TN Division of TennCare

November 29, 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 July – September 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,

[redacted]

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

cc: Trina D. Roberts, Acting Associate Regional Administrator, Atlanta Regional Office
Kenni Howard, Tennessee Coordinator, Atlanta Regional Office

TennCare II

Section 1115 Quarterly Report

(For the period July - September 2017)

Demonstration Year: 16 (7/1/17 - 6/30/18)
Federal Fiscal Quarter: 4/2017 (7/17 - 9/17)
Waiver Quarter: 1/2018 (7/17 - 9/17)

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 Division of TennCare contracts with several Managed Care Contractors (MCCs) to provide services to more than 1.4 million enrollees. During this quarter, these entities included Managed Care Organizations (MCOs) for medical services, behavioral health 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 #
7/1/17	Updated enrollment targets for CHOICES Group 2 and for all Employment and Community First CHOICES benefit groups went into effect. (The targets are identified in Section V of this report under the headings of "CHOICES" and "Employment and Community First CHOICES".)	31.d.ii and 32.d.ii
7/6/17	The State submitted to CMS a proposed technical change to Attachment C of the TennCare Demonstration. The proposal would modify the limitations on private duty nursing services.	
7/24/17	The Monthly Call for July was cancelled.	43
7/28/17	The State notified the public of its intent to submit to CMS Amendment 32 to the TennCare Demonstration. The proposal would establish a two-year pilot project in which certain TennCare enrollees receive a medication therapy management benefit in addition to the traditional TennCare benefits package.	15
8/22/17	The Monthly Call for August was cancelled.	43
8/25/17	CMS approved Statewide MCO Contract Amendment 6 for BlueCare and United Healthcare, and TennCare Select Contract Amendment 41.	39
8/29/17	The State submitted the Quarterly Progress Report for the April-June 2017 quarter to CMS.	44

Date	Action	STC #
9/1/17	In reference to the proposed technical change to Attachment C of the TennCare Demonstration (regarding limitations on private duty nursing services), the State submitted to CMS an updated budget neutrality workbook illustrating the fiscal impact of the proposal.	
9/6/17	The State submitted to CMS Amendment 32 to the TennCare Demonstration.	
9/19/17	The Monthly Call for September was cancelled.	43
9/21/17	CMS sent the State a letter indicating that the submission of Amendment 32 met the requirements for a complete amendment.	
9/29/17	The State submitted point-in-time and annual aggregate data about the CHOICES program to CMS.	42

II. Enrollment and Benefits Information

Information about enrollment by category is presented in Table 2.

Table 2
Enrollment Counts for the July – September 2017 Quarter
Compared to the Previous Two Quarters

Demonstration Populations	Total Number of TennCare Enrollees		
	Jan – Mar 2017	Apr – Jun 2017	Jul – Sept 2017
EG1 Disabled, Type 1 State Plan eligibles	143,490	141,777	141,551
EG9 H-Disabled, Type 2 Demonstration Population	249	260	273
EG2 Over 65, Type 1 State Plan eligibles	294	353	378
EG10 H-Over 65, Type 2 Demonstration Population	45	87	96
EG3 Children, Type 1 State Plan eligibles	799,933	766,701	755,723
EG4 Adults, Type 1 State Plan eligibles	447,730	432,394	398,220
EG5 Duals, Type 1 State Plan eligibles and EG11 H-Duals 65, Type 2 Demonstration Population	152,740	149,395	145,893
EG6E Expan Adult, Type 3 Demonstration Population	521	364	302

Demonstration Populations	Total Number of TennCare Enrollees		
	Jan – Mar 2017	Apr – Jun 2017	Jul – Sept 2017
EG7E Expan Child, Type 3 Demonstration Population	15	14	17
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	12,654	7,236	5,703
EG12E Carryover, Type 3, Demonstration Population	2,200	2,018	1,886
TOTAL*	1,559,871	1,500,599	1,450,042

*** 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 September 30, 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 32: Medication Therapy Management. On September 6, 2017, the Division of TennCare submitted Demonstration Amendment 32 to CMS. Consistent with legislation passed by the Tennessee General Assembly, Amendment 32 would establish a two-year pilot project in which certain TennCare enrollees receive a medication therapy management (MTM) benefit in addition to the traditional TennCare benefits package. MTM is a clinical service provided by licensed pharmacists, the aim of which is to optimize drug therapy and improve therapeutic outcomes for patients. MTM services include medication therapy

[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.

reviews, pharmacotherapy consults, monitoring efficacy and safety of medication therapy, and other clinical services. Amendment 32 proposes to make MTM available to TennCare members with high levels of clinical need and who are enrolled in the State's health home program, and to members with high levels of clinical need whose primary care providers are participants in the State's patient-centered medical home (PCMH) program. The pilot program would last from January 1, 2018, through December 31, 2019, and received initial funding in the Fiscal Year 2018 budget approved by the Tennessee legislature this year.

