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, 2014

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 October-December 2013 quarter. This report is being submitted in accordance with STC 45.

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 2013)

Demonstration Year: 12 (7/1/13 - 6/30/14)
Federal Fiscal Quarter: 1/2014 (10/13 - 12/13)
Waiver Quarter: 2/2014 (10/13 - 12/13)

I. Introduction

The goal of the TennCare Demonstration is to show that careful use of a managed care approach can enable the State to deliver quality care to all enrollees without spending more than would have been spent had the State continued its Medicaid program.

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

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

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

Table 1
Key Dates of Approval/Operation in the Quarter

Date	Action	STC #
10/15/13	CMS sent the State a response to the State's draft transition plan, which had been submitted to CMS on August 21, 2013. The purpose of the transition plan was to explain how the State would identify members of the demonstration populations who might be Medicaid-eligible in 2014 and move them to Medicaid.	
10/24/13	The CMS Project Officer cancelled the Monthly Call.	44
10/28/13	The State sent the CMS Project Officer a courtesy copy of State Plan Amendment (SPA) 13-003, which proposed to remove benzodiazepines and barbiturates from the set of drugs excluded by TennCare.	7
10/30/13	The State responded to CMS's October 15 comments on the August 21 transition plan.	
10/31/13	The State submitted the Draft Annual Report for Demonstration Year 11 to CMS.	46
11/12/13	The State sent CMS CHOICES point in time and annual aggregate data to update data submitted on 8/6/13.	43.d.iii.
11/26/13	The State submitted contract amendments 16 (for Middle Tennessee), 13 (for East/West Tennessee), and 33 (for TennCare Select) for review and approval.	43.a.
11/27/13	The State issued public notice of its intent to submit Demonstration Amendment 20 to CMS. Amendment 20	6, 15

Date	Action	STC #
	proposed to keep the At-Risk Demonstration eligibility category open to new enrollment through June 30, 2015; to add funds to the Essential Access Hospital Pool to offset the discontinuation of Tennessee's Disproportionate Share Hospital allotment; and to add Erlanger Medical Center to the Public Hospital Supplemental Payment Pool.	
11/27/13	The CMS Project Officer cancelled the Monthly Call scheduled for 11/28/13.	44
11/27/13	The State submitted the Quarterly Progress Report for the July-September 2013 quarter to CMS.	45
12/17/13	The State submitted Amendment 20 to CMS.	6, 7
12/18/13	CMS accepted the October 30 comments the State had made on the transition plan.	
12/18/13	The State held a public forum to accept comments on the progress of the TennCare Demonstration.	10
12/19/13	In reference to Amendment 20, CMS suggested that one precondition of approval would be treating costs related to the At-Risk Demonstration Group as demonstration expenditures rather than base expenditures.	
12/19/13	The State submitted to CMS a revised version of the budget neutrality data that had accompanied the July-September 2013 Quarterly Progress Report.	45
12/20/13	In reference to Amendment 20, the State pointed out that the STCs classify the At-Risk Demonstration Group as a "Type 2" population.	
12/24/13	With regard to Amendment 20, CMS communicated that the State's proposed changes concerning the At-Risk Demonstration Group would have "no impact" on budget neutrality calculations.	
12/26/13	The CMS Project Officer cancelled the Monthly Call.	44
12/26/13	In reference to Amendment 20, CMS requested clarification as to whether the At-Risk Demonstration Group was part of the CHOICES 217-Like HCBS Group.	
12/27/13	In response to CMS's question, the State explained that the At-Risk Demonstration Group was similar to the CHOICES 217-Like HCBS Group but that the two populations were enrolled in different eligibility categories and CHOICES Groups.	
12/27/13	At CMS's request, the State submitted budget neutrality calculations that reflected only the component of Amendment 20 related to the At-Risk Demonstration Group.	

Date	Action	STC #
12/27/13	The State submitted a request to CMS to be able to use the flat file prepared by CMS to enroll individuals in Medicaid or CHIP who had been determined eligible by the Federally Facilitated Marketplace (FFM). The flat file was a substitute for the full eligibility file Account Transfer, which was still being developed by CMS.	
12/30/13	CMS provided written approval of the component of Amendment 20 related to the At-Risk Demonstration Group. Included with the approval were modified versions of the expenditure authorities and STCs of the TennCare Demonstration.	
12/30/13	The State issued public notice of its intent to submit Demonstration Amendment 21 to CMS. Amendment 21 proposed a set of program reductions that would be required if the annual hospital assessment fee were not renewed by the Tennessee legislature in 2014.	6, 15

II. Enrollment and Benefits Information

Information about enrollment by category is presented in Table 2.

Table 2
Enrollment Counts for the October - December 2013 Quarter
Compared to the Previous Two Quarters

Demonstration Populations	Total Number of TennCare Enrollees		
	Apr – Jun 2013	Jul – Sept 2013	Oct – Dec 2013
EG1 Disabled, Type 1 State Plan eligibles	133,692	132,328	132,715
EG9 H-Disabled, Type 2 Demonstration Population	351	345	355
EG2 Over 65, Type 1 State Plan eligibles	37	49	55
EG10 H-Over 65, Type 2 Demonstration Population	0	0	0
EG3 Children, Type 1 State Plan eligibles	658,669	665,660	662,060
EG4 Adults, Type 1 State Plan eligibles	289,416	301,287	293,412

