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 30, 2014

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

RE: TennCare II, STC 45, Quarterly Progress Report

Dear Ms. Woodard:

Enclosed please find the Quarterly Progress Report for the January-March 2014 quarter. This report is being submitted in accordance with STC 45.

During the process of completing a quality check of the data presented in the report, we discovered an error in the logic related to Eligibility Groups. We are generating a corrected version of the data and will provide it to you shortly.

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 2014)

Demonstration Year: 12 (7/1/13 - 6/30/14)
Federal Fiscal Quarter: 2/2014 (1/14 - 3/14)
Waiver Quarter: 3/2014 (1/14 - 3/14)

I. Introduction

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

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

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

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

Table 1
Key Dates of Approval/Operation in the Quarter

Date	Action	STC #
1/3/14	In reference to Amendment 20, the State communicated to CMS that no comments had been received during the public notice period; the State also identified certain technical corrections that were needed.	
1/23/14	The CMS Project Officer cancelled the Monthly Call.	44
1/23/14	The State proposed to include in its written acceptance of CMS's partial approval of Amendment 20 a variety of technical corrections, including eligibility updates associated with the Affordable Care Act (ACA). CMS accepted this suggestion.	
1/27/14	The State submitted Demonstration Amendment 21 to CMS. Amendment 21 proposed a set of program reductions that would be required if the annual hospital assessment fee were not renewed by the Tennessee legislature in 2014. Amendment 21 was a companion to similar amendments submitted in previous years— Amendment 9 in 2010; Amendment 12 in 2011; Amendment 15 in 2012; and Amendment 17 in 2013.	6, 7
1/29/14	The State sent CMS a letter accepting the partial approval of Amendment 20 and identifying three types of technical corrections needed within the Demonstration agreement: modifications related to Amendment 20, updates	

Date	Action	STC #
	pertaining to ACA implementation, and miscellaneous revisions to outdated content. CMS acknowledged receipt of the State's letter.	
1/30/14	In response to the guidance issued in State Health Officer Letter #13-003, the State submitted a request to implement Strategy #2: "Extending the Medicaid renewal process so that renewals that would otherwise occur during the first quarter of CY 2014 occur later."	
2/3/14	With regard to Amendment 20, the State sent CMS a message clarifying the ACA-related technical corrections included in the acceptance letter of 1/29/14. The Project Officer acknowledged receipt of the message.	
2/7/14	The State returned to CMS the signed FFM Memorandum of Understanding that CMS had sent to the State. The next step is for CMS to execute the MOA and return it to the State.	
2/19/14	The State submitted to CMS a proposal for evaluating uncompensated care costs for the uninsured after the implementation of ACA. The proposal identified two sources of data on which the evaluation could be based (the Joint Annual Report of Hospitals and the annual Disproportionate Share Hospital audit) and envisioned completion of the evaluation by December 31, 2015.	69
2/24/14	The CMS Project Officer cancelled the Monthly Call scheduled for 02/27/14.	44
2/25/14	The CMS Project Officer provided the State a status update regarding the components of Amendment 20 still under review.	
2/28/14	The State submitted the Quarterly Progress Report for the October-December 2013 quarter to CMS.	45
3/6/14	CMS sent the State two items: questions related to the component of Amendment 20 that would add Erlanger Medical Center to the Public Hospital Supplemental Payment (PHSP) Pool, and potential definitions of the term "uncompensated care." The State, in turn, offered draft definitions of the terms "uncompensated care," "charity care," and "TennCare shortfall."	
3/7/14	The State submitted responses to CMS's questions about Erlanger Medical Center. CMS acknowledged receipt of the submission and also approved the three definitions that the State had provided on 3/6/14.	
3/17/14	CMS provided written approval of the State's 2013 Quality	43.c.

Date	Action	STC #
	Improvement Strategy.	
3/26/14	The State submitted a formal plan for evaluating uncompensated care costs for the uninsured after the implementation of ACA.	69
3/27/14	The Monthly Call was held. Topics addressed during the call included the two components of Amendment 20 yet to be approved by CMS; the State's plan for evaluating uncompensated care costs for the uninsured; technical corrections to the STCs proposed by the State; items to be included in the State's next amendment to the TennCare Demonstration; and the State's progress in submitting State Plan Amendments related to compliance with ACA.	44
3/28/14	At CMS's request, the State resubmitted the budget neutrality workbook that had accompanied the State's original submission of Amendment 20 on 12/17/13. CMS, in turn, provided written approval of the two remaining components of Amendment 20 (addition of funds to the Essential Access Hospital Pool and inclusion of Erlanger Medical Center in the PHSP).	

II. Enrollment and Benefits Information

Information about enrollment by category is usually presented in the Quarterly Report as Table 2. Table 2 for the January-March 2014 quarter, however, will be submitted to CMS under separate cover. The Managed Care Contractors providing services to TennCare enrollees as of the end of the quarter are listed in Table 3.

Table 3
TennCare Managed Care Contractors as of March 31, 2014

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

[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.

