Division of
Health Care
Finance & Administration

February 28, 2017

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

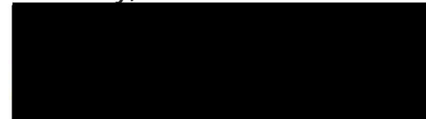
RE: TennCare II, STC 44, Quarterly Progress Report

Dear Ms. Woodard:

Enclosed please find the Quarterly Progress Report for the October – December 2016 quarter. This report is being submitted in accordance with STC 44 of the TennCare Demonstration.

Please let us know if you have comments or questions.

Sincerely,



Wendy Long, M.D., M.P.H.
Director, Bureau of TennCare

cc: 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 2016)

Demonstration Year: 15 (7/1/16 - 6/30/17)
Federal Fiscal Quarter: 1/2017 (10/16 - 12/16)
Waiver Quarter: 2/2017 (10/16 - 12/16)

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.

The Bureau of TennCare contracts with several Managed Care Contractors (MCCs) to provide services to more than 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, together with the corresponding Special Terms and Conditions (STCs), if applicable, are presented in Table 1. All STC references here and throughout this Quarterly Progress Report use the STC numbers in effect on the last day of the October-December 2016 quarter.

Table 1
Key Dates of Approval/Operation in the Quarter

Date	Action	STC #
Throughout most of the October-December 2016 quarter	The State and CMS continued discussions on Tennessee's application to renew the TennCare Demonstration. Much of this work focused on drafting mutually agreeable versions of the STCs that would govern the Demonstration through June 30, 2021.	
10/18/16	The State submitted the 2016 Quality Assessment and Performance Improvement Strategy to CMS.	42.c.
10/24/16	The Monthly Call scheduled for October 27, 2016, was cancelled at CMS's request.	43
10/25/16	The State requested approval by CMS of Statewide MCO Contract Amendment 5 and TennCare Select Contract Amendment 40.	39
10/28/16	The State submitted the Draft Annual Report for Demonstration Year 14 to CMS. The Draft Annual Report will be made final upon the receipt of comments from CMS.	45
10/31/16	CMS issued a letter approving the continued operation of the TennCare Demonstration under the existing terms and conditions through November 30, 2016.	

Date	Action	STC #
11/14/16	The State published the details (including date, time, and location) of a public forum at which comments on the progress of the TennCare Demonstration would be accepted.	10
11/24/16	The Monthly Call was cancelled at CMS's request.	
11/30/16	The State submitted the Quarterly Progress Report for the July-September 2016 quarter to CMS.	44
11/30/16	CMS issued a letter approving the continued operation of the TennCare Demonstration under the existing terms and conditions through December 16, 2016.	
12/15/16	The State held a public forum to accept comments on the progress of the TennCare Demonstration.	10
12/16/16	CMS issued a letter approving an extension of the TennCare Demonstration through June 30, 2021.	
12/21/16	The Monthly Call scheduled for December 22, 2016, was cancelled at CMS's request.	43
12/21/16 and 12/28/16	The State submitted to CMS the annual report concerning Title XXI Medicaid Expansion Children. The report was submitted via the CHIP Annual Reporting Template System on December 21, 2016, and via the Performance Metrics Database and Analytics portal on December 28, 2016.	45

II. Enrollment and Benefits Information

Information about enrollment by category is presented in Table 2.

Table 2
Enrollment Counts for the October – December 2016 Quarter
Compared to the Previous Two Quarters

Demonstration Populations	Total Number of TennCare Enrollees		
	Apr – Jun 2016	Jul – Sept 2016	Oct – Dec 2016
EG1 Disabled, Type 1 State Plan eligibles	145,195	146,317	147,754
EG9 H-Disabled, Type 2 Demonstration Population	247	242	252
EG2 Over 65, Type 1 State Plan eligibles	235	182	203
EG10 H-Over 65, Type 2 Demonstration Population	36	48	43
EG3 Children, Type 1 State Plan eligibles	782,727	793,980	801,365

Demonstration Populations	Total Number of TennCare Enrollees		
	Apr – Jun 2016	Jul – Sept 2016	Oct – Dec 2016
EG4 Adults, Type 1 State Plan eligibles	462,175	477,014	455,487
EG5 Duals, Type 1 State Plan eligibles and EG11 H-Duals 65, Type 2 Demonstration Population	149,707	151,725	153,409
EG6E Expan Adult, Type 3 Demonstration Population	757	734	710
EG7E Expan Child, Type 3 Demonstration Population	40	53	45
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	18,515	18,157	15,356
EG12E Carryover, Type 3, Demonstration Population	2,904	2,624	2,393
TOTAL*	1,562,538	1,591,076	1,577,017

*** 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 80 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, 2016

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

[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 is operated by UnitedHealthcare Plan of the River Valley, Inc.
[3] TennCare Select is operated by VSHP.

Tennessee Eligibility Determination System. Work on the development of the Tennessee Eligibility Determination System (TEDS) continued during the October-December 2016 quarter. On October 1, TennCare began work with its systems integrator partner, Deloitte Consulting, LLP. The first phase of this work has focused on requirements validation and entry into systems design. HCFA is working toward a single release of the TEDS system that includes an eligibility worker portal that will process applications for all TennCare and CoverKids eligibility categories; a self-service member portal that will allow applicants to apply online for health coverage, create user accounts to report changes, and view notices sent to them; and a partner portal to be used by other State agencies and provider partners (such as the Tennessee Department of Health) who make presumptive eligibility determinations for certain TennCare populations.

