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

February 28, 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 #47, Quarterly Progress Report

Dear Ms. Woodard:

Enclosed please find the Quarterly Progress Report for the October-December 2012 quarter. This report is being submitted in accordance with STC #47.

Please let us know if you have comments or questions.

Sincerely,

[redacted]

Darin J. Gordon
Director, Bureau of TennCare

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

TennCare II

Section 1115 Quarterly Report

(For the period October - December 2012)

Demonstration Year: 11 (7/1/12 - 6/30/13)
Federal Fiscal Quarter: 1/2013 (10/12 - 12/12)
Waiver Quarter: 2/2013 (10/12 - 12/12)

I. Introduction

The goal of the TennCare Demonstration is to show that careful use of a managed care approach can enable the State to enroll a certain number of people who are not otherwise eligible for Medicaid and to deliver quality care to all enrollees, without spending more than would have been spent had the State continued its Medicaid program.

TennCare contracts with several Managed Care Contractors (MCCs) to provide services to about 1.2 million enrollees. During this quarter, these entities included Managed Care Organizations (MCOs) for medical, behavioral, and certain long-term services and supports, a Dental Benefits Manager (DBM) for dental services, and a Pharmacy Benefits Manager (PBM) for pharmacy services.

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

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

Table 1
Key Dates of Approval/Operation in the Quarter

Date	Action	STC #
10/1/12	Governor Bill Haslam wrote to Health and Human Services Secretary Kathleen Sebelius regarding the 120-day timeframe that CMS has for approving the State's application to renew the TennCare Demonstration. Based on a provision in federal law that allows this period to be extended with the consent of the Chief Executive Officer of the State, Governor Haslam asked that the approval deadline be changed to December 31, 2012.	
10/10/12	The CMS Project Officer asked the State to identify the waiver and expenditure authorities that would be needed under the renewed TennCare Demonstration. The State expressed its preference to continue using all of the waiver and expenditure authorities currently in effect. The State reiterated that the only changes to the Demonstration being requested were the deletion of two obsolete demonstration groups, updates to certain CHOICES information, and the addition of three more years to certain tables that conclude with Demonstration Year (DY) 11 data.	
10/11/12	The Semi-Monthly Call was held. CMS notified the State that the federal comment period on the renewal request	

Date	Action	STC #
	had closed. Regarding the Technical Corrections sent to CMS on August 9, 2012 (in connection with the approval of Demonstration Amendments 14 and 16), the CMS Project Officer suggested that Expenditure Authority 9 ("The CHOICES 217-Like HCBS Group") be modified to include a reference to TennCare Select.	
10/12/12	In response to the Project Officer's suggestion about Expenditure Authority 9, the State indicated that there are no CHOICES members in TennCare Select.	
10/12/12	The State submitted to CMS revised quarterly Budget Neutrality documents covering the period from the first quarter of State Fiscal Year (SFY) 10 through the third quarter of SFY 12. A copy of the Budget Neutrality document for the fourth quarter of SFY 12, which had already been submitted, was included.	47
10/12/12	With regard to the State's Technical Corrections of August 9, 2012, the CMS Project Officer recommended removing Proposed Item (c)—concerning expenditures for Cost-Effective Alternative Services—from Expenditure Authority 11 ("The At Risk Demonstration Group").	
10/15/12	The State agreed with CMS's recommendation regarding Expenditure Authority 11.	
10/22/12	CMS approved TennCare's Quality Improvement Strategy.	45
10/31/12	The State submitted the Draft Annual Report.	48
10/31/12	CMS notified the State that the Technical Corrections requested on July 10, 2012 (in connection with the approval of Amendments 14 and 16) and amended on August 9 and in subsequent discussions had been accepted. A new version of the STCs, Expenditure Authorities, and Waiver List was forwarded to the State.	
11/2/12	The Monthly Call for October was held. CMS announced their intention, as part of the Demonstration renewal process, to revise some of the STCs—beginning with those on Eligibility, CHOICES, and Cost Sharing—for greater clarity. CMS also raised the possibility of amending Waiver 8 ("Freedom of Choice") to limit its scope to Section 1902(a)(23)(A) of the Social Security Act, thereby clarifying that freedom of choice with regard to family planning providers is not waived.	46
11/2/12	CMS wrote to the State to acknowledge receipt of Governor Haslam's letter of October 1, 2012.	
11/8/12	The Semi-Monthly Call was cancelled by CMS.	

Date	Action	STC #
11/19/12	The State sent CMS an updated version of the Operational Protocol.	Section XIV
11/22/12	Since the November Monthly Call had been scheduled to take place on Thanksgiving day, both CMS and the State agreed to a cancellation. No alternate call was scheduled.	46
11/29/12	The State sent CMS copies of correspondence to enrollees associated with implementation of the Cost-Sharing Plan on January 1, 2013. This correspondence had been requested by CMS in its letter of April 18, 2012, approving the Cost-Sharing Plan.	37
11/30/12	The State submitted the Quarterly Progress Report.	47
12/5/12	The State received the first draft of Demonstration renewal edits from CMS. The State responded with comments.	
12/12/12	The State received the second draft of Demonstration renewal edits from CMS.	
12/13/12	The Semi-Monthly Call was held.	
12/13/12	The State received the third draft of Demonstration renewal edits from CMS. These edits were discussed during the Semi-Monthly Call. (See above.)	
12/17/12	The State sent comments to CMS on the Demonstration renewal edits.	
12/19/12	The State sent CMS additional budget neutrality calculations that CMS had requested in connection with the renewal application.	
12/21/12	The State wrote to the Medicare-Medicaid Coordination Office (MMCO) to withdraw its proposal for a Financial Alignment Demonstration for full benefit dual eligible beneficiaries (referred to as "TennCare PLUS").	
12/22/12	The State received the fourth draft of Demonstration renewal edits from CMS.	
12/27/12	The State held its Monthly Call with CMS for the purpose of discussing the Demonstration renewal.	46
12/31/12	CMS sent the State an approval letter for the Demonstration renewal.	

