STATE OF TENNESSEE
DEPARTMENT OF FINANCE AND ADMINISTRATION
DIVISION OF HEALTH CARE FINANCE AND ADMINISTRATION
BUREAU OF TENNCARE
310 Great Circle Road
NASHVILLE, TENNESSEE 37243

May 29, 2015

Ms. Megan Lepore
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. Lepore:

Enclosed please find the Quarterly Progress Report for the January – March 2015 quarter. This report is being submitted in accordance with STC 45.

Please let us know if you have comments or questions.

Sincerely,

[redacted]

Darin J. Gordon
Director, Bureau of TennCare

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

TennCare II

Section 1115 Quarterly Report

(For the period January - March 2015)

Demonstration Year: 13 (7/1/14 - 6/30/15)
Federal Fiscal Quarter: 2/2015 (1/15 - 3/15)
Waiver Quarter: 3/2015 (1/15 - 3/15)

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 almost 1.4 million enrollees. During this quarter, these entities included Managed Care Organizations (MCOs) for medical, behavioral, and certain Long-Term Services and Supports (LTSS), a Dental Benefits Manager (DBM) for dental services, and a Pharmacy Benefits Manager (PBM) for pharmacy services.

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

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

Table 1
Key Dates of Approval/Operation in the Quarter

Date	Action	STC #
1/8/15	The State notified the public of its intent to submit Demonstration Amendment 25 to CMS. Amendment 25 was Tennessee Governor Bill Haslam's "Insure Tennessee" plan, which was an alternative proposal for delivering services to persons who would qualify in the "VIII Group," a group of very low-income adults between the ages of 19 and 65. (As detailed in Section II of this report, however, Insure Tennessee was defeated in the Tennessee legislature, rendering Amendment 25 moot.)	15
1/22/15	The CMS Project Officer cancelled the Monthly Call.	44
2/1/15	The State entered into a contract with Manatt, Phelps, and Phillips, LLP, to advise the State on the evaluation of eligibility and enrollment systems required by STC 68.	68
2/24/15	The CMS Project Officer cancelled the Monthly Call scheduled for 2/26/15.	44
2/27/15	The State submitted the Quarterly Progress Report for the October-December 2014 quarter to CMS. One topic addressed within the report was the State's 12/17/14 public forum to accept comments on the progress of the TennCare Demonstration.	45, 10
3/2/15	The State submitted to CMS Amendment 1 to the contracts with MCOs Amerigroup, BlueCare, and UnitedHealthcare	40

Date	Action	STC #
	Community Plan, and Amendment 36 to the TennCare Select contract.	
3/4/15	The State submitted Demonstration Amendment 24 to CMS. Amendment 24 proposes to add two community-based residential alternative services—"community living supports" and "community living supports-family model"—to the menu of services covered by CHOICES.	7
3/5/15	The State submitted a letter to CMS expressing the intent to proceed with Demonstration Amendment 18. Amendment 18 proposes to allow coverage of Assisted Community Living Facility services under special circumstances for members of CHOICES 3 (including members of Interim CHOICES 3). The amendment had originally been submitted to CMS on 3/7/13 but had been placed on hold on 6/26/13 until new federal regulations concerning Home and Community-Based Services were published by CMS and reviewed by the State.	
3/9/15	In a conference call with CMS, the State provided an overview of Amendments 18 and 24.	
3/9/15 – 3/10/15	A five-person team from Manatt, Phelps, and Phillips, LLP, came to Tennessee for an in-person meeting with the State to discuss the evaluation required by STC 68.	68
3/17/15	CMS sent the State a first set of written questions about Amendments 18 and 24.	
3/18/15	CMS sent the State a letter acknowledging the submission of Amendment 24 and confirming that the submission was complete.	
3/19/15	The State submitted written responses to the first set of questions about Amendments 18 and 24.	
3/23/15	In a conference call with CMS, the State reviewed its responses to CMS's 3/17/15 questions about Amendments 18 and 24.	
3/25/15	CMS sent the State a second set of written questions about Amendments 18 and 24.	
3/26/15	The State submitted written responses to the second set of questions about Amendments 18 and 24.	
3/26/15	The CMS Project Officer cancelled the Monthly Call.	44

II. Enrollment and Benefits Information

Information about enrollment by category is presented in Table 2.

Table 2
Enrollment Counts for the January – March 2015 Quarter
Compared to the Previous Two Quarters

Demonstration Populations	Total Number of TennCare Enrollees		
	Jul – Sept 2014	Oct – Dec 2014	Jan – Mar 2015
EG1 Disabled, Type 1 State Plan eligibles	135,500	136,442	138,543
EG9 H-Disabled, Type 2 Demonstration Population	324	341	321
EG2 Over 65, Type 1 State Plan eligibles	26	46	34
EG10 H-Over 65, Type 2 Demonstration Population	0	0	0
EG3 Children, Type 1 State Plan eligibles	681,230	700,096	719,348
EG4 Adults, Type 1 State Plan eligibles	332,388	353,854	376,863
EG5 Duals, Type 1 State Plan eligibles and EG11 H-Duals 65, Type 2 Demonstration Population	132,440	136,188	138,673
EG6E Expan Adult, Type 3 Demonstration Population	1,193	1,257	1,249
EG7E Expan Child, Type 3 Demonstration Population	63	65	65
EG8, Med Exp Child, Type 2 Demonstration Population, Optional Targeted Low Income Children funded by Title XIX	0	0	0
Med Exp Child, Title XXI Demonstration Population	19,499	19,359	19,132
EG12E Carryover, Type 3, Demonstration Population	6,783	5,367	4,624
TOTAL*	1,309,446	1,353,015	1,398,852