Stakeholder engagement and public input processes that informed the design and development of Amendment 32 include—

- A series of Technical Advisory Group meetings held between November 2016 and June 2017 with a focus on operational design (i.e., model, reimbursement, evaluation, and quality metrics);
- A public notice and comment period on Amendment 32 held by TennCare from July 28 through September 1, 2017.

Additional information about the State's proposal may be found on the TennCare website at http://www.tn.gov/assets/entities/tenncare/attachments/ComprehensiveNotice.pdf.

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). During the July-September 2017 quarter, Deloitte Consulting, LLP—TennCare's systems integrator partner—presented formal design documents for review by the State. TennCare approved these materials during the last week of August, and Deloitte subsequently began development of the system. The State's attention has now turned to—

- Finalizing test scripts, which will be used to verify that TEDS performs according to expectations;
- Organizational Change Management, which involves development of training materials and actual training of TennCare staff on use of TEDS; and
- Working on ancillary services, such as the Master Person Index and Access Identity Management.

Implementation of the TEDS system is planned for late 2018.

Cost Sharing Compliance Plan. In its April 18, 2012, letter approving 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 July-September 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 nineteenth 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. TennCare 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
July – September 2017 Compared to the Previous Two Quarters

Activities	Jan – Mar 2017	Apr – Jun 2017	Jul – Sept 2017
Number of outreach activities/events	2,571	2,565	2,348
Number of people made contact with (mostly face to face at outreach events)	110,497	122,884	134,467

Activities	Jan – Mar 2017	Apr – Jun 2017	Jul – Sept 2017
Number of educational materials distributed	85,324	88,999	104,778
Number of coalitions/advisory board meetings attended or conducted	192	75	106
Number of attendees at coalitions/advisory board meetings	2,057	1,361	1,672
Number of educational preventive health radio/TV broadcasts	912	667	613
Number of educational preventive health newsletter/magazine articles	20	8	184
Number of educational preventive health billboards, scrolling billboards and bulletin boards	4,086	4,469	3,292
Number of presentations made to enrollees/professional staff who work with enrollees	96	83	74
Number of individuals attending presentations	1,981	1,168	1,108
Number of completed telephone calls regarding the importance of dental checkups	595	248	8
Number of home visits completed	982	1,393	878

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

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

Activities	Jan – Mar 2017	Apr – Jun 2017	Jul – Sept 2017
Number of enrollees reached	31,106	31,680	31,242
Number of enrollees who were assisted in scheduling an EPSDT exam for their children	349	254	240
Number of enrollees who were assisted in arranging for transportation	44	44	31

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 July-September 2017 Quarter, and Percentage that Passed Systems Edits, Compared to the Previous Two Quarters

	Jan – Mar 2017	Apr – Jun 2017	Jul – Sept 2017
No. of encounters received by TennCare (initial submission)	17,265,976	15,514,575	15,388,873
No. of encounters rejected by Edifecs upon initial submission	47,103	88,261	37,408
Percentage of encounters that were compliant with State standards (including HIPAA) upon initial submission	99.73%	99.43%	99.76%

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 July – September 2017 Compared to the Previous Two Quarters

	Statewide Enrollment Targets and Reserve Capacity[4]	Enrollment and Reserve Slots Being Held as of the End of Each Quarter		
		Jan – Mar 2017	Apr – Jun 2017	Jul – Sept 2017
CHOICES 1	Not applicable	16,783	16,560	16,621
CHOICES 2	10,500	9,115	9,190	9,297
CHOICES 3 (including Interim CHOICES 3)	To be determined	3,391	3,191	3,076
Total CHOICES	Not applicable	29,289	28,941	28,994
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. Thirteen separate reports of data pertaining to the CHOICES program have been submitted between August 2011 and September 2017.

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 16,597 individuals on June 30, 2017. 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 the year prior to implementation of the CHOICES program, as compared with 61 percent admitted to NFs in the sixth 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 15,937 after CHOICES had been in place for six full fiscal years. This trend was mirrored in point-in-time data

[4] Of the three active CHOICES groups, only CHOICES 2 has an enrollment target, which was updated on July 1, 2017. Interim CHOICES 3 closed to new enrollment on June 30, 2015; an enrollment target for CHOICES 3 has not been set at this time.

as well: on the day prior to CHOICES implementation, 4,861 individuals were using HCBS, but the number had grown to 12,381 by June 30, 2017. 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 implementa-tion	No. of TennCare enrollees accessing HCBS (E/D) on 6/30/16	Percent increase from the day prior to CHOICES implementa-tion to 6/30/16
6,226	15,937	156%	4,861[5]	12,381	155%

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
CHOICES Transition Allowances
for July – September 2017 Compared to the Previous Two Quarters

	Frequency and Use of Transition Allowances					
	Jan – Mar 2017		**Apr – Jun 2017**		**Jul – Sept 2017**	
Grand Region	# Distributed	Total Amount	# Distributed	Total Amount	# Distributed	Total Amount
East	14	$8,210	22	$30,988	12	$14,646
Middle	12	$16,432	16	$17,742	14	$12,034
West	12	$14,791	21	$21,423	21	$20,980
Statewide Total	38	$39,433	59	$70,153	47	$47,660

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

B. Employment and Community First CHOICES

Designed and implemented in partnership with people with intellectual and developmental disabilities, their families, advocates, providers, and other stakeholders, Employment and Community First 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.

