February 29, 2016

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 2015 quarter. This report is being submitted in accordance with STC 45.

Please let us know if you have comments or questions.

Sincerely,

Darin J. Gordon
Director, Bureau of TennCare

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

TennCare II

Section 1115 Quarterly Report

(For the period October - December 2015)

Demonstration Year: 14 (7/1/15 - 6/30/16)
Federal Fiscal Quarter: 1/2016 (10/15 - 12/15)
Waiver Quarter: 2/2016 (10/15 - 12/15)

I. Introduction

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

TennCare contracts with several Managed Care Contractors (MCCs) to provide services to nearly 1.5 million enrollees. During this quarter, these entities included Managed Care Organizations (MCOs) for medical, behavioral, and certain Long-Term Services and Supports (LTSS), a Dental Benefits Manager (DBM) for dental services, and a Pharmacy Benefits Manager (PBM) for pharmacy services.

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

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

Table 1
Key Dates of Approval/Operation in the Quarter

Date	Action	STC #
All three months of the quarter	The Monthly Call was not held.	44
10/8/15	The State submitted Demonstration Amendment 28 to CMS. Amendment 28 proposed to close the Standard Spend Down eligibility category.	7
10/8/15	The State submitted draft STCs for Demonstration Amendment 27 to CMS. The purpose of the draft STCs was to show how the *Employment and Community First CHOICES* program proposed in Amendment 27 would be integrated within the TennCare Demonstration.	
10/14/15	CMS sent the State written questions concerning Amendment 28.	
10/15/15	CMS sent the State a letter acknowledging the submission of Amendment 28 and confirming that the submission was complete.	
10/19/15	In reference to Amendment 28, the State sent responses to CMS's written questions of 10/14/15.	
10/21/15	CMS sent the State another written question concerning Amendment 28.	
10/23/15	In reference to Amendment 28, the State sent a response to CMS's written question of 10/21/15.	
10/30/15	The State submitted the Draft Annual Report for	46

Date	Action	STC #
	Demonstration Year 13 to CMS. The Draft Annual Report will be made final upon the receipt of comments from CMS.	
11/3/15	In reference to Amendment 27, the State submitted documentation of communications between TennCare and members of the Tennessee advocacy community regarding *Employment and Community First CHOICES*.	
11/16/15	The State notified the public of its intent to submit Demonstration Amendment 29 to CMS. Amendment 29 outlined benefit limits that would be necessary if CMS did not approve Amendment 26. (CMS ultimately approved Amendment 26 on 12/11/15, so there was no need to submit Amendment 29.)	15
11/18/15	The State submitted the annual update of its Quality Improvement Strategy to CMS.	43.c.
11/19/15	CMS sent the State written questions concerning the budget neutrality implications of Demonstration Amendment 26 (involving the State's authority to make hospital pool payments).	
11/20/15	In reference to Amendment 26, the State submitted responses to CMS's written questions of 11/19/15.	
11/30/15	CMS sent the State written questions concerning Amendment 27. The State, in turn, provided written responses to all of the questions.	
11/30/15	The State submitted the Quarterly Progress Report for the July-September 2015 quarter to CMS.	45
12/11/15	CMS issued written approval of Amendment 26. Included with the approval were revised versions of the Waiver List, Expenditure Authorities, and STCs comprising TennCare's Demonstration agreement with CMS.	
12/15/15	The State sent CMS a letter accepting the approval materials related to Amendment 26.	
12/16/15	The State sent CMS an updated version of the draft STCs for Amendment 27 that had originally been submitted on 10/8/15.	
12/17/15	The State held a public forum to accept comments on the progress of the TennCare Demonstration.	10
12/22/15	The State submitted to CMS an application to extend the TennCare Demonstration. Section VII of the application documented the State's compliance with relevant public notice and input requirements.	8

II. Enrollment and Benefits Information

Information about enrollment by category is presented in Table 2.

Table 2
Enrollment Counts for the October – December 2015 Quarter
Compared to the Previous Two Quarters

Demonstration Populations	Total Number of TennCare Enrollees		
	Apr – Jun 2015	Jul – Sept 2015	Oct – Dec 2015
EG1 Disabled, Type 1 State Plan eligibles	143,099	142,205	142,136
EG9 H-Disabled, Type 2 Demonstration Population	292	306	282
EG2 Over 65, Type 1 State Plan eligibles	148	197	141
EG10 H-Over 65, Type 2 Demonstration Population	22	39	44
EG3 Children, Type 1 State Plan eligibles	735,613	749,605	759,289
EG4 Adults, Type 1 State Plan eligibles	395,870	413,342	428,937
EG5 Duals, Type 1 State Plan eligibles and EG11 H-Duals 65, Type 2 Demonstration Population	142,046	143,895	145,490
EG6E Expan Adult, Type 3 Demonstration Population	829	814	793
EG7E Expan Child, Type 3 Demonstration Population	64	63	61
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	18,991	18,894	18,734
EG12E Carryover, Type 3, Demonstration Population	4,141	3,792	3,531
TOTAL*	1,441,115	1,473,142	1,499,438

*** 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 more than 79 percent of TennCare enrollees appearing in one of these categories.

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

Table 3
TennCare Managed Care Contractors as of December 31, 2015

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

Four proposed amendments to the TennCare Demonstration were in various stages of development during the quarter.

Demonstration Amendment 26: Expenditures for Hospital Pool Payments. Amendment 26, which was originally submitted to CMS in April 2015, dealt with the proposed termination date for TennCare's ability to make payments to certain hospitals through "pools" that exist outside the managed care program. The primary purpose of pool payments is to offset the costs that hospitals incur in delivering uncompensated care. Such payments have been predicated on a provision of the TennCare Demonstration—Expenditure Authority #4—that was scheduled to expire on December 31, 2015. Amendment 26 proposed to remove that expiration date.

During the October-December 2015 quarter, the Bureau provided additional documentation to CMS in support of Amendment 26, with particular emphasis on details related to budget neutrality. On December 11, 2015, CMS issued approval of Amendment 26, including updated versions of the STCs, the Waiver List, and the Expenditure Authorities comprising TennCare's demonstration agreement with the federal government. The December 31, 2015, expiration date had been deleted from these materials by CMS. Therefore, the Bureau sent CMS a letter of acceptance on December 15, 2015.

