November 30, 2015

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

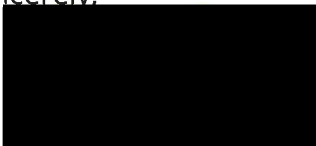
RE: TennCare II, STC 45, Quarterly Progress Report

Dear Ms. Woodard:

Enclosed please find the Quarterly Progress Report for the July – September 2015 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: Juliana Sharp, 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

Bureau of TennCare • 310 Great Circle Road • Nashville, TN 37243
Tel: 615-507-6480 • tn.gov/tenncare

TennCare II

Section 1115 Quarterly Report

(For the period July - September 2015)

Demonstration Year: 14 (7/1/15 - 6/30/16)
Federal Fiscal Quarter: 4/2015 (7/15 - 9/15)
Waiver Quarter: 1/2016 (7/15 - 9/15)

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 more than 1.4 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 #
7/4/15	The State responded to CMS's 6/29/15 written question concerning resource standards and deeming of income for Demonstration Amendment 27. Amendment 27 concerns *Employment and Community First CHOICES*, a new program of managed long-term services and supports for individuals with intellectual and developmental disabilities.	
7/6/15	CMS sent the State a letter acknowledging the submission of Demonstration Amendment 27 and confirming that the submission was complete.	
7/13/15	CMS sent the State written questions concerning Amendment 27.	
7/23/15	The State sent CMS a letter announcing its intention to close enrollment in the Standard Spend Down category permanently. The letter articulated the State's view that a demonstration amendment would not be necessary for this purpose, but it also invited CMS to treat the letter as Demonstration Amendment 28 if necessary.	
7/23/15	The Monthly Call was held. Topics included Demonstration Amendments 26 (involving hospital pool payments) and 27; technical corrections that the State had requested in response to the approval materials for Amendments 18 and 24; and the status of the *Wilson v. Gordon* lawsuit.	44

Date	Action	STC #
7/27/15	In reference to Amendment 27, the State sent responses to CMS's written questions of 7/13/15.	
7/31/15	CMS sent the State additional written questions concerning Amendment 27, as well as a request for State input concerning STCs that would be needed to implement the proposal.	
7/31/15	The State submitted to CMS two items related to hospital pool payments: financial data pertaining to Amendment 26 and an outline of the evaluation of uncompensated care costs for the uninsured required by STC 69.	
8/5/15	In reference to Amendment 27, the State sent responses to CMS's written questions of 7/31/15.	
8/12/15	In response to the State's 7/23/15 correspondence concerning closure of the Standard Spend Down eligibility category, CMS sent a letter indicating that the State's request would be considered a request to amend the TennCare Demonstration but that the criteria for a complete request had not been fulfilled.	
8/14/15	The State sent the CMS Project Officer a courtesy copy of State Plan Amendment (SPA) TN-15-0001, which involves changes to the reimbursement rate for compounded prescriptions prepared on behalf of TennCare enrollees.	7
8/27/15	The Monthly Call was held. Topics included Amendment 26; the evaluation required by STC 69; and technical corrections that the State had requested in response to the approval materials for Amendments 18 and 24.	44
8/28/15	The State notified the public of its intent to submit Demonstration Amendment 28 to CMS to close the Standard Spend Down eligibility category.	15
8/28/15	The State submitted point-in-time and annual aggregate data about the CHOICES program to CMS.	43.d.iii.
8/28/15	CMS sent the State approval of Amendment 37 to the TennCare Select contract.	40
8/31/15	The State submitted the Quarterly Progress Report for the April-June 2015 quarter to CMS.	45
8/31/15	The State sent the CMS Project Officer a courtesy copy of SPA TN-15-0002, which proposes updates to the State's Supplemental Rebate Agreement with pharmaceutical manufacturers.	7
9/22/15	The State submitted to CMS a report summarizing the results of the annual beneficiary survey.	47
9/28/15	The Monthly Call was held. The State provided an	44

Date	Action	STC #
	overview of pending demonstration amendments to the newly assigned CMS Project Officer and CMS Technical Director.	

II. Enrollment and Benefits Information

Information about enrollment by category is presented in Table 2. A change in the methodology by which enrollees are placed in eligibility groups was introduced this quarter and has been applied retroactively to the two preceding quarters to ensure meaningful comparison.

Table 2
Enrollment Counts for the July – September 2015 Quarter
Compared to the Previous Two Quarters

Demonstration Populations	Total Number of TennCare Enrollees		
	Jan – Mar 2015	Apr – Jun 2015	Jul – Sept 2015
EG1 Disabled, Type 1 State Plan eligibles	143,467	143,099	142,205
EG9 H-Disabled, Type 2 Demonstration Population	274	292	306
EG2 Over 65, Type 1 State Plan eligibles	139	148	197
EG10 H-Over 65, Type 2 Demonstration Population	21	22	39
EG3 Children, Type 1 State Plan eligibles	723,536	735,613	749,605
EG4 Adults, Type 1 State Plan eligibles	380,117	395,870	413,342
EG5 Duals, Type 1 State Plan eligibles and EG11 H-Duals 65, Type 2 Demonstration Population	140,901	142,046	143,895
EG6E Expan Adult, Type 3 Demonstration Population	845	829	814
EG7E Expan Child, Type 3 Demonstration Population	66	64	63
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	19,097	18,991	18,894