*** 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 78 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 March 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

Insure Tennessee. On December 15, 2014, Tennessee Governor Bill Haslam announced the Insure Tennessee plan, a two-year pilot program to provide health care coverage to certain low-income Tennesseans who currently lack access to health insurance or who have limited options in that regard. The program was designed to reward healthy behaviors, prepare members to transition to private coverage, promote personal responsibility, and incentivize choosing preventative and routine care instead of unnecessary use of emergency rooms. The Insure Tennessee plan evolved from Governor Haslam's announcement in March 2013 that he would not expand the traditional Medicaid program but that he would work with the federal government on an alternative plan for Tennessee that would take into consideration program cost, patient engagement, payment reform, and health outcomes.

On January 8, 2015, Governor Haslam issued a proclamation convening a special session of the Tennessee General Assembly to consider a joint resolution on Insure Tennessee. The session began on February 2 with the governor outlining his proposal to a joint convention of the Senate and the House of Representatives. Following hearings on Insure Tennessee over the next two days, the Tennessee Senate Health and Welfare Committee effectively ended the special session on February 4 by voting 7-4 against Insure Tennessee.

Several weeks after this development, Insure Tennessee was temporarily revived in the regular session of the 109th General Assembly. Senate Joint Resolution 93, which "authorizes the Governor to do all that is necessary to implement Insure Tennessee," passed the Senate Health and Welfare Committee by a 6-2-1 vote on March 25. On March 31, however, the Senate Commerce and Labor Committee defeated the measure by a 6-2-1 vote.

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

[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).

document having reached their aggregate cap, and how these situations were resolved." During the January-March 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 ninth 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 "TENNderCare," outreach is a significant area of interest for TennCare. The TennCare Bureau maintains a contract with the Tennessee Department of Health (TDH) to conduct a community outreach program for the purpose of educating families on EPSDT benefits and encouraging them to use those benefits, particularly preventive exams.

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

- Seasonal events. National Children's Dental Health Month in February, back-to-school events in August, and Child Health Week in October all have a profound influence on the focus and direction of outreach efforts during their respective quarters. TDH's communications strategy for each is based on an evaluation of past successes and current opportunities. During a round of Dental Health Month, for instance, TDH employed scrolling billboards prominently, whereas the strategy for Child Health Week eight months later placed greater emphasis on radio and television broadcasts and magazine articles.
- Collaborative partners. A variety of TDH's activities are dependent on the opportunities offered by other State agencies and by entities within the community. For example, publication of articles in newsletters and magazines is usually possible only when local media outlets offer space in their periodicals at no charge. Similarly, TDH's ability to educate the public through television and radio broadcasts is tied to the availability of open timeslots in those platforms. Even certain types of telephone outreach require input from other sources: calls to families to reinforce the importance of dental checkups (detailed in Table 4), for instance, are possible only because of referrals from the School-Based Dental Prevention Program (SBDPP).

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

Activities	Jul – Sept 2014	Oct – Dec 2014	Jan – Mar 2015
Number of outreach activities/events	2,903	2,956	3,310
Number of people made contact with (mostly face to face at outreach events)	159,165	175,176	139,810[4]
Number of educational materials distributed	170,958	186,230	126,138
Number of coalitions/advisory board meetings attended or conducted	71	58	82
Number of attendees at coalitions/advisory board meetings	974	1,034	1,483
Number of educational preventive health radio/TV broadcasts	3,250	1,748	1,714
Number of educational preventive health newsletter/magazine articles	192	263	303
Number of educational preventive health billboards, scrolling billboards and bulletin boards	7,769	6,612	6,657
Number of presentations made to enrollees/professional staff who work with enrollees	122	135	159
Number of individuals attending presentations	8,799	7,221	8,719
Number of attempted telephone calls regarding the importance of dental checkups	71	561	290
Number (approx) of completed telephone calls regarding the importance of dental checkups	32	285	162
Number of attempted home visits (educational materials left with these families)	16,407	12,746	115[5]
Number of home visits completed	6,511	4,181	35

The TennCare Bureau also contracts with TDH for a TENNderCare Call Center that employs operators to call all newly enrolled and newly re-certified members with children to inform

[4] In spite of an increase in the number of outreach events during the January-March 2015 quarter, contacts made at those events declined. This development, which coincides with a decrease in the number of educational materials distributed, appears to have been the result of low turnout stemming from inclement weather.