	West Tennessee	Middle Tennessee	East Tennessee
	TennCare Select[3]	TennCare Select	TennCare Select
Pharmacy Benefits Manager	Magellan Health Services		
Dental Benefits Manager	DentaQuest		

"Flat File" Option. Since January 1, 2014, the Federally-Facilitated Marketplace (FFM) has been conducting eligibility determinations for the Modified Adjusted Gross Income (MAGI) categories of Medicaid in Tennessee. The FFM reports to the State on individuals whom it has found eligible for Medicaid, and the State enrolls those individuals for whom the FFM reports complete and accurate eligibility information. For several months now, the federal government has been transmitting applicant information to the states through a mechanism called "Account Transfers (ATs)" which are intended to provide prompt information. The AT transmissions from the FFM to states were not ready to be implemented by January 1, 2014, so the federal government offered the State the opportunity to use AT flat files, which are static, periodic data transmittals, to enroll persons whom the FFM has determined to be eligible. Tennessee has accepted this option, and received approval to implement a "flat file option" to be able to use data from the flat files to enroll persons who were determined by the FFM to be eligible for TennCare in a MAGI-based category.

Extension of the Eligibility Renewal Process. In 2013 CMS sent out a letter (SHO #13-003) offering certain options to State Medicaid agencies in order for them to implement targeted enrollment strategies to facilitate Medicaid and CHIP enrollment and renewal in 2014. Five specific strategies were proposed and discussed in detail.

By far the most popular strategy among states has been Strategy 2, "Delayed Renewals and Date of Completion." Implementation of this strategy would relieve the State from having to operate two sets of eligibility rules during a period of time and would, instead, allow the State to process renewals on an alternative schedule. As of March 5, 2014, 35 states had received approval to implement this strategy, with more requests pending. TennCare has elected to pursue Strategy 2 and is awaiting approval.

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

- Continuing, through June 30, 2015, to offer new enrollment in the At Risk Demonstration Eligibility Category. Without approval by CMS of the changes proposed in Amendment 20, this category would have been closed to new enrollment on

[3] TennCare Select is operated by Volunteer State Health Plan, Inc. (VSHP).

December 31, 2013. To be eligible in this category, individuals must be adults (1) who are financially eligible for Long-Term Services and Supports (LTSS), (2) who meet the Level of Care criteria for LTSS that existed in Tennessee on June 30, 2012, but not the criteria that went into effect on July 1, 2012, and (3) who are at risk for institutionalization in the absence of Home and Community Based Services (HCBS) that are available to them through the CHOICES Program;

- Expanding the State's Essential Access Hospital (EAH) Pool to address the fact that Tennessee is now the only state in the country without a Disproportionate Share Hospital (DSH) allotment specified in federal statute. Under Amendment 20, funds previously associated with DSH payments in Tennessee would be added to the EAH Pool; and

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

Following CMS's approval on December 30, 2013, of the component of Amendment 20 concerning the At Risk Demonstration Eligibility Category, negotiations on the components pertaining to the EAH Pool and the PHSP Pool were conducted throughout the January-March 2014 quarter. CMS issued written approval of the remaining provisions of Amendment 20 on March 28, 2014.

Possible Changes to TennCare Benefits ("Demonstration Amendment 21"). On January 27, 2014, TennCare submitted Demonstration Amendment 21 to CMS. Amendment 21 repeats several changes proposed in each of the last four years that were made unnecessary each time by the Tennessee General Assembly's passage or renewal of a one-year hospital assessment fee. Changes to the TennCare benefit package for adults that would be necessary if the fee were not renewed in 2014 are as follows:

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

As of the end of the January-March 2014 quarter, negotiations between the State and CMS on Amendment 21 had been postponed until the General Assembly reached a decision about whether to extend the fee for State Fiscal Year 2014-2015.

Cost Sharing Compliance Plan. In its April 18, 2012 letter approving the Bureau's cost sharing compliance plan for the TennCare Standard population, CMS stipulated that "each Quarterly Report . . . must include a report on whether any families have contacted the State to document having reached their aggregate cap, and how these situations were resolved." During the January-March 2014 quarter, the Bureau received no notifications that a family with members enrolled in TennCare Standard had met its cost sharing limit.

III. Innovative Activities to Assure Access

Early 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 (DOH) to conduct a community outreach program for the purpose of educating families on EPSDT benefits and encouraging them to use those benefits, particularly preventive exams.

