May 30, 2017

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

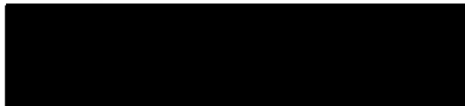
RE: TennCare II, STC 44, Quarterly Progress Report

Dear Ms. Woodard:

Enclosed please find the Quarterly Progress Report for the January – March 2017 quarter. This report is being submitted in accordance with STC 44 of the TennCare Demonstration.

Please let us know if you have comments or questions.

Sincerely,



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

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

TennCare II

Section 1115 Quarterly Report

(For the period January - March 2017)

Demonstration Year: 15 (7/1/16 - 6/30/17)
Federal Fiscal Quarter: 2/2017 (1/17 - 3/17)
Waiver Quarter: 3/2017 (1/17 - 3/17)

I. Introduction

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

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

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

The key dates of approval/operation in this quarter, together with the corresponding Special Terms and Conditions (STCs), if applicable, are presented in Table 1.

Table 1
Key Dates of Approval/Operation in the Quarter

Date	Action	STC #
1/12/17	The State sent CMS a letter accepting the approved extension of the TennCare Demonstration. The letter also outlined technical corrections to be made to the Waiver List, Expenditure Authorities, and STCs that had accompanied CMS's approval.	
1/12/17	The Monthly Call for January was cancelled at CMS's request.	43
2/23/17	The State notified the public of its intent to submit Demonstration Amendment 31 to CMS. Amendment 31 outlined program reductions that would be necessary if the Tennessee General Assembly did not renew the annual hospital assessment fee.	15
2/28/17	The State submitted the Quarterly Progress Report for the October-December 2016 quarter to CMS.	44
3/2/17	The Monthly Call for February (originally scheduled for February 23, 2017) was held.	43
3/22/17	The Monthly Call for March was cancelled at CMS's request.	43

II. Enrollment and Benefits Information

Information about enrollment by category is presented in Table 2.

Table 2
Enrollment Counts for the January – March 2017 Quarter
Compared to the Previous Two Quarters

Demonstration Populations	Total Number of TennCare Enrollees		
	Jul – Sept 2016	Oct – Dec 2016	Jan – Mar 2017
EG1 Disabled, Type 1 State Plan eligibles	146,317	147,754	143,490
EG9 H-Disabled, Type 2 Demonstration Population	242	252	249
EG2 Over 65, Type 1 State Plan eligibles	182	203	294
EG10 H-Over 65, Type 2 Demonstration Population	48	43	45
EG3 Children, Type 1 State Plan eligibles	793,980	801,365	799,933
EG4 Adults, Type 1 State Plan eligibles	477,014	455,487	447,730
EG5 Duals, Type 1 State Plan eligibles and EG11 H-Duals 65, Type 2 Demonstration Population	151,725	153,409	152,740
EG6E Expan Adult, Type 3 Demonstration Population	734	710	521
EG7E Expan Child, Type 3 Demonstration Population	53	45	15
EG8, Med Exp Child, Type 2 Demonstration Population, Optional Targeted Low Income Children funded by Title XIX	0	0	0
Med Exp Child, Title XXI Demonstration Population	18,157	15,356	12,654
EG12E Carryover, Type 3, Demonstration Population	2,624	2,393	2,200
TOTAL*	1,591,076	1,577,017	1,559,871

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

The majority of TennCare's enrollment continues to be categorized as Type 1 EG3 children and Type 1 EG4 adults, with 80 percent of TennCare enrollees appearing in one of these categories.

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

Table 3
TennCare Managed Care Contractors as of March 31, 2017

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

Demonstration Amendment 31: Program Modifications. During the January-March 2017 quarter, the Bureau notified the public of an amendment to the TennCare Demonstration to be submitted to CMS. Amendment 31 outlined program changes that would be needed if the hospital assessment fee were not renewed in 2017. These changes have also been proposed in previous years, but 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 non-exempt adults that would be necessary if the fee were not renewed in 2017 included the following:

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

The Bureau opened its public notice and comment period regarding Amendment 31 on February 23, 2017. By the conclusion of the January-March quarter, two comments had been received, each of which expressed opposition to the elimination of rehabilitative forms of therapy. The Tennessee General Assembly's decision regarding the hospital assessment fee was expected to be reached during the April-June 2017 quarter.

[1] BlueCare is operated by Volunteer State Health Plan, Inc. (VSHP), which is an independent licensee of the BlueCross BlueShield Association and a licensed HMO affiliate of its parent company, BlueCross BlueShield of Tennessee.
[2] UnitedHealthcare Community Plan is operated by UnitedHealthcare Plan of the River Valley, Inc.
[3] TennCare Select is operated by VSHP.

Additional Proposed Modifications to the TennCare Demonstration. On December 16, 2016, CMS approved the State's application to renew the TennCare Demonstration. This approval maintained key aspects of the TennCare program (such as the managed care service delivery system, eligibility categories, and benefits package) while making modifications to others (like the supplemental payment pools for Tennessee hospitals and the manner in which the TennCare Demonstration is evaluated).

CMS's approval letter included revised versions of the materials that govern the TennCare Demonstration, namely the Waiver List, Expenditure Authorities, and Special Terms and Conditions. According to the approval letter, the State had 30 days to acknowledge the approval and accept the new terms under which the TennCare Demonstration would operate. Therefore, on January 12, 2017, TennCare sent CMS written acknowledgement of the approval, as well as a request that technical corrections be made to the Waiver List, Expenditure Authorities, and Special Terms and Conditions. As of the end of the January-March 2017 quarter, CMS was still reviewing the proposed corrections.