II. Enrollment and Benefits Information

Information about enrollment by category is usually presented in the Quarterly Report as Table 2. Table 2 for the October-December 2012 quarter, however, will be submitted to CMS under separate cover. 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 December 31, 2012

	West Tennessee	Middle Tennessee	East Tennessee
Managed Care Organizations	BlueCare[1] UnitedHealthcare Community Plan[2] TennCare Select[3]	Amerigroup UnitedHealthcare Community Plan TennCare Select	BlueCare UnitedHealthcare Community Plan TennCare Select
Pharmacy Benefits Manager	SXC Health Solutions Corp.		
Dental Benefits Manager	TennDent[4]		

Dual Demonstration Proposal. On May 17, 2012, TennCare submitted a proposal to the Medicare Medicaid Coordination Office for a Financial Alignment Demonstration (FAD) to consolidate services for individuals who are dually eligible for Medicare and Medicaid. During the months that followed, Bureau management began to have several concerns about the project, including the methodology by which Tennessee health plans would be reimbursed, key policy decisions that could impede the effectiveness of the project, and delays that would make it difficult, if not impossible, for the State to achieve success within the prescribed timeframes. On December 21, 2012, therefore, the Bureau withdrew its proposal. However, TennCare remains committed to improving the quality and cost-effectiveness of care for dual eligibles in Tennessee and is moving forward on plans to improve coordination of care within the existing Medicare Part C authority.

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.

[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).
[4] TennDent is operated by Delta Dental.

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

Activities	Apr – June 2012	July – Sept 2012	Oct – Dec 2012[5]
Number of educational materials distributed	212,881	204,277	245,215
Number of outreach activities/events	3,746	3,444	3,154
Number of people made contact with (mostly face to face at outreach events)	147,939	167,903	193,100
Number of coalitions/advisory board meetings presided over	24	26	38
Number of attendees at coalitions/advisory board meetings	419	287	562
Number of educational preventive health radio/TV broadcasts[6]	12,807	8,994	13,618
Number of educational preventive health newsletter/magazine articles[7]	119	151	166
Number of educational preventive health billboards, scrolling billboards and bulletin boards	4,056	3,238[8]	5,916
Number of presentations made to enrollees/professional staff who work with enrollees	339	323	520
Number of individuals attending presentations	8,402	6,831	12,317
Number of immunization reminder telephone calls made to households[9]	224	169	102
Number (approx) of completed telephone calls re: importance of immunizations	79	83	44
Number of attempted home visits (educational materials left with these families)	15,418	18,161	17,263
Number of home visits completed	8,204	8,760	7,974

[5] Child Health Week, which ran from October 1-7, 2012, accounted for several of the statistical fluctuations evident in the October-December 2012 quarter. The distribution of educational materials, the number of radio and television broadcasts, the use of billboard and bulletin board advertising, and the level of presentation attendance all surged as a result of the annual event.

[6] 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.

[7] The number of such articles varies from quarter to quarter according to the opportunities for no-cost publication made available by local media outlets.

[8] The number of educational billboards and bulletin boards used by DOH during the July-September 2012 quarter was previously reported as 3,328 but is hereby revised based on an amended report submitted by DOH on November 7, 2012.

[9] Quarterly variations in this category are attributable to the number of referrals made by the federally funded Women, Infants, and Children program.

Activities	Apr – June 2012	July – Sept 2012	Oct – Dec 2012[5]
Number of outreach activities to the homeless[10]	57 events	51 events	52 events

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

Table 5
Department of Health
TENNderCare Call Center Activity
October - December 2012 Compared to the
Previous Two Quarters

Activities	Apr – June 2012	July – Sept 2012	Oct – Dec 2012
Number of families reached	48,714	51,181	49,233
Number of families who were assisted in scheduling an EPSDT exam for their children	2,916	3,113	3,477
Number of families who were assisted in arranging for transportation	130	146	255[11]

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.

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

[11] The rise in the number of families accessing transportation during the October-December 2012 quarter corresponds with greater success by the Call Center in scheduling EPSDT examinations (as detailed in the second row of Table 5).

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

	Apr – June 2012	July – Sept 2012	Oct – Dec 2012[12]
No. of encounters received by TennCare (initial submission)	11,466,818	10,146,567	8,079,096
No. of encounters rejected by Edifecs upon initial submission	57,371	214,186[13]	21,430
Percentage of encounters that were compliant with State standards (including HIPAA) upon initial submission	99.50%	97.89%	99.73%

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

A. CHOICES

CHOICES is the program that provides Long-Term Services and Supports (LTSS) to persons who meet the criteria for the Nursing Facility (NF) level of care. As of the end of the quarter, the total enrollment in CHOICES was 32,583, which represented 20,500 people in CHOICES Group 1, 10,189 people in CHOICES Group 2, and 1,894 people in Interim CHOICES 3. Pursuant to STC 34.e.iii.(A), the program is continuing to maintain 300 reserve slots for individuals being discharged from a NF and for individuals who are in imminent risk of being placed in a NF setting absent the provision of HCBS.

Data and trends of the designated CHOICES data elements: STC 45.d. requires the State to submit to CMS periodic statistical reports about the use of LTSS by TennCare enrollees. Three such reports—prepared in August 2011, June 2012, and September 2012—have been submitted so far.

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. Use of NF services appeared relatively stable over time, with 21,530 people receiving institutional care on June 30, 2011, and 20,968 people receiving it

[12] Both the number of encounters received by TennCare and the number of encounters rejected by Edifecs during the October-December 2012 quarter were low in comparison to totals from preceding quarters. From April through November of 2012, TennCare's MCOs were engaged in a mandatory reprocessing of claims to adjust reimbursement of providers retroactively. The bulk of this effort occurred prior to the October-December quarter, with September 2012 as the month with the single highest reprocessing volume.