Table 4 summarizes the community outreach activity during this quarter and the previous two quarters. 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. DOH's communications strategy for each is based on an evaluation of past successes and current opportunities. During the 2013 round of Dental Health Month, for instance, DOH 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 DOH'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, DOH'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
Department of Health
Community Outreach Activity for EPSDT
January – March 2014 Compared to the Previous Two Quarters

Activities	Jul – Sept 2013	Oct – Dec 2013	Jan – Mar 2014
Number of outreach activities/events	3,967	4,663	3,096
Number of people made contact with (mostly face to face at outreach events)	190,429	158,790	123,317
Number of educational materials distributed	209,598	190,540	139,549
Number of coalitions/advisory board meetings attended or conducted	91	54	53

Activities	Jul – Sept 2013	Oct – Dec 2013	Jan – Mar 2014
Number of attendees at coalitions/advisory board meetings	610	801	824
Number of educational preventive health radio/TV broadcasts	9,075	16,367	11,362
Number of educational preventive health newsletter/magazine articles	120	141	117
Number of educational preventive health billboards, scrolling billboards and bulletin boards	16,858	51,142	57,634
Number of presentations made to enrollees/professional staff who work with enrollees	221	222	139
Number of individuals attending presentations	5,457	8,505	7,096
Number of attempted telephone calls regarding the importance of immunizations and dental checkups	252	491[4]	403
Number (approx) of completed telephone calls regarding the importance of immunizations and dental checkups	105	260	144
Number of attempted home visits (educational materials left with these families)	17,039	16,259	16,626
Number of home visits completed	8,848	7,888	8,763

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

Table 5
Department of Health
TENNderCare Call Center Activity
January – March 2014 Compared to the
Previous Two Quarters

Activities	Jul – Sept 2013	Oct – Dec 2013	Jan – Mar 2014
Number of families reached	49,490	42,869	41,470
Number of families who were assisted in	3,803	2,518	2,219

[4] October-December 2013 was the first quarter in several years in which DOH TENNderCare Community Outreach staff did not make immunization-related calls on behalf of the Women, Infants, and Children (WIC) program. Ongoing logistical difficulties in coordinating the effort statewide finally prompted a decision to discontinue the initiative. Nevertheless, outreach staff still promote immunizations in all of their other activities.

Activities	Jul – Sept 2013	Oct – Dec 2013	Jan – Mar 2014
scheduling an EPSDT exam for their children			
Number of families who were assisted in arranging for transportation	145	169[5]	53

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 2014 Quarter, and Percentage that Passed Systems Edits, Compared to the Previous Two Quarters

	Jul – Sept 2013	Oct – Dec 2013	Jan – Mar 2014
No. of encounters received by TennCare (initial submission)	7,964,941	11,854,350[6]	14,755,963[7]
No. of encounters rejected by Edifecs upon initial submission	90,108	21,434	19,323
Percentage of encounters that were compliant with State standards (including HIPAA) upon initial submission	98.87%	99.82%	99.87%

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

A. CHOICES

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

[5] The previous Quarterly Progress Report identified this total as 40, which accounted for only one month of the October-December 2013 quarter.
[6] The number of encounters received during the October-December 2013 quarter was larger than totals reported for previous quarters because pharmacy encounters were included for the first time.
[7] Encounter totals grew during the January-March 2014 quarter as the result of Magellan Health Services' reprocessing of claims pertaining to certain generic drugs.

Table 7
TennCare CHOICES Enrollment and Reserve Slots
for January – March 2014 Compared to the Previous Two Quarters

	Statewide Enrollment Targets and Reserve Capacity[8]	Enrollment and Reserve Slots Being Held as of the End of Each Quarter		
		Jul – Sept 2013	Oct – Dec 2013	Jan – Mar 2014
CHOICES 1	Not applicable	19,115	18,969	18,462
CHOICES 2	12,500	9,388	9,164	8,802
Interim CHOICES 3	Not applicable	3,572	4,018	4,014
Total CHOICES	Not applicable	32,075	32,151	31,278
Reserve capacity	300	300	300	300

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

Data and trends of the designated CHOICES data elements: STC 43.d. requires the State to submit to CMS periodic statistical reports about the use of LTSS by TennCare enrollees. Five separate reports—from August 2011, June 2012, September 2012, June 2013, and November 2013[9]—had been submitted by the conclusion of the January-March 2014 quarter.

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

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

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

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

During the period from January 1, 2014, through March 31, 2014, NF PreAdmission Evaluations were approved for 97 individuals with acuity scores lower than 9, and 68 of these individuals were subsequently enrolled in CHOICES 1. Reasons that the remaining individuals were approved for—but not yet enrolled in—CHOICES 1 include:

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

In the same reporting period, HCBS PreAdmission Evaluations were approved for 18 individuals with acuity scores lower than 9, and 14 of the individuals were subsequently enrolled in CHOICES Group 2. The remaining individuals did not meet Medicaid financial eligibility requirements or otherwise failed to qualify for, or proceed with, enrollment in CHOICES 2.

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

Table 9
TennCare CHOICES Transition Allowances
for January – March 2014 Compared to the Previous Two Quarters

	Frequency and Use of Transition Allowances					
	Jul – Sept 2013		Oct – Dec 2013		Jan – Mar 2014	
Grand Region	# Distributed	Total Amount	# Distributed	Total Amount	# Distributed	Total Amount
East	13	$12,340	11	$14,820	4	$2,555
Middle	4	$2,874	2	$2,945	1	$45
West	8	$8,353	13	$15,734	6	$9,036
Statewide Total	25	$23,567	26	$33,499	11	$11,636

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

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

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

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

pay requirements, only the TennCare Bureau can assess applicable liquidated damages against these entities.