Demonstration Populations	Total Number of TennCare Enrollees		
	Jan – Mar 2015	Apr – Jun 2015	Jul – Sept 2015
EG12E Carryover, Type 3, Demonstration Population	4,601	4,141	3,792
TOTAL*	1,413,064	1,441,115	1,473,142

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

The majority of TennCare's enrollment continues to be categorized as Type 1 EG3 children and Type 1 EG4 adults, with nearly 79 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, 2015

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

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

Demonstration Amendment 26: Expenditures for Hospital Pool Payments. Under the terms of the TennCare Demonstration, TennCare has the "expenditure authority" (specifically, "Expenditure Authority #4") to make certain payments to providers through "pools" that exist outside the managed care program. The recipients of funds from most of the pools are identified groups of Tennessee hospitals. The primary purpose of pool funds is to offset the costs of delivering uncompensated care, but they have some other purposes as well, such as providing support for graduate medical education programs. Currently, Expenditure Authority #4 is scheduled to expire on December 31, 2015, which is six months prior to the end date of TennCare's current approval period on June 30, 2016. Therefore, Amendment 26 requests that

[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, formerly known as "AmeriChoice," is operated by UnitedHealthcare Plan of the River Valley, Inc.
[3] TennCare Select is operated by Volunteer State Health Plan, Inc. (VSHP).

the expiration of Expenditure Authority #4 be synchronized with the conclusion of the approval period.

During the July-September 2015 quarter, the Bureau provided additional documentation in support of Amendment 26, including details of pool expenditures to be made during Fiscal Year 2016. As of the end of the reporting period, CMS was still reviewing the proposal.

Demonstration Amendment 27: Employment and Community First CHOICES. As detailed in TennCare's last Quarterly Progress Report, the Bureau submitted Demonstration Amendment 27—detailing a new program named Employment and Community First (ECF) CHOICES—to CMS on June 23, 2015. The text of Amendment 27, available at http://www.tn.gov/assets/entities/tenncare/attachments/Amendment27ECFCHOICES.pdf, provides the following concise summary of ECF CHOICES:

> With Amendment 27 to the TennCare demonstration, Tennessee proposes to implement within its existing managed care demonstration an integrated managed long-term services and supports (MLTSS) program that is specifically geared toward promoting and supporting integrated, competitive employment and independent, integrated community living as the first and preferred option for individuals with intellectual and developmental disabilities (I/DD).

Negotiations between TennCare and CMS during the July-September 2015 quarter focused on ensuring that CMS had all of the information necessary to approve Amendment 27. At the conclusion of the quarter, furthermore, the Bureau was nearing completion of a set of draft Special Terms and Conditions (STCs) for the TennCare Demonstration. These STCs define the manner in which ECF CHOICES would operate within TennCare's managed care system, thereby facilitating CMS's review of the proposal.

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

Upon CMS's approval, TennCare would review members of the SSD population for eligibility in all open categories of TennCare coverage. Any individual found to qualify in another category would be automatically transferred with no interruption in coverage. Individuals who do not qualify in another category would be disenrolled from TennCare and referred to Medicare

and/or the Health Insurance Marketplace. By the end of the July-September 2015 quarter, the public comment period was nearing its conclusion, and no comments had been received.

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 2015 quarter, the Bureau received no notifications that a family with members enrolled in TennCare Standard had met its cost sharing limit. It should be noted that this is the eleventh 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,"[4] outreach is a significant area of interest for TennCare. The TennCare Bureau maintains a contract with the Tennessee Department of Health (TDH) to conduct a community outreach program for the purpose of educating families on EPSDT benefits and encouraging them to use those benefits, particularly preventive exams.

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

- Seasonal events. National Children's Dental Health Month in February, back-to-school events in August, and Child Health Week in October all have a profound influence on the focus and direction of outreach efforts during their respective quarters. TDH's communications strategy for each is based on an evaluation of past successes and current opportunities. During a 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).

[4] Until June 22, 2015, TennCare's EPSDT program had been known as "TENNderCare."

Table 4
Tennessee Department of Health
Community Outreach Activity for EPSDT
July – September 2015 Compared to the Previous Two Quarters

Activities	Jan – Mar 2015	Apr – Jun 2015	Jul – Sept 2015
Number of outreach activities/events	3,310	3,753	3,649
Number of people made contact with (mostly face to face at outreach events)	139,810[5]	170,368	203,202
Number of educational materials distributed	126,138	175,614	218,290
Number of coalitions/advisory board meetings attended or conducted	82	80	85
Number of attendees at coalitions/advisory board meetings	1,483	1,339	1,471
Number of educational preventive health radio/TV broadcasts	1,714	1,394	962
Number of educational preventive health newsletter/magazine articles	303	291	29
Number of educational preventive health billboards, scrolling billboards and bulletin boards	6,657	7,177	5,804
Number of presentations made to enrollees/professional staff who work with enrollees	159	128	118
Number of individuals attending presentations	8,719	3,578[6]	4,370
Number of attempted telephone calls regarding the importance of dental checkups	290	406	66
Number (approx) of completed telephone calls regarding the importance of dental checkups	162	159	48
Number of home visits completed	35	28	23

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.