Demonstration Amendment 27: Employment and Community First CHOICES. On June 23, 2015, following an in-depth 18-month stakeholder input process with individuals with intellectual and developmental disabilities and their families and providers, and more than a year of discussion with CMS on a Concept Paper, TennCare submitted Amendment 27.

[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).

Amendment 27 concerns a new program named Employment and Community First (ECF) CHOICES, which would—according to the text of the proposal—implement "an integrated managed long-term services and supports (MLTSS) program that is specifically geared toward promoting and supporting integrated, competitive employment and independent, integrated community living as the first and preferred option for individuals with intellectual and developmental disabilities (I/DD)."

TennCare continued during the October-December 2015 quarter to furnish CMS information that would facilitate review and approval of Amendment 27. Chief among the materials supplied by the Bureau was a set of draft STCs for the TennCare Demonstration, defining the manner in which ECF CHOICES would operate within TennCare's managed care system. As of the conclusion of the quarter, CMS's review of Amendment 27 was ongoing.

Demonstration Amendment 28: Closure of Standard Spend Down Category. TennCare submitted Amendment 28 to CMS on October 8, 2015. Amendment 28 would close a TennCare eligibility category called "Standard Spend Down" (or "SSD"), which provides coverage to approximately 800 individuals who are not otherwise eligible for Medicaid but 1) are aged, blind, disabled, or the caretaker relative of a Medicaid-eligible child and 2) have enough unreimbursed medical bills to allow them to "spend down" to the Medically Needy Income Standard, a very low threshold. New enrollment in the category has been closed since 2013, and TennCare anticipates that many of the remaining enrollees may be eligible for health coverage through either Medicare or the Health Insurance Marketplace established by the Affordable Care Act.

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

Demonstration Amendment 29: Program Modifications. Amendment 29 was a contingency plan to address the budgetary challenges that would have arisen if CMS had not extended TennCare's authority to make hospital pool payments by approving Amendment 26. (See "Expenditures for Hospital Pool Payments" above.) Specifically, Amendment 29 outlined several benefit limits to be imposed on non-exempt adults, including—

- A combined annual limit of eight days per person for inpatient hospital and impatient psychiatric hospital services;
- An annual limit on non-emergency outpatient hospital visits of eight occasions per person;
- A combined annual limit on health care practitioners' office visits of eight occasions per person;
- An annual limit on lab and X-ray services of eight occasions per person; and
- Elimination of coverage for occupational therapy, speech therapy, and physical therapy.

The Bureau held a public notice and comment period on Amendment 29 from November 16 through December 18, 2015. Near the conclusion of that period, CMS extended the authority for TennCare's hospital pool payments, thereby eliminating the need for Amendment 29. As a result, the proposal was not submitted to CMS.

Cost Sharing Compliance Plan. In its April 18, 2012, letter approving the Bureau of TennCare's cost sharing compliance plan for the TennCare Standard population, CMS stipulated that "each Quarterly Report . . . must include a report on whether any families have contacted the State to document having reached their aggregate cap, and how these situations were resolved." During the October-December 2015 quarter, the Bureau received no notifications that a family with members enrolled in TennCare Standard had met its cost sharing limit. It should be noted that this is the twelfth consecutive quarter since the plan was implemented in which no notifications have been received.

III. Innovative Activities to Assure Access

Early and Periodic Screening, Diagnosis and Treatment (EPSDT). EPSDT, or "TennCare Kids," outreach is a significant area of interest for TennCare. The TennCare Bureau maintains a contract with the Tennessee Department of Health (TDH) to conduct a community outreach program for the purpose of educating families on EPSDT benefits and encouraging them to use those benefits, particularly preventive exams.

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

- Seasonal events. Each year, National Children's Dental Health Month in February, back-to-school events in August, and Child Health Week in October all have a profound influence on the focus and direction of outreach efforts during their respective quarters. TDH's communications strategy for each is based on an evaluation of past successes and current opportunities. During one round of Dental Health Month, for instance, TDH employed scrolling billboards prominently, whereas the strategy for Child Health Week eight months later placed greater emphasis on radio and television broadcasts and magazine articles.
- Collaborative partners. A variety of TDH's activities are dependent on the opportunities offered by other State agencies and by entities within the community. For example, publication of articles in newsletters and magazines is usually possible only when local media outlets offer space in their periodicals at no charge. Similarly, TDH's ability to educate the public through television and radio broadcasts is tied to the availability of open timeslots in those platforms. Even certain types of telephone outreach require input from other sources: calls to families to reinforce the importance of dental

checkups (detailed in Table 4), for instance, are possible only because of referrals from the School-Based Dental Prevention Program (SBDPP).

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

Activities	Apr – Jun 2015	Jul – Sept 2015	Oct – Dec 2015
Number of outreach activities/events	3,753	3,649	3,141
Number of people made contact with (mostly face to face at outreach events)	170,368	203,202	188,186
Number of educational materials distributed	175,614	218,290	180,304
Number of coalitions/advisory board meetings attended or conducted	80	85	68
Number of attendees at coalitions/advisory board meetings	1,339	1,471	1,121
Number of educational preventive health radio/TV broadcasts	1,394	962	1,067
Number of educational preventive health newsletter/magazine articles	291	29	45
Number of educational preventive health billboards, scrolling billboards and bulletin boards	7,177	5,804	5,807
Number of presentations made to enrollees/professional staff who work with enrollees	128	118	129
Number of individuals attending presentations	3,578	4,370	3,699
Number of completed telephone calls regarding the importance of dental checkups	159	66	305
Number of home visits completed	28	23	30

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

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

Activities	Apr – Jun 2015	Jul – Sept 2015	Oct – Dec 2015
Number of enrollees reached	22,115	23,944	23,913
Number of enrollees who were assisted in scheduling an EPSDT exam for their children	417	766	723
Number of enrollees who were assisted in arranging for transportation	30	19	37