Tennessee Eligibility Determination System. Tennessee Eligibility Determination System (or "TEDS") is the name of the system that will be used by the State to process applications and identify persons who are eligible for TennCare and CoverKids (the State's separate CHIP program). Throughout the January-March 2017 quarter, TennCare continued working with systems integrator partner Deloitte Consulting, LLP, initially on defining the State's requirements for TEDS, and subsequently on actual system design.

One feature of TEDS will be its accessibility to a wide variety of users. Entry to the system will occur via various pathways, including—

- An eligibility worker portal that processes applications for all TennCare and CoverKids eligibility categories;
- A self-service member portal that allows applicants to apply online for health coverage, create user accounts to report changes, and view notices sent to them; and
- A partner portal to be used by other State agencies (such as the Tennessee Department of Health) and provider partners to make presumptive eligibility determinations for certain TennCare populations.

As originally conceived, implementation of TEDS was to occur in two phases: one for eligibility determinations based on modified adjusted gross income (or "MAGI"), and one for eligibility determinations not based on MAGI. Given how much progress has been made on the TEDS project to date, however, TennCare and Deloitte decided that the two phases could be consolidated into a single launch, tentatively planned for late 2018.

Cost Sharing Compliance Plan. In its April 18, 2012, letter approving the Bureau of TennCare's cost sharing compliance plan for the TennCare Standard population, CMS stipulated that "each Quarterly Report . . . must include a report on whether any families have contacted the State to document having reached their aggregate cap, and how these situations were

resolved." During the January-March 2017 quarter, the State received no notifications that a family with members enrolled in TennCare Standard had met its cost sharing limit. It should be noted that this is the seventeenth consecutive quarter since the plan was implemented in which no notifications have been received.

III. Innovative Activities to Assure Access

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

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

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

Table 4
Tennessee Department of Health
Community Outreach Activity for EPSDT
January – March 2017 Compared to the Previous Two Quarters

Activities	Jul – Sept 2016	Oct – Dec 2016	Jan – Mar 2017
Number of outreach activities/events	2,736	2,629	2,571
Number of people made contact with (mostly face to face at outreach events)	157,141	179,775	110,497
Number of educational materials distributed	123,675	126,813	85,324
Number of coalitions/advisory board meetings attended or conducted	127	87	192
Number of attendees at coalitions/advisory board meetings	1,805	1,824	2,057
Number of educational preventive health radio/TV broadcasts	738	803	912
Number of educational preventive health newsletter/magazine articles	37	21	20
Number of educational preventive health billboards, scrolling billboards and bulletin boards	3,283	4,161[4]	4,086
Number of presentations made to enrollees/professional staff who work with enrollees	120	108	96
Number of individuals attending presentations	1,871	2,409	1,981
Number of completed telephone calls regarding the importance of dental checkups	130	560	595
Number of home visits completed	243	481	982

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

[4] This figure was erroneously reported as 92 in the previous Quarterly Progress Report.

Table 5
Tennessee Department of Health
TennCare Kids Call Center Activity
January – March 2017 Compared to the
Previous Two Quarters

Activities	Jul – Sept 2016	Oct – Dec 2016	Jan – Mar 2017
Number of enrollees reached	13,449	25,181	31,106
Number of enrollees who were assisted in scheduling an EPSDT exam for their children	539	641	349
Number of enrollees who were assisted in arranging for transportation	40	29	44

IV. Collection and Verification of Encounter and Enrollment Data

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

Table 6
Number of Initial Encounters Received by TennCare During the January-March 2017 Quarter, and Percentage that Passed Systems Edits, Compared to the Previous Two Quarters

	Jul – Sept 2016	Oct – Dec 2016	Jan – Mar 2017
No. of encounters received by TennCare (initial submission)	15,657,014	21,723,287	17,265,976
No. of encounters rejected by Edifecs upon initial submission	35,809	7,123	47,103
Percentage of encounters that were compliant with State standards (including HIPAA) upon initial submission	99.77%	99.97%	99.73%

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

A. CHOICES

As required by STC 31.d., the State offers the following table delineating CHOICES enrollment as of the end of the quarter, as well as information about the number of available reserve slots.

Table 7
CHOICES Enrollment and Reserve Slots
for January – March 2017 Compared to the Previous Two Quarters

	Statewide Enrollment Targets and Reserve Capacity[5]	Enrollment and Reserve Slots Being Held as of the End of Each Quarter		
		Jul – Sept 2016	Oct – Dec 2016	Jan – Mar 2017
CHOICES 1	Not applicable	17,211	17,074	16,783
CHOICES 2	12,500	9,017	9,204	9,115
CHOICES 3 (including Interim CHOICES 3)	To be determined	3,619	3,511	3,391
Total CHOICES	Not applicable	29,847	29,789	29,289
Reserve capacity	300	300	300	300

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

Data and trends of the designated CHOICES data elements: STC 42.d. requires the State to submit to CMS periodic statistical reports about the use of LTSS by TennCare enrollees. Eleven separate reports—spanning the period of August 2011 through September 2016—had been submitted by the conclusion of the January-March 2017 quarter.