---

[5] The number of contacts made at outreach events was lower than usual during the January-March 2015 quarter, in part because of low turnout stemming from inclement weather.

[6] A notable decline in the number of individuals attending presentations during the April-June 2015 quarter resulted from the lack of a seasonal event on the scale of Dental Health Month in February or Child Health Week in October.

Table 5
Tennessee Department of Health
TennCare Kids Call Center Activity
July – September 2015 Compared to the
Previous Two Quarters

Activities	Jan – Mar 2015	Apr – Jun 2015	Jul – Sept 2015
Number of enrollees reached	19,600	22,115	23,944
Number of enrollees who were assisted in scheduling an EPSDT exam for their children	206	417[7]	766[8]
Number of enrollees who were assisted in arranging for transportation	11	30	19

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 2015 Quarter, and Percentage that Passed Systems Edits, Compared to the Previous Two Quarters

	Jan – Mar 2015	Apr – Jun 2015	Jul – Sept 2015
No. of encounters received by TennCare (initial submission)	12,862,995	13,376,983	16,066,893
No. of encounters rejected by Edifecs upon initial submission	20,303	16,366	11,183
Percentage of encounters that were compliant with State standards (including HIPAA) upon initial submission	99.84%	99.88%	99.96%

[7] The total number of enrollees whom TDH assisted with an EPSDT exam grew during the April-June 2015 quarter because of an increase in the number of outreach specialists engaged in contacting families, as well as a new emphasis in messaging on scheduling appointments before the "back-to-school rush."

[8] The number of enrollees whom TDH assisted with an EPSDT exam continued to grow during the July-September 2015 quarter. The increase coincided not only with the factors cited in Footnote 7, but also with increased dental outreach efforts.

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
TennCare CHOICES Enrollment and Reserve Slots
for July – September 2015 Compared to the Previous Two Quarters

	Statewide Enrollment Targets and Reserve Capacity[9]	Enrollment and Reserve Slots Being Held as of the End of Each Quarter		
		Jan – Mar 2015	Apr – Jun 2015	Jul – Sept 2015
CHOICES 1	Not applicable	17,391	17,069	17,169
CHOICES 2	12,500	8,386	8,301	8,455
CHOICES 3 (including Interim CHOICES 3)	Not applicable	4,902	4,939	4,690
Total CHOICES	Not applicable	30,679	30,309	30,314
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. Nine separate reports—spanning the period of August 2011 through August 2015—had been submitted by the conclusion of the July-September 2015 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 HCBS available to individuals whose needs can be safely and effectively met at home or in other non-institutional settings. Point in time data revealed declining use of NF services over time, with placement in institutional settings decreasing from 21,530 individuals on June 30, 2011, to 17,069 individuals on June 30, 2015. The aggregate number of TennCare enrollees accessing HCBS, by comparison, grew from 6,226 in the twelve-month period preceding CHOICES implementation in Middle Tennessee to 16,112 after CHOICES had been in place for four full

[9] Of the three active CHOICES groups, only CHOICES 2 has an enrollment target.

fiscal years. This trend was mirrored in point-in-time data as well: on the day prior to CHOICES implementation, 4,861 individuals were using HCBS, but the number had grown to 13,240 by June 30, 2015. This information is summarized in Table 8.

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

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

Enrollment of select members of the CHOICES population in Groups 1 and 2: STC 45.f. requires the State to provide "enrollment reports for individuals that would otherwise be eligible for *Interim* CHOICES 3 but meet the modified institutional level of care, and whether CHOICES 1 or CHOICES 2 was selected by the individual." The population of LTSS recipients described in this passage, then, consists of individuals who have been approved for Nursing Facility Level of Care in CHOICES 1 (NF) or CHOICES 2 (HCBS) despite having been assigned a score of less than 9 on the TennCare Nursing Facility Level of Care Acuity Scale. Each approval is based on a determination by TennCare that the applicant does not qualify for enrollment in Interim CHOICES 3. Such a determination would be made when the necessary intervention and supervision needed by the applicant could not be safely provided within the array of services and supports that would be available if the applicant were enrolled in Interim CHOICES 3, including—

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

[10] 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).

During the period from July 1, 2015, through September 30, 2015, NF PreAdmission Evaluations were approved for 184 individuals with acuity scores lower than 9, and 102 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 PreAdmission Evaluations were approved for 94 individuals with acuity scores lower than 9, and 69 of the individuals were subsequently enrolled in CHOICES Group 2. The remaining applicants did not meet Medicaid financial eligibility requirements or otherwise failed to qualify for, or proceed with, enrollment in CHOICES 2.