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

	Apr – Jun 2015	Jul – Sept 2015	Oct – Dec 2015
No. of encounters received by TennCare (initial submission)	13,376,983	16,066,893	15,597,491
No. of encounters rejected by Edifecs upon initial submission	16,366	11,183	19,529
Percentage of encounters that were compliant with State standards (including HIPAA) upon initial submission	99.88%	99.96%	99.87%

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

A. CHOICES

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

Table 7
TennCare CHOICES Enrollment and Reserve Slots
for October – December 2015 Compared to the Previous Two Quarters

	Statewide Enrollment Targets and Reserve Capacity[4]	Enrollment and Reserve Slots Being Held as of the End of Each Quarter		
		Apr – Jun 2015	Jul – Sept 2015	Oct – Dec 2015
CHOICES 1	Not applicable	17,069	17,169	17,202
CHOICES 2	12,500	8,301	8,455	8,588
CHOICES 3 (including Interim CHOICES 3)	To Be Determined	4,939	4,690	4,376
Total CHOICES	Not applicable	30,309	30,314	30,166
Reserve capacity	300	300	300	300

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

Data and trends of the designated CHOICES data elements: STC 43.d. requires the State to submit to CMS periodic statistical reports about the use of LTSS by TennCare enrollees. Nine separate reports—spanning the period of August 2011 through August 2015—had been submitted by the conclusion of the October-December 2015 quarter.

Taken together, the reports depict a program evolving according to the characteristics of LTSS recipients, with institutional care available to individuals with the highest acuity of need, and Home and Community-Based Services (HCBS) available to individuals whose needs can be safely and effectively met at home or in other non-institutional settings. Point in time data revealed declining use of NF services over time, with placement in institutional settings decreasing from 21,530 individuals on June 30, 2011, to 17,069 individuals on June 30, 2015. The aggregate number of TennCare enrollees accessing HCBS, by comparison, grew from 6,226 in the twelve-month period preceding CHOICES implementation in Middle Tennessee to 16,112 after

[4] Of the three active CHOICES groups, only CHOICES 2 has an enrollment target. Interim CHOICES 3 closed to new enrollment on June 30, 2015; an enrollment target for CHOICES 3 has not been set at this time.

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

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

Annual Aggregate Data			Point-in-Time Data		
No. of TennCare enrollees accessing HCBS (E/D), 3/1/09 – 2/28/10	No. of TennCare enrollees accessing HCBS (E/D), 7/1/13 – 6/30/14	Percent increase over a four-year period	No. of TennCare enrollees accessing HCBS (E/D) on the day prior to CHOICES implementation	No. of TennCare enrollees accessing HCBS (E/D) on 6/30/15	Percent increase from the day prior to CHOICES implementation to 6/30/15
6,226	16,112	159%	4,861[5]	13,240	172%

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

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

[5] The total of 4,861 comprises 1,479 individuals receiving HCBS (E/D) in Middle Tennessee on February 28, 2010 (the day prior to CHOICES implementation in that region), and 3,382 individuals receiving HCBS (E/D) in East and West Tennessee on July 31, 2010 (the day prior to CHOICES implementation in those regions).

During the period from October 1, 2015, through December 31, 2015, NF PreAdmission Evaluations (PAEs) were approved for 260 individuals with acuity scores lower than 9, and 156 of these individuals were subsequently enrolled in CHOICES 1 during the measurement period. Reasons that the remaining individuals were approved for—but not yet enrolled in—CHOICES 1 include:

- Pending notification by Nursing Facilities of the exhaustion of other sources of reimbursement (e.g., Medicare, other insurance, or private payment);
- Medicaid financial eligibility determination pending; and
- Failure of the individual to meet Medicaid financial eligibility requirements.

In the same reporting period, HCBS PAEs were approved for 147 individuals with acuity scores lower than 9, and 110 of the individuals were subsequently enrolled in CHOICES Group 2. The remaining applicants did not meet Medicaid financial eligibility requirements or otherwise failed to qualify for, or proceed with, enrollment in CHOICES 2.

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

Table 9
TennCare CHOICES Transition Allowances
for October – December 2015 Compared to the Previous Two Quarters

	Frequency and Use of Transition Allowances					
	Apr – Jun 2015		Jul – Sept 2015		Oct – Dec 2015	
Grand Region	# Distributed	Total Amount	# Distributed	Total Amount	# Distributed	Total Amount
East	11	$11,205	13	$19,431	20	$20,435
Middle	8	$9,065	9	$6,009	14	$13,089
West	11	$12,361	12	$8,256	15	$15,179
Statewide Total	30	$32,631	34	$33,696	49	$48,703

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

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

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

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

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

During the October-December 2015 quarter, the MCOs submitted their National Association of Insurance Commissioners (NAIC) Third Quarter 2015 Financial Statements. As of September 30, 2015, TennCare MCOs reported net worth as indicated in the table below.[6]

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

	Net Worth Requirement	Reported Net Worth	Excess/ (Deficiency)
Amerigroup Tennessee	$18,895,648	$160,078,554	$141,182,906
UnitedHealthcare Plan of the River Valley (UnitedHealthcare	$67,602,074	$465,398,529	$397,796,455

[6] The "Net Worth Requirement" and "Reported Net Worth" figures in the table are based on the MCOs' company-wide operations, not merely their TennCare operations. Amerigroup and Volunteer State Health Plan, for instance, operate Medicare Advantage Plans, while UnitedHealthcare has several lines of business in Illinois, Iowa, Virginia, and Tennessee.

	Net Worth Requirement	Reported Net Worth	Excess/ (Deficiency)
Community Plan)			
Volunteer State Health Plan (BlueCare & TennCare Select)	$37,185,058	$307,523,663	$270,338,605

During the October-December 2015 quarter, the MCOs were also required to comply with Tennessee's "Risk-Based Capital for Health Organizations" statute (T.C.A. § 56-46-201 *et seq.*). Risk-based capital (RBC) involves a method of calculating the minimum amount of capital necessary for a health entity to support its overall business operations depending on its size and risk profile. A health entity with a higher amount of risk is required to hold a higher amount of capital. The RBC statute gives TDCI the authority and mandate to use preventive and corrective measures that vary depending on the amount of capital deficiency indicated by the RBC calculations. A "Company Action Level" deficiency (defined at T.C.A. § 56-46-203(a)) would require the submission of a plan to correct the entity's capital deficiency.

