%
UnitedHealthcare Middle	Follow-up Care for Children Prescribed ADHD Medication—Initiation Phase*	33.87%	53.78%	6.00%	19.91%
	Follow-up Care for Children Prescribed ADHD Medication—Continuation Phase*	43.27%	63.94%	6.00%	20.67%
	HbA1C Control (poor<9%)**	51.79%	58.33%	6.00%	6.54%
UnitedHealthcare West	Controlling High Blood Pressure	46.23%	54.01%	6.00%	7.78%
	HbA1C Control (poor<9%)**	42.69%	53.97%	6.00%	11.28%
	HbA1C Testing	74.23%	79.23%	5.00%	5.00%
	Follow-up Care for Children Prescribed ADHD Medication—Initiation Phase*	29.22%	41.39%	6.00%	12.17%
	Follow-up Care for Children Prescribed ADHD Medication—Continuation Phase*	39.06%	58.44%	6.00%	19.38%

***To be eligible for an incentive payment for these measures, the MCO must demonstrate significant improvement for both rates comprising the measure.**
****For the "HbA1C Control" measure, the reverse of the HEDIS measure (i.e., 100 minus the percentage of individuals with poorly controlled HbA1C) is used.**

Provider Data Validation Report. In July 2013, TennCare's External Quality Review Organization (EQRO), Qsource, published the results of its provider data validation survey for the April-June 2013 quarter. Qsource took a sample of provider data files from TennCare's MCCs[35] and reviewed each for accuracy in the following categories:

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

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

The validity of such information is one measure of providers' availability and accessibility to TennCare enrollees. Qsource's report concluded that "[o]verall, the MCCs' accuracy rates have maintained a high level," especially in the categories of "active contract status with MCC" (97.7 percent accuracy), "provider credentialed specialty / behavioral health service code" (97.1 percent accuracy), "primary care services" (98.7 percent accuracy), and "prenatal care services" (99.1 percent accuracy).

While the results were comparable to the overall scores obtained last quarter and one year ago, to ensure improvement in these and other areas (such as "open/closed to new patients," which demonstrated only 89.7 percent accuracy), TennCare required each of its MCCs to submit a Corrective Action Plan no later than June 5, 2013. The Bureau, in turn, had received, reviewed, and accepted all of the plans by September 11, 2013. Results for the July-September 2013 quarter will be discussed in the next Quarterly Progress Report.

XI. Demonstration Evaluation

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

In addition, on October 31, 2012, the State submitted the Draft Annual Report as required by STC 46.[36] 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 provide updated information on the performance measures in each Annual Report.

[36] At the time of the 2012 submission, the Draft Annual Report was required by STC 48.

XII. Essential Access Hospital Pool[37]

A. Safety Net Hospitals

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

B. Children's Hospitals

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

C. Free Standing Psychiatric Hospitals

Pathways of Tennessee
Ridgeview Psychiatric Hospital and Center

D. Other Acute Care Hospitals

Parkridge Medical Center (with Parkridge Valley Psych)
Jackson - Madison County General Hospital
Methodist Healthcare – South
Methodist Healthcare – Memphis Hospitals
Saint Jude Children's Research Hospital
Baptist Hospital
Parkwest Medical Center (with Peninsula Psych)
Physicians Regional Medical Center
University Medical Center (with McFarland Psych)
Wellmont Holston Valley Medical Center
Saint Francis Hospital
Centennial Medical Center
Skyline Medical Center (with Madison campus)
Maury Regional Hospital
Methodist Healthcare – North
Middle Tennessee Medical Center
Fort Sanders Regional Medical Center

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

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

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

XIII. Graduate Medical Education (GME) Hospitals

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

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

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

Universities	Hospitals
University of Tennessee at Memphis	The Regional Medical Center (The MED) Methodist LeBonheur Erlanger Jackson Madison St. Francis
Vanderbilt University	Vanderbilt Hospital