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 2016 quarter, the State 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 sixteenth 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 community outreach activity during this quarter and the previous two quarters. Quarterly variations in the categories presented here are usually the result of factors such as:

- 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 an 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 2016 Compared to the Previous Two Quarters

Activities	Apr – Jun 2016	Jul – Sept 2016	Oct – Dec 2016
Number of outreach activities/events	3,111	2,736	2,629
Number of people made contact with (mostly face to face at outreach events)	155,997	157,141	179,775
Number of educational materials distributed	122,159	123,675	126,813
Number of coalitions/advisory board meetings attended or conducted	94	127	87
Number of attendees at coalitions/advisory board meetings	1,731	1,805	1,824
Number of educational preventive health radio/TV broadcasts	1,042	738	803
Number of educational preventive health newsletter/magazine articles	39	37	21
Number of educational preventive health billboards, scrolling billboards and bulletin boards	6,162	3,283	92[4]
Number of presentations made to enrollees/professional staff who work with enrollees	101	120	108
Number of individuals attending presentations	2,078	1,871	2,409
Number of completed telephone calls regarding the importance of dental checkups	490	130	560
Number of home visits completed	363	243	481

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.

[4] Decreased use of billboards and bulletin boards during the October-December 2016 quarter was primarily the result of fewer invitations from community partners to promote health initiatives.

Table 5
Tennessee Department of Health
TennCare Kids Call Center Activity
October – December 2016 Compared to the
Previous Two Quarters

Activities	Apr – Jun 2016	Jul – Sept 2016	Oct – Dec 2016
Number of enrollees reached	22,295	13,449	25,181
Number of enrollees who were assisted in scheduling an EPSDT exam for their children	850	539	641
Number of enrollees who were assisted in arranging for transportation	29	40	29

IV. Collection and Verification of Encounter and Enrollment Data

Edifecs is the software system being used by the State 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 2016 Quarter, and Percentage that Passed Systems Edits, Compared to the Previous Two Quarters

	Apr – Jun 2016	Jul – Sept 2016	Oct – Dec 2016
No. of encounters received by TennCare (initial submission)	16,181,311	15,657,014	21,723,287
No. of encounters rejected by Edifecs upon initial submission	11,689	35,809	7,123
Percentage of encounters that were compliant with State standards (including HIPAA) upon initial submission	99.93%	99.77%	99.97%

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

A. CHOICES

As required by STC 31.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
CHOICES Enrollment and Reserve Slots
for October – December 2016 Compared to the Previous Two Quarters

	Statewide Enrollment Targets and Reserve Capacity[5]	Enrollment and Reserve Slots Being Held as of the End of Each Quarter		
		Apr – Jun 2016	Jul – Sept 2016	Oct – Dec 2016
CHOICES 1	Not applicable	17,141	17,211	17,074
CHOICES 2	12,500	8,857	9,017	9,204
CHOICES 3 (including Interim CHOICES 3)	To Be Determined	3,797	3,619	3,511
Total CHOICES	Not applicable	29,795	29,847	29,789
Reserve capacity	300	300	300	300

The CMS letter approving CHOICES implementation in Middle Tennessee dated February 26, 2010, and STCs 42 and 44 require specific monitoring and reporting activities that include:

Data and trends of the designated CHOICES data elements: STC 42.d. requires the State to submit to CMS periodic statistical reports about the use of LTSS by TennCare enrollees. Eleven separate reports—spanning the period of August 2011 through September 2016—had been submitted by the conclusion of the October-December 2016 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 Nursing Facility (NF) services over time, with placement in institutional settings decreasing from 21,530 individuals on June 30, 2011, to 17,141 individuals on June 30, 2016. According to annual aggregate data contained in the reports, this downward trend was even more pronounced for new LTSS recipients, 81 percent of whom had been admitted to NFs in

[5] 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.

the year prior to implementation of the CHOICES program, as compared with 49 percent admitted to NFs in the fifth year of CHOICES.

By contrast, appropriate use of HCBS by TennCare enrollees grew significantly during these years. The aggregate number of members accessing HCBS increased from 6,226 in the twelve-month period preceding CHOICES implementation in Middle Tennessee to 16,454 after CHOICES had been in place for five 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 12,654 by June 30, 2016. 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), 7/1/14 – 6/30/15	Percent increase over a five-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 6/30/16	Percent increase from the day prior to CHOICES implementation to 6/30/16
6,226	16,454	164%	4,861[6]	12,654	160%

<u>Enrollment of select members of the CHOICES population in Groups 1 and 2</u>: Prior to December 16, 2016, the STCs had included a requirement that the State provide "enrollment reports for individuals who would otherwise be eligible for Interim CHOICES 3 but who meet the modified institutional level of care, and whether CHOICES 1 or CHOICES 2 was selected by the individual." The population of LTSS recipients contemplated in this requirement were individuals who had 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 was based on a determination by TennCare that the applicant did 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—

[6] 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).

- 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.