Data drawn from the first five quarters of the program's implementation indicate that Employment and Community First CHOICES is successfully enrolling eligible individuals. Participation in the program had increased to 1,842 individuals by the conclusion of the July-September 2017 quarter, a total representing nearly 70 percent of program capacity for the first two years of operation (July 1, 2016, through June 30, 2018). In this quarter alone, overall enrollment increased 33 percent, with more than 90 percent of new enrollees entering the program through one of the seven employment-related priority groups.

The success of Employment and Community First CHOICES is evident not solely in growing enrollment but also in employment gains for members. Over 17 percent of working-age enrollees already have competitive integrated employment after an average of only seven months of enrollment. This rate is 30 percent higher than the national average for individuals with intellectual and developmental disabilities, even though the average length of program enrollment in other states is typically much longer. Average wages for Employment and Community First CHOICES members are $8.60 per hour, and the average number of hours worked per week exceeds 17. Furthermore, nearly 150 enrollees who thought they did not want to work completed an Exploration process (i.e., a service that helps individuals make an informed choice about working), and 86 percent of these enrollees subsequently chose to pursue employment.

Additional details about Employment and Community First CHOICES, including instructions for individuals interested in enrolling in the program, are available on the TennCare website at http://www.tn.gov/tenncare/topic/employment-and-community-first-choices.

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 July – September 2017 Compared to the Previous Two Quarters

	Statewide Enrollment Targets and Reserve Capacity[6]	Enrollment and Reserve Slots Being Held as of the End of Each Quarter		
		Jan – Mar 2017[7]	Apr – Jun 2017[8]	Jul – Sept 2017
ECF CHOICES 4	800	333	420	619
ECF CHOICES 5	1,600	693	844	1,089
ECF CHOICES 6	300	84	125	173
Total ECF CHOICES	2,700	1,110	1,389	1,881
Reserve capacity	350	200	165	215
Waiver Transitions[9]	Not applicable	1	4	7

Data and trends of the designated ECF CHOICES data elements: STC 42.d. requires the State to submit to CMS periodic statistical reports about the ECF CHOICES program, the first of which was submitted on June 30, 2017. Since this inaugural submission consisted entirely of baseline data preceding implementation of ECF CHOICES, it is not yet possible to offer any observations regarding trends. Among the data points offered in the report are the following:

- As of June 30, 2016, the number of individuals with intellectual disabilities receiving HCBS through the TennCare program was 8,025.
- As of June 30, 2016, there were no individuals with developmental disabilities other than intellectual disabilities receiving HCBS through the TennCare program.
- In the twelve-month period preceding implementation of ECF CHOICES, HCBS expenditures for individuals with intellectual or developmental disabilities comprised 77.8 percent of all LTSS expenditures for that population.
- In the twelve-month period preceding implementation of ECF CHOICES, the average LTSS expenditure per person with an intellectual disability was nearly two and a half times greater in an institutional setting than in a community-based setting.

[6] Statewide enrollment targets and reserve capacity have been adjusted to reflect new appropriation authority, effective July 1, 2017.
[7] Enrollment data for the January-March 2017 quarter has been adjusted based on reports generated from the Medicaid Management Information System (MMIS).
[8] Enrollment data for the April-June 2017 quarter has been adjusted based on reports generated from the MMIS.
[9] Waiver transitions are instances in which an individual enrolled in a 1915(c) HCBS waiver program is transferred into the ECF CHOICES program. Since these individuals have an independent funding source (i.e., the money that would have been spent on their care in the 1915(c) program), their enrollment in ECF CHOICES does not count against the 2,700-person enrollment target.

As further data about the ECF CHOICES program is gathered and submitted to CMS, future Quarterly Progress Reports will address the aforementioned data points—and others—in terms of trends.

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. TennCare may 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 TennCare may assess applicable liquidated damages against these entities.