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

Table 9
TennCare CHOICES Transition Allowances
for July – September 2015 Compared to the Previous Two Quarters

	Frequency and Use of Transition Allowances					
	Jan – Mar 2015		Apr – Jun 2015		Jul – Sept 2015	
Grand Region	# Distributed	Total Amount	# Distributed	Total Amount	# Distributed	Total Amount
East	6	$5,388	11	$11,205	13	$19,431
Middle	4	$3,999	8	$9,065	9	$6,009
West	10	$6,090	11	$12,361	12	$8,256
Statewide Total	20	$15,477	30	$32,631	34	$33,696

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

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

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

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

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

During the July-September 2015 quarter, the MCOs submitted their National Association of Insurance Commissioners (NAIC) Second Quarter 2015 Financial Statements. As of June 30, 2015, TennCare MCOs reported net worth as indicated in the table below.[11]

Table 10
Net Worth Reported by MCOs as of June 30, 2015

	Net Worth Requirement	Reported Net Worth	Excess/ (Deficiency)
Amerigroup Tennessee	$18,895,648	$157,867,945	$138,972,297
UnitedHealthcare Plan of the River Valley (UnitedHealthcare Community Plan)	$67,602,074	$413,132,143	$345,530,069

[11] 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.

	Net Worth Requirement	Reported Net Worth	Excess/ (Deficiency)
Volunteer State Health Plan (BlueCare & TennCare Select)	$37,185,058	$359,764,211	$322,579,153

During the July-September 2015 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 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, 2015:

Table 11
Company Action Level Reported by MCOs as of June 30, 2015

	Company Action Level Requirement	Reported Net Worth	Excess/ (Deficiency)
Amerigroup Tennessee	$61,407,788	$157,867,945	$96,460,157
UnitedHealthcare Plan of the River Valley (UnitedHealthcare Community Plan)	$244,098,654	$413,132,143	$169,033,489
Volunteer State Health Plan (BlueCare & TennCare Select)	$109,546,612	$359,764,211	$250,217,599

All TennCare MCOs far exceeded their minimum net worth requirements and Company Action Level requirements as of June 30, 2015.

C. Beneficiary Survey

Every year since 1993, the Center for Business and Economic Research (CBER) 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.).

CBER prepared a summary of the results of the most recent survey entitled *The Impact of TennCare: A Survey of Recipients 2015*, and the Bureau submitted the document to CMS on September 22, 2015. Although the findings of a single survey must be viewed in context of long-term trends, several results from the report stand out:

- 95 percent of respondents covered by TennCare expressed satisfaction with the quality of care they had received. This level of satisfaction ties for the highest in the program's history and is the third time in five years that this peak has been attained. Furthermore, 2015 is the seventh straight year in which survey respondents have reported satisfaction levels exceeding 90 percent.
- The percentage of respondents classifying themselves as uninsured fell to 6.6 percent, the lowest level since 2004. Likewise, the percentage of respondents classifying their children as uninsured fell to 1.5 percent, the lowest level since the survey began in 1993.
- TennCare enrollees reported being able to get an appointment with a primary care physician more quickly in 2015. 42 percent of respondents stated that they were seen on the same day or the next day, as compared with 39 percent in 2014.

In summary, the report notes, "TennCare continues to receive positive feedback from its recipients, with 95 percent reporting satisfaction with the program, indicating TennCare is providing medical care in a satisfactory manner and up to the expectations of those it serves." The report may be viewed online at http://cber.haslam.utk.edu/tncare/tncare15.pdf.

D. SIM Grant Activity

In December 2014, the Tennessee Division of Health Care Finance and Administration, or HCFA—the division of state government that administers the TennCare Demonstration—was awarded a $65 million Round Two State Innovation Model (SIM) grant. In Tennessee, the SIM grant supports efforts related to payment reform, and it encompasses strategies that enhance the role of the primary care provider, that align multi-payer models, that focus on improving quality and shifting payment in the LTSS system, and that can be translated into "episodes of care" when multiple providers are involved in a specific health care event. Although the work supported by the SIM grant extends beyond TennCare, TennCare is a leading participant and a critical component of efforts to achieve payment reform in Tennessee.

During the July-September 2015 quarter, HCFA continued moving forward with its primary care transformation work, a model that entails the development of health homes for TennCare enrollees with severe mental illness and patient centered medical homes (PCMHs) for all TennCare enrollees. HCFA continued to convene a series of Technical Advisory Group (TAG) meetings for both health homes and PCMHs. During this quarter, HCFA contracted with the Tennessee Chapter of the American Academy of Pediatrics (TNAAP) to provide practice transformation and quality improvement training to pediatric practices across the state.

During this quarter, HCFA also continued to implement its episodes of care model for acute health care events involving multiple payers. Each episode of care has a designated Principal Accountable Provider (PAP), who receives information that helps him coordinate care over the course of the episode. The PAPs for HCFA's first wave of episodes have now completed the third quarter of the first year of their performance period, while PAPs associated with HCFA's second set of episodes continued to receive preview reports in preparation for a performance period that is scheduled to begin on January 1, 2016. HCFA has contracted with the Tennessee Hospital Association (THA) to develop a web-based tool to assist hospitals in understanding the quarterly reports from payers for each episode.

E. Electronic Health Record Incentive Program

The Electronic Health Record (EHR) Incentive Program is a partnership between federal and state governments that grew out of the Health Information Technology for Economic and Clinical Health (HITECH) Act. The purpose of the program is to provide financial incentives to Medicaid providers[12] to replace outdated, often paper-based approaches to medical record-keeping with electronic systems that meet rigorous certification criteria and that can improve health care delivery and quality. The federal government provides 100 percent of the funding for the incentive payments and 90 percent of the administrative costs.