[13] Rejections rose substantially during the July-September 2012 quarter as the result of errors in three files containing 169,000 encounter claims. Although the files were corrected and successfully resubmitted, the percentage of compliant claims fell by nearly two points this quarter as a result of the original submission.

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. 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 to 10,482 on June 30, 2012.

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 7.

Table 7
TennCare CHOICES Transition Allowances
for October – December 2012 Compared to the Previous Two Quarters

	Frequency and Use of Transition Allowances[14]					
	Apr – June 2012		**July – Sept 2012**		**Oct – Dec 2012**	
Grand Region	# Distributed	Total Amount	# Distributed	Total Amount	# Distributed	Total Amount
East	13	$18,249.75	17	$25,899.64	24	$33,215.27
Middle	18	$22,148.59	11	$14,535.66	16	$18,735.69
West	11	$13,651.47	16	$29,570.36	13	$18,591.81
Statewide Total	42	$54,049.81	44	$70,005.66	53	$70,542.77

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 subcontracted with an MCO). Furthermore, the MCOs are required to identify separately non-emergency transportation (NEMT) claims in the data files. Finally, the MCOs are required to submit

[14] As the number of CHOICES 2 enrollees (i.e., individuals receiving long-term services and supports at home or in the community) has increased, the use of transition allowances has generally grown as well.

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) Third Quarter 2012 Financial Statement. As of September 30, 2012, TennCare MCOs reported net worth as indicated in the table below.[15]

Table 8
Net Worth Reported by MCOs as of September 30, 2012

	Net Worth Requirement	Reported Net Worth	Excess/ (Deficiency)
Amerigroup Tennessee	$17,551,988	$101,682,118	$84,130,130
UnitedHealthcare Plan of the River Valley (UnitedHealthcare Community Plan)	$62,651,284	$457,732,244	$395,080,960
Volunteer State Health Plan (BlueCare & TennCare Select)	$34,832,427	$203,694,016	$168,861,589

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

C. Application to Renew the TennCare Demonstration

Unlike traditional fee-for-service Medicaid programs, TennCare is a demonstration project. In exchange for a waiver of certain federal statutes and regulations governing Medicaid, TennCare

[15] 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.

"demonstrates" the principle that a managed care approach to health care can result in a more efficient use of resources, thereby allowing the state to provide higher quality, more coordinated care to program enrollees and to extend coverage to people who would not otherwise be eligible for Medicaid. One limitation imposed on demonstration projects, however, is that they may operate only for finite periods of time (referred to as "approval periods") before having to be renewed.

Although the TennCare Demonstration does not expire until June 30, 2013, the Bureau filed its renewal application with CMS on June 29, 2012, to comply with provisions in federal regulation and the Demonstration agreement requiring submission a year in advance.[16] Following extensive negotiations between the two parties throughout the second half of 2012, CMS notified the Bureau on December 31, 2012, that a three-year renewal of the TennCare Demonstration had been approved. As of the end of the quarter, Bureau staff members were preparing to review the terms and conditions of the new Demonstration agreement and to submit to CMS any Technical Corrections that the State felt were needed.

D. Budget Presentation for State Fiscal Year 2014

On November 13, 2012, three members of TennCare's executive staff—Director Darin Gordon, Chief Medical Officer Wendy Long, and Chief Financial Officer Casey Dungan—made a budget presentation regarding State Fiscal Year 2014 to Governor Bill Haslam, Finance and Administration Commissioner Mark Emkes, and Budget Director David Thurman. The presentation addressed not only TennCare's budget, but also those of the other divisions within the Health Care Finance and Administration (HCFA) umbrella overseen by Director Gordon: the Office of eHealth Initiatives, Cover Tennessee, and the Insurance Exchange Planning Initiative.

The presentation document concisely summarized the manner in which TennCare has been able to deliver quality care and achieve high levels of patient satisfaction within the context of limited revenues and a sluggish economic recovery. Of particular note in this regard is the program's success at controlling inflation: from 2004 through 2010, TennCare provided care for each of its enrollees at a cost roughly one-and-a-half to two-and-a-half times less than the average cost nationwide. Projections from accounting firm PricewaterhouseCoopers included within the presentation indicate that this trend will continue: in State Fiscal Year 2014, inflation of medical costs under TennCare is expected to be held to 3.5 percent, as compared with a 7.5 percent inflation rate for commercial insurance programs.

Concluding with an overview of the challenges, opportunities, and costs associated with the Affordable Care Act (Medicaid expansion and the Insurance Exchange in particular), the presentation laid out the concerns that TennCare, Tennessee, and the entire nation will face in the arena of health care in the years ahead.

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

E. Possible Changes to TennCare Benefits ("Amendment 17")

In late December 2012, TennCare issued public notice of its intention to file Demonstration Amendment 17 with CMS. Amendment 17 repeats several changes proposed in each of the last three years that were made unnecessary each time by the Tennessee General Assembly's passage of a one-year Enhanced Coverage Fee. Changes to the TennCare benefit package for adults that would be necessary if the one-year Enhanced Coverage Fee were not renewed this year are as follows:

- Elimination of physical therapy, speech therapy, and occupational therapy for all adults
- Benefit limits on certain hospital services, lab and x-ray services, and health practitioners' office visits for non-pregnant adults and non-institutionalized adults

Additional information about Amendment 17 is available online at http://www.tn.gov/tenncare/pol-notice.shtml.

F. *John B.* Case

The *John B.* lawsuit addresses the adequacy of services provided by TennCare to children under the age of 21. *John B*. was a consent decree filed in 1998 that has been the subject of ongoing litigation since 2000. In February 2012, Judge Thomas A. Wiseman, Jr. ruled in favor of the State by dismissing the case on the grounds that TennCare had successfully established compliance with "all the binding provisions of the Consent Decree."[17] In response, the Plaintiffs filed a Notice of Appeal with the United States Court of Appeals for the Sixth Circuit on March 9, 2012.