Demonstration Populations	Total Number of TennCare Enrollees		
	Apr – Jun 2013	Jul – Sept 2013	Oct – Dec 2013
EG5 Duals, Type 1 State Plan eligibles and EG11 H-Duals 65, Type 2 Demonstration Population	133,701	133,146	132,875
EG6E Expan Adult, Type 3 Demonstration Population	1,630	1,558	1,459
EG7E Expan Child, Type 3 Demonstration Population	151	156	148
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	19,309	20,588	20,898
EG12E Carryover, Type 3, Demonstration Population	6,067	7,494	7,200
TOTAL*	1,243,023	1,262,611	1,251,177

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

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

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

Table 3
TennCare Managed Care Contractors as of December 31, 2013

	West Tennessee	Middle Tennessee	East Tennessee
Managed Care Organizations	BlueCare[1]	Amerigroup	BlueCare
	UnitedHealthcare Community Plan[2]	UnitedHealthcare Community Plan	UnitedHealthcare Community Plan
	TennCare Select[3]	TennCare Select	TennCare Select

[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).

	West Tennessee	Middle Tennessee	East Tennessee
Pharmacy Benefits Manager	Magellan Health Services		
Dental Benefits Manager	DentaQuest		

Preparation for the Implementation of Eligibility Changes Mandated by the Affordable Care Act (ACA) on January 1, 2014. The October-December 2013 quarter was a time of continued, intense preparation for these changes. On one hand, the State worked on coordinating with the newly established Federally Facilitated Marketplace (FFM), which began taking applications for the Marketplace on October 1, 2013. On the other hand, the Bureau of TennCare had been involved for over a year in building a new eligibility system that would be able to review applications for health care assistance and identify persons eligible for any of three "insurance affordability programs," meaning Medicaid, CoverKids, or subsidized insurance under the Marketplace. The new system is to be called "TEDS" (Tennessee Eligibility Determination System).

Toward the middle of the quarter, TennCare determined that without sufficient testing it would not be prudent to allow TEDS to begin processing electronic applications on January 1, 2014. Due to tight federal implementation timeframes, late changes being made by the federal government, and ongoing work on account transfers between the FFM and states, adequate testing had not taken place to minimize implementation challenges similar to those seen at the federal level in October. Rather than implementing TEDS prematurely, the Bureau developed a contingency plan for processing applications in the meantime, while simultaneously working with CMS to identify and resolve problems in the weekly flat files that had been sent to the State in lieu of account transfers.

Proposal Concerning CHOICES Program and Supplemental Pools ("Demonstration Amendment 20"). On December 17, 2013, the Bureau submitted Demonstration Amendment 20 to CMS. Amendment 20 proposed three modifications to the TennCare program:

- Continuing, through June 30, 2015, to offer new enrollment in the At-Risk Demonstration Eligibility Category. Without approval by CMS of the changes proposed in Amendment 20, this category would have been closed to new enrollment on December 31, 2013. To be eligible in this category, individuals must be adults who are financially eligible for Long-Term Services and Supports (LTSS), who meet the Level of Care criteria for LTSS that existed in Tennessee on June 30, 2012, but not the criteria that went into effect on July 1, 2012, and who are at risk for institutionalization in the absence of Home and Community Based Services (HCBS) that are available to them through the CHOICES Program;
- Expanding the State's Essential Access Hospital (EAH) Pool to address the fact that Tennessee is now the only state in the country without a Disproportionate Share Hospital (DSH) allotment specified in federal statute. Under Amendment 20, funds

previously associated with DSH payments in Tennessee would be added to the EAH Pool; and

- Increasing the State's Public Hospital Supplemental Payment (PHSP) Pool and adding Erlanger Medical Center in Chattanooga to the list of hospitals eligible for these special payments.

CMS notified TennCare on December 30, 2013, that the component of Amendment 20 concerning the At-Risk Demonstration Eligibility Category had been approved and that negotiations regarding the other two components would take place "in the coming weeks."

Possible Changes to TennCare Benefits ("Demonstration Amendment 21"). On December 30, 2013, the Bureau notified the public of another proposal to be submitted to CMS. Demonstration Amendment 21 repeats several changes proposed in each of the last four years that were made unnecessary each time by the Tennessee General Assembly's passage or renewal of a one-year hospital assessment fee. Changes to the TennCare benefit package for adults that would be necessary if the fee were not renewed in 2014 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 21 is available online at http://www.tn.gov/tenncare/pol-notice4.shtml.

Cost Sharing Compliance Plan. In its April 18, 2012 letter approving the Bureau's cost sharing compliance plan for the TennCare Standard population, CMS stipulated that "each Quarterly Report . . . must include a report on whether any families have contacted the State to document having reached their aggregate cap, and how these situations were resolved." During the October-December 2013 quarter, the Bureau received no notifications that a family with members enrolled in TennCare Standard had met its cost sharing limit.

III. Innovative Activities to Assure Access

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

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

Activities	Apr – Jun 2013	Jul – Sept 2013	Oct – Dec 2013[4]
Number of educational materials distributed	218,717	209,598	190,540
Number of outreach activities/events	3,492	3,967	4,663
Number of people made contact with (mostly face to face at outreach events)	171,107	190,429	158,790
Number of coalitions/advisory board meetings attended or conducted[5]	61	91	54
Number of attendees at coalitions/advisory board meetings[6]	855	610	801
Number of educational preventive health radio/TV broadcasts[7]	9,199	9,075	16,367
Number of educational preventive health newsletter/magazine articles[8]	19	120	141

[4] Child Health Week, which ran October 7-13, 2013, accounted for several of the statistical fluctuations in the October-December 2013 quarter. The number of radio and television broadcasts and newsletter/magazine articles, the use of billboard and bulletin board advertising, and the level of presentation attendance all increased significantly as a result of the annual event.