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

During the July-September 2017 quarter, the MCOs submitted their NAIC Second Quarter 2017 Financial Statements. As of June 30, 2017, TennCare MCOs reported net worth as indicated in the table below.[10]

Table 11
Net Worth Reported by MCOs as of June 30, 2017

	Net Worth Requirement	Reported Net Worth	Excess/ (Deficiency)
Amerigroup Tennessee	$33,420,759	$190,479,457	$157,058,698
UnitedHealthcare Plan of the River Valley (UnitedHealthcare Community Plan)	$57,158,856	$414,834,966	$357,676,110
Volunteer State Health Plan (BlueCare & TennCare Select)	$46,879,872	$431,219,175	$384,339,303

During the July-September 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 June 30, 2017:

Table 12
Company Action Level Reported by MCOs as of June 30, 2017

	Company Action Level Requirement	Reported Net Worth	Excess/ (Deficiency)
Amerigroup Tennessee	$122,877,816	$190,479,457	$67,601,641
UnitedHealthcare Plan of the River Valley (UnitedHealthcare Community Plan)	$205,480,268	$414,834,966	$209,354,698
Volunteer State Health Plan (BlueCare & TennCare Select)	$148,059,416	$431,219,175	$283,159,759

[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.

All TennCare MCOs exceeded their minimum net worth requirements and Company Action Level requirements as of June 30, 2017.

D. Payment Reform

Tennessee's Health Care Innovation Initiative is changing health care payment to reward providers for high-quality and efficient treatment of medical conditions, and to help in maintaining people's health over time.

One strategy being used to reform health care payment in Tennessee is Episodes of Care. Episode-based payment is applicable for most procedures, hospitalizations, acute outpatient care (e.g., broken bones), as well as some forms of treatment for chronic health conditions (e.g., cancer) and behavioral health conditions (e.g., ADHD). Episodes encompass care delivered by multiple providers in relation to a specific health care event. Each episode has a principal accountable provider (sometimes referred to as the "quarterback") who is in the best position to influence the cost and quality of the episode. To date, a total of 29 Episodes of Care have been implemented. Eighteen episodes covering orthopedics, hospitalist medicine, gynecological surgery, and general surgery are expected to be implemented in the spring of 2018.

Stakeholder input from Tennessee providers, payers, patients, and employers is central to the design of episodes of care and the other value-based payment strategies that are part of Tennessee's Health Care Innovation Initiative. The Initiative organizes Technical Advisory Groups (TAGs) composed of experts in the field to provide clinical feedback on each episode's design. Episode TAG meetings are held in the spring and fall.

Episode Design Feedback Sessions are another opportunity for stakeholders to provide input on existing episodes of care. On May 16, 2017, 160 providers from across Tennessee convened to comment on aspects of the program that are working well, as well as on areas for improvement in the design of the first 20 Episodes of Care. The meetings were held simultaneously in six cities across Tennessee (Chattanooga, Jackson, Johnson City, Knoxville, Memphis, and Nashville) and were connected via videoconference to make it easier for providers across the state to participate. Tennessee makes adjustments to episode design based on the feedback it receives.

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 of 2009. The purpose of the program is to provide financial incentives to Medicaid providers[11] to replace outdated, often paper-based approaches to

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

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 had submitted an attestation by April 30, 2017, the deadline for enrollment and first-time submission, and 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 July-September 2017 quarter as compared with payments made throughout the life of the program appear in the table below:

Table 13
EHR Payments
Quarterly and Cumulative

Payment Type	No. of Providers Paid During the Quarter	Quarterly Amount Paid (Jul-Sept 2017)	Cumulative Amount Paid To Date[12]
First-year payments	22[13]	$446,250	$181,556,067
Second-year payments	106	$892,501	$57,678,166
Third-year payments	137	$1,798,450	$32,301,505
Fourth-year payments	96	$799,002	$5,383,344

[12] Audits performed during the July-September 2017 quarter identified some past payments to eligible hospitals and an eligible practitioner to be recouped. The cumulative totals associated with first-year and second-year payments reflect these recoupments.

[13] Of the 22 providers receiving first-year payments in the July-September 2017 quarter, 8 earned their incentives by successfully attesting to meaningful use of EHR technology.

Payment Type	No. of Providers Paid During the Quarter	Quarterly Amount Paid (Jul-Sept 2017)	Cumulative Amount Paid To Date[12]
Fifth-year payments	100	$847,167	$2,776,668
Sixth-year payments	28	$238,000	$824,500

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

- Completing more than 100 technical assistance calls, 35 of which related to Meaningful Use;
- Responding to over 300 emails received in the EHR Incentive mailbox, and to over 300 emails received in the EHR Meaningful Use mailbox;
- Attendance at the 2017 Medicaid HITECH Multi-Regional Conference in Philadelphia, Pennsylvania, in August 2017;
- Making a presentation at the TriMED Healthcare Education Summit in Nashville in September 2017;
- Participation throughout the quarter in several Southeast Regional Collaboration for HIT/HIE (SERCH) calls;
- Mailing of reminder notices to eligible professionals whose attestations were incomplete; and
- Newsletters and alerts distributed by the TennCare's EHR ListServ.