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

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

EHR payments made by TennCare during the July-September 2015 quarter as compared with payments made throughout the life of the program appear in the table below:

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

Table 12
EHR Payments
Quarterly and Cumulative

Payment Type	No. of Providers Paid During the Quarter	Quarterly Amount Paid (Jul-Sept 2015)	Cumulative Amount Paid To Date
First-year payments	61[13]	$1,690,954	$155,767,688
Second-year payments	106	$847,400	$49,557,395
Third-year payments	147	$4,306,589	$16,911,038
Fourth-year payments	31	$263,500	$1,368,505

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

- Hosting 19 technical assistance calls during the quarter for eligible professionals attesting to meaningful use;
- Responding to more than 250 inquiries submitted to the EHR Meaningful Use email box;
- Hiring of a Clinical Educator to assist with Meaningful Use training activities;
- Participation throughout the quarter in several Southeast Regional Collaboration for HIT/HIE (SERCH) calls;
- Two email notices to providers reminding them to complete any remaining Meaningful Use attestations for payment year 2014;
- Monthly newsletters distributed by the Bureau's EHR ListServ; and
- A quarterly reminder to Tennessee providers who had registered at the federal level but who have not registered or attested at the state level.

TennCare continues to schedule EHR workshops with a variety of provider organizations to maintain the momentum of the program. Events being planned when the July-September 2015 quarter concluded, for instance, included participation in Tennessee Medical Association meetings throughout the state, as well as attendance at the 67th Annual Scientific Assembly of the Tennessee Academy of Family Physicians.

F. Award for Chief Information Officer (CIO)

On September 2, 2015, the *Nashville Business Journal* announced the winners of the periodical's 2015 CIO Awards. The awards are presented annually to "the top technological executives in Middle Tennessee who are using IT in innovative ways to create a competitive advantage, optimize business procedures, enable company growth and impact the company's bottom line." TennCare CIO Kyle Duke was one of three individuals in the category of

[13] Of the 61 providers receiving first-year payments in the July-September 2015 quarter, 13 earned their incentives by successfully attesting to meaningful use of EHR technology in their first year of participation in the program.

"Institution/Nonprofit" to be honored and was scheduled to receive the award at a ceremony hosted by the *Nashville Business Journal* on October 23, 2015.

Mr. Duke joined TennCare's Executive Staff in April 2014 after serving as Vice President of IT and Chief Information Security Officer for Cigna-HealthSpring. As of the end of the July-September 2015 quarter, he oversaw all aspects of the Bureau's information technology systems management.

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

In all three months of the July-September 2015 quarter, total state and local revenue collections were notably higher than they had been during the corresponding months of 2014, with an eight percent improvement in July, a four percent improvement in August, and a seven percent improvement in September.[14] In the arena of jobs, Tennessee demonstrated relative stability, with the unemployment rate remaining fixed at 5.7 percent in all three months of the quarter. These figures represent an improvement on the results from one year ago, when the Tennessee unemployment rate was fixed at 6.6 percent from July through September. The gap between the state and national unemployment rates was relatively small this quarter as well, with the difference ranging from 0.4 percent to 0.6 percent during the reporting period.[15]

VIII. Member Month Reporting

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

[14] The Department of Revenue's collection summaries are available online at https://www.tn.gov/revenue/article/revenue-collections-summaries.
[15] 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.

Table 13
Member Month Reporting for Use in Budget Neutrality Calculations
July – September 2015

Eligibility Group	July 2015	August 2015	September 2015	Sum for Quarter Ending 9/30/15
Medicaid eligibles (Type 1)				
EG1 Disabled, Type 1 State Plan eligibles	142,203	142,061	141,529	425,793
EG2 Over 65, Type 1 State Plan eligibles	129	138	187	454
EG3 Children, Type 1 State Plan eligibles	738,435	743,262	747,185	2,228,882
EG4 Adults, Type 1 State Plan eligibles	400,526	406,382	411,689	1,218,597
EG5 Duals, Type 1 State Plan eligibles	134,544	135,101	135,682	405,327
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	295	304	303	902
EG10 H-Over 65, Type 2 Demonstration Population	27	28	28	83
EG11 H-Duals, Type 2 Demonstration Population	6,192	6,203	6,181	18,576
TOTAL	1,422,351	1,433,479	1,442,784	4,298,614

Table 14
Member Month Reporting Not Used in Budget Neutrality Calculations
July – September 2015

Eligibility Group	July 2015	August 2015	September 2015	Sum for Quarter Ending 9/30/15
EG6E Expan Adult, Type 3, Demonstration Population	817	807	802	2,426
EG7E Expan Child, Type 3, Demonstration Population	63	63	63	189
Med Exp Child, Title XXI	18,938	18,907	18,851	56,696

Eligibility Group	July 2015	August 2015	September 2015	Sum for Quarter Ending 9/30/15
Demonstration Population				
EG12E Carryover, Type 3, Demonstration Population	3,929	3,826	3,723	11,478
TOTAL	23,747	23,603	23,439	70,789

IX. Consumer Issues

Eligibility Appeals. TennCare eligibility appeals concerning non-MAGI eligibility categories continued to be processed by the Tennessee Department of Human Services (DHS) during the quarter, while the Bureau maintained responsibility for MAGI-related eligibility appeals submitted directly to TennCare. Table 15 presents a summary of eligibility appeal activity by both agencies during the quarter, compared to the previous two quarters.