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

[6] Attendance at coalitions and advisory board meetings varies for a variety of reasons beyond DOH's control, not least of which is the calling of such meetings by community partners rather than by TENNderCare community outreach staff. Furthermore, attendance does not always correspond with the number of meetings held (as evidenced by the results of the last three quarters as presented in this table).

[7] 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.

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

Activities	Apr – Jun 2013	Jul – Sept 2013	Oct – Dec 2013[4]
Number of educational preventive health billboards, scrolling billboards and bulletin boards	41,297	16,858	51,142
Number of presentations made to enrollees/professional staff who work with enrollees	375	221	222
Number of individuals attending presentations	9,442	5,457	8,505
Number of attempted telephone calls regarding the importance of immunizations and dental checkups[9]	503	252	491[10]
Number (approx) of completed telephone calls regarding the importance of immunizations and dental checkups	208	105	260
Number of attempted home visits (educational materials left with these families)	14,499	17,039	16,259
Number of home visits completed	7,401	8,848	7,888
Number of outreach events directed to the homeless[11]	37	45	27

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 2013 Compared to the Previous Two Quarters

Activities	Apr – Jun 2013	Jul – Sept 2013	Oct – Dec 2013[12]
Number of families reached	45,236	49,490	42,869

[9] Quarterly variations in this category are attributable to the number of referrals made by the School-based Dental Prevention Program.

[10] October-December 2013 was the first quarter in several years in which DOH TENNderCare Community Outreach staff did not make immunization-related calls on behalf of the Women, Infants, and Children (WIC) program. This particular initiative was discontinued because of the logistical difficulties of coordinating the effort statewide. Nevertheless, outreach staff continue to promote immunizations in all of their other activities.

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

[12] Totals for the October-December 2013 quarter were lower than normal due in part to Call Center staffing shortages.

Activities	Apr – Jun 2013	Jul – Sept 2013	Oct – Dec 2013[12]
Number of families who were assisted in scheduling an EPSDT exam for their children	3,646	3,803	2,518
Number of families who were assisted in arranging for transportation	118	145	40

IV. Collection and Verification of Encounter and Enrollment Data

Edifecs is the software system being used by Information Systems staff to review encounter data sent from the MCOs and to identify encounters that are non-compliant so that they can be returned to the MCOs for correction. Edifecs enables the State to reject only the problem encounters, rather than rejecting and requiring resubmission of whole batches of encounter data because of a problem found. Table 6 illustrates the progress that has been made in reducing the number of claims that are returned to the MCOs due to data errors.

Table 6
Number of Initial Encounters Received by TennCare During the October – December 2013 Quarter, and Percentage that Passed Systems Edits, Compared to the Previous Two Quarters

	Apr – Jun 2013	Jul – Sept 2013	Oct – Dec 2013
No. of encounters received by TennCare (initial submission)	7,691,163	7,964,941	11,854,350[13]
No. of encounters rejected by Edifecs upon initial submission	34,340	90,108	21,434
Percentage of encounters that were compliant with State standards (including HIPAA) upon initial submission	99.54%	98.87%	99.82%

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

A. CHOICES

The Long-Term Care Community CHOICES Act of 2008 provided the framework that allowed the State to restructure its Long-Term Services and Supports (LTSS) delivery system, and the two-phased initial implementation of CHOICES was complete in August 2010. A primary aim of the CHOICES program is to increase access to and utilization of Home and Community Based

[13] The number of encounters received during the October-December 2013 quarter was larger than totals reported for previous quarters because pharmacy encounters were included for the first time.

Services (HCBS) options that are available to meet the needs of adults who are elderly or have physical disabilities and who require Nursing Facility (NF) level of care or are at risk of NF placement but can be served effectively in the community. Implementation of level of care changes on July 1, 2012, to target NF services to individuals with higher acuity of need while continuing to make HCBS more broadly available completed the program's original design as it was contemplated by the authorizing statute and approved by CMS. Fulfillment of this goal is proceeding apace, as the percentage of individuals receiving LTSS in the community has increased from 17 percent of the LTSS population when CHOICES began to 41 percent by the conclusion of December 2013.

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

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

	Statewide Enrollment Targets and Reserve Capacity[14]	**Enrollment and Reserve Slots Being Held as of the End of Each Quarter**		
		Apr – Jun 2013	**Jul – Sept 2013**	**Oct – Dec 2013**
CHOICES 1	Not applicable	19,415	19,115	18,969
CHOICES 2	12,500	9,612	9,388	9,164
Interim CHOICES 3	Not applicable	2,947	3,572	4,018
Total CHOICES	Not applicable	31,974	32,075	32,151
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. Five separate reports—from August 2011, June 2012, September 2012, June 2013, and November 2013[15]—had been submitted by the conclusion of the October-December 2013 quarter.

Taken together, the reports depict a program moving toward a more equitable balance, one that offers institutional care to individuals with the highest acuity of need, as well as HCBS for

[14] Of the three active CHOICES groups, only CHOICES 2 has an enrollment target.
[15] The November 2013 report was ready for submission on August 6, 2013, but a clerical error resulted in the resubmission of the June 2013 report instead.

individuals whose needs can be safely and effectively met at home or in other non-institutional settings. Point in time data revealed relatively consistent use of NF services over time, with institutional care reaching 21,530 enrollees on June 30, 2011, 20,968 enrollees on June 30, 2012, and 19,415 enrollees on June 30, 2013. The aggregate number of TennCare enrollees accessing HCBS, by comparison, grew from 6,226 in the twelve-month period preceding CHOICES implementation to 9,789 once CHOICES had been in place for a year, and then to 12,862 at the two-year mark. This trend was mirrored in point-in-time data as well: on the day prior to CHOICES implementation, 4,861 individuals were using HCBS, but the number had grown to 8,543 on June 30, 2011, then to 10,482 on June 30, 2012, and finally to 12,559 on June 30, 2013.