During the period from October 1, 2016, through December 31, 2016, NF PreAdmission Evaluations (PAEs) were approved for 316 individuals with acuity scores lower than 9, and 162 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 included:

- 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 225 individuals with acuity scores lower than 9, and 157 of the individuals were subsequently enrolled in CHOICES 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.[7]

Table 9
CHOICES Transition Allowances
for October – December 2016 Compared to the Previous Two Quarters

	Frequency and Use of Transition Allowances					
	Apr – Jun 2016		**Jul – Sept 2016**		**Oct – Dec 2016**	
Grand Region	# Distributed	Total Amount	# Distributed	Total Amount	# Distributed	Total Amount
East	18	$18,429	23	$27,295	38	$34,993
Middle	12	$18,326	33	$43,579	39	$37,574
West	18	$19,275	19	$17,788	28	$22,484
Statewide Total	48	$56,030	75	$88,662	105	$95,051

[7] MCOs may provide transition allowances as a cost-effective alternative (CEA) to continued institutional care for CHOICES members. Transition allowances are not available, however, as a CEA in the Employment and Community First CHOICES program.

B. Employment and Community First CHOICES

Designed in partnership with people with intellectual and developmental disabilities, their families, advocates, and other stakeholders, Employment and Community First (ECF) CHOICES is the first managed LTSS program in the nation that is focused on promoting and supporting integrated, competitive employment and independent community living as the first and preferred option for people with intellectual and other types of developmental disabilities.

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

Table 10
ECF CHOICES Enrollment, Enrollment Targets, and Reserve Slots
For October – December 2016 Compared to the Previous Quarter

	Statewide Enrollment Targets and Reserve Capacity for State Fiscal Year 2017	Enrollment as of September 30, 2016	Enrollment as of December 31, 2016
ECF CHOICES 4	500	71	188
ECF CHOICES 5	1,000	136	405
ECF CHOICES 6	200	6	30
Reserve Capacity	250	27	37[8]
Waiver Transitions[9]	N/A	0	2
Total ECF CHOICES	1,700	240	660

C. 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

[8] By the conclusion of the October-December 2016 quarter, 37 of the 250 reserve capacity slots in the ECF CHOICES program had been allocated for individuals meeting specified criteria and determined eligible to enroll. The 37-person total represents 6 individuals enrolled in ECF CHOICES Group 4; 22 individuals enrolled in ECF CHOICES Group 5; and 9 individuals enrolled in ECF CHOICES Group 6.

[9] Waiver transitions are instances in which an individual enrolled in a 1915(c) HCBS waiver program is transferred into the ECF CHOICES program. Since these individuals have an independent funding source (i.e., the money that would have been spent on their care in the 1915(c) program), their enrollment in ECF CHOICES does not count against the 1,700-person enrollment target.

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 and ECF CHOICES enrollees. TDCI then performs an analysis and reports the results of the prompt pay analyses by NEMT and CHOICES and ECF 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 reported on the National Association of Insurance Commissioners (NAIC) Annual Financial Statement 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 2016 quarter, the MCOs submitted their NAIC Third Quarter 2016 Financial Statements. As of September 30, 2016, TennCare MCOs reported net worth as indicated in the table below.[10]

Table 11
Net Worth Reported by MCOs as of September 30, 2016

	Net Worth Requirement	Reported Net Worth	Excess/ (Deficiency)
Amerigroup Tennessee	$29,016,782	$164,605,845	$135,589,063
UnitedHealthcare Plan of the River Valley (UnitedHealthcare	$55,361,026	$396,744,212	$341,383,186

[10] 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.

	Net Worth Requirement	Reported Net Worth	Excess/ (Deficiency)
Community Plan)			
Volunteer State Health Plan (BlueCare & TennCare Select)	$43,251,806	$376,230,137	$332,978,331

During the October-December 2016 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, 2016:

Table 12
Company Action Level Reported by MCOs as of September 30, 2016

	Company Action Level Requirement	Reported Net Worth	Excess/ (Deficiency)
Amerigroup Tennessee	$104,759,436	$164,605,845	$59,846,409
UnitedHealthcare Plan of the River Valley (UnitedHealthcare Community Plan)	$189,545,450	$396,744,212	$207,198,762
Volunteer State Health Plan (BlueCare & TennCare Select)	$133,523,082	$376,230,137	$242,707,055

All TennCare MCOs exceeded their minimum net worth requirements and Company Action Level requirements as of September 30, 2016.

D. Approved Extension of the TennCare Demonstration

On December 22, 2015, TennCare submitted to CMS an application to renew the TennCare Demonstration. The application requested that the approval period for the Demonstration—which was scheduled to end on June 30, 2016—be extended through June 30, 2021. On December 16, 2016, nearly one year after the application had been submitted, CMS issued written approval.

As detailed in TennCare's recent Quarterly Progress Reports, negotiations between the State and CMS on the renewal request were extensive. The State's application had requested no substantive changes to the Demonstration, but CMS raised a number of subjects for discussion, including supplemental pool payments to Tennessee hospitals, budget neutrality (i.e., not spending more under the Demonstration than would have been spent in its absence), enrollee cost-sharing, and the manner in which the Demonstration would be evaluated.

Some notable elements of CMS's December 16 approval included the following:

- Continuation of TennCare's managed care service delivery system, with minor modifications;
- Continuation of TennCare's current eligibility levels and benefits package;
- Revisions to the amounts and distribution methodologies associated with the supplemental payment pools for hospitals (to be phased in over multiple years);
- Concentration of evaluation efforts on two of TennCare's programs of long-term services and supports (CHOICES and Employment and Community First CHOICES); and
- Flexibility to amend the TennCare waiver, if needed, to reflect future changes in state or federal policy.

As of the end of the October-December 2016 quarter, Bureau staff members were reviewing these materials to determine whether any technical corrections would be needed. Proposed corrections were to be submitted within 30 days of the December 16 letter from CMS.