Although enrollment of new providers concluded on April 30, 2017, TennCare's EHR Incentive Program team continues to work with a variety of provider organizations to maintain the momentum of the program. The focus of outreach efforts has shifted from new enrollments to providers who attested to EHR requirements only once or who have not attested in recent years.

F. Pharmacy Benefits Manager Procurement

Following a competitive bidding process in which multiple companies submitted proposals, TennCare identified OptumRx on August 25, 2017, as having submitted a successful bid to become the program's new Pharmacy Benefits Manager (PBM). OptumRx was scheduled to replace Magellan Health Services, which has held the role since 2013. On September 1, 2017, however, Magellan Health Services protested the award of the contract to OptumRx. As of the end of the July-September 2017 quarter, the protest was ongoing, but a decision in the matter was expected by the conclusion of the calendar year.

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

TennCare continued to demonstrate budget neutrality during the July-September 2017 quarter. For more information about budget neutrality performance, see the spreadsheet comprising Attachment A to this Quarterly Progress Report.

From a state fiscal perspective, revenue collections remained robust throughout the July-September 2017 quarter. All three months achieved growth in total state and local collections relative to the corresponding months of 2016, with nearly a four percent improvement in July, more than a three percent improvement in August, and more than a three and a half percent improvement in September.[14]

Employment in Tennessee continued to reach record levels during the quarter. The unemployment rate within the state declined each month, falling from 3.4 percent in July 2017 to 3.3 percent in August 2017 and still further to 3.0 percent in September 2017. The Tennessee unemployment rate in all three months of the quarter was not only lower than the national rate during the same months (4.3 percent, 4.4 percent, and 4.2 percent respectively) but also significantly lower than the state rate during the corresponding months of 2016 (4.8 percent, 4.8 percent, and 4.9 percent respectively). Furthermore, the Tennessee unemployment rate in each month of the quarter represented an all-time low for the state at the time of its publication.[15]

VIII. Member Month Reporting

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

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

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

Table 14
Member Month Reporting for Use in Budget Neutrality Calculations
July – September 2017

Eligibility Group	July 2017	August 2017	September 2017	Sum for Quarter Ending 9/30/17
Medicaid eligibles (Type 1)				
EG1 Disabled, Type 1 State Plan eligibles	139,880	140,473	140,431	420,784
EG2 Over 65, Type 1 State Plan eligibles	259	258	350	867
EG3 Children, Type 1 State Plan eligibles	734,692	746,047	748,161	2,228,900
EG4 Adults, Type 1 State Plan eligibles	379,262	387,592	393,172	1,160,026
EG5 Duals, Type 1 State Plan eligibles	135,884	136,689	137,290	409,863
Demonstration eligibles (Type 2)				
EG8 Med Exp Child, Type 2 Demonstration Population, Optional Targeted Low Income Children funded by Title XIX	0	0	0	0
EG9 H-Disabled, Type 2 Demonstration Population	251	245	264	760
EG10 H-Over 65, Type 2 Demonstration Population	46	49	93	188
EG11 H-Duals, Type 2 Demonstration Population	6,144	6,124	6,099	18,367
TOTAL	1,396,418	1,417,477	1,425,860	4,239,755

Table 15
Member Month Reporting Not Used in Budget Neutrality Calculations
July – September 2017

Eligibility Group	July 2017	August 2017	September 2017	Sum for Quarter Ending 9/30/17
EG6E Expan Adult, Type 3, Demonstration Population	304	291	282	877
EG7E Expan Child, Type 3,	15	14	17	46

Eligibility Group	July 2017	August 2017	September 2017	Sum for Quarter Ending 9/30/17
Demonstration Population				
Med Exp Child, Title XXI Demonstration Population	6,392	5,843	5,657	17,892
EG12E Carryover, Type 3, Demonstration Population	1,918	1,887	1,855	5,660
TOTAL	8,629	8,035	7,811	24,475

IX. Consumer Issues

Eligibility Appeals. 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.

Table 16
Eligibility Appeals for July – September 2017
Compared to the Previous Two Quarters

	Jan – Mar 2017	Apr – Jun 2017	Jul – Sept 2017
No. of appeals received	28,586	49,377	24,180
No. of appeals resolved or withdrawn	26,297	32,941	37,833
No. of appeals taken to hearing	2,710	2,216	2,167
No. of hearings resolved in favor of appellant	192	117	109

Medical Service Appeals. 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 July – September 2017
Compared to the Previous Two Quarters

	Jan – Mar 2017	Apr – Jun 2017	Jul – Sept 2017
No. of appeals received	2,259	2,356	2,259
No. of appeals resolved	2,071	2,308	2,153
• Resolved at the MCC level	720	868	685
• Resolved at the TSU level	202	197	184