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

During this quarter, the MCOs submitted their 2013 National Association of Insurance Commissioners (NAIC) Annual Financial Statements. As of December 31, 2013, TennCare MCOs reported net worth as indicated in the table below.[10]

Table 10
Net Worth Reported by MCOs as of December 31, 2013

	Net Worth Requirement	Reported Net Worth	Excess/ (Deficiency)
Amerigroup Tennessee	$17,550,992	$108,075,136	$90,524,144
UnitedHealthcare Plan of the River Valley (UnitedHealthcare Community Plan)	$64,885,278	$513,401,130	$448,515,852
Volunteer State Health Plan (BlueCare & TennCare Select)	$34,942,038	$256,869,320	$221,927,282

All TennCare MCOs met their minimum net worth requirements as of December 31, 2013.

C. Managed Care Organization (MCO) Contracts

After issuing a Request for Proposals (RFP) for three MCOs to furnish managed care services to the TennCare population, the Bureau announced on December 16, 2013, that successful bids had been submitted by Amerigroup, BlueCare, and UnitedHealthcare, the companies already comprising TennCare's managed care network. The new contracts, which became effective on January 1, 2014, require delivery of physical health services, behavioral health services, and LTSS in all three of Tennessee's grand regions. Each of the previous contracts, by contrast, was limited to only one grand region.[11]

During the January-March 2014 quarter, TennCare began work with each contractor to ensure a seamless transition to the statewide service delivery model scheduled for implementation on

[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. Amerigroup, for instance, operates a Medicare Advantage Plan in Middle Tennessee, while UnitedHealthcare has several lines of business in Illinois, Iowa, Virginia, and Tennessee. Volunteer State Health Plan, by contrast, operates solely on TennCare's behalf.

[11] Under the previous arrangement, a single entity could hold more than one contract. BlueCare, for instance, had managed care contracts in East and West Tennessee. Amerigroup, by contrast, held a managed care contract only in Middle Tennessee.

January 1, 2015. Although a phased-in approach had originally been envisioned (with implementation in Middle Tennessee on January 1, 2015, and in East and West Tennessee later that calendar year), the MCOs' level of preparedness indicated that delivery of services could begin in all three grand regions simultaneously. In addition, the Bureau and the MCOs are coordinating their efforts to minimize the impact of the transition on enrollees: preliminary estimates are that only one-third of the enrollee population will be reassigned from one health plan to another.

D. Commitment Award from the Tennessee Center for Performance Excellence

On February 19, 2014, TennCare Director Darin Gordon attended the Excellence in Tennessee Awards Banquet hosted by the Tennessee Center for Performance Excellence (TNCPE). During the event, Director Gordon accepted TNCPE's "Commitment Award," which recognizes organizations that are "beginning to demonstrate serious commitment to, and implementation of, performance improvement principles." The award was the culmination of a cycle in which TennCare examined its principles, processes, and achievements; summarized them in a 20-page application to TNCPE; and hosted a day-long site visit for a team of examiners who offered the Bureau feedback on its operations.

TNCPE is a nonprofit organization whose stated mission is "to drive organizational excellence in Tennessee."[12] Since 1993, TNCPE has reviewed applications from more than 1,200 organizations across the state, including such government agencies as the Tennessee Department of Health, the Tennessee Department of Environment and Conservation, and the City of Germantown. The support of former Tennessee Governor Ned McWherter was an essential element to the formation of both TNCPE and TennCare in the early 1990s.

Additional information about TennCare's receipt of the Commitment Award is available at http://news.tn.gov/node/11758. TNCPE's website is located at https://www.tncpe.org/index.php.

E. Electronic Health Record Incentive Program

The Electronic Health Record (EHR) Incentive Program is a partnership between federal and state governments that grew out of the Health Information Technology for Economic and Clinical Health (HITECH) Act. The purpose of the program, as its name suggests, is to provide financial incentives to Medicaid providers[13] 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

[12] See TNCPE's "What We Do" page, located online at https://www.tncpe.org/what_we_do/index.php.

[13] 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).

percent of the funding for the incentive payments and 90 percent of the program's administrative costs.

Currently, Medicaid providers may qualify for three types of payments:

- First-year payments to providers who either adopt, implement, or upgrade to certified EHR technology capable of meeting "meaningful use" (i.e., use that is measurable in both quantity and quality) standards, or who 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 subsequently achieved meaningful use of certified EHR technology for any period of 90 consecutive days;
- Third-year payments to providers who continue to demonstrate meaningful use of certified EHR technology.

EHR payments made by TennCare during the January-March 2014 quarter as compared with payments made throughout the life of the program appear in the table below:

Table 11
EHR Payments
Quarterly and Cumulative

Payment Type	No. of Providers Paid During the Quarter	Quarterly Amount Paid (Jan-Mar 2014)	Cumulative Amount Paid To Date
First-year payments	125 providers[14] (54 nurse practitioners, 50 physicians, 13 dentists, 7 certified nurse midwives, and 1 physician assistant)	$2,656,250	$135,125,690[15]
Second-year payments	185 providers (112 physicians, 56 nurse practitioners, and 17 hospitals)	$8,815,266	$36,008,454
Third-year payments	60 providers (44 physicians, 14 nurse practitioners, 1 certified nurse midwife,	$704,531	$704,531

[14] Of the 125 providers receiving first-year payments in the January-March 2014 quarter, 4 earned their incentives by successfully attesting to meaningful use of EHR technology in their first year of participation in the program.