E. Budget Planning for State Fiscal Year 2018

On November 22, 2016, four members of TennCare's executive staff—Director Wendy Long, Deputy Director and Chief of Staff Will Cromer, Deputy Director and Chief Operating Officer Gabe Roberts, and Chief Financial Officer William Aaron—presented the State Fiscal Year 2018 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 concisely summarized the manner in which TennCare had 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 included the following:

- Provision of health insurance to 1.5 million Tennesseans, including 39,500 individuals receiving long-term services and supports and more than half of the children born in Tennessee;
- Enrollee satisfaction levels above 90 percent for eight years in a row;
- The third highest quality scores among the states in the Southeast region;

- Accreditation of all three TennCare health plans by the National Committee for Quality Assurance; and
- Medical inflation levels well below those of commercial insurance programs and of Medicaid programs nationally (3.3 percent for TennCare as opposed to 6.5 percent for commercial plans and 6.9 percent for Medicaid programs as a whole).

In addition to these accomplishments were updates concerning four of HCFA's chief priorities (all of which are discussed at greater length in other sections of this Quarterly Progress Report): the Tennessee Health Care Innovation Initiative; the Employment and Community First CHOICES program; the application to renew the TennCare Demonstration; and improvements being made to processes for determining and reverifying eligibility for TennCare coverage.

As in previous years, HCFA identified a list of areas in which expenditures were likely to increase, as well as a set of proposals for reducing program expenditures. Examples of the former included federally required increases in state Medicare spending, further investment in the development of the Tennessee Eligibility Determination System, and rising costs associated with pharmacy coverage. Potential cost-controlling measures identified by HCFA ranged from ongoing reform of payment and delivery systems to educating providers on proper approaches to prescribing opioid drugs, and from refining the Bureau's estate recovery processes to elimination of paper remittance advices for TennCare providers.

F. Payment Reform

Tennessee's Health Care Innovation Initiative is changing health care payment to reward providers for high-quality and efficient treatment of medical conditions, and to help in maintaining people's health over time. The Initiative has three strategies: episodes of care, long-term services and supports, and primary care transformation. Significant developments in the first and third of these strategies occurred during the October-December 2016 quarter.

Episodes of care. This strategy focuses on acute or specialist-driven health care delivered during a specified time period to treat physical or behavioral conditions such as an acute diabetes exacerbation or oppositional defiant disorder. Each episode has a principal accountable provider (sometimes referred to as the "quarterback") who is in the best position to influence the cost and quality of the episode. Episodes of care are implemented in groups or—in the terminology of the program—"waves."

In October 2016, evidence of the success of the first wave of episodes—comprising perinatal, acute asthma exacerbation, and total joint replacement (hip and knee)—was published. During the first year of financial accountability for Wave 1, doctors and hospitals reduced costs while maintaining quality of care. Implementation of these three episodes resulted in a reduction in costs of 3.4 percent in perinatal, 8.8 percent in acute asthma exacerbation, and 6.7 percent in total joint replacement. Overall, the cost of services in these three types of episodes was $6.3 million less than the previous year, even though medical costs were projected to increase by

5.5 percent nationally. Conservatively assuming a 3 percent increase would have taken place in the absence of the Initiative, the Wave 1 episodes reduced costs by $11.1 million.

These successes would not have been possible without significant input from such stakeholders as Tennessee providers, payers, patients, and employers. This feedback is central to the design of episodes of care and the other value-based payment strategies that are part of Tennessee's Health Care Innovation Initiative. For each episode, the Initiative organizes Technical Advisory Groups (TAGs) composed of experts in the field to provide clinical feedback on each episode's design. The TAG meetings for Wave 6 episodes were held this past fall (September to November 2016). In addition to designing new episodes, TAGs also review existing episodes to determine how they may be improved.

Primary care transformation. During the October-December 2016 quarter, the Tennessee Health Care Innovation Initiative made preparations to launch a new statewide program known as "Tennessee Health Link." Providers in the Tennessee Health Link program will coordinate health care services for TennCare members with the most significant behavioral health needs. The program is designed to produce improved member outcomes, greater provider accountability and flexibility in the delivery of care, and improved cost control for the State.

Health Link providers are encouraged to ensure the best care setting for each member, offer expanded access to care, improve treatment adherence, and reduce hospital admissions. To achieve these goals, the providers commit to delivering such services as comprehensive care management, care coordination, referrals to social supports, member and family support, transitional care, health promotion, and population health management. Providers will receive training and technical assistance, quarterly reports with actionable data, and other resources intended to help them succeed within the Health Link model. Compensation consists of activity payments as well as opportunities for annual outcome payments based on performance in terms of quality and efficiency.

G. Electronic Health Record Incentive Program

The Electronic Health Record (EHR) Incentive Program is a partnership between federal and state governments that grew out of the Health Information Technology for Economic and Clinical Health (HITECH) Act of 2009. The purpose of the program is to provide financial incentives to Medicaid providers[11] 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 funding for administrative costs.

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

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

- First-year payments (through the 2016 Program Year) to 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 a 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, fourth-year, and fifth-year payments to providers who continue to demonstrate meaningful use of certified EHR technology.

Eligible practitioners who successfully attest may receive incentive payments in up to six program years. With CMS approval, TennCare chose to divide the full amount of incentive payments available to eligible hospitals among three program years. Eligible hospitals must continue to attest annually beyond the three years of payments in order to avoid Medicare payment adjustments.