A three-judge panel of the Sixth Circuit heard oral arguments on the appeal on October 5, 2012. Plaintiffs and Defendants subsequently filed supplemental briefs on the subject of TennCare's periodicity schedule, a timeline identifying the points in a child enrollee's life when the State must provide screenings and diagnostic and treatment services.[18] To date, the Sixth Circuit has not rendered a decision on the appeal.

G. Electronic Health Record Incentive Program

The Electronic Health Record (EHR) Incentive Program is a partnership between federal and state governments that grew out of the Health Information Technology for Economic and Clinical Health (HITECH) Act. The purpose of the program, as its name suggests, is to provide

[17] John B. v. Emkes. U.S. District Court for the Middle District of Tennessee at Nashville. Order, pages 1-2. February 14, 2012.

[18] TennCare's periodicity schedule is available online at http://www.tn.gov/tenncare/tenndercare/screeningsched.shtml.

financial incentives to Medicaid providers[19] 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 and achieved meaningful use of EHR technology for any period of 90 consecutive days in Fiscal Year 2012 (for eligible hospitals) or Calendar Year 2012 (for eligible professionals).

First-year and second-year EHR payments made by TennCare during the October-December 2012 quarter as compared with payments made throughout the life of the program appear in the table below:

Table 9
EHR First-Year and Second-Year Payments
Quarterly and Cumulative

Payment Type	Number of Providers	Quarterly Amount Paid (Oct-Dec 2012)	Cumulative Amount Paid To Date
First-year payments	99 providers (43 physicians, 29 nurse practitioners, 18 dentists, 8 hospitals, and 1 physician assistant)	$5,832,603.00	$99,972,662.97
Second-year payments	111 providers (64 physicians, 31 nurse practitioners, 15 hospitals, and 1 certified nurse midwife)	$5,821,506.00	$7,926,369.00

Outreach activities conducted during the quarter included:

[19] 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).

- Participation in the Meharry Medical/Dental Conference on October 12;
- Presentation to more than 250 providers at the Tennessee Academy of Family Physicians Conference (October 30-November 2);
- Activities at the UHC Community Plan Provider Information Fair on November 7;
- 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 not at the state level.

The conclusion of Calendar Year 2012 marked two years since Tennessee's EHR program began accepting attestations from providers. Only ten other states can claim this achievement.

H. New Pharmacy Benefits Manager

Following a competitive bidding process in which three companies submitted proposals, TennCare named Magellan Health Services the program's new Pharmacy Benefits Manager (PBM) on November 6, 2012. Magellan will replace Catamaran (formerly SXC Health Solutions), which has held the role since 2008.

Although Magellan will not start processing claims for TennCare until June 1, 2013, the company began preparations in December 2012. Priorities during this period of transition include the following:

- Establishing a pharmacy network
- Building a claims processing system and loading it with enrollee information and with edits specific to TennCare's preferred drug list, prior authorization program, and clinical/quantity requirements
- Creating a call center and a website to assist patients and providers
- Contracting with drug manufacturers for supplemental rebates

Although these tasks are sizable, Magellan's experience managing pharmacy benefits for eight million individuals is a positive indication of the company's ability to succeed with projects of similar scope. TennCare's contract with Magellan lasts through May 31, 2016, and contains an option for two one-year extensions.

I. Catalyst for Payment Reform

On December 19, 2012, TennCare announced its decision to join Catalyst for Payment Reform (CPR). CPR is a national independent organization led by large purchasers of health insurance with active involvement of providers, health plans, consumers, and labor groups working to improve health care quality and reduce costs by identifying and coordinating workable solutions to improve how health care is paid for in the United States.

TennCare joins more than 20 other large purchasers of health insurance in this effort. This includes companies such as FedEx, GE, Intel, Verizon, Xerox, 3M and Walmart, as well as Medicaid programs in South Carolina and Ohio. Purchasing partners interact on a regular basis with major health insurance companies such as Aetna, CIGNA, UnitedHealthcare, and WellPoint to discuss progress in advancing innovations, paying for value, and aligning payments with purchaser goals.

CPR provides member organizations with resources such as market assessment tools, model health plan contract language, action briefs, a payment framework, and opportunities to collaborate and share best practices with other CPR member organizations. The members of CPR share a common interest in designing payment methodologies that cut waste and reflect performance, create alignment between purchasers and federal organizations such as CMS and the Department of Health and Human Services, and implement price transparency and value pricing.

TennCare's commitment to CPR includes performing a self-assessment of capabilities and coordination with current plans, using CPR model health plan contract language when appropriate, and participating in coordinated initiatives with other purchasers.

Additional information about the Catalyst for Payment Reform may be found at http://www.catalyzepaymentreform.org.

J. Award for Chief Information Officer

On December 11, 2012, the Information Technology Management Association (ITMA) honored TennCare Chief Information Officer Brent Antony as Outstanding IT Director for 2012.

The ITMA is an organization whose stated mission is to "provide a forum for . . . Information Systems Management professionals to share information relating to their environment and State government" with the ultimate goal of "identifying common concerns, arriving at a consensus, and working toward their resolution."[20] In bestowing the award, ITMA recognized Mr. Antony for having made the most significant contribution to the organization based on the agency's strategic plan.

Antony, who joined TennCare in 2005 and holds dual master's degrees—an MBA and a master's of public health—in health systems management, oversees all aspects of the Bureau's information technology systems management. He has been distinguished twice within the field of information technology in as many years. In June 2011, he was named by eMids Technologies and Healthcare Payer News as one of eleven top executives and thought leaders in the healthcare information technology industry.

[20] See the "Information Technology Management Association" profile contained within The State of Tennessee 2009-2010 Information Systems Statewide Plan, an online document located at http://www.state.tn.us/finance/oir/prd/stplan.pdf.