	Jan – Mar 2017	Apr – Jun 2017	Jul – Sept 2017
• Resolved at the LSU level	1,149	1,243	1,284
No. of appeals that did not involve a valid factual dispute	173	145	151
No. of directives issued	304	338	278
No. of appeals taken to hearing	1,149	1,243	1,284
No. of appeals that were withdrawn by the enrollee at or prior to the hearing	420	395	387
Appeals that went to hearing and were decided in the State's favor	399	446	437
Appeals that went to hearing and were decided in the appellant's favor	34	26	43

By way of explanation:

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

- The "TSU" level is the TennCare Solutions Unit. The TSU is a unit within TennCare 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 TennCare 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 July – September 2017
Compared to the Previous Two Quarters

	Jan – Mar 2017	Apr – Jun 2017	Jul – Sept 2017
No. of appeals received	203	175	125

	Jan – Mar 2017	Apr – Jun 2017	Jul – Sept 2017
No. of appeals resolved or withdrawn	103	79	60
No. of appeals set for hearing	89	112	49
No. of hearings resolved in favor of appellant	0	2	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 April-June 2017 quarter is provided in Table 19. Data for the period of July through September 2017 will be provided in the next Quarterly Progress Report.

Table 19
Population Health Data*, April – June 2017

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	620,791
Level 1: low or moderate risk	Maternity Program	Engage pregnant women in timely prenatal care and deliver a healthy, term infant without complications	9,026
	Health Risk Management	Prevent, reduce, or delay exacerbation and complications of a condition or health risk behavior	669,886
	Care Coordination	Assure that members receive the services they need to reduce the risk of an adverse health outcome	26,714

Risk Level	Intervention Type	Intervention Goal(s)	Number of Unique Members at End of Quarter
Level 2: high risk	Chronic Care Management	Provide intense self-management education and support to members with multiple chronic conditions to improve their quality of life, health status, and use of services	5,422
	High Risk Pregnancy Management	Engage pregnant women in timely prenatal care and deliver a healthy, term infant without complications	1,407
	Complex Case Management	Move members to optimal levels of health and well-being through timely coordination of quality services and self-management support	1,608
Total PH Enrollment			**1,334,854**

*** 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 July 2017, TennCare's External Quality Review Organization (EQRO), Qsource, published the results of its provider data validation survey for the April-June 2017 quarter. Qsource took a sample of provider data files from TennCare's MCCs[16] and reviewed each for accuracy in the following categories:

- Active contract status
- Provider address
- Provider specialty / behavioral health service code
- Provider panel status
- 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 demonstrated generally strong performance by the MCCs, especially in the categories of "active contract status" (98.0 percent accuracy), "provider specialty / behavioral health service code" (97.2 percent accuracy), "routine care services" (97.4

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

percent accuracy), "urgent care services" (98.7 percent accuracy), "primary care services" (99.5 percent accuracy), and "prenatal care services" (99.4 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 January-March 2017, 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 September 5, 2017. TennCare, in turn, had received, reviewed, and accepted all of the plans by September 10, 2017. Results for the July-September 2017 quarter will be discussed in the next Quarterly Progress Report.

XI. Demonstration Evaluation

When CMS approved the State's application to extend the TennCare Demonstration on December 16, 2016, the terms and conditions of the approval stipulated that the State's evaluation efforts should focus "on the CHOICES program, ECF CHOICES program and the state plan and demonstration populations enrolled in those programs." On April 17, 2017, therefore, the State submitted to CMS its proposed evaluation design for the current approval period of the TennCare Demonstration (December 16, 2016, through June 30, 2021). The central issue addressed by the design is how the CHOICES and ECF CHOICES managed LTSS programs compare with various fee-for-service LTSS programs operated by the State in the past and present. To guide evaluation efforts, the design includes five program objectives related to CHOICES and five related to ECF CHOICES, each of which is supported with appropriate data elements.

On June 21, 2017, CMS sent the State written feedback on the proposed evaluation design. The State and CMS are currently working to finalize the evaluation design.

XII. Essential Access Hospital Pool[17]

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)

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

Metro Nashville General Hospital

B. Children's Hospitals

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

C. Free Standing Psychiatric Hospitals

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

D. Other Acute Care Hospitals

Parkridge Medical Center (with Parkridge Valley Psych)
Jackson – Madison County General Hospital
TriStar Centennial Medical Center
Methodist Healthcare – Memphis Hospitals
Saint Jude Children's Research Hospital
Methodist Healthcare – South
Parkridge East Hospital
TriStar Skyline Medical Center (with Madison campus)
Parkwest Medical Center (with Peninsula Psych)
Baptist Memorial Hospital – Memphis
Methodist Healthcare – North
University Medical Center (with McFarland Psych)
Saint Francis Hospital
Saint Thomas Rutherford Hospital
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
Saint Thomas DeKalb Hospital
Jamestown Regional Medical Center
Saint Thomas 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 Woodridge Hospital Holston Valley Medical Center Bristol Regional Medical Center
Meharry Medical College	Metro General Meharry Medical Group
University of Tennessee at Memphis	The Regional Medical Center (The MED) Methodist LeBonheur Erlanger Jackson Madison St. Francis
Vanderbilt University	Vanderbilt Hospital