EHR payments made by TennCare during the October-December 2016 quarter as compared with payments made throughout the life of the program appear in the table below:

Table 13
EHR Payments
Quarterly and Cumulative

Payment Type	No. of Providers Paid During the Quarter	Quarterly Amount Paid (Oct-Dec 2016)	Cumulative Amount Paid To Date
First-year payments	97[12]	$2,027,567	$171,129,417
Second-year payments	21	$159,706	$54,778,476
Third-year payments	11	$445,050	$27,559,843
Fourth-year payments	7	$59,500	$3,584,175
Fifth-year payments	0	$0	$952,000

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

- Acceptance of Incentive Year 2016 meaningful use attestations based on Modified Stage 2 measures;
- Holding 24 technical assistance calls;

[12] Of the 97 providers receiving first-year payments in the October-December 2016 quarter, 3 earned their incentives by successfully attesting to meaningful use of EHR technology.

- Responding to 300 emails received in the EHR meaningful use mailbox;
- Conducting two onsite visits to physician offices;
- Attendance at October meetings hosted by the Tennessee Medical Association (TMA) in Chattanooga, Jackson, Kingsport, Knoxville, Memphis, and Nashville;
- Participating in the 68th Annual Scientific Assembly of the Tennessee Academy of Family Physicians in October;
- Attending the November joint town hall meetings hosted by Amerigroup and UnitedHealthcare in Chattanooga, Johnson City, Knoxville, Memphis, and Nashville;
- Participation throughout the quarter in several Southeast Regional Collaboration for HIT/HIE (SERCH) calls;
- Newsletters and occasional alerts 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. The Bureau is currently making every effort to alert eligible professionals and eligible hospitals that 2016 is the last year in which they may enroll in the EHR program and begin attesting. (Enrolled providers may continue to attest—and earn payments, if eligible—through Program Year 2021.) This particular information campaign will continue through March 31, 2017, the enrollment deadline.

H. Public Forum on the TennCare Demonstration

In compliance with federal regulation—42 CFR § 431.420(c)—and the terms of its Demonstration agreement with CMS, TennCare hosted a public forum in the downtown branch of the Nashville Public Library on December 15, 2016. 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 15 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 to which comments could be sent. Although the Bureau received no comments through any of these outlets, 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.

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

Revenue collections remained robust throughout the October-December 2016 quarter. In all three months, total state and local collections were higher than during the corresponding months of 2015, with nearly a two percent improvement in October 2016, just under a one percent improvement in November 2016, and a better than ten percent improvement in December 2016.[13]

Employment prospects in Tennessee presented mixed news during the quarter. The unemployment rate was 4.8 percent in October and November (up from the 4.6 percent level recorded in September) and then ticked up again to 4.9 percent in December. In addition, the jobless rate in Tennessee lost ground to the national rate, which was 0.2 percent lower during November and December. Nonetheless, Tennessee's unemployment figures remained a noticeable improvement on the results from one year ago, when the state's jobless rate was fixed at 5.6 percent in all three months of the quarter.[14]

VIII. Member Month Reporting

Tables 14 and 15 below present the member month reporting by eligibility group for each month in the quarter.

Table 14
Member Month Reporting for Use in Budget Neutrality Calculations
October – December 2016

Eligibility Group	October 2016	November 2016	December 2016	Sum for Quarter Ending 12/31/16
Medicaid eligibles (Type 1)				
EG1 Disabled, Type 1 State Plan eligibles	148,581	147,856	147,107	443,544
EG2 Over 65, Type 1 State Plan eligibles	151	172	191	514
EG3 Children, Type 1 State Plan eligibles	790,133	794,674	792,817	2,377,624
EG4 Adults, Type 1 State Plan eligibles	440,427	445,183	438,079	1,323,689

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

[14] 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.

Eligibility Group	October 2016	November 2016	December 2016	Sum for Quarter Ending 12/31/16
EG5 Duals, Type 1 State Plan eligibles	144,852	144,937	145,492	435,281
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	223	236	248	707
EG10 H-Over 65, Type 2 Demonstration Population	34	38	41	113
EG11 H-Duals, Type 2 Demonstration Population	6,136	6,177	6,172	18,485
TOTAL	1,530,537	1,539,273	1,530,147	4,599,957

Table 15
Member Month Reporting Not Used in Budget Neutrality Calculations
October – December 2016

Eligibility Group	October 2016	November 2016	December 2016	Sum for Quarter Ending 12/31/16
EG6E Expan Adult, Type 3, Demonstration Population	715	707	701	2,123
EG7E Expan Child, Type 3, Demonstration Population	45	44	42	131
Med Exp Child, Title XXI Demonstration Population	15,665	15,283	14,888	45,836
EG12E Carryover, Type 3, Demonstration Population	2,430	2,384	2,360	7,174
TOTAL	18,855	18,418	17,991	55,264

IX. Consumer Issues

Eligibility Appeals. TennCare eligibility appeals are handled by the Bureau of TennCare. Table 16 presents a summary of eligibility appeal activity during the quarter, compared to the previous two quarters. It should be noted that appeals (whether related to eligibility, medical

services, or LTSS) may be resolved or taken to hearing in a quarter other than the one in which they are initially received by TennCare.