The following table compares the MCOs' net worth to the Company Action Level requirements as of September 30, 2015:

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

	Company Action Level Requirement	Reported Net Worth	Excess/ (Deficiency)
Amerigroup Tennessee	$61,407,788	$160,078,554	$98,670,766
UnitedHealthcare Plan of the River Valley (UnitedHealthcare Community Plan)	$244,098,654	$465,398,529	$221,299,875
Volunteer State Health Plan (BlueCare & TennCare Select)	$109,546,612	$307,523,663	$197,977,051

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

C. Application to Renew the TennCare Demonstration

Unlike traditional fee-for-service Medicaid programs, TennCare is a demonstration project. As such, TennCare receives waivers of certain federal statutes and regulations in order to "demonstrate" that a managed care approach to health care can be used to extend coverage to certain people who would not otherwise be eligible for Medicaid without increasing expenditures or diminishing the quality of care. 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.

The current demonstration agreement expires on June 30, 2016. In accordance with the Special Terms and Conditions (STCs) of the agreement, the Bureau of TennCare submitted an application to renew the demonstration to CMS six months prior to the end of the approval period. The renewal request, which was submitted on December 22, 2015, and which may be accessed online at http://www.tn.gov/assets/entities/tenncare/attachments/TennCareExtension.pdf, seeks an extension of the TennCare Demonstration through June 30, 2021. The request asks for only one change to the Demonstration: that the waiver of retroactive eligibility currently scheduled to expire on June 30, 2016, be extended throughout the next approval period.

Prior to submission of the renewal application, the Bureau held a public notice and comment period from November 12, 2015, through December 14, 2015. Notice of the State's intent to seek an extension appeared on dedicated pages of the TennCare website, in several Tennessee newspapers and the Tennessee Administrative Register, and via Facebook and Twitter. A working draft of the application was published on the TennCare website. To enable members of the public to offer feedback on the application, the Bureau accepted comments via mail, email, and two public hearings held on November 18 and 23, 2015. These comments were reviewed as part of the process of preparing the final version of the application.

Negotiations with CMS on the application are expected to take place during the first half of 2016. Additional information about renewal of the TennCare Demonstration is available at http://www.tn.gov/tenncare/article/extension-of-tenncare-demonstration.

D. Budget Presentation

On December 1, 2015, four members of TennCare's executive staff—Director Darin Gordon, Deputy Director and Chief of Staff Dr. Wendy Long, Chief Financial Officer Casey Dungan, and Chief of Long-Term Services and Supports Patti Killingsworth—presented the Fiscal Year 2017 proposed budget for the Division of Health Care Finance and Administration (HCFA) to Governor Bill Haslam, Finance and Administration Commissioner Larry Martin, Budget Director David Thurman, and Chief Operating Officer Greg Adams.

The presentation document itself, which is available on TennCare's website at http://www.tn.gov/assets/entities/hcfa/attachments/HCFAbudgetFY17.pdf, concisely summarizes the manner in which the Bureau has been able to deliver quality care and achieve high levels of member satisfaction while continuing to manage inflationary growth. Evidence of these achievements as highlighted by the presentation includes the following:

- Provision of health insurance to approximately half of Tennessee children and more than 20 percent of the entire state population;

- Enrollee satisfaction levels above 90 percent for seven years in a row, including an all-time high of 95 percent in 2015;
- Improvement in 85 percent of 33 HEDIS (Healthcare Effectiveness Data and Information Set) measures tracked since 2007;
- Ranking of three TennCare health plans in the top half of plans nationwide; and
- Medical inflation levels well below those of commercial insurance programs and of Medicaid programs nationally.

A portion of the presentation was devoted to TennCare's ECF CHOICES proposal (described above in the summary of Demonstration Amendment 27). The need for ECF CHOICES arises from a variety of challenges impacting the service delivery system for individuals with intellectual and developmental disabilities, including the disproportionately high cost in Tennessee of providing HCBS to individuals with intellectual disabilities; a substantial waiting list for such services; the current lack of HCBS options for individuals who have developmental disabilities but not intellectual disabilities; and a significant gap between the number of people with intellectual disabilities who want to work and those who are actually working. ECF CHOICES has been designed to address these issues in a number of ways. For instance, services in ECF CHOICES will be tiered based on the needs of persons served, allowing those services to be provided more cost-effectively; the resulting cost savings will allow more individuals currently on waiting lists to be served and will begin to address the needs of individuals with developmental disabilities other than intellectual disabilities. In addition, the unique array of employment services and supports in ECF CHOICES will help to create a pathway to employment, even for individuals with significant disabilities, resulting in improved employment, better health and quality of life outcomes, and reduced reliance on public benefits.

As Governor Haslam had requested of all State agencies, HCFA included within its budget presentation a proposal for reducing expenditures by 3.5 percent. Potential cost-controlling measures identified by HCFA ranged from use of Guaranteed Net Unit Pricing (GNUP) in pharmacy contracts and ongoing reform of payment and delivery systems to value-based purchasing for enhanced respiratory care and elimination of the perinatal grant program.

Touching on the application to renew the TennCare Demonstration for five years, as well as the challenges posed by various cost drivers (such as Medicare costs borne by the State), the presentation outlined the environment in which TennCare (and HCFA) will operate for years to come and reiterated the agency's commitment to high-quality, cost-effective services that offer the best value for Tennessee taxpayers.

E. Payment Reform

In February 2013, Governor Haslam launched Tennessee's Health Care Innovation Initiative to change the way that health care is paid for in Tennessee. The desired direction is to move from paying for volume to paying for value by rewarding health care providers for certain outcomes

such as high quality and efficient treatment of medical conditions, and to help in maintaining people's health over time.