XIV. Critical Access Hospitals

Camden General Hospital
Copper Basin Medical Center
Cumberland River Hospital
Erlanger Bledsoe Hospital
Johnson County Community Hospital
Lauderdale Community Hospital
Macon County General Hospital
Marshall Medical Center
Rhea Medical Center
Riverview Regional Medical Center

Saint Thomas Hickman Hospital
Three Rivers Hospital
TriStar Ashland City Medical Center
Trousdale Medical Center
Wellmont Hancock County Hospital

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Date Submitted to CMS: November 29, 2017

Attachment A

Budget Neutrality Calculations for the Quarter

Actual TennCare Budget Neutrality (April - Jun 2017)

I. The Extension of the Baseline

Baseline PMPM

	SFY 2018 PMPM
1-Disabled (can be any ages)	$1,905.21
2-Child <=18	$535.50
3-Adult >= 65	$1,223.63
4-Adult <= 64	$1,111.34
Duals (17)	$781.68

Actual Member months of Groups I and II

1-Disabled (can be any ages)	421,544
2-Child <=18	2,228,900
3-Adult >= 65	1,055
4-Adult <= 64	1,160,026
Duals (17)	428,230
Total	4,239,755

Ceiling without DSH

	Baseline * MM
1-Disabled (can be any ages)	$803,127,862
2-Child <=18	$1,193,573,035
3-Adult >= 65	$1,290,932
4-Adult <= 64	$1,289,179,849
17s	$334,740,281
Total	**$3,621,911,958**

DSH

DSH Adjustment (Quarterly)	$115,999,213

Total Ceiling

Budget Neutrality Cap	
Total w/DSH Adj.	**$3,737,911,171**

II. Actual Expenditures

Group 1 and 2

1-Disabled (can be any ages)	$ 516,033,669
2-Child <=18	$ 468,608,700
3-Adult >= 65	$ 2,007,714
4-Adult <= 64	$ 396,673,263

Duals (17)	$	365,899,794
Total		**1,749,223,141**

Group 3

1-Disabled (can be any ages)	$	-
2-Child <=18	$	4,217,056
3-Adult >= 65	$	27,869,341
4-Adult <= 64	$	191,597
Duals (17)	$	-
Total		**32,277,994**

Pool Payments and Admin

Total Pool Payments	$	204,749,226

Admin		124,957,669

Quarterly Drug Rebates		(100,058,970)
Quarterly Premium Collections	$	-

Total Net Quarterly Expenditures	**$**	**2,011,149,060**

III. Surplus/(Deficit)

	$1,726,762,112
Federal Share	**$1,121,704,668**

HCI Result	MM201707	MM201708	MM201709	TOTAL	HCI ASO	HCI Rx	HCI DTL	HCI MCO CAP (TCS Admin)	HCI BHO CAP	State-Only Allocation	UNK Allocation	Taxes	Allocation on Differences between DV and HCI-CAP	TOTAL
EG1-TYPE1 (disabled, type1 state plan eligibles)	139,880	140,473	140,431	420,784	$68,141,627	$124,763,880	$1,802,319	$316,610,708	$0	$0	-	$0	$0	$511,318,534
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)	259	258	350	867	$0	$45,234	$0	$938,153	$0	$0	-	$0	$0	$983,387
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)	734,692	746,047	748,161	2,228,900	$10,905,788	$62,879,039	$35,652,171	$359,171,702	$0	$0	-	$0	$0	$468,608,700
Med Exp Child (Title XXI Demo Pop; EG3-Type2)	6,392	5,843	5,657	17,892	$99,284	$1,142,199	$438,184	$2,527,888	$0	$0	-	$0	$0	$4,207,554
EG4-TYPE1 (adults, type1 State plan eligibles)	379,262	387,592	393,172	1,160,026	$1,383,327	$76,059,709	$2,691,792	$316,538,435	$0	$0	-	$0	$0	$396,673,263
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)	135,884	136,689	137,290	409,863	$1,442,014	$869,675	$29,548	$290,216,708	$0	$0	-	$0	$0	$292,557,944
EG6E-TYPE3 (Expan adult, type3 demonstration pop)	304	291	282	877	$0	$23,878	$0	$167,719	$0	$0	-	$0	$0	$191,597
EG7E-TYPE3 (Expan child, type3 demonstration pop)	15	14	17	46		$1,929	$413	$7,160	$0	$0	-	$0	$0	$9,502
EG8-TYPE2 (med exp child)	0	0	0	0	$0	$0	$0	$0	$0	$0	-	$0	$0	$0
EG9 H-Disabled (TYPE 2 Eligibles)	251	245	264	760	$0	$239,230	$0	$4,475,905	$0	$0	-	$0	$0	$4,715,135
EG10 H-Senior	46	49	93	188	$0	$11,095	$0	$1,013,232			-			$1,024,327
EG11H, H-Dual	6,144	6,124	6,099	18,367	$0	$4,198	$0	$73,337,651	$0	$0	-	$0	$0	$73,341,849
EG12E, Carryovers	1,918	1,887	1,855	5,660	$0	$94,569	$0	$26,750,444	$0	$0	-	$0	$0	$26,845,013
Total	**1,405,047**	**1,425,512**	**1,433,671**	**4,264,230**	**$81,972,040**	**$266,134,636**	**$40,614,427**	**$1,391,755,705**	**$0**	**$0**	**$0**	**$0**	**$0**	**$1,780,476,808**