The higher volume of eligibility appeals that began in the July-September 2016 quarter and continued during the October-December 2016 quarter is attributable to three primary factors. First, implementation of Tennessee's approved redetermination plan has increased annual redeterminations of eligibility. Second, TennCare has recently increased the number of enrollees who are selected on a quarterly basis for failure to report a valid Social Security number in at least twelve months. Third, there was an increase in appeals related to redetermination that are often resolved administratively by remailing redetermination-related notices. This administrative resolution accounts for much of the rise in the number of appeals resolved or withdrawn during the October-December 2016 quarter.

Table 16
Eligibility Appeals for October – December 2016
Compared to the Previous Two Quarters

	Apr – Jun 2016	Jul – Sept 2016	Oct – Dec 2016
No. of appeals received	6,371	18,264	23,173
No. of appeals resolved or withdrawn	2,729	9,621	19,920
No. of appeals taken to hearing	3,231	2,759	2,314
No. of hearings resolved in favor of appellant	322	263	147

Medical Service Appeals. Medical service appeals are handled by the Bureau of TennCare. Table 17 below presents a summary of the medical service appeals handled during the quarter, compared to the previous two quarters.

Table 17
Medical Service Appeals for October – December 2016
Compared to the Previous Two Quarters

	Apr – Jun 2016	Jul – Sept 2016	Oct – Dec 2016
No. of appeals received	2,163	2,115	2,293
No. of appeals resolved	2,029	1,993	2,097
• Resolved at the MCC level	854	717	763
• Resolved at the TSU level	178	192	186
• Resolved at the LSU level	997	1,084	1,148
No. of appeals that did not involve a valid factual dispute	204	158	211
No. of directives issued	281	301	271
No. of appeals taken to hearing	997	1,084	1,148

	Apr – Jun 2016	Jul – Sept 2016	Oct – Dec 2016
No. of appeals that were withdrawn by the enrollee at or prior to the hearing	319	360	383
Appeals that went to hearing and were decided in the State's favor	337	386	385
Appeals that went to hearing and were decided in the appellant's favor	41	28	25

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 is a unit within the TennCare Bureau that reviews requests for hearings. 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 within the TennCare Bureau 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. The following table provides information regarding certain appeals administered by the Long-Term Services and Supports Division for the quarter (e.g., appeals of PreAdmission Evaluation denials, appeals of PreAdmission Screening and Resident Review determinations, etc.), compared to the previous two quarters.

Table 18
Long-Term Services and Supports Appeals for October – December 2016
Compared to the Previous Two Quarters

	Apr – Jun 2016	Jul – Sept 2016	Oct – Dec 2016
No. of appeals received	214	210	194
No. of appeals resolved or withdrawn	105	81	89
No. of appeals set for hearing	88	96	116
No. of hearings resolved in favor of appellant	1	3	5

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 2016 quarter is provided in Table 19. Data for the period of October through December 2016 will be provided in the next Quarterly Progress Report.

Table 19
Population Health Data*, July – September 2016

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	720,153
Level 1: low or moderate risk	Maternity Program	Engage pregnant women in timely prenatal care and deliver a healthy, term infant without complications	15,680
	Health Risk Management	Prevent, reduce, or delay exacerbation and complications of a condition or health risk behavior	716,051
	Care Coordination	Assure that members receive the services they need to reduce the risk of an adverse health outcome	22,593
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	5,601

Risk Level	Intervention Type	Intervention Goal(s)	Number of Unique Members at End of Quarter
	High Risk Pregnancy Management	Engage pregnant women in timely prenatal care and deliver a healthy, term infant without complications	1,559
	Complex Case Management	Move members to optimal levels of health and well-being through timely coordination of quality services and self-management support	855
Total PH Enrollment			**1,482,492**

*** 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 2016, TennCare's External Quality Review Organization (EQRO), Qsource, published the results of its provider data validation survey for the July-September 2016 quarter. Qsource took a sample of provider data files from TennCare's MCCs[15] 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 (MCO only)
- Prenatal care services (MCO only)
- 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 "provider credentialed specialty / behavioral health service code" (98.4 percent accuracy), "routine care services" (98.0 percent accuracy), "urgent care services" (99.2 percent accuracy), "services to patients under age 21" (98.1 percent accuracy), "primary care services" (99.2 percent accuracy), and "prenatal care services" (99.5 percent accuracy).

Because the MCOs' transition to a statewide service delivery model occurred relatively recently, progress in accuracy rates is currently being measured on a quarter-to-quarter basis.

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

Compared with the period of April-June 2016, 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, 2016. The Bureau, in turn, had received, reviewed, and accepted all of the plans by December 9, 2016. Results for the October-December 2016 quarter will be discussed in the next Quarterly Progress Report.

XI. Demonstration Evaluation

On December 22, 2015, the State submitted to CMS 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.

In addition, on October 18, 2016, the State sent CMS a new version of the strategy to evaluate and improve the quality and accessibility of care offered to enrollees through TennCare's managed care network. The document, titled *2016 Quality Assessment and Performance Improvement Strategy*, incorporates a number of new initiatives, including the ECF CHOICES program. As of the end of the October-December 2016 quarter, CMS's review of the strategy was ongoing.

Furthermore, on October 28, 2016, in compliance with STC 45, the State submitted to CMS its Draft Annual Report for Demonstration Year 14. Part V of that report provided the progress to date on the performance measures outlined in the Evaluation Design in effect at the time. This Design effectively ended on December 16, 2016, however, when CMS approved the State's application to renew the TennCare Demonstration. The revised STCs that accompanied the approval included a requirement that a draft of a new evaluation design be submitted by the State within 120 days of the December 16 approval.