[15] TennCare's previous Quarterly Progress Report identified the cumulative total of first-year EHR payments as $132,790,952. This total was subsequently revised to $132,469,440 based on corrections made by Maximus, the company with which TennCare contracts to maintain its Provider Incentive Payment Program system.

Payment Type	No. of Providers Paid During the Quarter	Quarterly Amount Paid (Jan-Mar 2014)	Cumulative Amount Paid To Date
	and 1 hospital)		

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

- Participation throughout the quarter in five Southeast Regional Collaboration for HIT/HIE (SERCH) calls, in which government officials from 11 states pool knowledge and resources to address areas of common concern within the field of Health Information Technology;
- Telephone assistance throughout the quarter for eligible professionals attesting to Meaningful Use;
- Hosting a Meaningful Use webinar on January 27;
- Attending a demonstration on March 11 of the Immunization Registry electronic transmissions system at Vanderbilt University Medical Center, an application that allows Vanderbilt clinics to exchange information related to routine immunizations with the Tennessee Department of Health;
- Conducting a conference call on March 12 to aid a children's hospital with Meaningful Use attestation;
- Meeting with tnREC (Tennessee's regional extension center for health information technology) on March 27 to improve alignment between the information that providers include in their attestations and the requirements of the EHR program;
- 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.

Several projects are being planned for—or are culminating in—the upcoming months. Workshops for providers throughout the state, for instance, are being arranged for the April-June 2014 quarter. In addition, TennCare will submit an annual report of EHR incentive activity to CMS by the conclusion of April, the same month in which a semi-automated tool for evaluating Stage 2 Meaningful Use attestations is expected to be finalized.

VI. Action Plans for Addressing Any Issues Identified

There were no action plans developed this quarter to address identified problems.

VII. Financial/Budget Neutrality Development Issues

Total state and local revenue collections were higher in both January and March 2014 than they had been during the corresponding months of the preceding year, with the three percent increase achieved in March 2014 especially remarkable.[16] The unemployment rate fell every month, starting at 7.2 percent in January and declining to 6.9 percent in February and again to 6.7 percent in March.[17] Tennessee's jobless rate fell to the level of the national rate in March 2014, which was the first time the state had matched the nation in this respect since April 2012.[18]

VIII. Member Month Reporting

Member month reporting by eligibility group for each month in the quarter is usually presented in the Quarterly Report as Tables 12 and 13. Tables 12 and 13 for the January-March 2014 quarter, however, will be submitted to CMS under separate cover.

IX. Consumer Issues

Eligibility Appeals. On December 10, 2013, TennCare submitted a State Plan Amendment to CMS (effective date October 1, 2013) in which the State delegated authority to the Federally-Facilitated Marketplace (FFM) to make MAGI-based eligibility determinations for TennCare. At the same time, the State also delegated authority to the Office of Marketplace Eligibility Appeals (OMEA) to conduct fair hearings for groups of individuals whose eligibility is determined by the FFM based on MAGI methodology.

It is currently the responsibility of OMEA to handle all MAGI-related eligibility appeals for TennCare. TennCare has communicated to CMS that it has processes in place to conduct fair hearings, in the event an applicant who is determined ineligible by the FFM requests to have his hearing conducted by the State Medicaid agency instead of OMEA. The State cannot, however, process appeals without the underlying information on which the FFM's denial was based, and, to date, neither the FFM nor OMEA has been able to transmit that information to the State. Therefore, as communicated to the FFM by letter dated March 7, 2014, the State is currently sending all MAGI-based appeals it receives to the FFM to process.

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

[17] 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.

[18] The U.S. Department of Labor's Bureau of Labor Statistics furnishes national and state employment data on its website, located at http://www.bls.gov/home.htm.

Eligibility appeals concerning non-MAGI eligibility categories continued to be processed by the Tennessee Department of Human Services during this quarter. Table 14 presents a summary of the number and types of eligibility appeals handled during the quarter, compared to the previous two quarters.

Table 14
Eligibility Appeals Handled by the Department of Human Services
During the January – March 2014 Quarter, Compared to the Previous Two Quarters

	Jul – Sept 2013	Oct – Dec 2013	Jan – Mar 2014
TennCare Medicaid			
No. of appeals received	3,582	3,222	1,466
No. of appeals resolved or withdrawn	1,525	1,568	1,084
No. of appeals taken to hearing	1,774	1,718	623
No. of appeals that did not involve a valid factual dispute	1,201	955	718
Appeals previously heard that were decided in the State's favor	1,225	1,064	594
Appeals previously heard that were decided in the appellant's favor	116	179	124
TennCare Standard			
No. of appeals received	125	106	11
No. of appeals resolved or withdrawn	27	33	10
No. of appeals taken to hearing	56	74	28
No. of appeals that did not involve a valid factual dispute	31	25	19
Appeals previously heard that were decided in the State's favor	32	48	23
Appeals previously heard that were decided in the appellant's favor	4	5	2