[5] TDH made a strategic decision in the January-March 2015 quarter to focus their efforts on outreach activities/events instead of home visits. Because TDH staff members making home visits typically arrive unannounced and uninvited, their ability to communicate successfully about EPSDT has traditionally been limited. A new home visit model based on voluntary family participation and scheduled appointments is currently being developed.

them about TENNderCare 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
TENNderCare Call Center Activity
January – March 2015 Compared to the
Previous Two Quarters

Activities	Jul – Sept 2014	Oct – Dec 2014	Jan – Mar 2015
Number of families reached[6]	28,410	22,322	19,600
Number of families who were assisted in scheduling an EPSDT exam for their children	137	284	206
Number of families who were assisted in arranging for transportation	8	13	11

IV. Collection and Verification of Encounter and Enrollment Data

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

Table 6
Number of Initial Encounters Received by TennCare During the January – March 2015 Quarter, and Percentage that Passed Systems Edits, Compared to the Previous Two Quarters

	Jul – Sept 2014	Oct – Dec 2014	Jan – Mar 2015
No. of encounters received by TennCare (initial submission)	13,358,785	15,660,193	12,862,995
No. of encounters rejected by Edifecs upon initial submission	46,570	40,445	20,303
Percentage of encounters that were compliant with State standards (including HIPAA) upon initial submission	99.65%	99.74%	99.84%

[6] Totals in this category include families reached through a TDH special project that focuses on educating enrollees about the importance of back-to-school immunizations and/or well-child examinations (as age-appropriate).

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

A. CHOICES

On March 4, 2015, TennCare submitted Demonstration Amendment 24 to CMS. Amendment 24 would add two community-based residential alternative services to the menu of benefits covered by CHOICES. Both of the services in question—"community living supports" (CLS) and "community living supports-family model" (CLS-FM, an "adult foster care" arrangement)—are alternatives to Nursing Facility (NF) care: each provides access to services and supports in a small shared residential setting, allowing the individual to reside in the community. Delivery of CLS and CLS-FM would adhere to recently enacted federal regulations governing the provision of Home and Community-Based Services (HCBS) and HCBS settings. The proposal, which would take effect on July 1, 2015, is not projected to increase program expenditures: coverage is conditioned on a determination that provision of CLS or CLS-FM would not cost more than provision of other forms of CHOICES HCBS that the person would otherwise receive.

To date, discussions between CMS and TennCare on Amendment 24 have focused on points of clarification, such as the Bureau's plans for ensuring providers' compliance with relevant federal regulations and the capability of existing provider networks to deliver such services throughout the state.

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 January – March 2015 Compared to the Previous Two Quarters

	Statewide Enrollment Targets and Reserve Capacity[7]	Enrollment and Reserve Slots Being Held as of the End of Each Quarter		
		Jul – Sept 2014	Oct – Dec 2014	Jan – Mar 2015
CHOICES 1	Not applicable	17,943	17,944	17,391
CHOICES 2	12,500	8,600	8,508	8,386
Interim CHOICES 3	Not applicable	4,688	4,901	4,902
Total CHOICES	Not applicable	31,231	31,353	30,679
Reserve capacity	300	300	300	300

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

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. Seven separate reports—spanning the period of August 2011 through August 2014—had been submitted by the conclusion of the January-March 2015 quarter.

A summary of the most current trends in enrollment statistics is provided in Table 8.

TABLE 8
Update on CHOICES Enrollment Statistics

	March 2011	March 2012	March 2013	March 2014	March 2015
NF enrollees (CHOICES 1)	21,779	20,904	19,644	18,462	17,391
HCBS enrollees (CHOICES 2)	7,813	10,440	9,830	8,802	8,386
HCBS enrollees (Interim CHOICES 3)[8]	N/A	N/A	2,370	4,014	4,902
Total	29,592	31,344	31,844	31,278	30,679

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

- CHOICES HCBS up to the Expenditure Cap of $15,000;

[8] The Interim CHOICES 3 category approved by CMS as part of Demonstration Amendment 14 did not open until July 1, 2012.

- 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 January 1, 2015, through March 31, 2015, NF PreAdmission Evaluations were approved for 146 individuals with acuity scores lower than 9, and 72 of these individuals were subsequently enrolled in CHOICES 1 during the measurement period. Reasons that the remaining individuals were approved for—but not yet enrolled in—CHOICES 1 include:

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

In the same reporting period, HCBS PreAdmission Evaluations were approved for 24 individuals with acuity scores lower than 9, and 18 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. Historically, the number of transition allowances and the total amount of corresponding funding tend to peak during the October-December quarter, as families strive to bring members home for the holidays. This factor—combined with the harsher weather and higher incidence of cold and flu during the January-March quarter—helps explain the smaller totals for this reporting period.