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 October-December 2012 quarter yielded some good news for the Tennessee economy. According to data compiled by the Tennessee Department of Revenue, revenue collections for all three months of the quarter were higher than those for the same months of 2011.[21] Total state and local collections during October 2012 were particularly vital, with revenues outperforming those from October 2011 by more than $55 million, a 5.8 percent improvement.

Even more encouraging was a significant decline in the Tennessee unemployment rate.[22] After a modest decrease from 8.3 percent in September 2012 to 8.2 percent in October 2012, Tennessee unemployment fell to 7.6 percent for both November and December 2012. In addition to reaching the lowest state level since October 2008, the rate was even better than that of the nation as a whole, which was 7.7 percent during November and ticked upward to 7.8 percent in December.

According to a report published recently by the University of Tennessee's Center for Business and Economic Research, however, factors beyond the state's control could hamper progress toward returning the economy to pre-recession health. Noting the partisan standoff that characterizes politics in Washington, DC, the report acknowledges that "growth will nonetheless be hampered by fiscal indecision, brinksmanship and the risk of inaction."[23] This problem, coupled with ongoing sluggishness in other economies around the world, indicates that Tennessee growth will be only "modest" in 2013 but "stronger" in 2014.[24]

VIII. Member Month Reporting

Member month reporting by eligibility group for each month in the quarter is usually presented in the Quarterly Progress Report as Tables 10 and 11. Tables 10 and 11 for the October-December 2012 quarter, however, will be submitted to CMS under separate cover.

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

[22] 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.

[23] Murray, M., "An Economic Report to the Governor of the State of Tennessee: The State's Economic Outlook, January 2013," p. 20. Center for Business and Economic Research, University of Tennessee. The report is available online at http://cber.bus.utk.edu/erg/erg2013.pdf .

[24] Ibid, p. 30.

IX. Consumer Issues

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

Table 12
Eligibility Appeals Handled by the Department of Human Services
During the October – December 2012 Quarter, Compared to the Previous Two Quarters

	Apr – June 2012	July – Sept 2012	Oct – Dec 2012
TennCare Medicaid			
No. of appeals received	3,589	3,551	3,552
No. of appeals resolved or withdrawn	1,532	1,331	1,327
No. of appeals taken to hearing	1,370	1,098	938
No. of appeals that did not involve a valid factual dispute	1,590	1,818	1,365
Appeals previously heard that were decided in the State's favor	928	731	579
Appeals previously heard that were decided in the appellant's favor	87	69	68
TennCare Standard			
No. of appeals received	125	108	104
No. of appeals resolved or withdrawn	48	41	36
No. of appeals taken to hearing	60	25	40
No. of appeals that did not involve a valid factual dispute	47	55	21
Appeals previously heard that were decided in the State's favor	45	22	30
Appeals previously heard that were decided in the appellant's favor	6	0	2

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

Table 13
Medical Service Appeals Handled by the Bureau of TennCare
During the October – December 2012 Quarter, Compared to the Previous Two Quarters

	Apr – Jun 2012	July – Sept 2012	Oct – Dec 2012
No. of appeals received	1,145	1,256	1,339

	Apr – Jun 2012	July – Sept 2012	Oct – Dec 2012
No. of appeals resolved	1,203	1,119	1,330
• Resolved at the MCC level	511	483	557
• Resolved at the TSU level	193	188	205
• Resolved at the LSU level	499	448	568
No. of appeals that did not involve a valid factual dispute	278	292	295
No. of directives issued	172	152	171
No. of appeals taken to hearing	499	448	568
No. of appeals that were withdrawn by the enrollee at or prior to the hearing	181	139	183
Appeals that went to hearing and were decided in the State's favor	123	113	144
Appeals that went to hearing and were decided in the appellant's favor	15	13	13

By way of explanation:

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

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

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

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. The following table provides information regarding certain appeals administered by the LTSS Division for the quarter, compared to the previous two quarters.

Table 14
Long-Term Services and Supports Appeals for October – December 2012
Compared to the Previous Two Quarters

	Apr – June 2012	July – Sept 2012	Oct – Dec 2012
No. of appeals of PreAdmission Evaluation (PAE) denials	116	302[25]	257
No. of appeals of PASRR determinations	5	4	1
No. of appeals of denial for enrollment into CHOICES	23	13	16
No. of appeals of involuntary disenrollment from CHOICES	6	5	4
No. of appeals of denial of Consumer Direction	0	0	0
No. of appeals of involuntary withdrawal of Consumer Direction	1	0	1
No. of appeals withdrawn prior to hearing	1	8	7
No. of appeals dismissed at hearing	17	7	14
No. of appeals that went to hearing and were decided in the State's favor	23[26]	3	6
No. of appeals that went to hearing and were decided in the appellant's favor	2	1	2

X. Quality Assurance/Monitoring Activity

Disease Management (DM). MCOs are required to have the following ten DM programs.

- Asthma
- Bipolar Disorder
- Chronic Obstructive Pulmonary Disease (COPD)
- Congestive Heart Failure (CHF)
- Coronary Artery Disease (CAD)
- Diabetes
- Major Depression
- Maternity Management

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

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

- Obesity
- Schizophrenia

The focus of DM programs is on preventing worsening of and complications from these diseases. DM programs educate members in order to increase their understanding of their condition(s) and the factors that affect their health status, as well as to empower members to be more effective in self-care and management of their health. Information on enrollment in DM is provided in Table 15. Figures for the period of October through December, 2012, will be provided in the next Quarterly Progress Report.