Taken together, the reports depict a program evolving according to the characteristics of LTSS recipients, with institutional care available to individuals with the highest acuity of need, and Home and Community-Based Services (HCBS) available to individuals whose needs can be safely and effectively met at home or in other non-institutional settings. Point-in-time data revealed declining use of Nursing Facility (NF) services over time, with placement in institutional settings decreasing from 21,530 individuals on June 30, 2011, to 17,141 individuals on June 30, 2016. According to annual aggregate data contained in the reports, this downward trend was even more pronounced for new LTSS recipients, 81 percent of whom had been admitted to NFs in

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

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

By contrast, appropriate use of HCBS by TennCare enrollees grew significantly during these years. The aggregate number of members accessing HCBS increased from 6,226 in the twelve-month period preceding CHOICES implementation in Middle Tennessee to 16,454 after CHOICES had been in place for five full fiscal years. This trend was mirrored in point-in-time data as well: on the day prior to CHOICES implementation, 4,861 individuals were using HCBS, but the number had grown to 12,654 by June 30, 2016. This information is summarized in Table 8.

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

Annual Aggregate Data			Point-in-Time Data		
No. of TennCare enrollees accessing HCBS (E/D), 3/1/09 – 2/28/10	No. of TennCare enrollees accessing HCBS (E/D), 7/1/14 – 6/30/15	Percent increase over a five-year period	No. of TennCare enrollees accessing HCBS (E/D) on the day prior to CHOICES implementation	No. of TennCare enrollees accessing HCBS (E/D) on 6/30/16	Percent increase from the day prior to CHOICES implementation to 6/30/16
6,226	16,454	164%	4,861[6]	12,654	160%

Frequency and use of MCO-distributed transition allowances (CHOICES approval letter dated February 26, 2010): The allocation of CHOICES transition allowance funds is detailed in Table 9.[7]

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

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

Table 9
CHOICES Transition Allowances
for January – March 2017 Compared to the Previous Two Quarters

	Frequency and Use of Transition Allowances					
	Jul – Sept 2016		Oct – Dec 2016		Jan – Mar 2017	
Grand Region	# Distributed	Total Amount	# Distributed	Total Amount	# Distributed	Total Amount
East	23	$27,295	38	$34,993	14	$8,210
Middle	33	$43,579	39	$37,574	12	$16,432
West	19	$17,788	28	$22,484	12	$14,791
Statewide Total	75	$88,662	105	$95,051	38	$39,433

B. Employment and Community First CHOICES

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

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

Table 10
ECF CHOICES Enrollment, Enrollment Targets, and Reserve Slots
For January – March 2017 Compared to the Previous Quarter

	Statewide Enrollment Targets and Reserve Capacity	Enrollment and Reserve Slots Being Held as of the End of Each Quarter		
		Jul – Sept 2016	Oct – Dec 2016	Jan – Mar 2017
ECF CHOICES 4	500	74	194	333
ECF CHOICES 5	1,000	155	427	689
ECF CHOICES 6	200	11	39	84
Total ECF CHOICES	1,700	240	660	1,106
Reserve capacity	250	223	213	200
Waiver	Not applicable	0	1	1

	Statewide Enrollment Targets and Reserve Capacity	Enrollment and Reserve Slots Being Held as of the End of Each Quarter		
		Jul – Sept 2016	Oct – Dec 2016	Jan – Mar 2017
Transitions[8]				

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

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

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

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

Net Worth and Company Action Level Requirements. According to Tennessee's "Health Maintenance Organization Act of 1986" statute (T.C.A. § 56-32-101 *et seq.*), the minimum net

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

worth requirement for each TennCare MCO is calculated based on premium revenue reported on the National Association of Insurance Commissioners (NAIC) Annual Financial Statement for the most recent calendar year, as well as any TennCare payments made to the MCO that are not reported as premium revenue.

During the January-March 2017 quarter, the MCOs submitted their 2016 NAIC Annual Financial Statements. As of December 31, 2016, TennCare MCOs reported net worth as indicated in the table below.[9]

Table 11
Net Worth Reported by MCOs as of December 31, 2016

	Net Worth Requirement	Reported Net Worth	Excess/ (Deficiency)
Amerigroup Tennessee	$33,420,759	$178,196,525	$144,775,766
UnitedHealthcare Plan of the River Valley (UnitedHealthcare Community Plan)	$57,158,856	$434,309,068	$377,150,212
Volunteer State Health Plan (BlueCare & TennCare Select)	$46,879,872	$420,834,784	$373,954,912

During the January-March 2017 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, 2016:

Table 12
Company Action Level Reported by MCOs as of December 31, 2016

	Company Action Level Requirement	Reported Net Worth	Excess/ (Deficiency)
Amerigroup Tennessee	$122,877,816	$178,196,525	$55,318,709

[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.

	Company Action Level Requirement	Reported Net Worth	Excess/ (Deficiency)
UnitedHealthcare Plan of the River Valley (UnitedHealthcare Community Plan)	$205,480,268	$434,309,068	$228,828,800
Volunteer State Health Plan (BlueCare & TennCare Select)	$148,059,416	$420,834,784	$272,775,368

All TennCare MCOs exceeded their minimum net worth requirements and Company Action Level requirements as of December 31, 2016.

D. Patient-Centered Medical Home Program

The Patient-Centered Medical Home (PCMH) program is one component of the State's strategy for primary care transformation, which assists providers in promoting better quality care, improving population health, and reducing the cost of care. Following much stakeholder input and design work, the PCMH program was launched by TennCare on January 2, 2017.

PCMH is a comprehensive care delivery model designed to improve the quality of primary care services for TennCare members, the capabilities and practice standards of primary care providers, and the overall value of health care delivered to the TennCare population. Participating providers receive training and technical assistance, quarterly reports with actionable data, and access to the state's care coordination tool. These providers are compensated with ongoing financial support and an opportunity for an annual outcome payment based on quality and efficiency performance. As of the launch date, 29 practices were participating in the PCMH program, with additional practices to be added in subsequent years.