Table 9
TennCare CHOICES Transition Allowances
for January – March 2015 Compared to the Previous Two Quarters

	Frequency and Use of Transition Allowances					
	Jul – Sept 2014		**Oct – Dec 2014**		**Jan – Mar 2015**	
Grand Region	# Distributed	Total Amount	# Distributed	Total Amount	# Distributed	Total Amount
East	5	$3,626	21	$15,587	6	$5,388
Middle	4	$4,767	17	$24,889	4	$3,999
West	15	$20,211	18	$18,109	10	$6,090
Statewide Total	24	$28,604	56	$58,585	20	$15,477

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 Tennessee region (i.e., East, Middle, or West Grand Region) and by subcontractor (e.g., claims processed by a vision benefits manager). Furthermore, the MCOs are required to identify separately non-emergency transportation (NEMT) claims in the data files. Finally, the MCOs are required to submit separate claims data files representing a subset of electronically submitted NF and applicable HCBS claims for CHOICES enrollees. TDCI then performs an analysis and reports the results of the prompt pay analyses by NEMT and CHOICES claim types, by subcontractor, by Tennessee region, 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 January-March 2015 quarter, the MCOs submitted their 2014 National Association of Insurance Commissioners (NAIC) Annual Financial Statements. As of December 31, 2014, TennCare MCOs reported net worth as indicated in the table below.[9]

Table 10
Net Worth Reported by MCOs as of December 31, 2014

	Net Worth Requirement	Reported Net Worth	Excess/ (Deficiency)
Amerigroup Tennessee	$18,895,648	$156,552,359	$137,656,711
UnitedHealthcare Plan of the River Valley (UnitedHealthcare Community Plan)	$67,602,074	$600,328,649	$532,726,575
Volunteer State Health Plan (BlueCare & TennCare Select)	$37,185,058	$330,054,375	$292,869,317

For the January-March 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 December 31, 2014:

Table 11
Company Action Level Reported by MCOs as of December 31, 2014

	Company Action Level	Reported Net Worth	Excess/ (Deficiency)
Amerigroup Tennessee	$61,407,788	$156,552,359	$95,144,571
UnitedHealthcare Plan of the River Valley (UnitedHealthcare Community Plan)	$244,098,654	$600,328,649	$356,229,995
Volunteer State Health Plan	$109,546,612	$330,054,375	$220,507,763

[9] 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.

	Company Action Level	Reported Net Worth	Excess/ (Deficiency)
(BlueCare & TennCare Select)			

All TennCare MCOs met their minimum net worth requirements and Company Action Level requirements as of December 31, 2014.

C. *Wilson v. Gordon*

Wilson v. Gordon is a class action lawsuit filed against the Bureau by the Tennessee Justice Center, the Southern Poverty Law Center, and the National Health Law Program. The suit alleges a variety of flaws in the enrollment process TennCare has been using since January 1, 2014.

Currently, two separate courts are hearing arguments in the case. The first is the U.S. District Court for the Middle District of Tennessee, where Plaintiffs originally filed suit in July 2014. The District Court granted class action status to the case and issued a preliminary injunction requiring the Defendants (specifically, TennCare) to provide an opportunity for a fair hearing on any delayed adjudications of applications for TennCare coverage. TennCare took immediate action to comply with these rulings but also filed an appeal with a second court, the U.S. Court of Appeals for the Sixth Circuit in Cincinnati.

The Defendants filed a motion at the District Court level on February 25, 2015, requesting that the process of discovery in *Wilson v. Gordon* be suspended until the case had been adjudicated by the Court of Appeals. The basis for this request was that any resources devoted to discovery would be wasted if the Court of Appeals ultimately dismissed the matter altogether. The District Court denied this request on March 20, 2015, but did encourage the parties to prioritize discovery requests in such a way as not to interfere with TennCare's efforts to adjudicate applications in a timely manner.

D. Tennessee Eligibility Determination System

On January 12, 2015, TennCare announced plans to select a new vendor for the continued development of the Tennessee Eligibility Determination System (TEDS). The purpose of TEDS is to review applications for health care assistance and identify which persons are eligible for an "insurance affordability program," meaning TennCare, CoverKids, or subsidized insurance under the Health Insurance Marketplace.

After months of delays and missed benchmarks, the State had decided in 2014 to hire an independent international consulting firm, KPMG LLP, to perform an assessment of TEDS. The assessment was to provide—

- A review of progress to date by then-vendor Northrop Grumman Systems Corporation;
- Identification of project deficiencies;

- Determination of potential risks to the TennCare program; and
- Options for resuming development of the TEDS project and leading it to a successful outcome.

In late 2014, KPMG LLP released a comprehensive report to the State. As a result of the detailed findings within the report, TennCare and Northrop Grumman mutually decided it to be in their respective best interests to terminate their contract early. The State will move forward with the process for selecting a new vendor.

E. Statewide MCOs

On January 1, 2015, following months of intensive preparations, TennCare MCOs Amerigroup, BlueCare, and UnitedHealthcare began delivering physical health services, behavioral health services, and LTSS to enrollees in all three of Tennessee's grand regions. Previously, only two MCOs had operated in each grand region, and only UnitedHealthcare had served all three regions.

Coinciding with this January 1 implementation date was the transfer of approximately 411,000 TennCare members to different health plans to ensure a more even distribution of enrollment among the three statewide MCOs. Two enrollee notices mailed during the previous quarter aided this transition.

- The first notice was directed to affected members of CHOICES. The letter alerted recipients to the impending transfer, so that each recipient's new MCO could introduce itself and provide assurances that plans of care would be transitioned smoothly.
- The second notice was directed to all affected enrollees and provided instructions for remaining with their current MCO if preferred. In addition, individuals who had transferred to new health plans on January 1 retained the option of returning to their former MCOs as long as their requests had been received by February 14, 2015. Approximately 15 percent of members affected by the transfer decided to remain with—or return to—their original plans.