Enrollment of select members of the CHOICES population in Groups 1 and 2: STC 45.f. requires the State to provide "quarterly enrollment reports for individuals that would otherwise be eligible for *Interim* CHOICES 3 but meet the modified institutional level of care, and whether CHOICES 1 or CHOICES 2 was selected by the individual." The population of long-term services and supports recipients described in this passage, then, consists of individuals who have been approved for Nursing Facility Level of Care in CHOICES 1 (NF) or CHOICES 2 (HCBS) despite having been assigned a score of less than 9 on the TennCare Nursing Facility Level of Care Acuity Scale. Each approval is based on a determination by TennCare that the applicant does not qualify for enrollment in Interim CHOICES 3, including instances in which the necessary intervention and supervision needed by the applicant cannot 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, private insurance or other funding sources, and unpaid supports provided by family members and other caregivers.

During the period from October 1, 2013, through December 31, 2013, NF PreAdmission Evaluations were approved for 140 individuals with acuity scores lower than 9, and 105 of these individuals were subsequently enrolled in CHOICES 1. 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 19 individuals with acuity scores lower than 9, and 15 of the individuals were subsequently enrolled in CHOICES Group 2. The remaining individuals 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 October – December 2013 Compared to the Previous Two Quarters

	Frequency and Use of Transition Allowances					
	Apr – Jun 2013		Jul – Sept 2013		Oct – Dec 2013	
Grand Region	# Distributed	Total Amount	# Distributed	Total Amount	# Distributed	Total Amount
East	20	$21,677	13	$12,340	11	$14,820
Middle	7	$5,744	4	$2,874	2	$2,945
West	11	$9,408	8	$8,353	13	$15,734
Statewide Total	38	$36,829	25	$23,567	26	$33,499

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

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

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

If an MCO does not comply with the prompt pay requirements based on the total claims processed in a month, TDCI has the statutory authority to levy an administrative penalty of $10,000 for each month of non-compliance after the first instance of non-compliance was

reported to the plan. The TennCare Bureau can also assess liquidated damages pursuant to the terms of the TennCare Contract. If the DBM and PBM do not meet their contractual prompt pay requirements, only the TennCare Bureau can assess applicable liquidated damages against these entities.

Net Worth Requirement. By statute, the minimum net worth requirement for each TennCare MCO is calculated based on premium revenue for the most recent calendar year, as well as any TennCare payments made to the MCO that are not reported as premium revenue.

During this quarter, the MCOs submitted their National Association of Insurance Commissioners (NAIC) Third Quarter 2013 Financial Statements. As of September 30, 2013, TennCare MCOs reported net worth as indicated in the table below.[16]

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

	Net Worth Requirement	Reported Net Worth	Excess/ (Deficiency)
Amerigroup Tennessee	$17,323,202	$95,287,126	$77,963,924
UnitedHealthcare Plan of the River Valley (UnitedHealthcare Community Plan)	$64,481,178	$467,656,463	$403,175,285
Volunteer State Health Plan (BlueCare & TennCare Select)	$35,639,453	$242,079,721	$206,440,268

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

C. Managed Care Organization (MCO) Contracts

The Bureau issued a Request for Proposals (RFP) on October 2, 2013, for three MCOs to furnish managed care services to the TennCare population. The RFP required the successful bidders to provide physical health services, behavioral health services, and LTSS throughout the state, with actual service delivery scheduled to begin in Middle Tennessee on January 1, 2015, and in East and West Tennessee later that calendar year. (Each of TennCare's current managed care contracts is limited to one of Tennessee's three grand regions, although a single entity may hold more than one contract. BlueCare, for instance, has managed care contracts in East Tennessee and West Tennessee. See Table 3 for additional details.)

[16] 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.

On December 16, 2013, the Bureau announced that successful proposals had been submitted by Amerigroup, BlueCare, and UnitedHealthcare, the three companies that currently form TennCare's managed care network. New contracts with these entities last from January 1, 2014, through December 31, 2016, and contain options for five one-year extensions.

D. Budget Presentation

On November 18, 2013, three members of TennCare's executive staff—Director Darin Gordon, Deputy Director and Chief of Staff Dr. Wendy Long, and Chief Financial Officer Casey Dungan—presented the Fiscal Year 2015 proposed budget for the Division of Health Care Finance and Administration (HCFA) to a panel of Tennessee officials consisting of Governor Bill Haslam, Department of Finance and Administration Commissioner Larry Martin, Budget Director David Thurman, and Chief Operating Officer Greg Adams.

The presentation document itself, which is available on HCFA's website at http://tn.gov/HCFA/forms/HCFAbudgetFY15.pdf, concisely summarizes the manner in which TennCare has been able to deliver quality care and achieve high levels of member satisfaction while continuing to control inflationary growth. Projections from accounting firm PricewaterhouseCoopers and the CMS Office of the Actuary included within the presentation indicate that, due to fiscal controls implemented by TennCare, inflation of medical costs under TennCare is expected to be held to 3.5 percent over a three year period, as compared to a 7.5 percent inflation rate for commercial insurance programs and a 6.6 percent inflation rate for Medicaid programs as a whole. Factors contributing to this accomplishment, as stated in the presentation, include the use of enrollment and claims data to pinpoint and eliminate inefficiencies, as well as the successful integration of most TennCare services within managed care.