E. Enhanced Respiratory Care

Effective January 1, 2017, TennCare adjusted value-based rates of reimbursement for enhanced respiratory care services provided by qualified and contracted nursing facilities (NFs). These adjustments reflect NFs' quality performance between April and September 2016. Since implementing the new, value-based reimbursement approach on July 1, 2016, TennCare has seen a marked increase in ventilator liberation, as was the goal of the quality improvement initiative. All but two facilities have increased their ventilator weaning rates, including the weaning of multiple patients who had been ventilator-dependent for more than 700 days. During the January-March 2017 quarter, TennCare also met with the Tennessee Health Care Association and with Tier 1 enhanced respiratory care providers to ensure agreement on the proposed approach for the initiative as it moves forward.

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 of 2009. 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 funding for administrative costs.

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

- First-year payments (through the 2016 Program Year) to eligible hospitals or practitioners who either—
    - Adopt, implement, or upgrade to certified EHR technology capable of meeting "meaningful use" in accordance with CMS standards, or
    - Achieve meaningful use of certified EHR technology for a period of 90 consecutive days;
- Second-year payments to providers who have received first-year payments and who achieved meaningful use for a subsequent period of 90 consecutive days;
- Third-year, fourth-year, fifth-year, and sixth-year payments to providers who continue to demonstrate meaningful use of certified EHR technology.

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

EHR payments made by TennCare during the January-March 2017 quarter as compared with payments made throughout the life of the program appear in the table below:

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

Table 13
EHR Payments
Quarterly and Cumulative

Payment Type	No. of Providers Paid During the Quarter	Quarterly Amount Paid (Jan-Mar 2017)	Cumulative Amount Paid To Date
First-year payments	109[11]	$2,651,952	$173,781,369
Second-year payments	89	$828,091	$55,606,567
Third-year payments	39	$1,169,816	$28,729,659
Fourth-year payments	48	$408,000	$3,992,175
Fifth-year payments	53	$450,500	$1,402,500
Sixth-year payments	19	$161,500	$161,500

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

- Acceptance of Program Year 2016 attestations from all new and returning providers;
- Holding 36 technical assistance calls;
- Responding to over 400 emails received in the EHR meaningful use mailbox;
- Conducting four onsite visits to physician offices in Memphis;
- Attendance at the Population Health Colloquium;
- Submission to CMS of Tennessee's State Medicaid Health Information Technology Plan (SMHP) Addendum, followed by CMS's approval of the document;
- Updates to TennCare's Provider Incentive Payment Program (or "PIPP") attestation software to enable attestations based on Meaningful Use Stage 3 measures to begin in April 2017;
- A campaign to alert eligible professionals and eligible hospitals that 2016 is the last program year in which they may enroll in the EHR program and begin attesting[12];
- Participation throughout the quarter in several Southeast Regional Collaboration for HIT/HIE (SERCH) calls;
- Newsletters and alerts distributed by the Bureau's EHR ListServ; and
- A quarterly reminder to Tennessee providers who had registered at the federal level but who have not registered or attested at the state level.

TennCare's EHR Incentive Program team continues to work with a variety of provider organizations to maintain the momentum of the program. In the coming months, the focus of outreach efforts will shift from enrolling new providers in the program to bringing back providers who attested to EHR requirements only once.

[11] Of the 109 providers receiving first-year payments in the January-March 2017 quarter, all earned their incentives by successfully attesting to adoption, implementation, or upgrading of EHR technology.
[12] Enrolled providers may continue to attest—and earn payments, if eligible—through Program Year 2021.

G. *Wilson v. Gordon*

Wilson v. Gordon is a class action lawsuit filed against the Bureau of TennCare by the Tennessee Justice Center, the Southern Poverty Law Center, and the National Health Law Program. The suit, which is being heard by the U.S. District Court for the Middle District of Tennessee, alleges federal noncompliance in the Medicaid application and appeals process TennCare has been using since implementation of the Affordable Care Act.

Central to the *Wilson* suit is the issue of whether applications for TennCare coverage are being resolved in a proper and timely manner. In the fall of 2016, the State filed a Motion to Decertify the Class and Dismiss the Case. The basis of the motion was that processes used by TennCare and CMS for Medicaid applications and application appeals in Tennessee had evolved substantially. As a result of this evolution, the Motion contends, there are no remaining members in the Plaintiff class originally certified by the District Court, and any eligibility issues arising in 2016 are completely different from the issues that originally prompted the *Wilson* suit.

As reported in a previous Quarterly Report to the General Assembly, the District Court had reserved ruling on this motion in advance of a bench trial that was scheduled to take place on March 28, 2017. By order of the District Court on March 31, 2017, however, the trial was rescheduled for December 12, 2017. As of the end of the January-March 2017 quarter, oral argument on the State's Motion to Decertify the Class and Dismiss the Case was to be heard on April 27, 2017.