Preliminary reports indicate that the first quarter of the statewide service delivery model has been successful. TennCare monitored the rollout carefully and found that access to services had not been interrupted and, in particular, that critical care patients continued to receive needed care.

As of the end of the January-March 2015 quarter, both the Bureau and the MCOs were preparing for a second round of enrollee transfers on April 1, 2015. Approximately 6,900 enrollees (CHOICES members only) were scheduled to be transitioned to new plans during this second implementation phase, and TennCare mailed each affected individual the two notice letters well before the conclusion of the January-March 2015 quarter.

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[10] 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 January-March 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 (Jan-Mar 2015)	Cumulative Amount Paid To Date
First-year payments	122[11]	$2,585,417	$150,636,919
Second-year payments	34	$1,952,672	$47,999,894
Third-year payments	69	$3,665,234	$8,808,717
Fourth-year payments	31	$263,500	$331,500

[10] 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).

[11] Of the 122 providers receiving first-year payments in the January-March 2015 quarter, 7 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:

- Expansion of the contract with Qsource (TennCare's External Quality Review Organization) to assist Tennessee providers with the attestation process;
- Participation throughout the quarter in several Southeast Regional Collaboration for HIT/HIE (SERCH) calls;
- Telephone assistance throughout the quarter for eligible professionals attesting to Meaningful Use (with particular emphasis on the EHR final rule that took effect on October 1, 2014);
- Responding to more than 500 inquiries submitted to the EHR Meaningful Use email box;
- Monthly newsletters distributed by the Bureau's EHR ListServ; and
- A quarterly reminder issued through the Provider Incentive Payment Program ("PIPP") system to Tennessee providers who had registered at the federal level but who have not registered or attested at the state level.

TennCare continues to schedule EHR workshops with a variety of provider organizations to maintain the momentum of the program.

VI. Action Plans for Addressing Any Issues Identified

As reported in Section V, TennCare continues to comply with orders issued in the *Wilson v. Gordon* court action.

In addition, effective February 1, 2015, the State entered into a contract with Manatt, Phelps, and Phillips, LLP, to conduct the evaluation of eligibility and enrollment systems required by STC 68. The evaluation was planned to occur in five stages:

1. Proposal of a set of measures and development of a plan for use of the measures;
2. Assessment of readiness activities for collecting and analyzing the data;
3. Completion of an initial analysis of the data;
4. Completion of a final analysis of the data; and
5. Submission of a report to CMS.

A team from Manatt came to Tennessee for a two-day site visit on March 9-10, 2015. The visit provided an opportunity to meet with key TennCare staff members in various offices, such as Member Services, Health Care Informatics, Information Systems, Quality Oversight, the Office of General Counsel, and the Policy Office.

VII. Financial/Budget Neutrality Development Issues

In the first two months of the January-March 2015 quarter, total state and local revenue collections were markedly higher than they had been during the corresponding months of 2014, with a 22 percent improvement in January and a 7 percent improvement in February. These gains more than compensated for a slight downturn in March 2015, when revenues declined one and a half percent in comparison to those from March 2014.[12] With regard to Tennessee's performance in the arena of jobs, the unemployment rate fell throughout the quarter, beginning at 6.7 percent in January, decreasing to 6.6 percent in February, and dropping still further to 6.3 percent in March. These figures, which are virtually identical to the state unemployment rate during the corresponding months of 2014, continue to lag behind the national rate, which ranged from 5.5 percent to 5.7 percent during the reporting period.[13]

VIII. Member Month Reporting

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

Table 13
Member Month Reporting for Use in Budget Neutrality Calculations
January – March 2015

Eligibility Group	January 2015	February 2015	March 2015	Sum for Quarter Ending 3/31/15
Medicaid eligibles (Type 1)				
EG1 Disabled, Type 1 State Plan eligibles	138,695	138,135	137,655	414,485
EG2 Over 65, Type 1 State Plan eligibles	33	34	34	101
EG3 Children, Type 1 State Plan eligibles	710,131	714,026	717,306	2,141,463
EG4 Adults, Type 1 State Plan eligibles	364,106	370,411	375,565	1,110,082
EG5 Duals, Type 1 State Plan eligibles	130,149	130,134	130,155	390,438

[12] The Department of Revenue's collection summaries are available online at http://www.state.tn.us/revenue/statistics/summaries.shtml.
[13] Information about Tennessee's unemployment rate is available on the Department of Labor and Workforce Development's website at https://news.tn.gov/taxonomy/term/32.