Table 15
DM Program Enrollment, July - September 2012
Compared to the Previous Two Quarters[27]

DM Program	Jan – Mar 2012		Apr – June 2012		July – Sept 2012	
	Non-CHOICES Members	CHOICES Members	Non-CHOICES Members	CHOICES Members	Non-CHOICES Members	CHOICES Members
Asthma	109,494	31	110,366	24	110,581	24
Bipolar	21,579	17	22,045	12	22,314	16
Chronic Obstructive Pulmonary Disease	3,712	55	3,636	57	3,468	48
Congestive Heart Failure	1,616	189	1,546	177	1,532	194
Coronary Artery Disease	4,978	55	4,962	48	4,923	50
Diabetes	16,501	524	15,865	481	15,420	537
HIV[28]	254	6	245	6	238	8
Hypertension[29]	4,255	133	4,124	136	3,989	150
Major Depression	51,622	49	52,501	60	56,241	67
Maternity	15,853	0	16,414	0	17,827	1
Multiple Conditions	48,050	279	50,258	264	52,802	367
Obesity	23,270	14	24,994	9	25,155	6

[27] The numbers in this table reflect DM enrollment at the end of the quarter and are not unduplicated: a person enrolled in two different MCOs during the reporting period could be counted in a particular DM program twice. In addition, some persons may be enrolled in more than one DM program.
[28] A DM program for HIV is not a requirement, but Amerigroup has chosen to have a program for this condition.
[29] A DM program for Hypertension is not a requirement, but Amerigroup has chosen to have a program for this condition.

DM Program	Jan – Mar 2012		Apr – June 2012		July – Sept 2012	
	Non-CHOICES Members	CHOICES Members	Non-CHOICES Members	CHOICES Members	Non-CHOICES Members	CHOICES Members
Other[30]	19,133	288	17,310	270	15,702	284
Schizophrenia	6,098	53	6,138	30	6,118	34
Total DM Enrollment	**326,415**	**1,693**	**330,404**	**1,574**	**336,310**	**1,786**
Total CHOICES and Non-CHOICES DM Enrollment	**328,108**		**331,978**		**338,096**	

By July 1, 2013, TennCare's MCOs will have replaced the Disease Management program with a new model referred to as "Population Health." This approach is more proactive, in that it 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. Nonetheless, measures will remain in place to assist enrollees who already have a complex chronic condition. Data for the Population Health program will be forthcoming later in Calendar Year 2013.

Quality Improvement Strategy. As required by federal law,[31] federal regulation,[32] and the State's Demonstration agreement with CMS,[33] TennCare has developed a strategy for evaluating and improving the quality and accessibility of care offered to enrollees through the managed care network. The Bureau submitted its annual update of the strategy—entitled "2012 Quality Assessment and Performance Improvement Strategy and Quality Strategy: Annual Update Report"—to CMS on August 1, 2012. In addition to laying out the measures of quality assurance already in place, the report outlines TennCare's goals and objectives for the year ahead. The report, which was approved by CMS on October 22, 2012, is available online at http://www.tn.gov/tenncare/forms/qualitystrategy2012.pdf.

Provider Data Validation Report. TennCare's External Quality Review Organization (EQRO), Qsource, published the results of its provider data validation survey for the October-December 2012 quarter. Qsource took a sample of provider data files from TennCare's MCCs[34] and reviewed each for accuracy in the following categories:

- Contract status with MCC

[30] Other conditions for which Amerigroup has chosen to establish DM programs include Transplants, End Stage Renal Disease, etc.
[31] 42 U.S.C. § 1396u-2(c)(1)(A)
[32] 42 C.F.R. § 438.202
[33] Special Term and Condition 45.c. of the TennCare Demonstration.
[34] TennCare's pharmacy benefits manager (PBM) was not included in the survey.

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

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" (98.4 percent accuracy), "provider credentialed specialty / behavioral health service code" (98.1 percent accuracy), "primary care services" (99.8 percent accuracy), and "prenatal care services" (99.3 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 90.3 percent accuracy), TennCare required each of its MCCs to submit a Corrective Action Plan by December 5, 2012. The Bureau, in turn, had received, reviewed, and accepted all of the plans by December 6, 2012.

XI. Demonstration Evaluation

On October 31, 2011, the State submitted the Draft Annual Report as required by STC #48. Part V of that report provided the progress to date on the performance measures that were outlined in the approved Evaluation Design. It is the State's intention to update the performance measures in each Annual Report.

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

XII. Essential Access Hospital Pool[35]

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
Community Behavioral Health

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)
Pathways of Tennessee
Wellmont Holston Valley Medical Center
Saint Francis Hospital
Centennial Medical Center
Skyline Medical Center (with Madison campus)
Maury Regional Hospital
Methodist Healthcare – North

[35] 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.

Middle Tennessee Medical Center
Fort Sanders Regional Medical Center
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
Riverview Regional Medical Center – North

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

Universities	Hospitals
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
Erlanger Bledsoe
Hickman Community Hospital
Johnson County Community Hospital
Lauderdale Community Hospital
Macon County General Hospital
Marshall Medical Center
Medical Center of Manchester
Patients' Choice Medical Center of Erin
Rhea Medical Center
Riverview Regional Medical Center
Scott County 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: February 28, 2013

Attachment A

Budget Neutrality Calculations for the Quarter

This material will be submitted under separate cover.

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

April 5, 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 47, Enrollment, Member Month, and Budget Neutrality Data

Dear Ms. Woodard:

On February 28, 2013, in accordance with STC 47, TennCare submitted the October-December 2012 Quarterly Progress Report to CMS. We noted at that time, however, that the following segments of the report would be submitted under separate cover:

- Table 2, Enrollment Counts for the October-December 2012 Quarter Compared to the Previous Two Quarters
- Table 10, Member Month Reporting for Use in Budget Neutrality Calculations, October-December 2012
- Table 11, Member Month Reporting Not Used in Budget Neutrality Calculations, October-December 2012
- Attachment A, Budget Neutrality Calculations for the Quarter

Enclosed are the aforementioned items. Please let us know if you have comments or questions.