VI. Action Plans for Addressing Any Issues Identified

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

VII. Financial/Budget Neutrality Development Issues

Revenue collections presented mixed news during the January-March 2017 quarter. Total state and local collections were notably higher in the first two months of the year than they had been during the corresponding months of 2016, with a better than nine percent improvement in January 2017 and nearly a four percent improvement in February 2017. Total revenues in March 2017, however, were nearly nine percent lower than those collected in March 2016.[13]

Employment prospects within the state improved each month during the January-March 2017 quarter but lagged behind the performance of the nation as a whole during the same period, as

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

well as the performance of Tennessee during the first quarter of 2016. The state unemployment rate fell from 5.4 percent in January 2017 to 5.3 percent in February 2017 and then again to 5.1 percent in March 2017. The national rate, by contrast, posted marks of 4.8 percent, 4.7 percent, and 4.5 percent in those respective months. Furthermore, throughout the first quarter of 2016, Tennessee's unemployment rate had remained less than 5 percent.[14]

VIII. Member Month Reporting

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

Table 14
Member Month Reporting for Use in Budget Neutrality Calculations
January – March 2017

Eligibility Group	January 2017	February 2017	March 2017	Sum for Quarter Ending 3/31/17
Medicaid eligibles (Type 1)				
EG1 Disabled, Type 1 State Plan eligibles	144,464	142,460	141,006	427,930
EG2 Over 65, Type 1 State Plan eligibles	192	228	273	693
EG3 Children, Type 1 State Plan eligibles	790,559	781,221	760,017	2,331,797
EG4 Adults, Type 1 State Plan eligibles	435,308	430,961	422,667	1,288,936
EG5 Duals, Type 1 State Plan eligibles	143,859	143,211	141,993	429,063
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	221	236	247	704
EG10 H-Over 65, Type 2 Demonstration Population	41	42	44	127

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

Eligibility Group	January 2017	February 2017	March 2017	Sum for Quarter Ending 3/31/17
EG11 H-Duals, Type 2 Demonstration Population	6,065	6,087	6,086	18,238
TOTAL	1,520,709	1,504,446	1,472,333	4,497,488

Table 15
Member Month Reporting Not Used in Budget Neutrality Calculations
January – March 2017

Eligibility Group	January 2017	February 2017	March 2017	Sum for Quarter Ending 3/31/17
EG6E Expan Adult, Type 3, Demonstration Population	524	476	428	1,428
EG7E Expan Child, Type 3, Demonstration Population	15	15	15	45
Med Exp Child, Title XXI Demonstration Population	12,887	11,021	8,434	32,342
EG12E Carryover, Type 3, Demonstration Population	2,269	2,182	2,161	6,612
TOTAL	15,695	13,694	11,038	40,427

IX. Consumer Issues

Eligibility Appeals. TennCare eligibility appeals are handled by the Bureau of TennCare. Table 16 presents a summary of eligibility appeal activity during the quarter, compared to the previous two quarters. It should be noted that appeals (whether related to eligibility, medical services, or LTSS) may be resolved or taken to hearing in a quarter other than the one in which they are initially received by TennCare.

The growing volume of eligibility appeals visible in Table 16 is attributable to three primary factors. First, implementation of Tennessee's approved redetermination plan has increased annual redeterminations of eligibility. Second, TennCare has increased the number of enrollees who are selected on a quarterly basis for failure to report a valid Social Security number in at least twelve months. Third, there has been an increase in appeals related to redetermination that are often resolved administratively by remailing redetermination-related notices.

Table 16
Eligibility Appeals for January – March 2017
Compared to the Previous Two Quarters

	Jul – Sept 2016	Oct – Dec 2016	Jan – Mar 2017
No. of appeals received	18,264	23,173	28,586
No. of appeals resolved or withdrawn	9,621	19,920	26,297
No. of appeals taken to hearing	2,759	2,314	2,710
No. of hearings resolved in favor of appellant	263	147	192

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

Table 17
Medical Service Appeals for January – March 2017
Compared to the Previous Two Quarters

	Jul – Sept 2016	Oct – Dec 2016	Jan – Mar 2017
No. of appeals received	2,115	2,293	2,259
No. of appeals resolved	1,993	2,097	2,071
• Resolved at the MCC level	717	763	720
• Resolved at the TSU level	192	186	202
• Resolved at the LSU level	1,084	1,148	1,149
No. of appeals that did not involve a valid factual dispute	158	211	173
No. of directives issued	301	271	304
No. of appeals taken to hearing	1,084	1,148	1,149
No. of appeals that were withdrawn by the enrollee at or prior to the hearing	360	383	420
Appeals that went to hearing and were decided in the State's favor	386	385	399
Appeals that went to hearing and were decided in the appellant's favor	28	25	34

By way of explanation:

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

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

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

LTSS Appeals. The following table provides information regarding certain appeals administered by the Long-Term Services and Supports Division for the quarter (e.g., appeals of PreAdmission Evaluation denials, appeals of PreAdmission Screening and Resident Review determinations, etc.), compared to the previous two quarters.

Table 18
Long-Term Services and Supports Appeals for January – March 2017
Compared to the Previous Two Quarters

	Jul – Sept 2016	Oct – Dec 2016	Jan – Mar 2017
No. of appeals received	210	194	203
No. of appeals resolved or withdrawn	81	89	103
No. of appeals set for hearing	96	116	89
No. of hearings resolved in favor of appellant	3	5	0

X. Quality Assurance/Monitoring Activity

Population Health. “Population Health” (PH) is TennCare’s model of targeted health care interventions. Key benefits of PH include—

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

Enrollees are assigned to one of three levels of health risk and one of seven programs for reducing risk. Information on the risk levels addressed by PH, the manner in which these risks are addressed, and the total number of unique members enrolled in PH at the conclusion of the October-December 2016 quarter is provided in Table 19. Data for the period of January through March 2017 will be provided in the next Quarterly Progress Report.