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

Table 15
Medical Service Appeals Handled by the Bureau of TennCare
During the January – March 2014 Quarter, Compared to the Previous Two Quarters

	Jul – Sept 2013	Oct – Dec 2013	Jan – Mar 2014
No. of appeals received	880	924	901

	Jul – Sept 2013	Oct – Dec 2013	Jan – Mar 2014
No. of appeals resolved	771	961	829
• Resolved at the MCC level	195	301	274
• Resolved at the TSU level	93	115	108
• Resolved at the LSU level	483	545	447
No. of appeals that did not involve a valid factual dispute	531	275	227
No. of directives issued	148	178	163
No. of appeals taken to hearing	483	545	447
No. of appeals that were withdrawn by the enrollee at or prior to the hearing	165	172	157
Appeals that went to hearing and were decided in the State's favor	144	170	123
Appeals that went to hearing and were decided in the appellant's favor	16	17	22

By way of explanation:

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

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

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

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

Table 16
Long-Term Services and Supports Appeals for January – March 2014
Compared to the Previous Two Quarters

	Jul – Sept 2013	Oct – Dec 2013	Jan – Mar 2014
No. of appeals of PreAdmission Evaluation (PAE) denials	402	447	326
No. of appeals of PASRR determinations	3	3	5
No. of appeals of denial for enrollment into CHOICES	12	7	8
No. of appeals of involuntary disenrollment from CHOICES	4	4	5
No. of appeals of denial of Consumer Direction	1	0	1
No. of appeals of involuntary withdrawal of Consumer Direction	0	0	0
No. of appeals of involuntary disenrollment from an HCBS waiver for individuals with intellectual disabilities	0	0	0
No. of appeals resolved in appellant's favor prior to hearing	124	143	156
No. of appeals withdrawn prior to hearing	7	9	27
No. of appeals dismissed at hearing	34	55	86
No. of appeals continued at hearing	9	33	5
No. of appeals that went to hearing and were decided in the State's favor	21	36	50
No. of appeals that went to hearing and were decided in the appellant's favor	7	4	10

X. Quality Assurance/Monitoring Activity

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

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

- targets a much larger portion of the TennCare population;

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

The transition of DM members to PH began on January 1, 2013. Full implementation of the program—meaning assignment of members to one of three levels of health risk and one of seven programs for reducing risk—was completed on July 1, 2013. Information on the risk levels addressed by PH, the manner in which these risks are addressed, and the total number of unique members enrolled in PH at the conclusion of the October-December 2013 quarter is provided in Table 17. Data for the period of January through March 2014 will be provided in the next Quarterly Progress Report.

Table 17
Population Health Data*, October – December 2013

Risk Level	Intervention Type	Intervention Goal(s)	Number of Unique Members at End of Quarter
Level 0: no identified risk	Wellness Program	Keep members healthy as long as possible	621,365
Level 1: low or moderate risk	Maternity Program	Engage pregnant women in timely prenatal care and deliver a healthy, term infant without complications	10,705
	Health Risk Management	Prevent, reduce, or delay exacerbation and complications of a condition or health risk behavior	491,395
	Care Coordination	Assure that members receive the services they need to reduce the risk of an adverse health outcome	12,816
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	5,640
	High Risk Pregnancy Management	Engage pregnant women in timely prenatal care and deliver a healthy, term infant without complications	4,225
	Complex Case Management	Move members to optimal levels of health and well-being through timely coordination of quality services and self-management support	2,522

Risk Level	Intervention Type	Intervention Goal(s)	Number of Unique Members at End of Quarter
Total PH Enrollment			**1,148,668**

*** 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 2014, TennCare's External Quality Review Organization (EQRO), Qsource, published the results of its provider data validation survey for the October-December 2013 quarter. Qsource took a sample of provider data files from TennCare's MCOs[19] 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" (98.5 percent accuracy), "provider credentialed specialty / behavioral health service code" (97.0 percent accuracy), "primary care services" (99.0 percent accuracy), and "prenatal care services" (99.7 percent accuracy).

While the results were comparable to the overall scores obtained last quarter and one year ago, to ensure improvement in these and other areas (such as "open/closed to new patients," which demonstrated only 90.7 percent accuracy), TennCare required each of its MCCs to submit a Corrective Action Plan no later than March 5, 2014. The Bureau, in turn, had received, reviewed, and accepted all of the plans by March 10, 2014. Results for the January-March 2014 quarter will be discussed in the next Quarterly Progress Report.

[19] Although the provider data validation survey report usually includes an evaluation of files maintained by TennCare's Dental Benefits Manager, this element was not part of the January 2014 report because of the recent transition from TennDent to DentaQuest. Validation of DentaQuest's data will, however, be part of the next survey.