HCI Result	MM201707	MM201708	MM201709	TOTAL	HCI ASO PMPM	HCI Rx PMPM	HCI DTL PMPM	HCI MCO CAP (TCS Admin)	HCI BHO CAP	State-Only Allocation	UNK Allocation	Taxes	Allocation on Differences between DV and HCI-CAP	TOTAL
EG1-TYPE1 (disabled, type1 state plan eligibles)	139,880	140,473	140,431	420,784	$161.94	$296.50	$4.28	$752.43	$0.00	$0.00	$0.00	$0.00	$0.00	$1,215.16
EG1-TYPE2 (disabled, type2 transition group)	0	0	0	-										
EG2-TYPE1 (over 65, type1 state plan eligibles)	259	258	350	867	$0.00	$52.17	$0.00	$1,082.07	$0.00	$0.00	$0.00	$0.00	$0.00	$1,134.24
EG2-TYPE2 (over 65, type2 state plan eligibles)	0	0	0	-	-	-	-	-	-	-	-	-	-	-
EG3-TYPE1 (children, type1 state plan eligibles)	734,692	746,047	748,161	2,228,900	$4.89	$28.21	$16.00	$161.14	$0.00	$0.00	$0.00	$0.00	$0.00	$210.24
Med Exp Child (Title XXI Demo Pop; EG3-Type2)	6,392	5,843	5,657	17,892	$5.55	$63.84	$24.49	$141.29	$0.00	$0.00	$0.00	$0.00	$0.00	$235.16

EG4-TYPE1 (adults, type1 State plan eligibles)	379,262	387,592	393,172	1,160,026	$1.19	$65.57	$2.32	$272.87	$0.00	$0.00	$0.00	$0.00	$0.00	$341.95
EG4-TYPE2 (adults, type2 demonstration pop)	0	0	0	-										
EG5-TYPE1 (duals, state plan eligibles)	135,884	136,689	137,290	409,863	$3.52	$2.12	$0.07	$708.08	$0.00	$0.00	$0.00	$0.00	$0.00	$713.79
EG6E-TYPE3 (Expan adult, type3 demonstration pop)	304	291	282	877	$0.00	$27.23	$0.00	$191.24	$0.00	$0.00	$0.00	$0.00	$0.00	$218.47
EG7E-TYPE3 (Expan child, type3 demonstration pop)	15	14	17	46	$0.00	$41.94	$8.99	$155.65	$0.00	$0.00	$0.00	$0.00	$0.00	$206.57
EG8-TYPE2 (emd exp child)	0	0	0	-										
EG9 H-Disabled (TYPE 2 Eligibles)	251	245	264	760	$0.00	$314.78	$0.00	$5,889.35	$0.00	$0.00	$0.00	$0.00	$0.00	$6,204.13
EG10 H-Senior	46	49	93	188	$0.00	$59.02	$0.00	$5,389.53	$0.00	$0.00	$0.00			
EG11H, H-Dual	6,144	6,124	6,099	18,367	$0.00	$0.23	$0.00	$3,992.90	$0.00	$0.00	$0.00	$0.00	$0.00	$3,993.13
EG12E, Carryovers	1,918	1,887	1,855	5,660	$0.00	$16.71	$0.00	$4,726.23	$0.00	$0.00	$0.00	$0.00	$0.00	$4,742.94
Total	**1,405,047**	**1,425,512**	**1,433,671**	**4,264,230**	**$19.22**	**$62.41**	**$9.52**	**$326.38**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$417.54**

CMS 64 Budget Neutrality Totals - September Q 2017

All reported totals are based on total computable dollars.

	CMS reported June Q	
Critical Access Hospitals	-	
CPE	38,317,248	
Essential Access Hospitals	25,000,000	
DSH	35,757,611	
GME	2,669,200	
MeHarry	2,500,000	
Hospital Enhanced Coverage	505,167	
IGT	100,000,000	
All Eligibility Waviers for quarter	1,737,512,275	including EG asst. and admin.
Administration	124,957,669	Total Admin.
Premium Refunds	0	
Drug Rebates	(100,058,970)	