Table 15
Eligibility Appeals Handled by TennCare and the Department of Human Services
During the July – September 2015 Quarter, Compared to the Previous Two Quarters

	Jan – Mar 2015	Apr – Jun 2015	Jul – Sept 2015
No. of appeals received	4,944	4,301	4,382
No. of appeals resolved or withdrawn	5,328	6,257	3,205
No. of appeals taken to hearing	2,567	2,926	1,966

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

Table 16
Medical Service Appeals Handled by the Bureau of TennCare
During the July – September 2015 Quarter, Compared to the Previous Two Quarters

	Jan – Mar 2015	Apr – Jun 2015	Jul – Sept 2015
No. of appeals received	1,287	1,740	2,149
No. of appeals resolved	1,297	1,572	1,800
• Resolved at the MCC level	492	807	795
• Resolved at the TSU level	95	114	132
• Resolved at the LSU level	710	651	873
No. of appeals that did not involve a valid factual dispute	113	180	235

	Jan – Mar 2015	Apr – Jun 2015	Jul – Sept 2015
No. of directives issued	159	167	201
No. of appeals taken to hearing	710	651	873
No. of appeals that were withdrawn by the enrollee at or prior to the hearing	222	198	293
Appeals that went to hearing and were decided in the State's favor	255	232	293
Appeals that went to hearing and were decided in the appellant's favor	21	19	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. In the CMS letter approving CHOICES implementation in Middle Tennessee dated February 26, 2010, the Bureau was asked to monitor and provide information on CHOICES-specific appeals. In the approval letter sent to the State on August 3, 2010, CMS said that they looked forward to "continuing our collaboration with the State for monitoring the CHOICES Program through sharing of standardized reports, monthly Demonstration monitoring calls, and the Quarterly and Annual Reports." The following table provides information regarding certain appeals administered by the Long-Term Services and Supports Division for the quarter, compared to the previous two quarters.

Table 17
Long-Term Services and Supports Appeals for July – September 2015
Compared to the Previous Two Quarters

	Jan – Mar 2015	Apr – Jun 2015	Jul – Sept 2015
No. of appeals received	217	234	297

	Jan – Mar 2015	Apr – Jun 2015	Jul – Sept 2015
No. of appeals resolved or withdrawn	145	181	147
No. of appeals set for hearing	73	70	72

X. Quality Assurance/Monitoring Activity

Population Health. "Population Health" (PH) is the model of targeted health care interventions implemented by TennCare in the months leading up to—and culminating on—July 1, 2013. 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 2015 quarter is provided in Table 18. Data for the period of July through September 2015 will be provided in the next Quarterly Progress Report.

Table 18
Population Health Data*, April – June 2015

Risk Level	Intervention Type	Intervention Goal(s)	Number of Unique Members at End of Quarter
Level 0: no identified risk	Wellness Program	Keep members healthy as long as possible	786,627
Level 1: low or moderate risk	Maternity Program	Engage pregnant women in timely prenatal care and deliver a healthy, term infant without complications	17,522
	Health Risk Management	Prevent, reduce, or delay exacerbation and complications of a condition or health risk behavior	548,463

Risk Level	Intervention Type	Intervention Goal(s)	Number of Unique Members at End of Quarter
	Care Coordination	Assure that members receive the services they need to reduce the risk of an adverse health outcome	28,709[16]
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	4,726
	High Risk Pregnancy Management	Engage pregnant women in timely prenatal care and deliver a healthy, term infant without complications	2,296
	Complex Case Management	Move members to optimal levels of health and well-being through timely coordination of quality services and self-management support	1,086
Total PH Enrollment			**1,360,720**

*** 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 2015, TennCare's External Quality Review Organization (EQRO), Qsource, published the results of its provider data validation survey for the April-June 2015 quarter. Qsource took a sample of provider data files from TennCare's MCCs[17] and reviewed each for accuracy in the following categories:

- Contract status with MCC
- Provider address
- Provider credentialed specialty / behavioral health service code
- Open / closed to new patients
- Services to 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

[16] Each recipient of care coordination services is also enrolled in another PH intervention program. To avoid duplication, therefore, the enrollment total for care coordination is not included in the overall PH enrollment total.
[17] TennCare's Pharmacy Benefits Manager (PBM) was not included in the survey.

The validity of such information is one measure of providers' availability and accessibility to TennCare enrollees. Qsource's report concluded that "[o]verall, the MCCs' accuracy rates have maintained a high level," especially in the categories of "active contract status with MCC" (98.8 percent accuracy), "provider credentialed specialty / behavioral health service code" (97.8 percent accuracy), "urgent care services" (98.1 percent accuracy), "primary care services" (96.0 percent accuracy), and "prenatal care services" (99.9 percent accuracy).