As Governor Haslam had requested of all State agencies, HCFA included within its budget a proposed plan for reducing expenditures by 5 percent. Potential cost-controlling measures ranged from enhanced anti-fraud efforts and managed care strategies to limited reductions in provider reimbursement rates, enrollee benefits, and grant funding.

Touching on program changes necessitated by the Affordable Care Act and concluding with an overview of the system of payment reform that TennCare is pursuing, the presentation laid out the challenges and opportunities facing HCFA and Tennessee in the years to come.

E. Electronic Health Record Incentive Program

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

financial incentives to Medicaid providers[17] 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 2012 and who achieved meaningful use of EHR technology for any period of 90 consecutive days in Fiscal Year 2013 (for eligible hospitals) or Calendar Year 2013 (for eligible professionals).

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

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

Payment Type	No. of Providers Paid During the Quarter	Quarterly Amount Paid (Oct-Dec 2013)	Cumulative Amount Paid To Date
First-year payments	100 providers (35 nurse practitioners, 33 physicians, 18 dentists, 6 certified nurse midwives, 5 hospitals, and 3 physician assistants)	$3,364,873	$132,790,952
Second-year payments	81 providers (45 physicians, 18 nurse practitioners, 14 hospitals, and 4 certified nurse midwives)	$4,181,236	$27,193,188

[17] 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).

EHR-related outreach activities conducted by Bureau staff during the quarter included:

- Participation in six statewide workshops conducted by the Tennessee Medical Association during October;
- Hosting a provider help desk at the annual meeting of the Tennessee Academy of Family Physicians from October 29 through November 1;
- Conducting a "Meaningful Use Technical Assistance" webinar on November 1;
- Presentation to 30 members of tnREC (Tennessee's regional extension center for health information technology) on November 18;
- Participation in the UnitedHealthcare Provider Expo in December;
- Attendance at the eHealth Summit on December 6;
- Monthly newsletters distributed by the Bureau's EHR ListServ; and
- A quarterly reminder issued through the Provider Incentive Payment Program ("PIPP") system to Tennessee providers who had registered at the federal level but who have not registered or attested at the state level.

A significant priority for the Bureau during the first quarter of Calendar Year 2014 is the planning of several provider workshops throughout the state. The meetings, which will be coordinated with tnREC, are designed to update providers on—and thereby maintain the momentum of—the EHR program.

F. Public Forum on the TennCare Demonstration

In compliance with federal regulation and the terms of its Demonstration agreement with CMS, TennCare hosted a public forum in downtown Nashville on December 18, 2013. The purpose of the forum was to provide members of the public an opportunity to comment on the progress of the TennCare Demonstration project, which has delivered Medicaid services to eligible Tennesseans under a managed care model since 1994.

The December 18 open meeting was not the only avenue through which feedback could be offered. Notice of the forum—which appeared in such diverse settings as the TennCare website, eight different Tennessee newspapers, and county offices of the Department of Human Services—included an email address, a physical address, and a dedicated phone line at which comments would be accepted. Indeed, the only comment the Bureau received in any format was a voicemail message requesting discontinuation of TennCare coverage for a child who had successfully enrolled in her grandmother's private insurance plan. Following further investigation of the matter, TennCare processed the request less than two weeks later.

Additional opportunities to comment on the progress of the TennCare Demonstration will be available in subsequent years, as TennCare is required to convene a forum on this subject each year for the foreseeable future.

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

Tennessee's economic recovery continued to find its footing during the October-December 2013 quarter. Although total state and local revenue collections in November 2013 were 3.91 percent higher than those for November 2012, collections in October and December 2013 were lower than those from the corresponding months of the preceding year.[18] News about current employment levels showed improvement. The unemployment rate fell steadily during the quarter, moving from 8.4 percent in October to 8.1 percent in November and then to 7.8 percent in December.[19]

Within a broader context, the Tennessee economy is positioned for important gains in 2014 and 2015. According to a report published by the University of Tennessee's Center for Business and Economic Research in January 2014, the state's unemployment rate will decline to 7.5 percent in 2014 and to 7.0 percent in 2015, while, at the same time, nonfarm and manufacturing employment, nominal personal income, and nominal taxable sales will all grow.[20] Given these factors, the report concludes that Tennessee's near-term outlook is "as bright as it has been since the end of the recession."[21]

This encouraging assessment was bolstered by a variety of other developments during the final quarter of Calendar Year 2013, including:

- Knoxville Locomotive Works is investing $6.1 million in an assembly and fabrication plant that will add 203 jobs in three years.[22]
- October 2013 was a record month for Nashville's tourism industry, with more than 600,000 hotel room nights booked.[23]

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

[19] Information about Tennessee's unemployment rate is available on the Department of Labor and Workforce Development's website at https://news.tn.gov/taxonomy/term/32.

[20] Murray, M., "An Economic Report to the Governor of the State of Tennessee: The State's Economic Outlook, January 2014, p. 31. Center for Business and Economic Research, University of Tennessee. The report is located at http://cber.bus.utk.edu/erg/erg2014.pdf.

[21] Ibid, p. xiii.

[22] "Railroad Company Investing $6 Million in Expansion." *Knoxville News Sentinel* 21 Nov. 2013. http://www.knoxnews.com/news/2013/nov/21/railroad-company-investing-6-million-in/.