Eligibility Group	January 2015	February 2015	March 2015	Sum for Quarter Ending 3/31/15
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	323	321	319	963
EG10 H-Over 65, Type 2 Demonstration Population	0	0	0	0
EG11 H-Duals, Type 2 Demonstration Population	6,055	5,990	6,011	18,056
TOTAL	1,349,492	1,359,051	1,367,045	4,075,588

Table 14
Member Month Reporting Not Used in Budget Neutrality Calculations
January – March 2015

Eligibility Group	January 2015	February 2015	March 2015	Sum for Quarter Ending 3/31/15
EG6E Expan Adult, Type 3, Demonstration Population	1,249	1,243	1,241	3,733
EG7E Expan Child, Type 3, Demonstration Population	65	65	63	193
Med Exp Child, Title XXI Demonstration Population	19,224	19,163	19,107	57,494
EG12E Carryover, Type 3, Demonstration Population	4,775	4,638	4,491	13,904
TOTAL	25,313	25,109	24,902	75,324

IX. Consumer Issues

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

Table 15
Eligibility Appeals Handled by TennCare and the Department of Human Services
During the October – December 2014 Quarter, Compared to the Previous Two Quarters

	Jul – Sept 2014	Oct – Dec 2014	Jan – Mar 2015
No. of appeals received	4,017	5,839	4,944
No. of appeals resolved or withdrawn	469	727	5,328[14]
No. of appeals taken to hearing	140	326	2,567[15]

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

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

	Jul – Sept 2014	Oct – Dec 2014	Jan – Mar 2015
No. of appeals received	1,832	1,547	1,287
No. of appeals resolved	1,672	1,628	1,297
• Resolved at the MCC level	883	645	492
• Resolved at the TSU level	114	129	95
• Resolved at the LSU level	675	854	710
No. of appeals that did not involve a valid factual dispute	243	349	113
No. of directives issued	195	182	159
No. of appeals taken to hearing	675	854	710
No. of appeals that were withdrawn by the enrollee at or prior to the hearing	229	272	222
Appeals that went to hearing and were decided in the State's favor	193	285	255
Appeals that went to hearing and were decided in the appellant's favor	29	29	21

[14] During the first quarter of Calendar Year 2015, TennCare began performing hearings for appeals of FFM effective dates and denials. The State was not previously able to perform these hearings due to a lack of information on the eligibility decisions that were made at the FFM and, therefore, forwarded such appeals to CMS for resolution. In the first quarter of Calendar Year 2015, the numbers for both "appeals resolved or withdrawn" and "appeals taken to hearing" increased substantially because, in late 2014, the FFM had begun providing the State with the information necessary for the State to perform these hearings.

[15] See Footnote 14.

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. Recent improvements made to medical eligibility determination processes—including earlier safety determinations—coincide with a decline in the number of LTSS appeals filed during the two most recent quarters.

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

	Jul – Sept 2014	Oct – Dec 2014	Jan – Mar 2015
No. of appeals received	380	220	217
No. of appeals resolved or withdrawn	198	131	145
No. of appeals set for hearing	63	71	73

X. Quality Assurance/Monitoring Activity

Population Health. "Population Health" (PH) is the model of targeted health care interventions implemented by TennCare in the months leading up to—and culminating on—July 1, 2013. Advantages of PH over the "Disease Management" program it replaced 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 October-December 2014 quarter is provided in Table 18. Data for the period of January through March 2015 will be provided in the next Quarterly Progress Report.

Table 18
Population Health Data*, October – December 2014

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	526,657
Level 1: low or moderate risk	Maternity Program	Engage pregnant women in timely prenatal care and deliver a healthy, term infant without complications	19,276
	Health Risk Management	Prevent, reduce, or delay exacerbation and complications of a condition or health risk behavior	764,266
	Care Coordination	Assure that members receive the services they need to reduce the risk of an adverse health outcome	23,135[16]
Level 2: high risk	Chronic Care Management	Provide intense self-management education and support to members	5,150

[16] Each recipient of care coordination services is also enrolled in another PH intervention program. To avoid duplication, therefore, the enrollment total for care coordination is not included in the overall PH enrollment total.

Risk Level	Intervention Type	Intervention Goal(s)	Number of Unique Members at End of Quarter
		with multiple chronic conditions to improve their quality of life, health status, and use of services	
	High Risk Pregnancy Management	Engage pregnant women in timely prenatal care and deliver a healthy, term infant without complications	2,463
	Complex Case Management	Move members to optimal levels of health and well-being through timely coordination of quality services and self-management support	926
Total PH Enrollment			**1,318,738**

*** 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 January 2015, TennCare's External Quality Review Organization (EQRO), Qsource, published the results of its provider data validation survey for the October-December 2014 quarter. Qsource took a sample of provider data files from TennCare's MCCs[17] and reviewed each for accuracy in the following categories:

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

The validity of such information is one measure of providers' availability and accessibility to TennCare enrollees. Qsource's report concluded that "[o]verall, the MCCs' accuracy rates have maintained a high level," especially in the categories of "active contract status with MCC" (98.3 percent accuracy), "provider credentialed specialty / behavioral health service code" (97.6 percent accuracy), "primary care services" (99.3 percent accuracy), and "prenatal care services" (99.8 percent accuracy).

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

While the results were comparable to the overall scores obtained last quarter and one year ago, to ensure improvement in these and other areas (such as "services to patients age 21 or older," which demonstrated only 93.2 percent accuracy), TennCare required each of its MCCs to submit a Corrective Action Plan no later than March 5, 2015. The Bureau, in turn, had received, reviewed, and accepted all of the plans by March 11, 2015. Results for the January-March 2015 quarter will be discussed in the next Quarterly Progress Report.