The Tennessee Health Care Innovation Initiative is located in HCFA, the agency in which TennCare is located as well. Although the Initiative's goals transcend Medicaid, there is much emphasis on Medicaid and TennCare as playing a pivotal role in meeting these goals. All of TennCare's providers are included in the Initiative.

Two of the most important strategies being used to reform health care payment approaches are primary care transformation and episodes of care:

- Primary care transformation focuses on the role of the primary care provider in promoting the delivery of preventive services and managing chronic illnesses over time. The Initiative is developing an aligned model for multi-payer Patient Centered Medical Homes (PCMHs), Health Homes for TennCare members with Serious and Persistent Mental Illness, and a shared care coordination tool that includes hospital and Emergency Department admission, discharge, and transfer alerts for attributed providers.
- Episodes of care focuses on the health care delivered in association with acute health care events, such as a surgical procedure or an inpatient hospitalization. Episodes encompass care delivered by multiple providers in relation to a specific health care event. Each episode has a "quarterback" who leads and coordinates the team of care providers and helps drive improvement through various activities including, but not limited to, care coordination, early intervention, and patient education.

Both of these strategies have benefitted from the input of Technical Advisory Groups (TAGs) composed of subject matter experts. TAG recommendations span a variety of topics, including the patient journey and care pathways, the definition of the principal accountable provider (i.e., the quarterback), any aspects of care delivery unique to Tennessee, the components of the episode of care, and appropriate quality measures.

During the October-December 2015 quarter, TAGs completed their reviews and provided advice on the fourth set ("Wave 4") of episodes of care, consisting of Attention Deficit Hyperactivity Disorder and Oppositional Defiant Disorder; Coronary Artery Bypass Graft and Valve Repair and Replacement; Acute Exacerbation of Congestive Heart Failure; and Bariatric Surgery. Although the State and participating insurance companies are still working to implement these episodes, the intent of the Initiative is to incorporate all of the advice of the TAGs. Furthermore, finalized TAG recommendations concerning PCMHs and Health Homes are expected in early Spring 2016, while the next round of recommendations related to episodes of care is expected in early Summer 2016.

F. Electronic Health Record Incentive Program

The Electronic Health Record (EHR) Incentive Program is a partnership between federal and state governments that grew out of the Health Information Technology for Economic and Clinical Health (HITECH) Act. The purpose of the program is to provide financial incentives to Medicaid providers[7] to replace outdated, often paper-based approaches to medical record-keeping with electronic systems that meet rigorous certification criteria and that can improve health care delivery and quality. The federal government provides 100 percent of the funding for the incentive payments and 90 percent of the administrative costs.

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

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

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

Table 12
EHR Payments
Quarterly and Cumulative

Payment Type	No. of Providers Paid During the Quarter	Quarterly Amount Paid (Oct-Dec 2015)	Cumulative Amount Paid To Date
First-year payments	332[8]	$1,360,495	$157,128,183
Second-year payments	40	$628,863	$50,186,258
Third-year payments	6	$51,000	$16,962,038
Fourth-year payments	3	$25,500	$1,394,005

[7] 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).

[8] Of the 332 providers receiving first-year payments in the October-December 2015 quarter, 21 earned their incentives by successfully attesting to meaningful use of EHR technology in their first year of participation in the program.

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

- Hosting seven webinars for eligible professionals on the subject of CMS's final rule—published on October 16, 2015—on EHR programs;
- Attending more than a dozen meetings throughout the state, including six sessions hosted by the Tennessee Medical Association (TMA), six town hall meetings hosted jointly by Amerigroup and UnitedHealthcare, and the 67th Annual Scientific Assembly of the Tennessee Academy of Family Physicians;
- Participation throughout the quarter in several Southeast Regional Collaboration for HIT/HIE (SERCH) calls;
- Monthly newsletters distributed by the Bureau's EHR ListServ; and
- A quarterly reminder to Tennessee providers who had registered at the federal level but who have not registered or attested at the state level.

TennCare continues to schedule EHR workshops with a variety of provider organizations to maintain the momentum of the program. Events planned for the spring of 2016, for instance, include participation in the statewide TMA meeting.

G. Public Forum on the TennCare Demonstration

In compliance with the federal regulation at 42 CFR § 431.420(c) and Special Term and Condition 10 of the TennCare Demonstration, the Bureau hosted a public forum in Nashville on December 17, 2015. 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 17 open meeting was not the only avenue through which feedback could be offered. Notice of the forum, which appeared on the TennCare website, included an email address and a physical address at which comments would be accepted. Although the Bureau received comments from only two sources, additional opportunities to assess the TennCare Demonstration will be available, as TennCare is required to convene a forum on this subject each year for the foreseeable future.

Each of the two sets of comments received by TennCare was prepared by an attorney with experience in the field of elder law, and each addressed a wide range of subjects. One commenter viewed the current framework of coverage provided by TennCare as worth preserving but identified certain areas in which improvement could be made. Examples of such suggested program modifications included a more responsive, reliable application process; the need for additional pathways to TennCare eligibility; a larger package of CHOICES benefits; expanded outreach and assistance to spouses of CHOICES applicants and enrollees; and an estate recovery process that gives greater consideration to families of enrollees receiving LTSS.

The other commenter rejected the TennCare program in its entirety, arguing that the program's very existence violates the Tennessee Constitution and various provisions of Tennessee statutory law. The commenter also suggested that individuals enrolled in TennCare have an economic incentive to remain unemployed or underemployed and that a shift away from Medicaid toward Health Savings Accounts and purchase of private insurance would be preferable.

VI. Action Plans for Addressing Any Issues Identified

TennCare continues to comply with orders issued in the *Wilson v. Gordon* court action.