Table 19
Population Health Data*, October – December 2016

Risk Level	Intervention Type	Intervention Goal(s)	Number of Unique Members at End of Quarter
Level 0: no identified risk	Wellness Program	Keep members healthy as long as possible	704,078
Level 1: low or moderate risk	Maternity Program	Engage pregnant women in timely prenatal care and deliver a healthy, term infant without complications	14,717
	Health Risk Management	Prevent, reduce, or delay exacerbation and complications of a condition or health risk behavior	718,878
	Care Coordination	Assure that members receive the services they need to reduce the risk of an adverse health outcome	20,897
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	5,239
	High Risk Pregnancy Management	Engage pregnant women in timely prenatal care and deliver a healthy, term infant without complications	1,638
	Complex Case Management	Move members to optimal levels of health and well-being through timely coordination of quality services and self-management support	725
Total PH Enrollment			**1,466,172**

*** 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 2017, TennCare's External Quality Review Organization (EQRO), Qsource, published the results of its provider data validation survey for

the October-December 2016 quarter. Qsource took a sample of provider data files from TennCare's MCCs[15] and reviewed each for accuracy in the following categories:

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

The validity of such information is one measure of providers' availability and accessibility to TennCare enrollees. Qsource's report concluded that "[o]verall, the MCCs' accuracy rates have maintained a high level," especially in the categories of "provider credentialed specialty / behavioral health service code" (98.7 percent accuracy), "routine care services" (98.2 percent accuracy), "urgent care services" (98.4 percent accuracy), "primary care services" (99.4 percent accuracy), and "prenatal care services" (99.6 percent accuracy).

Because the MCOs' transition to a statewide service delivery model occurred relatively recently, progress in accuracy rates is currently being measured on a quarter-to-quarter basis. Compared with the period of July-September 2016, the MCCs—according to the report—"have maintained relatively high accuracy rates this quarter." Nonetheless, to ensure ongoing improvement in all ten categories of the survey, TennCare required each of its MCCs to submit a Corrective Action Plan no later than March 5, 2017. The Bureau, in turn, had received, reviewed, and accepted all of the plans by March 9, 2017. Results for the January-March 2017 quarter will be discussed in the next Quarterly Progress Report.

XI. Demonstration Evaluation

On December 22, 2015, the State submitted to CMS its application to renew the TennCare Demonstration, Part VI of which was an Interim Evaluation Report addressing progress in three areas: 1) medical and behavioral health measures; 2) efficiency, stability, and viability measures; and 3) measures for the TennCare CHOICES program.

In addition, on October 18, 2016, the State sent CMS a new version of the strategy to evaluate and improve the quality and accessibility of care offered to enrollees through TennCare's managed care network. The document, titled *2016 Quality Assessment and Performance*

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

Improvement Strategy, incorporates a number of new initiatives, including the ECF CHOICES program. As of the end of the January-March 2017 quarter, CMS's review of the strategy was ongoing.

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

XII. Essential Access Hospital Pool[16]

A. Safety Net Hospitals

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

B. Children's Hospitals

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

C. Free Standing Psychiatric Hospitals

Pathways of Tennessee
Ridgeview Psychiatric Hospital and Center
Rolling Hills Hospital
PremierCare Tennessee, Inc.

D. Other Acute Care Hospitals

Parkridge Medical Center (with Parkridge Valley Psych)
Jackson – Madison County General Hospital

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

TriStar Centennial Medical Center
Methodist Healthcare – Memphis Hospitals
Saint Jude Children's Research Hospital
Methodist Healthcare – South
Parkridge East Hospital
TriStar Skyline Medical Center (with Madison campus)
Parkwest Medical Center (with Peninsula Psych)
Baptist Memorial Hospital – Memphis
Methodist Healthcare – North
University Medical Center (with McFarland Psych)
Saint Francis Hospital
Saint Thomas Rutherford Hospital
Lincoln Medical Center
Baptist Memorial Hospital for Women
Wellmont – Holston Valley Medical Center
Fort Sanders Regional Medical Center
Saint Thomas Midtown Hospital
Wellmont – Bristol Regional Medical Center
Cookeville Regional Medical Center
Maury Regional Hospital
Tennova Healthcare – Newport Medical Center
TriStar StoneCrest Medical Center
Tennova Healthcare
Blount Memorial Hospital
TriStar Horizon Medical Center
TriStar Summit Medical Center
Gateway Medical Center
TriStar Southern Hills Medical Center
Sumner Regional Medical Center
Skyridge Medical Center
TriStar Hendersonville Medical Center
Dyersburg Regional Medical Center
NorthCrest Medical Center
Morristown – Hamblen Healthcare System
LeConte Medical Center
Methodist Medical Center of Oak Ridge
Jellico Community Hospital
Takoma Regional Hospital
Tennova Healthcare – Harton Regional Medical Center
Tennova Healthcare – LaFollette Medical Center
Indian Path Medical Center
Sycamore Shoals Hospital
Starr Regional Medical Center – Athens
Skyridge Medical Center – Westside

Grandview Medical Center – Jasper
Heritage Medical Center
Bolivar General Hospital
Regional Hospital of Jackson
Southern Tennessee Regional Health System – Winchester
Henry County Medical Center
Baptist Memorial Hospital – Union City
Henderson County Community Hospital
Saint Thomas River Park Hospital
Hardin Medical Center
Roane Medical Center
Lakeway Regional Hospital
Southern Tennessee Regional Health System – Lawrenceburg
Hillside Hospital
Claiborne County Hospital
McKenzie Regional Hospital
Erlanger Health System – East Campus
DeKalb Community Hospital
Jamestown Regional Medical Center
Stones River Hospital
Volunteer Community Hospital
Wayne Medical Center
United Regional Medical Center and Medical Center of Manchester
Southern Tennessee Regional Health System – Sewanee