XI. Demonstration Evaluation

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

In addition, on October 31, 2014, the State submitted the Draft Annual Report as required by STC 46. Part V of that report provided the progress to date on the performance measures 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 13, 2014, the State submitted its annual update of the strategy to evaluate and improve the quality and accessibility of care offered to enrollees through the managed care network. The document, entitled *2014 Annual Update Report of the 2013 Quality Assessment and Performance Improvement Strategy*, is available on TennCare's website at http://www.tn.gov/tenncare/forms/qualitystrategy.pdf.

XII. Essential Access Hospital Pool[18]

A. Safety Net Hospitals

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

[18] Within the four Essential Access Hospital (EAH) groupings (Safety Net Hospitals, Children's Hospitals, Free Standing Psychiatric Hospitals, and Other Acute Care Hospitals), hospitals are arranged—in descending order—according to the amount of compensation each receives from the EAH pool.

B. Children's Hospitals

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

C. Free Standing Psychiatric Hospitals

Pathways of Tennessee
Ridgeview Psychiatric Hospital and Center
Rolling Hills Hospital

D. Other Acute Care Hospitals

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

LeConte Medical Center
Morristown – Hamblen Healthcare System
Southern Hills Medical Center
Heritage Medical Center
Sumner Regional Medical Center
Takoma Regional Hospital
Tennova Healthcare – Newport Medical Center
Sweetwater Hospital Association
Laughlin Memorial Hospital
Methodist Medical Center of Oak Ridge
TriStar Hendersonville Medical Center
Harton Regional Medical Center
Henry County Medical Center
Tennova Healthcare – LaFollette Medical Center
Grandview Medical Center
Sycamore Shoals Hospital
Skyridge Medical Center – Westside
Regional Hospital of Jackson
Baptist Memorial Hospital – Union City
Lakeway Regional Hospital
Indian Path Medical Center
Wellmont Hawkins County Memorial Hospital
Jellico Community Hospital
Hardin Medical Center
McNairy Regional Hospital
Starr Regional Medical Center – Athens
River Park Hospital
Henderson County Community Hospital
Roane Medical Center
United Regional Medical Center
Hillside Hospital
Crockett Hospital
Livingston Regional Hospital
McKenzie Regional Hospital
Volunteer Community Hospital
Bolivar General Hospital
Wayne Medical Center
Erlanger Health System – East Campus
Baptist Memorial Hospital – Huntingdon
DeKalb Community Hospital
Methodist Healthcare – Fayette
Emerald Hodgson Hospital

XIII. Graduate Medical Education (GME) Hospitals

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

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

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

XIV. Critical Access Hospitals

Camden General Hospital
Copper Basin Medical Center
Erlanger Bledsoe
Hickman Community Hospital
Johnson County Community Hospital
Lauderdale Community Hospital
Macon County General Hospital
Marshall Medical Center
Medical Center of Manchester
Rhea Medical Center

Riverview Regional Medical Center
Three Rivers Hospital
TriStar Ashland City Medical Center
Trousdale Medical Center
Wellmont Hancock County Hospital

State Contact:

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

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

Date Submitted to CMS: May 29, 2015

Attachment A

Budget Neutrality Calculations for the Quarter

This material will be submitted under separate cover.

Actual TennCare Budget Neutrality (January - March 2015)

I. The Extension of the Baseline

Baseline PMPM

	SFY 2015 PMPM
1-Disabled (can be any ages)	$1,641.09
2-Child <=18	$484.39
3-Adult >= 65	$1,069.19
4-Adult <= 64	$962.76
Duals (17)	$683.02

Actual Member months of Groups I and II

1-Disabled (can be any ages)	415,448
2-Child <=18	2,141,463
3-Adult >= 65	101
4-Adult <= 64	1,110,082
Duals (17)	408,494
Total	4,075,588

Ceiling without DSH

	Baseline * MM
1-Disabled (can be any ages)	$681,789,494
2-Child <=18	$1,037,307,154
3-Adult >= 65	$107,988
4-Adult <= 64	$1,068,745,702
17s	$279,011,122
Total	**$3,066,961,461**

DSH

DSH Adjustment (Quarterly)	$115,999,213

Total Ceiling

Budget Neutrality Cap	
Total w/DSH Adj.	**$3,182,960,675**

II. Actual Expenditures

Group 1 and 2

1-Disabled (can be any ages)	$ 515,351,320
2-Child <=18	$ 459,102,281
3-Adult >= 65	$ 76,126
4-Adult <= 64	$ 391,063,208

Duals (17)	$	307,684,162
Total		**1,673,277,098**

Group 3

1-Disabled (can be any ages)	$	-
2-Child <=18	$	13,337,718
3-Adult >= 65	$	79,912,321
4-Adult <= 64	$	1,620,370
Duals (17)	$	-
Total		**94,870,410**

Pool Payments and Admin

Total Pool Payments		$305,838,640

Admin	$	88,335,566

Quarterly Drug Rebates	$	126,258,483
Quarterly Premium Collections	$	648
Total Net Quarterly Expenditures	**$**	**2,036,062,583**