Because April-June 2015 was only the second quarter in which all of the MCOs delivered services statewide, the results of the survey were not entirely comparable to results achieved by the MCOs in previous quarters, when accuracy was measured on a regional basis. Compared with the first quarter of the statewide approach, however, the MCCs—according to the report—"have maintained relatively high accuracy rates this quarter." Nonetheless, to ensure ongoing improvement in all ten categories of the survey, TennCare required each of its MCCs to submit a Corrective Action Plan no later than September 5, 2015. The Bureau, in turn, had received, reviewed, and accepted all of the plans by September 11, 2015. Results for the July-September 2015 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 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) new measures for the TennCare CHOICES program. The State is currently preparing another Interim Evaluation Report for the next demonstration renewal application, which will be submitted to CMS in December 2015.

On October 31, 2014, the State submitted its most recent Draft Annual Report as required by STC 46. 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 (including the one for Demonstration Year 13, which—as of the end of the July-September quarter—was being prepared for submission in October 2015).

Furthermore, on November 13, 2014, the State submitted its annual update of the strategy to evaluate and improve the quality and accessibility of care offered to enrollees through the managed care network. The document, entitled *2014 Annual Update Report of the 2013 Quality Assessment and Performance Improvement Strategy*, is available on TennCare's website at http://www.tn.gov/assets/entities/tenncare/attachments/qualitystrategy.pdf.

XII. Essential Access Hospital Pool[18]

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
Methodist Healthcare – South
Saint Jude Children's Research Hospital
University Medical Center (with McFarland Psych)
Saint Thomas Midtown Hospital
TriStar Skyline Medical Center (with Madison campus)
Wellmont Holston Valley Medical Center
Fort Sanders Regional Medical Center
TriStar Centennial Medical Center
Methodist Healthcare – North
Saint Francis Hospital
Parkridge East Hospital
Maury Regional Hospital
Parkwest Medical Center (with Peninsula Psych)

[18] 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 Thomas Rutherford Hospital
Wellmont Bristol Regional Medical Center
Cookeville Regional Medical Center
Tennova Healthcare – Physicians Regional Medical Center
Methodist Hospital – Germantown
Baptist Memorial Hospital for Women
Skyridge Medical Center
Blount Memorial Hospital
Gateway Medical Center
TriStar Horizon Medical Center
TriStar StoneCrest Medical Center
TriStar Summit Medical Center
NorthCrest Medical Center
Delta Medical Center
Dyersburg Regional Medical Center
LeConte Medical Center
Morristown – Hamblen Healthcare System
Southern Hills Medical Center
Heritage Medical Center
Sumner Regional Medical Center
Takoma Regional Hospital
Tennova Healthcare – Newport Medical Center
Sweetwater Hospital Association
Laughlin Memorial Hospital
Methodist Medical Center of Oak Ridge
TriStar Hendersonville Medical Center
Harton Regional Medical Center
Henry County Medical Center
Tennova Healthcare – LaFollette Medical Center
Grandview Medical Center
Sycamore Shoals Hospital
Skyridge Medical Center – Westside
Regional Hospital of Jackson
Baptist Memorial Hospital – Union City
Lakeway Regional Hospital
Indian Path Medical Center
Wellmont Hawkins County Memorial Hospital
Jellico Community Hospital
Hardin Medical Center
McNairy Regional Hospital
Starr Regional Medical Center – Athens
River Park Hospital
Henderson County Community Hospital
Roane Medical Center

United Regional Medical Center
Hillside Hospital
Crockett Hospital
Livingston Regional Hospital
McKenzie Regional Hospital
Volunteer Community Hospital
Bolivar General Hospital
Wayne Medical Center
Erlanger Health System – East Campus
Baptist Memorial Hospital – Huntingdon
DeKalb 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 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 Meharry Medical Group
University of Tennessee at Memphis	The Regional Medical Center (The MED) Methodist LeBonheur Erlanger Jackson Madison St. Francis
Vanderbilt University	Vanderbilt Hospital

XIV. Critical Access Hospitals

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

State Contact:

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

Phone: 615-507-6480
Fax: 615-253-2917

Date Submitted to CMS: November 30, 2015

Attachment A

Budget Neutrality Calculations for the Quarter

Actual TennCare Budget Neutrality (July - September 2015)

I. The Extension of the Baseline

Baseline PMPM

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

Actual Member months of Groups I and II

1-Disabled (can be any ages)	426,695
2-Child <=18	2,228,882
3-Adult >= 65	454
4-Adult <= 64	1,218,597
Duals (17)	423,903
Total	4,298,531

Ceiling without DSH

	Baseline * MM
1-Disabled (can be any ages)	$735,959,477
2-Child <=18	$1,116,360,378
3-Adult >= 65	$507,742
4-Adult <= 64	$1,230,707,688
17s	$302,854,484
Total	**$3,386,389,769**

DSH

DSH Adjustment (Quarterly)	$115,999,213

Total Ceiling

Budget Neutrality Cap	
Total w/DSH Adj.	**$3,502,388,982**

II. Actual Expenditures

Group 1 and 2

1-Disabled (can be any ages)	$	541,041,448
2-Child <=18	$	468,267,607
3-Adult >= 65	$	2,578,392
4-Adult <= 64	$	430,336,534

Duals (17)	$	315,358,793
Total		**1,757,582,774**

Group 3

1-Disabled (can be any ages)	$	-
2-Child <=18	$	13,178,530
3-Adult >= 65	$	49,309,056
4-Adult <= 64	$	955,418
Duals (17)	$	-
Total		**63,443,004**