[23] "Nashville Sees Record Gains in Tourism." *The Tennessean* 26 Nov 2013. http://www.tennessean.com/article/20131126/BUSINESS01/311260021/Nashville-sees-record-gains-tourism.

- The Tennessee Department of Economic and Community Development added four new locations—in Anderson, Gibson, Lauderdale, and Tipton Counties—to the list of sites available for investment and expansion.[24]

While not decisive in Tennessee's return to economic vitality, these events are indicative of the state's movement in a positive direction.

VIII. Member Month Reporting

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

Table 12
Member Month Reporting for Use in Budget Neutrality Calculations
October – December 2013

Eligibility Group	October 2013	November 2013	December 2013	Sum for Quarter Ending 12/31/13
Medicaid eligibles (Type 1)				
EG1 Disabled, Type 1 State Plan eligibles	132,451	131,556	129,886	393,893
EG2 Over 65, Type 1 State Plan eligibles	35	35	35	105
EG3 Children, Type 1 State Plan eligibles	648,815	645,551	651,108	1,945,474
EG4 Adults, Type 1 State Plan eligibles	276,700	274,184	280,600	831,484
EG5 Duals, Type 1 State Plan eligibles	123,350	122,939	121,793	368,082
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	305	326	345	976
EG10 H-Over 65, Type 2 Demonstration Population	0	0	0	0

[24] "4 Sites Selected for Company Investment." *Knoxville News Sentinel* 13 Dec. 2013. http://www.knoxnews.com/news/2013/dec/13/4-sites-selected-for-company-investment/.

Eligibility Group	October 2013	November 2013	December 2013	Sum for Quarter Ending 12/31/13
EG11 H-Duals, Type 2 Demonstration Population	6,272	6,295	6,384	18,951
TOTAL	1,187,928	1,180,886	1,190,151	3,558,965

Table 13
Member Month Reporting Not Used in Budget Neutrality Calculations
October – December 2013

Eligibility Group	October 2013	November 2013	December 2013	Sum for Quarter Ending 12/31/13
EG6E Expan Adult, Type 3, Demonstration Population	1,442	1,305	1,257	4,004
EG7E Expan Child, Type 3, Demonstration Population	146	141	132	419
Med Exp Child, Title XXI Demonstration Population	19,138	19,818	19,199	58,155
EG12E Carryover, Type 3, Demonstration Population	7,197	7,105	7,002	21,304
TOTAL	27,923	28,369	27,590	83,882

IX. Consumer Issues

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

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

	Apr – Jun 2013	Jul – Sept 2013	Oct – Dec 2013
TennCare Medicaid			
No. of appeals received	3,598	3,582	3,222
No. of appeals resolved or withdrawn	1,535	1,525	1,568
No. of appeals taken to hearing	1,755	1,774	1,718
No. of appeals that did not involve a valid factual dispute	1,728	1,201	955
Appeals previously heard that were	1,145	1,225	1,064

	Apr – Jun 2013	Jul – Sept 2013	Oct – Dec 2013
decided in the State's favor			
Appeals previously heard that were decided in the appellant's favor	152	116	179
TennCare Standard			
No. of appeals received	101	125	106
No. of appeals resolved or withdrawn	45	27	33
No. of appeals taken to hearing	52	56	74
No. of appeals that did not involve a valid factual dispute	44	31	25
Appeals previously heard that were decided in the State's favor	40	32	48
Appeals previously heard that were decided in the appellant's favor	5	4	5

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

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

	Apr – Jun 2013	Jul – Sept 2013	Oct – Dec 2013
No. of appeals received	1,072	880	924
No. of appeals resolved	1,170	771	961
• Resolved at the MCC level	499	195	301
• Resolved at the TSU level	163	93	115
• Resolved at the LSU level	508	483	545
No. of appeals that did not involve a valid factual dispute	339	531	275
No. of directives issued	162	148	178
No. of appeals taken to hearing	508	483	545
No. of appeals that were withdrawn by the enrollee at or prior to the hearing	184	165	172
Appeals that went to hearing and were decided in the State's favor	129	144	170
Appeals that went to hearing and were decided in the appellant's favor	17	16	17

By way of explanation:

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

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

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

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

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

	Apr – Jun 2013	Jul – Sept 2013	Oct – Dec 2013
No. of appeals of PreAdmission Evaluation (PAE) denials	450	402	447
No. of appeals of PASRR determinations	5	3	3
No. of appeals of denial for enrollment into CHOICES	6	12	7
No. of appeals of involuntary disenrollment from CHOICES	5	4	4
No. of appeals of denial of Consumer Direction	0	1	0
No. of appeals of involuntary withdrawal of Consumer Direction	1	0	0

	Apr – Jun 2013	Jul – Sept 2013	Oct – Dec 2013
No. of appeals of involuntary disenrollment from an HCBS waiver for individuals with intellectual disabilities	2	0	0
No. of appeals resolved in appellant's favor prior to hearing	148	124	143
No. of appeals withdrawn prior to hearing	4	7	9
No. of appeals dismissed at hearing	39	34	55
No. of appeals continued at hearing	13	9	33
No. of appeals that went to hearing and were decided in the State's favor	27	21	36
No. of appeals that went to hearing and were decided in the appellant's favor	2	7	4

X. Quality Assurance/Monitoring Activity

Population Health. As noted in previous Quarterly Progress Reports, TennCare phased out its "Disease Management" (DM) model of targeted health care interventions in favor of a new model referred to as "Population Health" (PH). This process was completed on July 1, 2013.