Sincerely,

[redacted]

Casey Dungan
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

Table 2
Enrollment Counts for the October - December 2012 Quarter
Compared to the Previous Two Quarters

Demonstration Populations	Total Number of TennCare Enrollees		
	Apr – June 2012	July – Sept 2012	Oct – Dec 2012
EG1 Disabled, Type 1 State Plan eligibles	139,624	137,701	136,384
EG1 Disabled and EG9 H-Disabled, Type 2 Demonstration Population	291	309	369
EG2 Over 65, Type 1 State Plan eligibles	41	39	50
EG2 Over 65 and EG10 H-Over 65, Type 2 Demonstration Population	0	0	0
EG3 Children, Type 1 State Plan eligibles	691,043	695,237	700,828
EG4 Adults, Type 1 State Plan eligibles	279,762	281,982	285,536
EG4 Adults, Type 2 Demonstration Population[1]	0	0	0
EG5 Duals, Type 1 State Plan eligibles and EG11 H-Duals 65, Type 2 Demonstration Population	143,234	142,706	140,887
EG6E Expan Adult, Type 3 Demonstration Population	1,530	1,724	1,638
EG7E Expan Child, Type 3 Demonstration Population	272	255	247
EG8, Med Exp Child, Type 2 Demonstration Population, Optional Targeted Low Income Children funded by Title XIX	0	0	0
Med Exp Child, Title XXI Demonstration Population	18,907	20,120	21,153
EG12E Carryover, Type 3 Demonstration Population[2]	N/A	295	2,594
TOTAL *	1,274,704	1,280,368	1,289,686

[1] This eligibility group—individuals between 19 and 64 years old who are medically needy rollovers—contains no members and is unlikely to have any in the future.

[2] This category did not open until July 1, 2012; consequently, there is no enrollment figure for the April-June 2012 quarter. The enrollment count of 295 for the July-September 2012 quarter represents the number of TennCare members enrolled in the PACE program during that period rather than a fully updated accounting of the Carryover Groups for CHOICES 1, CHOICES 2, and PACE.

Table 10
Member Month Reporting for Use in Budget Neutrality Calculations
October - December 2012

Eligibility Group	October 2012	November 2012	December 2012	Sum for Quarter Ending 12/31/12
EG1 Disabled, Type 1 State Plan eligibles	136,046	134,765	133,503	404,314
EG1 Disabled, Type 2 Demonstration Population[3]	N/A	N/A	N/A	N/A
EG9 H-Disabled, Type 2 Demonstration Population	360	364	364	1,088
EG2 Over 65, Type 1 State Plan eligibles	29	31	26	86
EG2 Over 65, Type 2 Demonstration Population[4]	N/A	N/A	N/A	N/A
EG10 H-Over 65, Type 2 Demonstration Population	0	0	0	0
EG3 Children, Type 1 State Plan eligibles	687,848	674,307	669,052	2,031,207
EG4 Adults, Type 1 State Plan eligibles	269,409	260,324	257,815	787,548
EG4 Adults, Type 2 Demonstration Population[5]	0	0	0	0
EG5 Duals, Type 1 State Plan eligibles	130,830	129,875	129,218	389,923
EG11 H-Duals, Type 2 Demonstration Population	6,640	6,653	6,738	20,031
EG8 Med Exp Child, Type 2 Demonstration Population, Optional Targeted Low Income Children funded by Title XIX	0	0	0	0
TOTAL	1,231,162	1,206,319	1,196,716	3,634,197

[3] This eligibility group was valid only for the reporting of enrollment and member months prior to July 1, 2010. See STC 55.b.(iv).
[4] This eligibility group was valid only for the reporting of enrollment and member months prior to July 1, 2010. See STC 55.b.(vi).
[5] This eligibility group—individuals between 19 and 64 years old who are medically needy rollovers—contains no members and is unlikely to have any in the future.

Table 11
Member Month Reporting Not Used in Budget Neutrality Calculations
October - December 2012

Eligibility Group	October 2012	November 2012	December 2012	Sum for Quarter Ending 12/31/12
EG6E Expan Adult, Type 3 Demonstration Population	1,631	1,497	1,401	4,529
EG7E Expan Child, Type 3 Demonstration Population	241	244	235	720
Med Exp Child, Title XXI Demonstration Population	19,576	20,388	20,154	60,118
EG12E Carryover, Type 3 Demonstration Population	2,594	2,589	2,564	7,747
TOTAL	24,042	24,718	24,354	73,114

Actual TennCare Budget Neutrality (Oct - Dec 2012)

I. The Extension of the Baseline

Baseline PMPM

	FY 2013 PMPM
1-Disabled (can be any ages)	$1,485.69
2-Child <=18	$453.06
3-Adult >= 65	$977.22
4-Adult <= 64	$874.92
Duals (17)	$624.27

Actual Member months of Groups I and II

1-Disabled (can be any ages)	405,402
2-Child <=18	2,031,207
3-Adult >= 65	86
4-Adult <= 64	787,548
Duals (17)	409,954
Total	3,634,197

Ceiling without DSH

	Baseline * MM
1-Disabled (can be any ages)	$602,301,697
2-Child <=18	$920,258,643
3-Adult >= 65	$84,041
4-Adult <= 64	$689,041,496
17s	$255,921,984
Total	$2,467,607,861

DSH

DSH Adjustment (Quarterly)	$115,999,213

Total Ceiling

Budget Neutrality Cap	
Total w/DSH Adj.	$2,583,607,075

II. Actual Expenditures

Group 1 and 2

1-Disabled (can be any ages)	$ 514,373,519
2-Child <=18	$ 408,507,038
3-Adult >= 65	$ 217,196
4-Adult <= 64	$ 298,487,118

Duals (17)	$	385,806,833
Total		**1,607,391,703**

Group 3

1-Disabled (can be any ages)	$	-
2-Child <=18	$	10,365,938
3-Adult >= 65	$	32,735,635
4-Adult <= 64	$	2,308,857
Duals (17)	$	-
Total		**45,410,430**