XI. Demonstration Evaluation

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

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

XII. Essential Access Hospital Pool[20]

A. Safety Net Hospitals

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

B. Children's Hospitals

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

C. Free Standing Psychiatric Hospitals

Pathways of Tennessee
Ridgeview Psychiatric Hospital and Center

D. Other Acute Care Hospitals

Parkridge Medical Center (with Parkridge Valley Psych)
Jackson – Madison County General Hospital
Methodist Healthcare – South
Methodist Healthcare – Memphis Hospitals

[20] 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.

Saint Jude Children's Research Hospital
University Medical Center (with McFarland Psych)
Saint Thomas Midtown Hospital
Centennial Medical Center
Physicians Regional Medical Center
Methodist Healthcare – North
Skyline Medical Center (with Madison campus)
Saint Francis Hospital
Saint Thomas Rutherford Hospital
Parkwest Medical Center (with Peninsula Psych)
Wellmont Holston Valley Medical Center
Maury Regional Hospital
Fort Sanders Regional Medical Center
Skyridge Medical Center
Gateway Medical Center
Cookeville Regional Medical Center
Delta Medical Center
Parkridge East Hospital
Methodist Hospital – Germantown
Blount Memorial Hospital
Wellmont Bristol Regional Medical Center
Baptist Memorial Hospital for Women
Haywood Park Community Hospital
NorthCrest Medical Center
Southern Hills Medical Center
LeConte Medical Center
Horizon Medical Center
Sumner Regional Medical Center
Tennova Healthcare – Newport Medical Center
Rolling Hills Hospital
Takoma Regional Hospital
Methodist Medical Center of Oak Ridge
Heritage Medical Center
Baptist Memorial Hospital – Tipton
StoneCrest Medical Center
Summit Medical Center
Tennova Healthcare – LaFollette Medical Center
Dyersburg Regional Medical Center
Morristown – Hamblen Healthcare System
Henry County Medical Center
Sweetwater Hospital Association
Sycamore Shoals Hospital
Harton Regional Medical Center
Grandview Medical Center

Indian Path Medical Center
Humboldt General Hospital
Regional Hospital of Jackson
Baptist Memorial Hospital – Union City
Lakeway Regional Hospital
Jellico Community Hospital
Wellmont Hawkins County Memorial Hospital
Hardin Medical Center
Crockett Hospital
Athens Regional Medical Center
River Park Hospital
Southern Tennessee Medical Center
Livingston Regional Hospital
Tennova Healthcare – Jefferson Memorial Hospital
Henderson County Community Hospital
McNairy Regional Hospital
Roane Medical Center
Skyridge Medical Center – Westside
Bolivar General Hospital
McKenzie Regional Hospital
Claiborne County Hospital
Hillside Hospital
Volunteer Community Hospital
Gibson General Hospital
United Regional Medical Center
Jamestown Regional Medical Center
Wayne Medical Center
Methodist Healthcare – Fayette
Erlanger Health System – East Campus
DeKalb Community Hospital
Baptist Memorial Hospital – Huntingdon
White County Community Hospital
Emerald Hodgson Hospital

XIII. Graduate Medical Education (GME) Hospitals

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

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

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

XIV. Critical Access Hospitals

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

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Attachment A

Budget Neutrality Calculations for the Quarter

This material will be submitted under separate cover.

Actual TennCare Budget Neutrality (January-March 2014)

I. The Extension of the Baseline

Baseline PMPM

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

Actual Member months of Groups I and II

1-Disabled (can be any ages)	400,163
2-Child <=18	1,943,487
3-Adult >= 65	54
4-Adult <= 64	863,438
Duals (17)	384,762
Total	3,591,904

Ceiling without DSH

	Baseline * MM
1-Disabled (can be any ages)	$624,838,518
2-Child <=18	$910,445,920
3-Adult >= 65	$55,197
4-Adult <= 64	$792,454,762
17s	$251,245,738
Total	**$2,579,040,136**

DSH

DSH Adjustment (Quarterly)	$115,999,213

Total Ceiling

Budget Neutrality Cap	
Total w/DSH Adj.	**$2,695,039,349**

II. Actual Expenditures

Group 1 and 2

1-Disabled (can be any ages)	$ 535,118,559
2-Child <=18	$ 427,969,047
3-Adult >= 65	$ 122,837
4-Adult <= 64	$ 325,564,953

Duals (17)	$	285,273,331
Total		**1,574,048,727**

Group 3

1-Disabled (can be any ages)		
2-Child <=18	$	14,713,240
3-Adult >= 65	$	60,617,734
4-Adult <= 64	$	2,002,358
Duals (17)		
Total		**77,333,332**

Pool Payments and Admin

Total Pool Payments	$	253,367,392

Admin	$	117,212,944

Quarterly Drug Rebates	$	81,733,755.00
Quarterly Premium Collections		
Total Net Quarterly Expenditures	**$**	**1,940,228,641**