Whereas DM aimed to prevent the worsening of chronic conditions that had already developed, PH is more proactive in that it—

- targets a much larger portion of the TennCare population;
- identifies risky behaviors likely to lead to disease in the future (such as poor eating habits, physical inactivity, and drug use);
- assists enrollees in discontinuing such activities; and
- retains interventions to assist enrollees who already have a complex chronic condition.

The transition of DM members to PH began on January 1, 2013. Full implementation of the program—meaning assignment of members to one of three levels of health risk and one of seven programs for reducing risk—was completed on July 1, 2013. Information on the risk levels addressed by PH, the manner in which these risks are addressed, and the total number of members enrolled in PH by the conclusion of the July-September 2013 quarter is provided in Table 17. Data for the period of October through December 2013, will be provided in the next Quarterly Progress Report.

Table 17
Population Health Data*, July – September 2013

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	635,528
Level 1: low or moderate risk	Maternity Program	Engage pregnant women in timely prenatal care and deliver a healthy, term infant without complications	13,339
	Health Risk Management	Prevent, reduce, or delay exacerbation and complications of a condition or health risk behavior	504,973
	Care Coordination	Assure that members receive the services they need to reduce the risk of an adverse health outcome	12,001
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	2,441
	High Risk Pregnancy Management	Engage pregnant women in timely prenatal care and deliver a healthy, term infant without complications	2,873
	Complex Case Management	Move members to optimal levels of health and well-being through timely coordination of quality services and self-management support	556
Total PH Enrollment			**1,171,711**

*** 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 October 2013, TennCare's External Quality Review Organization (EQRO), Qsource, published the results of its provider data validation survey for the July-September 2013 quarter. Qsource took a sample of provider data files from TennCare's MCCs[25] and reviewed each for accuracy in the following categories:

- Contract status with MCC
- Provider address

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

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

The validity of such information is one measure of providers' availability and accessibility to TennCare enrollees. Qsource's report concluded that "[o]verall, the MCCs' accuracy rates have maintained a high level," especially in the categories of "active contract status with MCC" (97.6 percent accuracy), "provider credentialed specialty / behavioral health service code" (96.7 percent accuracy), "primary care services" (99.4 percent accuracy), and "prenatal care services" (99.4 percent accuracy).

While the results were comparable to the overall scores obtained last quarter and one year ago, to ensure improvement in these and other areas (such as "open/closed to new patients," which demonstrated only 89.8 percent accuracy), TennCare required each of its MCCs to submit a Corrective Action Plan no later than December 5, 2013. The Bureau, in turn, had received, reviewed, and accepted all of the plans by December 10, 2013. Results for the October-December 2013 quarter will be discussed in the next Quarterly Progress Report.

XI. Demonstration Evaluation

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

In addition, on October 31, 2013, the State submitted the Draft Annual Report as required by STC 46. Part V of that report provided the progress to date on the performance measures that were outlined in the approved Evaluation Design. It is the State's intention to provide updated information on the performance measures in each Annual Report.

XII. Essential Access Hospital Pool[26]

A. Safety Net Hospitals

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

B. Children's Hospitals

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

C. Free Standing Psychiatric Hospitals

Pathways of Tennessee
Ridgeview Psychiatric Hospital and Center

D. Other Acute Care Hospitals

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

[26] 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.

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

Tennova Healthcare – Jefferson Memorial Hospital
Henderson County Community Hospital
McNairy Regional Hospital
Roane Medical Center
Skyridge Medical Center – Westside
Bolivar General Hospital
McKenzie Regional Hospital
Claiborne County Hospital
Hillside Hospital
Volunteer Community Hospital
Gibson General Hospital
United Regional Medical Center
Jamestown Regional Medical Center
Wayne Medical Center
Methodist Healthcare – Fayette
Erlanger Health System – East Campus
DeKalb Community Hospital
Baptist Memorial Hospital – Huntingdon
White County Community Hospital
Emerald Hodgson Hospital

XIII. Graduate Medical Education (GME) Hospitals

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

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

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

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

XIV. Critical Access Hospitals

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

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Date Submitted to CMS: February 28, 2014

Attachment A

Budget Neutrality Calculations for the Quarter

Actual TennCare Budget Neutrality (October-December 2013)

I. The Extension of the Baseline

Baseline PMPM

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

Actual Member months of Groups I and II

1-Disabled (can be any ages)	394,726
2-Child <=18	1,946,790
3-Adult >= 65	100
4-Adult <= 64	831,475
Duals (17)	387,061
Total	3,560,152

Ceiling without DSH

	Baseline * MM
1-Disabled (can be any ages)	$616,348,860
2-Child <=18	$911,993,243
3-Adult >= 65	$102,217
4-Adult <= 64	$763,119,440
17s	$252,746,962
Total	**$2,544,310,723**

DSH

DSH Adjustment (Quarterly)	$115,999,213

Total Ceiling

Budget Neutrality Cap	
Total w/DSH Adj.	**$2,660,309,936**

II. Actual Expenditures

Group 1 and 2

1-Disabled (can be any ages)	$ 522,096,521
2-Child <=18	$ 408,628,966
3-Adult >= 65	$ 201,104
4-Adult <= 64	$ 311,421,910

Duals (17)	$	297,858,069
Total		**1,540,206,570**

Group 3

1-Disabled (can be any ages)		
2-Child <=18	$	11,220,387
3-Adult >= 65	$	85,990,820
4-Adult <= 64	$	2,472,176
Duals (17)		
Total		**99,683,383**