XIII. Graduate Medical Education (GME) Hospitals

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

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

Universities	Hospitals
East Tennessee State University	Mountain State Health Alliance Wellmont ETSU Quillen Mission Hospital Johnson City Medical Center Johnson City Health Center

Universities	Hospitals
	Woodridge Hospital Holston Valley Medical Center Bristol Regional Medical Center
Meharry Medical College	Metro General Meharry Medical Group
University of Tennessee at Memphis	The Regional Medical Center (The MED) Methodist LeBonheur Erlanger Jackson Madison St. Francis
Vanderbilt University	Vanderbilt Hospital

XIV. Critical Access Hospitals

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

State Contact:

Aaron Butler
Director of Policy
Bureau of TennCare
310 Great Circle Road
Nashville, TN 37243
Phone: 615-507-6448

Date Submitted to CMS: May 30, 2017

Attachment A

Budget Neutrality Calculations for the Quarter

Actual TennCare Budget Neutrality (January - March 2017)

I. The Extension of the Baseline

Baseline PMPM

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

Actual Member months of Groups I and II

1-Disabled (can be any ages)	428,634
2-Child <=18	2,331,797
3-Adult >= 65	693
4-Adult <= 64	1,288,936
Duals (17)	447,301
Total	4,050,060

Ceiling without DSH

	Baseline * MM
1-Disabled (can be any ages)	$798,516,571
2-Child <=18	$1,345,850,647
3-Adult >= 65	$823,461
4-Adult <= 64	$1,426,383,231
17s	$346,452,100
Total	**$3,918,026,008**

DSH

DSH Adjustment (Quarterly)	$115,999,213

Total Ceiling

Budget Neutrality Cap	
Total w/DSH Adj.	**$4,034,025,221**

II. Actual Expenditures

Group 1 and 2

1-Disabled (can be any ages)	$ 549,194,253
2-Child <=18	$ 494,805,249
3-Adult >= 65	$ 667,612
4-Adult <= 64	$ 432,652,916

Duals (17)	$	400,429,535
Total		**1,877,749,566**

Group 3

1-Disabled (can be any ages)	$	-
2-Child <=18	$	6,999,638
3-Adult >= 65	$	34,710,447
4-Adult <= 64	$	295,944
Duals (17)	$	-
Total		**42,006,030**

Pool Payments and Admin

Total Pool Payments	$	323,118,625
Admin		156,284,210
Quarterly Drug Rebates		(119,633,976)
Quarterly Premium Collections	$	-
Total Net Quarterly Expenditures	**$**	**2,279,524,455**

III. Surplus/(Deficit)

	$1,754,500,766
Federal Share	**$1,141,039,573**

HCI Result	MM201701	MM201702	MM201703	TOTAL	HCI ASO	HCI Rx	HCI DTL	HCI MCO CAP (TCS Admin)	HCI BHO CAP	State-Only Allocation	UNK Allocation	Taxes	Allocation on Difference	TOTAL
EG1-TYPE1 (disabled, type1 state plan eligibles)	144,464	142,460	141,006	427,930	$76,409,024	$135,411,644	$1,681,705	$328,143,927	$0	$0	2,862,166	$0	$0	$544,508,466
EG1-TYPE2 (disabled, type2 transition group)	0	0	0	0	$0	$0	$0	$0	$0	$0	-	$0	$0	$0
EG2-TYPE1 (over 65, type1 state plan eligibles)	192	228	273	693	$537	$25,810	$0	$637,757	$0	$0	3,509	$0	$0	$667,612
EG2-TYPE2 (over 65, type2 state plan eligibles)	0	0	0	0	$0	$0	$0	$0	$0	$0	-	$0	$0	$0
EG3-TYPE1 (children, type1 state plan eligibles)	790,559	781,221	760,017	2,331,797	$10,128,622	$74,720,535	$35,323,831	$372,031,356	$0	$0	2,600,905	$0	$0	$494,805,249
Med Exp Child (Title XXI Demo Pop; EG3-Type2)	12,887	11,021	8,434	32,342	$187,958	$1,891,842	$631,122	$4,237,351	$0	$0	36,716	$0	$0	$6,984,989
EG4-TYPE1 (adults, type1 State plan eligibles)	435,308	430,961	422,667	1,288,936	$1,698,237	$78,121,601	$2,734,335	$347,842,415	$0	$0	2,256,329	$0	$0	$432,652,916
EG4-TYPE2 (adults, type2 demonstration pop)	0	0	0	0	$0	$0	$0	$0	$0	$0	-	$0	$0	$0
EG5-TYPE1 (duals, state plan eligibles)	143,859	143,211	141,993	429,063	$1,561,586	$1,060,677	$19,364	$319,463,984	$0	$0	1,702,070	$0	$0	$323,807,681
EG6E-TYPE3 (Expan adult, type3 demonstration pop)	524	476	428	1,428	$0	$40,355	$0	$254,034	$0	$0	1,556	$0	$0	$295,944
EG7E-TYPE3 (Expan child, type3 demonstration pop)	15	15	15	45		$3,570	$907	$10,095	$0	$0	77	$0	$0	$14,650
EG8-TYPE2 (med exp child)	0	0	0	0	$0	$0	$0	$0	$0	$0	-	$0	$0	$0
EG9 H-Disabled (TYPE 2 Eligibles)	221	236	247	704	$2,142	$279,289	$0	$4,379,725	$0	$0	24,630	$0	$0	$4,685,787
EG10 H-Senior	41	42	44	127	$0	$15,678	$0	$804,449			4,334			$824,460
EG11H, H-Dual	6,065	6,087	6,086	18,238	$0	$20,026	$0	$76,199,071	$0	$0	402,757	$0	$0	$76,621,854
EG12E, Carryovers	2,269	2,182	2,161	6,612	$0	$123,603	$0	$33,584,265	$0	$0	178,119	$0	$0	$33,885,987
Total	**1,536,404**	**1,518,140**	**1,483,371**	**4,537,915**	**$89,988,106**	**$291,714,631**	**$40,391,264**	**$1,487,588,429**	**$0**	**$0**	**$10,073,167**	**$0**	**$0**	**$1,919,755,596**