XIV. Critical Access Hospitals

Camden General Hospital
Copper Basin Medical Center
Erlanger Bledsoe
Hickman Community Hospital
Houston County Community Hospital
Johnson County Community Hospital
Lauderdale Community Hospital
Macon County General Hospital
Marshall Medical Center
Medical Center of Manchester
Rhea Medical Center
Riverview Regional Medical Center
Three Rivers Hospital
TriStar Ashland City Medical Center
Trousdale Medical Center
Wellmont Hancock County Hospital

State Contact:

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

Phone: 615-507-6480
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Date Submitted to CMS: November 27, 2013

Attachment A

Budget Neutrality Calculations for the Quarter

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

December 19, 2013

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

RE: TennCare II, STC 45, Budget Neutrality Data

Dear Ms. Woodard:

On November 27, 2013, in accordance with STC 45, TennCare submitted the July-September 2013 Quarterly Progress Report to CMS. Attachment A to the report was a spreadsheet detailing TennCare's budget neutrality calculations for the quarter. Subsequent review of this spreadsheet revealed, however, that its calculations were based on per member per month (PMPM) rates from the previous approval period.

Enclosed is a revised version of Attachment A, one based on PMPM rates for the current approval period. Please let us know if you have comments or questions.

Sincerely,

Chief Financial Officer, 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

Actual TennCare Budget Neutrality (July-September 2013)

I. The Extension of the Baseline

Baseline PMPM

	SFY 2014 PMPM
1-Disabled (can be any ages)	$1,561.46
2-Child <=18	$468.46
3-Adult >= 65	$1,022.17
4-Adult <= 64	$917.79
Duals (17)	$652.99

Actual Member months of Groups I and II

1-Disabled (can be any ages)	393,480
2-Child <=18	1,942,192
3-Adult >= 65	101
4-Adult <= 64	835,342
Duals (17)	388,192
Total	3,559,307

Ceiling without DSH

	Baseline * MM
1-Disabled (can be any ages)	$614,403,281
2-Child <=18	$909,839,264
3-Adult >= 65	$103,239
4-Adult <= 64	$766,668,534
17s	$253,485,494
Total	**$2,544,499,813**

DSH

DSH Adjustment (Quarterly)	$115,999,213

Total Ceiling

Budget Neutrality Cap	
Total w/DSH Adj.	**$2,660,499,026**

II. Actual Expenditures

Group 1 and 2

1-Disabled (can be any ages)	$	513,431,363
2-Child <=18	$	425,665,816
3-Adult >= 65	$	232,473
4-Adult <= 64	$	330,030,112

Duals (17)	$	288,427,552
Total		**1,557,787,316**

Group 3

1-Disabled (can be any ages)		
2-Child <=18	$	12,026,792
3-Adult >= 65	$	86,768,338
4-Adult <= 64	$	3,259,029
Duals (17)		
Total		**102,054,159**

Pool Payments and Admin

Total Pool Payments	$	445,050,789

Admin	$	73,900,125

Quarterly Drug Rebates	$	153,065,459
Quarterly Premium Collections	$	1,000.00
Total Net Quarterly Expenditures	**$**	**2,025,725,930**