VII. Financial/Budget Neutrality Development Issues

In all three months of the October-December 2015 quarter, total state and local revenue collections were notably higher than they had been during the corresponding months of 2014, with an eleven percent improvement in October, a nine percent improvement in November, and an eight percent improvement in December.[9] In the arena of jobs, Tennessee demonstrated relative stability: the unemployment rate fluctuated only mildly—between 5.5 percent and 5.6 percent—throughout the quarter. These figures represent an improvement on the results from one year ago, when the Tennessee unemployment rate was fixed at 6.6 percent from October through December. The gap between the state and national unemployment rates was relatively small this quarter as well, with the difference ranging from 0.5 percent to 0.6 percent during the reporting period.[10]

VIII. Member Month Reporting

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

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

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

Table 13
Member Month Reporting for Use in Budget Neutrality Calculations
October – December 2015

Eligibility Group	October 2015	November 2015	December 2015	Sum for Quarter Ending 12/31/15
Medicaid eligibles (Type 1)				
EG1 Disabled, Type 1 State Plan eligibles	142,810	142,322	141,688	426,820
EG2 Over 65, Type 1 State Plan eligibles	98	124	132	354
EG3 Children, Type 1 State Plan eligibles	750,560	753,933	754,765	2,259,258
EG4 Adults, Type 1 State Plan eligibles	416,131	421,527	427,314	1,264,972
EG5 Duals, Type 1 State Plan eligibles	136,712	137,141	137,707	411,560
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	277	278	280	835
EG10 H-Over 65, Type 2 Demonstration Population	35	41	41	117
EG11 H-Duals, Type 2 Demonstration Population	6,175	6,110	6,109	18,394
TOTAL	1,452,798	1,461,476	1,468,036	4,382,310

Table 14
Member Month Reporting Not Used in Budget Neutrality Calculations
October – December 2015

Eligibility Group	October 2015	November 2015	December 2015	Sum for Quarter Ending 12/31/15
EG6E Expan Adult, Type 3, Demonstration Population	796	793	790	2,379
EG7E Expan Child, Type 3, Demonstration Population	63	61	61	185
Med Exp Child, Title XXI	18,801	18,769	18,732	56,302

Eligibility Group	October 2015	November 2015	December 2015	Sum for Quarter Ending 12/31/15
Demonstration Population				
EG12E Carryover, Type 3, Demonstration Population	3,638	3,536	3,467	10,641
TOTAL	23,298	23,159	23,050	69,507

IX. Consumer Issues

Eligibility Appeals. TennCare eligibility appeals are handled by the Bureau of TennCare. Table 15 presents a summary of eligibility appeal activity during the quarter, compared to the previous two quarters.

Table 15
Eligibility Appeals for October – December 2015
Compared to the Previous Two Quarters

	Apr – Jun 2015	Jul – Sept 2015	Oct – Dec 2015
No. of appeals received	4,301	4,382	4,794
No. of appeals resolved or withdrawn	6,257	3,205	3,487
No. of appeals taken to hearing	2,926	1,966	1,380

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

Table 16
Medical Service Appeals for October – December 2015
Compared to the Previous Two Quarters

	Apr – Jun 2015	Jul – Sept 2015	Oct – Dec 2015
No. of appeals received	1,740	2,149	2,188
No. of appeals resolved	1,572	1,800	2,285
• Resolved at the MCC level	807	795	972
• Resolved at the TSU level	114	132	209
• Resolved at the LSU level	651	873	1,104
No. of appeals that did not involve a valid factual dispute	180	235	264
No. of directives issued	167	201	315

	Apr – Jun 2015	Jul – Sept 2015	Oct – Dec 2015
No. of appeals taken to hearing	651	873	1,104
No. of appeals that were withdrawn by the enrollee at or prior to the hearing	198	293	333
Appeals that went to hearing and were decided in the State's favor	232	293	355
Appeals that went to hearing and were decided in the appellant's favor	19	28	43

By way of explanation:

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

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

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

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

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

	Apr – Jun 2015	Jul – Sept 2015	Oct – Dec 2015
No. of appeals received	234	297	258

	Apr – Jun 2015	Jul – Sept 2015	Oct – Dec 2015
No. of appeals resolved or withdrawn	181	147	142
No. of appeals set for hearing	70	72	78

X. Quality Assurance/Monitoring Activity

Population Health. "Population Health" (PH) is TennCare's model of targeted health care interventions. Key benefits of PH include—

- Selection of a much larger portion of the TennCare population than had been attempted previously;
- Identification of risky behaviors likely to lead to disease in the future (such as poor eating habits, physical inactivity, and drug use);
- Assistance to enrollees in discontinuing such activities; and
- Interventions to assist enrollees who already have a complex chronic condition.

Enrollees are assigned to one of three levels of health risk and one of seven programs for reducing risk. Information on the risk levels addressed by PH, the manner in which these risks are addressed, and the total number of unique members enrolled in PH at the conclusion of the July-September 2015 quarter is provided in Table 18. Data for the period of October through December 2015 will be provided in the next Quarterly Progress Report.

Table 18
Population Health Data*, July – September 2015

Risk Level	Intervention Type	Intervention Goal(s)	Number of Unique Members at End of Quarter
Level 0: no identified risk	Wellness Program	Keep members healthy as long as possible	771,521
Level 1: low or moderate risk	Maternity Program	Engage pregnant women in timely prenatal care and deliver a healthy, term infant without complications	17,871
	Health Risk Management	Prevent, reduce, or delay exacerbation and complications of a condition or health risk behavior	588,550
	Care Coordination	Assure that members receive the services they need to reduce the risk of an adverse health outcome	26,965

Risk Level	Intervention Type	Intervention Goal(s)	Number of Unique Members at End of Quarter
Level 2: high risk	Chronic Care Management	Provide intense self-management education and support to members with multiple chronic conditions to improve their quality of life, health status, and use of services	5,290
	High Risk Pregnancy Management	Engage pregnant women in timely prenatal care and deliver a healthy, term infant without complications	2,280
	Complex Case Management	Move members to optimal levels of health and well-being through timely coordination of quality services and self-management support	944
Total PH Enrollment			**1,413,421**

*** 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 2015, TennCare's External Quality Review Organization (EQRO), Qsource, published the results of its provider data validation survey for the July-September 2015 quarter. Qsource took a sample of provider data files from TennCare's MCCs[11] and reviewed each for accuracy in the following categories:

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

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" (95.8 percent accuracy), "provider credentialed specialty / behavioral health service code" (96.2

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

percent accuracy), "urgent care services" (96.9 percent accuracy), "primary care services" (99.0 percent accuracy), and "prenatal care services" (99.7 percent accuracy).