Pool Payments and Admin

Total Pool Payments	$	254,408,258

Admin	$	119,555,104

Quarterly Drug Rebates	$	66,759,331
Quarterly Premium Collections	$	-
Total Net Quarterly Expenditures	**$**	**1,947,093,984**

III. Surplus/(Deficit)

	$713,215,952
Federal Share	**$465,658,695**

HCI Result	MM201310	MM201311	MM201312	TOTAL	HCI ASO	HCI Rx	HCI DTL	HCI MCO CAP (TCS Admin)	TOTAL
EG1-TYPE1 (disabled, type1 state plan eligibles)	132,433	131,504	129,769	393,706	$83,835,919	$93,164,517	$1,869,452	$337,724,365	$516,987,959
EG1-TYPE2 (disabled, type2 transition group)	0	0	0	-					$0
EG2-TYPE1 (over 65, type1 state plan eligibles)	35	32	33	100	$155,697	$5,840	$0	$39,467	$201,104
EG2-TYPE2 (over 65, type2 state plan eligibles)	0	0	0	-					$0
EG3-TYPE1 (children, type1 state plan eligibles)	649,016	645,614	652,160	1,946,790	$14,784,836	$58,759,141	$33,526,400	$299,611,799	$408,628,966
Med Exp Child (Title XXI Demo Pop; EG3-Type2)	19,677	20,121	19,456	59,254	$61,488	$3,162,980	$1,271,311	$6,621,012	$11,176,045
EG4-TYPE1 (adults, type1 State plan eligibles)	276,722	274,200	280,553	831,475	$1,987,281	$46,074,525	$3,210,833	$259,317,796	$311,421,910
EG4-TYPE2 (adults, type2 demonstration pop)	0	0	0	-					$0
EG5-TYPE1 (duals, state plan eligibles)	123,255	122,797	121,632	367,684	$1,097,140	$679,725	$137,125	$241,494,314	$243,775,988
EG6E-TYPE3 (Expan adult, type3 demonstration pop)	1,446	1,306	1,259	4,011	$4,863	$554,343	$984	$1,907,975	$2,472,176
EG7E-TYPE3 (Expan child, type3 demonstration pop)	151	148	132	431	$391	$556	$10,034	$32,930	$44,342
EG8-TYPE2 (emd exp child)	0	0	0	-					$0
EG9 H-Disabled (TYPE 2 Eligibles)	316	340	364	1,020	$67	$250,621	$0	$4,856,854	$5,108,562
EG11H, H-Dual	6,402	6,443	6,532	19,377	$0	$35,524	$710	$54,026,470	$54,082,081
EG12E, Carryovers	7,196	7,104	7,002	21,302	$1,827	$1,585,275	$1,885	$84,380,531	$85,990,820
Total	**1,216,649**	**1,209,609**	**1,218,892**	**3,645,150**	**$101,929,509**	**$204,273,047**	**$40,028,734**	**$1,290,013,513**	**$1,639,889,953**

HCI Result	MM201310	MM201311	MM201312	TOTAL	HCI ASO PMPM	HCI Rx PMPM	HCI DTL PMPM	HCI MCO CAP (TCS Admin)	TOTAL
EG1-TYPE1 (disabled, type1 state plan eligibles)	132,433	131,504	129,769	393,706	$212.94	$236.63	$4.75	$857.81	$1,313.13
EG1-TYPE2 (disabled, type2 transition group)	0	0	0	-					
EG2-TYPE1 (over 65, type1 state plan eligibles)	35	32	33	100	$1,556.97	$58.40	$0.00	$394.67	$2,011.04
EG2-TYPE2 (over 65, type2 state plan eligibles)	0	0	0	-	-	-	-	-	-
EG3-TYPE1 (children, type1 state plan eligibles)	649,016	645,614	652,160	1,946,790	$7.59	$30.18	$17.22	$153.90	$209.90
Med Exp Child (Title XXI Demo Pop; EG3-Type2)	19,677	20,121	19,456	59,254	$1.04	$53.38	$21.46	$111.74	$188.61
EG4-TYPE1 (adults, type1 State plan eligibles)	276,722	274,200	280,553	831,475	$2.39	$55.41	$3.86	$311.88	$374.54
EG4-TYPE2 (adults, type2 demonstration pop)	0	0	0	-					
EG5-TYPE1 (duals, state plan eligibles)	123,255	122,797	121,632	367,684	$2.98	$1.85	$0.37	$656.80	$663.00
EG6E-TYPE3 (Expan adult, type3 demonstration pop)	1,446	1,306	1,259	4,011	$1.21	$138.21	$0.25	$475.69	$616.35
EG7E-TYPE3 (Expan child, type3 demonstration pop)	151	148	132	431	$0.91	$1.29	$23.28	$76.40	$102.88
EG8-TYPE2 (emd exp child)	0	0	0	-					
EG9 H-Disabled (TYPE 2 Eligibles)	316	340	364	1,020	$0.07	$245.71	$0.00	$4,761.62	$5,008.39
EG11H, H-Dual	6,402	6,443	6,532	19,377	$0.00	$1.83	$0.04	$2,788.18	$2,791.05
EG12E, Carryovers	7,196	7,104	7,002	21,302	$0.09	$74.42	$0.09	$3,961.16	$4,036.75
Total	**1,216,649**	**1,209,609**	**1,218,892**	**3,645,150**	**$27.96**	**$56.04**	**$10.98**	**$353.90**	**$449.88**

* Does not include January cap payment made in December 2013 for January 2014