III. Surplus/(Deficit)

III. Surplus/(Deficit)	**$634,773,096**
Federal Share	**$419,775,448**

HCI Result	MM201307	MM201308	MM201309	TOTAL	HCI ASO	HCI Rx	HCI DTL	HCI MCO CAP (TCS Admin)	TOTAL
EG1-TYPE1 (disabled, type1 state plan eligibles)	132,142	131,371	129,967	393,480	$70,768,927	$91,206,818	$1,772,088	$345,343,164	$509,090,997
EG1-TYPE2 (disabled, type2 transition group)	0	0	0	-					$0
EG2-TYPE1 (over 65, type1 state plan eligibles)	32	36	33	101	$185,607	$6,976	$0	$39,890	$232,473
EG2-TYPE2 (over 65, type2 state plan eligibles)	0	0	0	-					$0
EG3-TYPE1 (children, type1 state plan eligibles)	651,624	647,009	643,559	1,942,192	$11,880,610	$52,993,309	$31,359,915	$329,431,982	$425,665,816
Med Exp Child (Title XXI Demo Pop; EG3-Type2)	19,170	19,483	19,432	58,085	$32,667	$3,040,930	$1,348,493	$7,432,408	$11,854,498
EG4-TYPE1 (adults, type1 State plan eligibles)	283,882	276,348	275,112	835,342	$2,012,656	$49,517,279	$3,483,842	$275,016,335	$330,030,112
EG4-TYPE2 (adults, type2 demonstration pop)	0	0	0	-					$0
EG5-TYPE1 (duals, state plan eligibles)	124,007	123,548	122,779	370,334	$991,825	$693,214	$29,988	$236,992,910	$238,707,937
EG6E-TYPE3 (Expan adult, type3 demonstration pop)	1,552	1,492	1,487	4,531	$3,149	$630,648	$0	$2,625,232	$3,259,029
EG7E-TYPE3 (Expan child, type3 demonstration pop)	152	151	144	447		$102,698	$10,242	$59,354	$172,294
EG8-TYPE2 (emd exp child)	0	0	0	-					$0
EG9 H-Disabled (TYPE 2 Eligibles)	306	313	331	950	$590	$316,757	$0	$4,023,019	$4,340,366
EG11H, H-Dual	5,814	5,946	6,098	17,858	$0	$22,691	$0	$49,696,924	$49,719,615
EG12E, Carryovers	7,492	7,397	7,319	22,208	$2,263	$1,656,698	$0	$85,109,377	$86,768,338
Total	**1,226,173**	**1,213,094**	**1,206,261**	**3,645,528**	**$85,878,294**	**$200,188,018**	**$38,004,568**	**$1,335,770,595**	**$1,659,841,475**

$1,659,841,475

HCI Result	MM201307	MM201308	MM201309	TOTAL	HCI ASO PMPM	HCI Rx PMPM	HCI DTL PMPM	HCI MCO CAP (TCS Admin)	TOTAL
EG1-TYPE1 (disabled, type1 state plan eligibles)	132,142	131,371	129,967	393,480	$179.85	$231.80	$4.50	$877.66	$1,293.82
EG1-TYPE2 (disabled, type2 transition group)	0	0	0	-					
EG2-TYPE1 (over 65, type1 state plan eligibles)	32	36	33	101	$1,837.69	$69.07	$0.00	$394.95	$2,301.71
EG2-TYPE2 (over 65, type2 state plan eligibles)	0	0	0	-	-	-	-	-	-
EG3-TYPE1 (children, type1 state plan eligibles)	651,624	647,009	643,559	1,942,192	$6.12	$27.29	$16.15	$169.62	$219.17
Med Exp Child (Title XXI Demo Pop; EG3-Type2)	19,170	19,483	19,432	58,085	$0.56	$52.35	$23.22	$127.96	$204.09
EG4-TYPE1 (adults, type1 State plan eligibles)	283,882	276,348	275,112	835,342	$2.41	$59.28	$4.17	$329.23	$395.08
EG4-TYPE2 (adults, type2 demonstration pop)	0	0	0	-					
EG5-TYPE1 (duals, state plan eligibles)	124,007	123,548	122,779	370,334	$2.68	$1.87	$0.08	$639.94	$644.57
EG6E-TYPE3 (Expan adult, type3 demonstration pop)	1,552	1,492	1,487	4,531	$0.69	$139.19	$0.00	$579.39	$719.27
EG7E-TYPE3 (Expan child, type3 demonstration pop)	152	151	144	447	$0.00	$229.75	$22.91	$132.78	$385.45
EG8-TYPE2 (emd exp child)	0	0	0	-					
EG9 H-Disabled (TYPE 2 Eligibles)	306	313	331	950	$0.62	$333.43	$0.00	$4,234.76	$4,568.81
EG11H, H-Dual	5,814	5,946	6,098	17,858	$0.00	$1.27	$0.00	$2,782.89	$2,784.16
EG12E, Carryovers	7,492	7,397	7,319	22,208	$0.10	$74.60	$0.00	$3,832.37	$3,907.08
Total	**1,226,173**	**1,213,094**	**1,206,261**	**3,645,528**	**$23.56**	**$54.91**	**$10.42**	**$366.41**	**$455.31**