Pool Payments and Admin

Total Pool Payments		**245,302,203**

Admin	**$**	**44,860,560**

Quarterly Drug Rebates		$139,433,107
Quarterly Premium Collections		$997
Total Net Quarterly Expenditures	**$**	**1,803,530,793**

III. Surplus/(Deficit)

	$780,076,282
Federal Share	**$515,864,445**

HCI Result	MM201210	MM201211	MM201212	TOTAL	HCI ASO Oct -Dec 12	HCI Rx Oct - Dec 12	HCI DTL Oct - Dec 12	HCI MCO CAP (w/o TSL)	UNK Allocation	TOTAL
EG1-TYPE1 (disabled, type1 state plan eligibles)	136,046	134,765	133,503	404,314	$80,485,352	$89,226,132	$1,873,182	$333,323,726	$3,113,769	$508,022,161
EG1-TYPE2 (disabled, type2 transition group)	0	0	0	-					$0	$0
EG2-TYPE1 (over 65, type1 state plan eligibles)	29	31	26	86	$187,549	$2,236	$0	$27,140	$271	$217,196
EG2-TYPE2 (over 65, type2 state plan eligibles)	0	0	0	-					$0	$0
EG3-TYPE1 (children, type1 state plan eligibles)	687,848	674,307	669,052	2,031,207	$12,566,271	$59,704,482	$34,912,056	$298,541,057	$2,783,173	$408,507,038
Med Exp Child (Title XXI Demo Pop; EG3-Type2)	19,576	20,388	20,154	60,118	$46,338	$2,976,721	$1,345,653	$5,810,278	$54,148	$10,233,138
EG4-TYPE1 (adults, type1 State plan eligibles)	269,409	260,324	257,815	787,548	$2,538,284	$44,853,110	$2,403,116	$246,396,305	$2,296,303	$298,487,118
EG4-TYPE2 (adults, type2 demonstration pop)	0	0	0	-					$0	$0
EG5-TYPE1 (duals, state plan eligibles)	130,830	129,875	129,218	389,923	$867,580	$705,786	$35,355	$302,636,885	$2,820,225	$307,065,831
EG6E-TYPE3 (Expan adult, type3 demonstration pop)	1,631	1,497	1,401	4,529	$0	$441,435	$0	$1,850,181	$17,241	$2,308,857
EG7E-TYPE3 (Expan child, type3 demonstration pop)	241	244	235	720	$3,345	$46,903	$16,348	$65,593	$612	$132,801
EG8-TYPE2 (emd exp child)	0	0	0	-					$0	$0
EG9 H-Disabled (TYPE 2 Eligibles)	360	364	364	1,088	$0	$363,618	$0	$5,932,458	$55,282	$6,351,358
EG11H, H-Dual	6,640	6,653	6,738	20,031	$0	$21,616	$0	$77,992,606	$726,779	$78,741,001
Eg12E, Carryovers (PACE, Choices 1, Choices 2)	2,594	2,589	2,564	7,747	$1,232	$611,794	$0	$31,826,036	$296,573	$32,735,635
Total	1,255,204	1,231,037	1,221,070	3,707,311	$96,695,951	$198,953,833	$40,585,710	$1,304,402,265	$12,164,375	**$1,652,802,134**

HCI Result	MM201210	MM201211	MM201212	TOTAL	HCI ASO PMPM	HCI Rx PMPM	HCI DTL PMPM	HCI MCO CAP (w/o TSL)	UNK Allocation	TOTAL
EG1-TYPE1 (disabled, type1 state plan eligibles)	136,046	134,765	133,503	404,314	$199.07	$220.69	$4.63	$824.42	$7.70	$1,256.50
EG1-TYPE2 (disabled, type2 transition group)	0	0	0	-						
EG2-TYPE1 (over 65, type1 state plan eligibles)	29	31	26	86	$2,180.80	$26.00	$0.00	$315.58	$3.15	$2,525.53
EG2-TYPE2 (over 65, type2 state plan eligibles)	0	0	0	-	-	-	-	-	-	-
EG3-TYPE1 (children, type1 state plan eligibles)	687,848	674,307	669,052	2,031,207	$6.19	$29.39	$17.19	$146.98	$1.37	$201.12
Med Exp Child (Title XXI Demo Pop; EG3-Type2)	19,576	20,388	20,154	60,118	$0.77	$49.51	$22.38	$96.65	$0.90	$170.22
EG4-TYPE1 (adults, type1 State plan eligibles)	269,409	260,324	257,815	787,548	$3.22	$56.95	$3.05	$312.87	$2.92	$379.01
EG4-TYPE2 (adults, type2 demonstration pop)	0	0	0	-						
EG5-TYPE1 (duals, state plan eligibles)	130,830	129,875	129,218	389,923	$2.23	$1.81	$0.09	$776.15	$7.23	$787.50
EG6E-TYPE3 (Expan adult, type3 demonstration pop)	1,631	1,497	1,401	4,529	$0.00	$97.47	$0.00	$408.52	$3.81	$509.79
EG7E-TYPE3 (Expan child, type3 demonstration pop)	241	244	235	720	$4.65	$65.14	$22.71	$91.10	$0.85	$184.45
EG8-TYPE2 (emd exp child)	0	0	0	-						
EG9 H-Disabled (TYPE 2 Eligibles)	360	364	364	1,088	$0.00	$334.21	$0.00	$5,452.63	$50.81	$5,837.65
EG11H, H-Dual	6,640	6,653	6,738	20,031	$0.00	$1.08	$0.00	$3,893.60	$36.28	$3,930.96
Eg12E, Carryovers (PACE, Choices 1, Choices 2)	2,594	2,589	2,564	7,747	$0.16	$78.97	$0.00	$4,108.18	$38.28	$4,225.59
Total	1,255,204	1,231,037	1,221,070	3,707,311	$26.08	$53.67	$10.95	$351.85	$3.28	**$445.82**