Because July-September 2015 was only the third quarter in which all of the MCOs delivered services statewide, the results of the survey were not entirely comparable to results achieved by the MCOs during the corresponding quarters of 2014, when accuracy was measured on a regional basis. Compared with the first two quarters of the statewide approach, however, the MCCs—according to the report—"have maintained relatively high accuracy rates this quarter." Nonetheless, to ensure ongoing improvement in all ten categories of the survey, TennCare required each of its MCCs to submit a Corrective Action Plan no later than December 5, 2015. The Bureau, in turn, had received, reviewed, and accepted all of the plans by December 10, 2015. Results for the October-December 2015 quarter will be discussed in the next Quarterly Progress Report.

XI. Demonstration Evaluation

On October 30, 2015, in compliance with STC 46, the State submitted to CMS its Draft Annual Report for Demonstration Year 13. Part V of that report provided the progress to date on the performance measures outlined in the approved Evaluation Design. It is the State's intention to provide updated information on the performance measures in each Annual Report.

Furthermore, on November 18, 2015, the State submitted to CMS its annual update of the strategy to evaluate and improve the quality and accessibility of care offered to enrollees through the managed care network. The document, entitled *2015 Annual Update Report of the 2013 Quality Assessment and Performance Improvement Strategy*, is available on TennCare's website at http://www.tn.gov/assets/entities/tenncare/attachments/qualitystrategy.pdf.

In addition, on December 22, 2015, the State submitted its application to renew the TennCare Demonstration, Part VI of which was an Interim Evaluation Report addressing progress in three areas: 1) medical and behavioral health measures; 2) efficiency, stability, and viability measures; and 3) measures for the TennCare CHOICES program. The renewal application—including the Interim Evaluation Report—remains available online at http://www.tn.gov/assets/entities/tenncare/attachments/TennCareExtension.pdf.

XII. Essential Access Hospital Pool[12]

A. Safety Net Hospitals

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

B. Children's Hospitals

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

C. Free Standing Psychiatric Hospitals

Pathways of Tennessee
Ridgeview Psychiatric Hospital and Center
Rolling Hills Hospital

D. Other Acute Care Hospitals

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

[12] 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.

Maury Regional Hospital
Baptist Memorial Hospital for Women
Wellmont Bristol Regional Medical Center
Cookeville Regional Medical Center
Fort Sanders Regional Medical Center
Tennova Healthcare – Physicians Regional Medical Center
Blount Memorial Hospital
Delta Medical Center
TriStar Summit Medical Center
TriStar StoneCrest Medical Center
Skyridge Medical Center
Southern Hills Medical Center
NorthCrest Medical Center
Gateway Medical Center
TriStar Horizon Medical Center
Sumner Regional Medical Center
Morristown – Hamblen Healthcare System
Dyersburg Regional Medical Center
Baptist Memorial Hospital – Tipton
Methodist Medical Center of Oak Ridge
TriStar Hendersonville Medical Center
Jellico Community Hospital
LeConte Medical Center
Baptist Rehabilitation – Germantown
Harton Regional Medical Center
Takoma Regional Hospital
Tennova Healthcare – LaFollette Medical Center
Grandview Medical Center
Skyridge Medical Center – Westside
Southern Tennessee Medical Center
United Regional Medical Center and Medical Center of Manchester
Sycamore Shoals Hospital
Indian Path Medical Center
Lakeway Regional Hospital
Roane Medical Center
Laughlin Memorial Hospital
Starr Regional Medical Center – Athens
Regional Hospital of Jackson
Hardin Medical Center
Crockett Hospital
Henry County Medical Center
Stones River Hospital
Wellmont Hawkins County Memorial Hospital
River Park Hospital

Jamestown Regional Medical Center
Hillside Hospital
Livingston Regional Hospital
Heritage Medical Center
Baptist Memorial Hospital – Union City
McNairy Regional Hospital
Claiborne County Hospital
McKenzie Regional Hospital
Erlanger Health System – East Campus
Henderson County Community Hospital
Volunteer Community Hospital
Wayne Medical Center
DeKalb Community Hospital
Cumberland River Hospital
Decatur County General Hospital
Baptist Memorial Hospital – Huntingdon
Emerald Hodgson Hospital

XIII. Graduate Medical Education (GME) Hospitals

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

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

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

Universities	Hospitals
Memphis	Methodist LeBonheur Erlanger Jackson Madison St. Francis
Vanderbilt University	Vanderbilt Hospital

XIV. Critical Access Hospitals

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

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Attachment A

Budget Neutrality Calculations for the Quarter

Actual TennCare Budget Neutrality (October - December 2015)

I. The Extension of the Baseline

Baseline PMPM

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

Actual Member months of Groups I and II

1-Disabled (can be any ages)	425,567
2-Child <=18	2,259,258
3-Adult >= 65	2,003
4-Adult <= 64	1,264,972
Duals (17)	429,954
Total	4,381,754

Ceiling without DSH

	Baseline * MM
1-Disabled (can be any ages)	$734,013,913
2-Child <=18	$1,131,574,536
3-Adult >= 65	$2,240,105
4-Adult <= 64	$1,277,543,573
17s	$307,177,578
Total	**$3,452,549,705**

DSH

DSH Adjustment (Quarterly)	$115,999,213

Total Ceiling

Budget Neutrality Cap	
Total w/DSH Adj.	**$3,568,548,918**

II. Actual Expenditures

Group 1 and 2

1-Disabled (can be any ages)	$ 480,107,689
2-Child <=18	$ 473,413,221
3-Adult >= 65	$ 2,988,864
4-Adult <= 64	$ 482,230,960

Duals (17)	$	340,452,617
Total		**1,779,193,350**

Group 3

1-Disabled (can be any ages)	$	-
2-Child <=18	$	12,310,105
3-Adult >= 65	$	47,755,514
4-Adult <= 64	$	873,566
Duals (17)	$	-
Total		**60,939,185**

Pool Payments and Admin

Total Pool Payments		147,474,132

Admin	$	89,157,475

Quarterly Drug Rebates	$	(150,762,945)
Quarterly Premium Collections	$	-
Total Net Quarterly Expenditures	**$**	**1,926,001,197**