III. Surplus/(Deficit)

	$1,146,898,091
Federal Share	**$748,809,764**

HCI Result	MM201501	MM201502	MM201503	TOTAL	HCI ASO	HCI Rx	HCI DTL	HCI MCO CAP (TCS Admin)	UNK Allocation	TOTAL
EG1-TYPE1 (disabled, type1 state plan eligibles)	138,695	138,135	137,655	414,485	$78,641,021	$110,030,787	$1,527,862	$321,373,077	(1,359,422)	$510,213,325
EG1-TYPE2 (disabled, type2 transition group)	0	0	0	-				$0	-	$0
EG2-TYPE1 (over 65, type1 state plan eligibles)	33	34	34	101	$5,398	$6,296	$0	$64,635	(203)	$76,126
EG2-TYPE2 (over 65, type2 state plan eligibles)	0	0	0	-				$0	-	$0
EG3-TYPE1 (children, type1 state plan eligibles)	710,131	714,026	717,306	2,141,463	$10,844,141	$67,723,113	$29,184,169	$352,574,268	(1,223,410)	$459,102,281
Med Exp Child (Title XXI Demo Pop; EG3-Type2)	19,224	19,163	19,107	57,494	$124,696	$3,109,233	$1,092,183	$8,992,042	(35,397)	$13,282,755
EG4-TYPE1 (adults, type1 State plan eligibles)	364,106	370,411	375,565	1,110,082	$845,344	$61,310,372	$2,571,115	$327,378,442	(1,042,065)	$391,063,208
EG4-TYPE2 (adults, type2 demonstration pop)	0	0	0	-				$0	-	$0
EG5-TYPE1 (duals, state plan eligibles)	130,149	130,134	130,155	390,438	$950,489	$922,392	$818,475	$255,747,650	(686,788)	$257,752,219
EG6E-TYPE3 (Expan adult, type3 demonstration pop)	1,249	1,243	1,241	3,733	$257	$386,106	$11,422	$1,226,903	(4,318)	$1,620,370
EG7E-TYPE3 (Expan child, type3 demonstration pop)	65	65	63	193		$22,567	$3,174	$29,368	(146)	$54,963
EG8-TYPE2 (emd exp child)	0	0	0	-		$0		$0	-	$0
EG9 H-Disabled (TYPE 2 Eligibles)	323	321	319	963		$319,689	$0	$4,831,998	(13,692)	$5,137,995
EG11H, H-Dual	6,055	5,990	6,011	18,056		$9,440	$10,065	$50,045,492	(133,054)	$49,931,943
EG12E, Carryovers	4,775	4,638	4,491	13,904	$950	$1,633,862	$16,270	$78,474,191	(212,952)	$79,912,321
Total	**1,374,805**	**1,384,160**	**1,391,947**	**4,150,912**	**$91,412,296**	**$245,473,856**	**$35,234,737**	**$1,400,738,066**	**-$4,711,448**	**$1,768,147,508**

HCI Result	MM201410	MM201411	MM201412	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)	138,695	138,135	137,655	414,485	$189.73	$265.46	$3.69	$775.36	-$3.28	$1,230.96
EG1-TYPE2 (disabled, type2 transition group)	0	0	0	-						
EG2-TYPE1 (over 65, type1 state plan eligibles)	33	34	34	101	$53.45	$62.33	$0.00	$639.95	-$2.01	$753.72
EG2-TYPE2 (over 65, type2 state plan eligibles)	0	0	0	-	-	-	-	-	-	-
EG3-TYPE1 (children, type1 state plan eligibles)	710,131	714,026	717,306	2,141,463	$5.06	$31.62	$13.63	$164.64	-$0.57	$214.39
Med Exp Child (Title XXI Demo Pop; EG3-Type2)	19,224	19,163	19,107	57,494	$2.17	$54.08	$19.00	$156.40	-$0.62	$231.03
EG4-TYPE1 (adults, type1 State plan eligibles)	364,106	370,411	375,565	1,110,082	$0.76	$55.23	$2.32	$294.91	-$0.94	$352.28
EG4-TYPE2 (adults, type2 demonstration pop)	0	0	0	-						
EG5-TYPE1 (duals, state plan eligibles)	130,149	130,134	130,155	390,438	$2.43	$2.36	$2.10	$655.03	-$1.76	$660.16
EG6E-TYPE3 (Expan adult, type3 demonstration pop)	1,249	1,243	1,241	3,733	$0.07	$103.43	$3.06	$328.66	-$1.16	$434.07
EG7E-TYPE3 (Expan child, type3 demonstration pop)	65	65	63	193	$0.00	$116.93	$16.45	$152.17	-$0.76	$284.78
EG8-TYPE2 (emd exp child)	0	0	0	-						
EG9 H-Disabled (TYPE 2 Eligibles)	323	321	319	963	$0.00	$331.97	$0.00	$5,017.65	-$14.22	$5,335.40
EG11H, H-Dual	6,055	5,990	6,011	18,056	$0.00	$0.52	$0.56	$2,771.68	-$7.37	$2,765.39
EG12E, Carryovers	4,775	4,638	4,491	13,904	$0.07	$117.51	$1.17	$5,644.00	-$15.32	$5,747.43
Total	**1,374,805**	**1,384,160**	**1,391,947**	**4,150,912**	**$22.02**	**$59.14**	**$8.49**	**$337.45**	**-$1.14**	**$425.97**

* Unknown allocation was performed within the Service category totals.