HCI Result	MM201701	MM201702	MM201703	TOTAL	HCI ASO PMPM	HCI Rx PMPM	HCI DTL PMPM	HCI MCO CAP (TCS Admin)	HCI BHO CAP	State-Only Allocation	UNK Allocation	Taxes	on Difference	TOTAL
EG1-TYPE1 (disabled, type1 state plan eligibles)	144,464	142,460	141,006	427,930	$178.55	$316.43	$3.93	$766.82	$0.00	$0.00	$6.69	$0.00	$0.00	$1,272.42
EG1-TYPE2 (disabled, type2 transition group)	0	0	0	-										
EG2-TYPE1 (over 65, type1 state plan eligibles)	192	228	273	693	$0.77	$37.24	$0.00	$920.28	$0.00	$0.00	$5.06	$0.00	$0.00	$963.37
EG2-TYPE2 (over 65, type2 state plan eligibles)	0	0	0	-	-	-	-	-	-	-	-	-	-	-
EG3-TYPE1 (children, type1 state plan eligibles)	790,559	781,221	760,017	2,331,797	$4.34	$32.04	$15.15	$159.55	$0.00	$0.00	$1.12	$0.00	$0.00	$212.20
Med Exp Child (Title XXI Demo Pop; EG3-Type2)	12,887	11,021	8,434	32,342	$5.81	$58.49	$19.51	$131.02	$0.00	$0.00	$1.14	$0.00	$0.00	$215.97
EG4-TYPE1 (adults, type1 State plan eligibles)	435,308	430,961	422,667	1,288,936	$1.32	$60.61	$2.12	$269.87	$0.00	$0.00	$1.75	$0.00	$0.00	$335.67
EG4-TYPE2 (adults, type2 demonstration pop)	0	0	0	-										
EG5-TYPE1 (duals, state plan eligibles)	143,859	143,211	141,993	429,063	$3.64	$2.47	$0.05	$744.56	$0.00	$0.00	$3.97	$0.00	$0.00	$754.69
EG6E-TYPE3 (Expan adult, type3 demonstration pop)	524	476	428	1,428	$0.00	$28.26	$0.00	$177.89	$0.00	$0.00	$1.09	$0.00	$0.00	$207.24
EG7E-TYPE3 (Expan child, type3 demonstration pop)	15	15	15	45	$0.00	$79.34	$20.15	$224.34	$0.00	$0.00	$1.71	$0.00	$0.00	$325.55
EG8-TYPE2 (emd exp child)	0	0	0	-										
EG9 H-Disabled (TYPE 2 Eligibles)	221	236	247	704	$3.04	$396.72	$0.00	$6,221.20	$0.00	$0.00	$34.99	$0.00	$0.00	$6,655.95
EG10 H-Senior	41	42	44	127	$0.00	$123.45	$0.00	$6,334.24	$0.00	$0.00	$34.12			
EG11H, H-Dual	6,065	6,087	6,086	18,238	$0.00	$1.10	$0.00	$4,178.04	$0.00	$0.00	$22.08	$0.00	$0.00	$4,201.22
EG12E, Carryovers	2,269	2,182	2,161	6,612	$0.00	$18.69	$0.00	$5,079.29	$0.00	$0.00	$26.94	$0.00	$0.00	$5,124.92
Total	**1,536,404**	**1,518,140**	**1,483,371**	**4,537,915**	**$19.83**	**$64.28**	**$8.90**	**$327.81**	**$0.00**	**$0.00**	**$2.22**	**$0.00**	**$0.00**	**$423.05**

* Unknown allocation was performed within the Service category totals.

	alloated payment in unknown in each EG Group			payment in blank category in each subject
28.51%	2,872,166	MEDICAL	$	478,190
0.00%	-	PHARMACY	$	948,813
0.03%	3,522	DENTAL	$	80,884
0.00%	-	CAP	$	8,565,280
25.91%	2,609,992			
0.37%	36,844	**TOTAL**	**$**	**10,073,167**
22.66%	2,282,152			
0.00%	-			
16.96%	1,708,016			
0.02%	1,561			
0.00%	77			
0.00%	-			
0.25%	24,717			
0.04%	4,349			
4.01%	404,164			
1.77%	178,741			
	10,126,301			

$1,909,682,429

(Used to calculate approximate percentages for each EG group -- O18 = Q18+S18)

Enrollment changes	Cumulative Total	AVG. Enrollment
SFY2017Q1	4,655,221	1,551,740.33
SFY2017Q2	4,537,915	1,512,638.33
% Changes in Total:	-2.52%	-2.52%

CAP PMPM changes:	CAP PMPM	Total CAP in QTR	Payment changes from current QTR to previous QTR
SFY2017Q1	$319.31	$ 1,488,567,809	
SFY2017Q2	$327.81	$ 1,496,153,708	$ 7,585,899
	2.66%	0.51%	