XII. Essential Access Hospital Pool[16]

A. Safety Net Hospitals

Vanderbilt University Hospital
Regional One Health
Erlanger Medical Center
University of Tennessee Memorial Hospital
Johnson City Medical Center Hospital (with Woodridge Psych)

[16] 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.

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
TriStar Centennial Medical Center
Methodist Healthcare – Memphis Hospitals
Saint Jude Children's Research Hospital
Methodist Healthcare – South
Parkridge East Hospital
TriStar Skyline Medical Center (with Madison campus)
Parkwest Medical Center (with Peninsula Psych)
Baptist Memorial Hospital – Memphis
Methodist Healthcare – North
University Medical Center (with McFarland Psych)
Saint Francis Hospital
Saint Thomas Rutherford Hospital
Baptist Memorial Hospital for Women
Wellmont – Holston Valley Medical Center
Fort Sanders Regional Medical Center
Saint Thomas Midtown Hospital
Cookeville Regional Medical Center
Maury Regional Hospital
TriStar StoneCrest Medical Center
Blount Memorial Hospital
TriStar Horizon Medical Center
TriStar Summit Medical Center
Gateway Medical Center
TriStar Southern Hills Medical Center
Sumner Regional Medical Center
Skyridge Medical Center
TriStar Hendersonville Medical Center
Dyersburg Regional Medical Center

NorthCrest Medical Center
Morristown – Hamblen Healthcare System
LeConte Medical Center
Methodist Medical Center of Oak Ridge
Jellico Community Hospital
Takoma Regional Hospital
Sycamore Shoals Hospital
Starr Regional Medical Center – Athens
Skyridge Medical Center – Westside
Grandview Medical Center – Jasper
Heritage Medical Center
Bolivar General Hospital
Regional Hospital of Jackson
Southern Tennessee Regional Health System – Winchester
Henry County Medical Center
Baptist Memorial Hospital – Union City
Henderson County Community Hospital
Saint Thomas River Park Hospital
Hardin Medical Center
Roane Medical Center
Lakeway Regional Hospital
Southern Tennessee Regional Health System – Lawrenceburg
PremierCare Tennessee, Inc.
Hillside Hospital
Claiborne County Hospital
McKenzie Regional Hospital
Erlanger Health System – East Campus
DeKalb Community Hospital
Jamestown Regional Medical Center
Stones River Hospital
Volunteer Community Hospital
Wayne Medical Center
United Regional Medical Center
Southern Tennessee Regional Health System – Sewanee

XIII. Graduate Medical Education (GME) Hospitals

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

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

Universities	Hospitals
East Tennessee State University	Mountain State Health Alliance Wellmont ETSU Quillen Mission Hospital Johnson City Medical Center Johnson City Health Center Woodridge Hospital Holston Valley Medical Center Bristol Regional Medical Center
Meharry Medical College	Metro General Meharry Medical Group
University of Tennessee at Memphis	The Regional Medical Center (The MED) Methodist LeBonheur Erlanger Jackson Madison St. Francis
Vanderbilt University	Vanderbilt Hospital

XIV. Critical Access Hospitals

Camden General Hospital
Copper Basin Medical Center
Cumberland River Hospital
Erlanger Bledsoe Hospital
Johnson County Community Hospital
Lauderdale Community Hospital
Macon County General Hospital
Marshall Medical Center
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 2016)

I. The Extension of the Baseline

Baseline PMPM

	SFY 2017 PMPM
1-Disabled (can be any ages)	$1,862.93
2-Child <=18	$577.17
3-Adult >= 65	$1,188.25
4-Adult <= 64	$1,106.64
Duals (17)	$774.54

Actual Member months of Groups I and II

1-Disabled (can be any ages)	444,251
2-Child <=18	2,377,624
3-Adult >= 65	514
4-Adult <= 64	1,323,689
Duals (17)	453,766
Total	4,599,844

Ceiling without DSH

	Baseline * MM
1-Disabled (can be any ages)	$827,610,001
2-Child <=18	$1,372,300,761
3-Adult >= 65	$610,763
4-Adult <= 64	$1,464,842,158
17s	$351,459,495
Total	**$4,016,823,178**

DSH

DSH Adjustment (Quarterly)	$115,999,213

Total Ceiling

Budget Neutrality Cap	
Total w/DSH Adj.	**$4,132,822,391**

II. Actual Expenditures

Group 1 and 2

1-Disabled (can be any ages)	$ 551,840,458
2-Child <=18	$ 481,829,076
3-Adult >= 65	$ 311,221
4-Adult <= 64	$ 457,569,394

Duals (17)	$ 366,773,829
Total	**1,858,323,978**

Group 3

1-Disabled (can be any ages)	$ -
2-Child <=18	$ 11,140,606
3-Adult >= 65	$ 32,569,518
4-Adult <= 64	$ 663,728
Duals (17)	$ -
Total	**44,373,852**

Pool Payments and Admin

Total Pool Payments	$ 216,506,157

Admin	127,484,824

Quarterly Drug Rebates	(174,115,200)
Quarterly Premium Collections	$ -
Total Net Quarterly Expenditures	**$ 2,072,573,611**