III. Surplus/(Deficit)

	$754,810,708
Federal Share	**$492,815,911**

HCI Result	MM201401	MM201402	MM201403	TOTAL	HCI ASO	HCI Rx	HCI DTL	HCI MCO CAP (TCS Admin)	UNK Allocation	TOTAL
EG1-TYPE1 (disabled, type1 state plan eligibles)	133,533	133,042	132,720	399,295	$73,254,565	$98,166,020	$1,293,314	$357,138,665	628,682	$530,880,541
EG1-TYPE2 (disabled, type2 transition group)	0	0	0	-				$0	-	$0
EG2-TYPE1 (over 65, type1 state plan eligibles)	17	18	19	54	$95,633	$4,030	$0	$22,975	145	$122,837
EG2-TYPE2 (over 65, type2 state plan eligibles)	0	0	0	-				$0	-	$0
EG3-TYPE1 (children, type1 state plan eligibles)	642,223	646,729	654,535	1,943,487	$13,100,796	$60,270,324	$24,368,668	$327,778,960	506,812	$427,969,047
Med Exp Child (Title XXI Demo Pop; EG3-Type2)	19,712	19,757	19,706	59,175	$40,415	$3,216,263	$1,007,663	$10,299,213	17,337	$14,640,066
EG4-TYPE1 (adults, type1 State plan eligibles)	278,181	286,917	298,340	863,438	$1,853,140	$48,324,185	$2,123,820	$272,014,828	385,542	$325,564,953
EG4-TYPE2 (adults, type2 demonstration pop)	0	0	0	-				$0	-	$0
EG5-TYPE1 (duals, state plan eligibles)	122,323	122,288	122,438	367,049	$1,028,386	$834,401	$638,932	$232,339,242	278,870	$235,486,880
EG6E-TYPE3 (Expan adult, type3 demonstration pop)	1,113	1,110	1,111	3,334		$461,219	$4,014	$1,531,420	2,371	$2,002,358
EG7E-TYPE3 (Expan child, type3 demonstration pop)	61	62	62	185		$21,682	$4,847	$46,373	87	$73,174
EG8-TYPE2 (emd exp child)	0	0	0	-				$0	-	$0
EG9 H-Disabled (TYPE 2 Eligibles)	308	286	274	868	$3,386	$234,295	$0	$3,994,450	5,019	$4,238,018
EG11H, H-Dual	6,067	5,863	5,783	17,713		$45,554	$9,693	$49,654,533	58,958	$49,786,451
EG12E, Carryovers	5,735	5,761	5,774	17,270	$217	$214,811	$8,062	$60,305,589	71,785	$60,617,734
Total	**1,209,273**	**1,221,833**	**1,240,762**	**3,671,868**	**$89,376,538**	**$211,792,784**	**$29,459,013**	**$1,321,944,874**	**$1,955,609**	**$1,651,382,060**

HCI Result	MM201401	MM201402	MM201403	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)	133,533	133,042	132,720	399,295	$183.46	$245.85	$3.24	$894.42	$1.57	$1,329.54
EG1-TYPE2 (disabled, type2 transition group)	0	0	0	-						
EG2-TYPE1 (over 65, type1 state plan eligibles)	17	18	19	54	$1,770.98	$74.63	$0.00	$425.46	$2.69	$2,274.77
EG2-TYPE2 (over 65, type2 state plan eligibles)	0	0	0	-	-	-	-	-	-	-
EG3-TYPE1 (children, type1 state plan eligibles)	642,223	646,729	654,535	1,943,487	$6.74	$31.01	$12.54	$168.66	$0.26	$220.21
Med Exp Child (Title XXI Demo Pop; EG3-Type2)	19,712	19,757	19,706	59,175	$0.68	$54.35	$17.03	$174.05	$0.29	$247.40
EG4-TYPE1 (adults, type1 State plan eligibles)	278,181	286,917	298,340	863,438	$2.15	$55.97	$2.46	$315.04	$0.45	$377.06
EG4-TYPE2 (adults, type2 demonstration pop)	0	0	0	-						
EG5-TYPE1 (duals, state plan eligibles)	122,323	122,288	122,438	367,049	$2.80	$2.27	$1.74	$632.99	$0.76	$641.57
EG6E-TYPE3 (Expan adult, type3 demonstration pop)	1,113	1,110	1,111	3,334	$0.00	$138.34	$1.20	$459.33	$0.71	$600.59
EG7E-TYPE3 (Expan child, type3 demonstration pop)	61	62	62	185	$0.00	$117.20	$26.20	$250.66	$0.47	$395.53
EG8-TYPE2 (emd exp child)	0	0	0	-						
EG9 H-Disabled (TYPE 2 Eligibles)	308	286	274	868	$3.90	$269.93	$0.00	$4,601.90	$5.78	$4,882.51
EG11H, H-Dual	6,067	5,863	5,783	17,713	$0.00	$2.57	$0.55	$2,803.28	$3.33	$2,810.73
EG12E, Carryovers	5,735	5,761	5,774	17,270	$0.01	$12.44	$0.47	$3,491.93	$4.16	$3,510.00
Total	**1,209,273**	**1,221,833**	**1,240,762**	**3,671,868**	**$24.34**	**$57.68**	**$8.02**	**$360.02**	**$0.53**	**$449.74**

* Unknown allocation was performed within the Service category totals.

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