Pool Payments and Admin

Total Pool Payments	$	254,606,619

Admin	$	89,157,475

Quarterly Drug Rebates	$	(150,762,945)
Quarterly Premium Collections	$	-
Total Net Quarterly Expenditures	**$**	**2,014,026,927**

III. Surplus/(Deficit)

III. Surplus/(Deficit)	**$1,488,362,055**
Federal Share	**$967,182,314**

HCI Result	MM201507	MM201508	MM201509	TOTAL	HCI ASO	HCI Rx	HCI DTL	HCI MCO CAP (TCS Admin)	UNK Allocation	TOTAL
EG1-TYPE1 (disabled, type1 state plan eligibles)	142,203	142,061	141,529	425,793	$74,883,663	$114,214,805	$1,694,982	$336,218,603	(175,494)	$526,836,558
EG2-TYPE1 (over 65, type1 state plan eligibles)	129	138	187	454	$688	$178,601		$2,399,964	(861)	$2,578,392
EG3-TYPE1 (children, type1 state plan eligibles)	738,435	743,262	747,185	2,228,882	$11,102,391	$61,143,543	$31,733,025	$364,444,640	(155,992)	$468,267,607
Med Exp Child (Title XXI Demo Pop; EG3-Type2)	18,938	18,907	18,851	56,696	$384,374	$2,885,221	$1,166,250	$8,695,653	(4,373)	$13,127,126
EG4-TYPE1 (adults, type1 State plan eligibles)	400,526	406,382	411,689	1,218,597	$1,181,138	$66,044,106	$2,863,777	$360,390,886	(143,374)	$430,336,534
EG5-TYPE1 (duals, state plan eligibles)	134,544	135,101	135,682	405,327	$966,831	$1,020,949	$732,813	$268,971,239	(90,483)	$271,601,350
EG6E-TYPE3 (Expan adult, type3 demonstration pop)	817	807	802	2,426		$222,578	$3,973	$729,185	(318)	$955,418
EG7E-TYPE3 (Expan child, type3 demonstration pop)	63	63	63	189	$62	$20,008	$2,528	$28,824	(17)	$51,404
EG9 H-Disabled (TYPE 2 Eligibles)	295	304	303	902		$230,264	$5,473	$13,973,895	(4,741)	$14,204,891
EG10 H-Senior	27	28	28	83		$6,979		$459,218		$466,197
EG11H, H-Dual	6,192	6,203	6,181	18,576		$5,499	$9,942	$43,756,571	(14,570)	$43,757,443
EG12E, Carryovers	3,929	3,826	3,723	11,478	$1,646	$156,501	$9,592	$48,691,386	(16,267)	$48,842,859
Total	**1,446,098**	**1,457,082**	**1,466,223**	**4,369,403**	**$88,520,792**	**$246,129,055**	**$38,222,354**	**$1,448,760,064**	**-$606,488**	**$1,821,025,778**

HCI Result	MM201507	MM201508	MM201509	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)	142,203	142,061	141,529	425,793	$175.87	$268.24	$3.98	$789.63	-$0.41	$1,237.31
EG2-TYPE1 (over 65, type1 state plan eligibles)	129	138	187	454	$1.52	$393.39	$0.00	$5,286.26	-$1.90	$5,679.28
EG3-TYPE1 (children, type1 state plan eligibles)	738,435	743,262	747,185	2,228,882	$4.98	$27.43	$14.24	$163.51	-$0.07	$210.09
Med Exp Child (Title XXI Demo Pop; EG3-Type2)	18,938	18,907	18,851	56,696	$6.78	$50.89	$20.57	$153.37	-$0.08	$231.54
EG4-TYPE1 (adults, type1 State plan eligibles)	400,526	406,382	411,689	1,218,597	$0.97	$54.20	$2.35	$295.74	-$0.12	$353.14
EG5-TYPE1 (duals, state plan eligibles)	134,544	135,101	135,682	405,327	$2.39	$2.52	$1.81	$663.59	-$0.22	$670.08
EG6E-TYPE3 (Expan adult, type3 demonstration pop)	817	807	802	2,426	$0.00	$91.75	$1.64	$300.57	-$0.13	$393.82
EG7E-TYPE3 (Expan child, type3 demonstration pop)	63	63	63	189	$0.33	$105.86	$13.37	$152.51	-$0.09	$271.98
EG9 H-Disabled (TYPE 2 Eligibles)	295	304	303	902	$0.00	$255.28	$6.07	$15,492.12	-$5.26	$15,748.22
EG10 H-Senior	27	28	28	83	$0.00	$84.09	$0.00	$5,532.75	$0.00	
EG11H, H-Dual	6,192	6,203	6,181	18,576	$0.00	$0.30	$0.54	$2,355.54	-$0.78	$2,355.59
EG12E, Carryovers	3,929	3,826	3,723	11,478	$0.14	$13.63	$0.84	$4,242.15	-$1.42	$4,255.35
Total	**1,446,098**	**1,457,082**	**1,466,223**	**4,369,403**	**$20.26**	**$56.33**	**$8.75**	**$331.57**	**-$0.14**	**$416.77**

* Unknown allocation was performed within the Service category totals.