III. Surplus/(Deficit)

	$2,060,248,780
Federal Share	**$1,339,882,794**

HCI Result	MM201607	MM201608	MM201609	TOTAL	HCI ASO	HCI Rx	HCI DTL	HCI MCO CAP (TCS Admin)	UNK Allocation	TOTAL
EG1-TYPE1 (disabled, type1 state plan eligibles)	146,835	146,428	145,724	438,987	$75,307,936	$124,665,425	$1,879,924	$328,837,948	1,199,833	$531,891,066
EG1-TYPE2 (disabled, type2 transition group)	0	0	0	0	$0	$0	$0	$0	-	$0
EG2-TYPE1 (over 65, type1 state plan eligibles)	137	158	157	452	$35,714	$18,674	$0	$373,177	967	$428,531
EG2-TYPE2 (over 65, type2 state plan eligibles)	0	0	0	0	$0	$0	$0	$0	-	$0
EG3-TYPE1 (children, type1 state plan eligibles)	782,501	787,003	784,952	2,354,456	$11,272,797	$64,952,021	$35,580,127	$362,929,973	1,070,240	$475,805,159
Med Exp Child (Title XXI Demo Pop; EG3-Type2)	18,238	17,010	16,530	51,778	$511,169	$2,790,701	$1,074,328	$7,435,588	26,611	$11,838,398
EG4-TYPE1 (adults, type1 State plan eligibles)	464,088	453,274	452,552	1,369,914	$1,480,551	$77,358,319	$2,988,859	$388,886,225	1,061,155	$471,775,109
EG4-TYPE2 (adults, type2 demonstration pop)	0	0	0	0	$0	$0	$0	$0	-	$0
EG5-TYPE1 (duals, state plan eligibles)	142,870	143,207	143,608	429,685	$1,402,694	$1,005,988	$26,930	$291,289,764	662,166	$294,387,542
EG6E-TYPE3 (Expan adult, type3 demonstration pop)	741	730	724	2,195	$0	$110,663	$0	$592,187	1,584	$704,434
EG7E-TYPE3 (Expan child, type3 demonstration pop)	53	53	48	154	$606	$18,047	$4,158	$21,665	100	$44,576
EG8-TYPE2 (med exp child)	0	0	0	0	$0	$0	$0	$0	-	$0
EG9 H-Disabled (TYPE 2 Eligibles)	225	235	237	697	$0	$400,486	$0	$3,704,085	9,253	$4,113,824
EG10 H-Senior	35	43	46	124	$0	$7,106	$0	$676,266		$683,372
EG11H, H-Dual	6,073	6,116	6,120	18,309	$276	$18,726	$0	$64,983,888	146,544	$65,149,434
EG12E, Carryovers	2,686	2,610	2,578	7,874	$0	$125,238	$0	$35,420,895	80,128	$35,626,261
Total	**1,564,482**	**1,556,867**	**1,553,276**	**4,674,625**	**$90,011,746**	**$271,471,393**	**$41,554,326**	**$1,485,151,661**	**$4,258,582**	**$1,892,447,708**

HCI Result	MM201607	MM201608	MM201609	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)	146,835	146,428	145,724	438,987	$171.55	$283.98	$4.28	$749.08	$2.73	$1,211.63
EG1-TYPE2 (disabled, type2 transition group)	0	0	0	-						
EG2-TYPE1 (over 65, type1 state plan eligibles)	137	158	157	452	$79.01	$41.31	$0.00	$825.61	$2.14	$948.08
EG2-TYPE2 (over 65, type2 state plan eligibles)	0	0	0	-	-	-	-	-	-	-
EG3-TYPE1 (children, type1 state plan eligibles)	782,501	787,003	784,952	2,354,456	$4.79	$27.59	$15.11	$154.15	$0.45	$202.09
Med Exp Child (Title XXI Demo Pop; EG3-Type2)	18,238	17,010	16,530	51,778	$9.87	$53.90	$20.75	$143.61	$0.51	$228.64
EG4-TYPE1 (adults, type1 State plan eligibles)	464,088	453,274	452,552	1,369,914	$1.08	$56.47	$2.18	$283.88	$0.77	$344.38
EG4-TYPE2 (adults, type2 demonstration pop)	0	0	0	-						
EG5-TYPE1 (duals, state plan eligibles)	142,870	143,207	143,608	429,685	$3.26	$2.34	$0.06	$677.91	$1.54	$685.12
EG6E-TYPE3 (Expan adult, type3 demonstration pop)	741	730	724	2,195	$0.00	$50.42	$0.00	$269.79	$0.72	$320.93
EG7E-TYPE3 (Expan child, type3 demonstration pop)	53	53	48	154	$3.94	$117.19	$27.00	$140.68	$0.65	$289.46
EG8-TYPE2 (emd exp child)	0	0	0	-						
EG9 H-Disabled (TYPE 2 Eligibles)	225	235	237	697	$0.00	$574.59	$0.00	$5,314.33	$13.28	$5,902.19
EG10 H-Senior	35	43	46	124	$0.00	$57.31	$0.00	$5,453.76	$0.00	
EG11H, H-Dual	6,073	6,116	6,120	18,309	$0.02	$1.02	$0.00	$3,549.29	$8.00	$3,558.33
EG12E, Carryovers	2,686	2,610	2,578	7,874	$0.00	$15.91	$0.00	$4,498.46	$10.18	$4,524.54
Total	**1,564,482**	**1,556,867**	**1,553,276**	**4,674,625**	**$19.26**	**$58.07**	**$8.89**	**$317.70**	$0.91	$404.83

* Unknown allocation was performed within the Service category totals.