III. Surplus/(Deficit)

	$1,642,547,721
Federal Share	**$1,068,230,910**

HCI Result	MM201510	MM201511	MM201512	TOTAL	HCI ASO	HCI Rx	HCI DTL	HCI MCO CAP (TCS Admin)	UNK Allocation	TOTAL
EG1-TYPE1 (disabled, type1 state plan eligibles)	142,298	141,806	141,183	425,287	$97,728,297	$126,034,145	$1,783,686	$251,074,673	(876,454)	$475,744,347
EG1-TYPE2 (disabled, type2 transition group)	0	0	0	0	$0	$0	$0	$0	-	$0
EG2-TYPE1 (over 65, type1 state plan eligibles)	610	639	637	1,886	$7,681	$183,245	$0	$2,803,931	(5,993)	$2,988,864
EG2-TYPE2 (over 65, type2 state plan eligibles)	0	0	0	0	$0	$0	$0	$0	-	$0
EG3-TYPE1 (children, type1 state plan eligibles)	750,560	753,933	754,765	2,259,258	$14,664,822	$69,910,541	$34,082,554	$355,641,587	(886,283)	$473,413,221
Med Exp Child (Title XXI Demo Pop; EG3-Type2)	18,801	18,769	18,732	56,302	$566,131	$3,132,375	$1,117,671	$7,463,410	(22,397)	$12,257,190
EG4-TYPE1 (adults, type1 State plan eligibles)	416,131	421,527	427,314	1,264,972	$2,257,146	$73,607,624	$3,006,683	$404,268,539	(909,032)	$482,230,960
EG4-TYPE2 (adults, type2 demonstration pop)	0	0	0	0	$0	$0	$0	$0	-	$0
EG5-TYPE1 (duals, state plan eligibles)	136,712	137,141	137,707	411,560	$1,495,808	$951,284	$1,176,931	$280,301,712	(570,486)	$283,355,249
EG6E-TYPE3 (Expan adult, type3 demonstration pop)	796	793	790	2,379	$0	$292,042	$9,942	$573,225	(1,644)	$873,566
EG7E-TYPE3 (Expan child, type3 demonstration pop)	63	61	61	185	$1,456	$22,601	$4,767	$24,184	(92)	$52,915
EG8-TYPE2 (med exp child)	0	0	0	0	$0	$0	$0	$0	-	$0
EG9 H-Disabled (TYPE 2 Eligibles)	277	278	280	835	$0	$235,791	$0	$4,136,203	(8,652)	$4,363,342
EG10 H-Senior	35	41	41	117	$0	$8,902	$0	$613,508		$622,410
EG11H, H-Dual	6,175	6,110	6,109	18,394	$0	$10,085	$22,777	$57,179,890	(115,385)	$57,097,367
EG12E, Carryovers	3,638	3,536	3,467	10,641	$0	$165,756	$12,727	$47,049,326	(94,705)	$47,133,104
Total	**1,476,096**	**1,484,634**	**1,491,086**	**4,451,816**	**$116,721,341**	**$274,554,391**	**$41,217,737**	**$1,411,130,188**	**-$3,491,122**	**$1,840,132,535**

HCI Result	MM201510	MM201511	MM201512	TOTAL	HCI ASO PMPM	HCI Rx PMPM	HCI DTL PMPM	HCI MCO CAP (TCS Admin)	UNK Allocation	TOTAL
EG1-TYPE1 (disabled, type1 state plan eligibles)	142,298	141,806	141,183	425,287	$229.79	$296.35	$4.19	$590.37	-$2.06	$1,118.64
EG1-TYPE2 (disabled, type2 transition group)	0	0	0	-						
EG2-TYPE1 (over 65, type1 state plan eligibles)	610	639	637	1,886	$4.07	$97.16	$0.00	$1,486.71	-$3.18	$1,584.76
EG2-TYPE2 (over 65, type2 state plan eligibles)	0	0	0	-	-	-	-	-	-	-
EG3-TYPE1 (children, type1 state plan eligibles)	750,560	753,933	754,765	2,259,258	$6.49	$30.94	$15.09	$157.42	-$0.39	$209.54
Med Exp Child (Title XXI Demo Pop; EG3-Type2)	18,801	18,769	18,732	56,302	$10.06	$55.64	$19.85	$132.56	-$0.40	$217.70
EG4-TYPE1 (adults, type1 State plan eligibles)	416,131	421,527	427,314	1,264,972	$1.78	$58.19	$2.38	$319.59	-$0.72	$381.22
EG4-TYPE2 (adults, type2 demonstration pop)	0	0	0	-						
EG5-TYPE1 (duals, state plan eligibles)	136,712	137,141	137,707	411,560	$3.63	$2.31	$2.86	$681.07	-$1.39	$688.49
EG6E-TYPE3 (Expan adult, type3 demonstration pop)	796	793	790	2,379	$0.00	$122.76	$4.18	$240.95	-$0.69	$367.20
EG7E-TYPE3 (Expan child, type3 demonstration pop)	63	61	61	185	$7.87	$122.17	$25.77	$130.72	-$0.50	$286.03
EG8-TYPE2 (emd exp child)	0	0	0	-						
EG9 H-Disabled (TYPE 2 Eligibles)	277	278	280	835	$0.00	$282.38	$0.00	$4,953.54	-$10.36	$5,225.56
EG10 H-Senior	35	41	41	117	$0.00	$76.09	$0.00	$5,243.66	$0.00	
EG11H, H-Dual	6,175	6,110	6,109	18,394	$0.00	$0.55	$1.24	$3,108.62	-$6.27	$3,104.13
EG12E, Carryovers	3,638	3,536	3,467	10,641	$0.00	$15.58	$1.20	$4,421.51	-$8.90	$4,429.39
Total	**1,476,096**	**1,484,634**	**1,491,086**	**4,451,816**	**$26.22**	**$61.67**	**$9.26**	**$316.98**	**-$0.78**	**$413.34**

* Unknown allocation was performed within the Service category totals.