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

November 28, 2014

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

RE: TennCare II, STC 45, Quarterly Progress Report

Dear Ms. Woodard:

Enclosed please find the Quarterly Progress Report for the July – September 2014 quarter. This report is being submitted in accordance with STC 45.

Please let us know if you have comments or questions.

Sincerely,

[redacted]

Darin J. Gordon
Director, Bureau of TennCare

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

TennCare II

Section 1115 Quarterly Report

(For the period July - September 2014)

Demonstration Year: 13 (7/1/14 - 6/30/15)
Federal Fiscal Quarter: 4/2014 (7/14 - 9/14)
Waiver Quarter: 1/2015 (7/14 - 9/14)

I. Introduction

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

TennCare contracts with several Managed Care Contractors (MCCs) to provide services to about 1.3 million enrollees. During this quarter, these entities included Managed Care Organizations (MCOs) for medical, behavioral, and certain Long-Term Services and Supports (LTSS), a Dental Benefits Manager (DBM) for dental services, and a Pharmacy Benefits Manager (PBM) for pharmacy services.

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

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

Table 1
Key Dates of Approval/Operation in the Quarter

Date	Action	STC #
7/1/14	The State sent the CMS Project Officer a courtesy copy of State Plan Amendment (SPA) 14-001, which proposes to reduce the reimbursement rate for Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs/IID) by one percent.	7
7/10/14	The State submitted the following contract amendments to CMS: Amendment 18 to the Middle Tennessee Contractor Risk Agreement (CRA), Amendment 15 to the East/West Tennessee CRA, and Amendment 35 to the TennCare Select contract.	43.a.
7/23/14	The State notified the public of its intent to submit Demonstration Amendment 24 to CMS. Amendment 24 proposes the addition of two community-based residential alternative services to the array of services covered by the CHOICES program.	15
7/24/14	The CMS Project Officer cancelled the Monthly Call.	44
7/28/14	The State submitted Demonstration Amendment 23 to CMS. Amendment 23 proposed the addition of expenditure authority for the provision of non-ambulatory services to pregnant women during periods of presumptive eligibility.	6, 7
7/31/14	The State sent CMS budget neutrality data for Amendment	7

Date	Action	STC #
	23.	
8/4/14	The State and CMS held a conference call to discuss the budget neutrality data related to Amendment 23.	
8/19/14	The State submitted point-in-time and annual aggregate data about the CHOICES program to CMS.	43.d.iii.
8/22/14	The State sent the CMS Project Officer a courtesy copy of State Plan Amendment (SPA) 14-002, which proposes a change in the reimbursement methodology for brand-name drugs.	7
8/28/14	The Monthly Call was held. Topics of discussion included the State's certified public expenditure reconciliation process and the status of Demonstration Amendment 23.	44
8/29/14	The State submitted the Quarterly Progress Report for the April-June 2014 quarter to CMS.	45
9/5/14	CMS provided written approval of Amendment 23. Included with the approval letter were amended versions of the waiver list, expenditure authorities, and STCs comprising the State's demonstration agreement with CMS.	
9/25/14	The State submitted the 2014 Beneficiary Survey report to CMS.	47
9/25/14	The CMS Project Officer cancelled the Monthly Call.	44

II. Enrollment and Benefits Information

Information about enrollment by category is presented in Table 2.

Table 2
Enrollment Counts for the July – September 2014 Quarter
Compared to the Previous Two Quarters

Demonstration Populations	Total Number of TennCare Enrollees		
	Jan – Mar 2014	Apr – Jun 2014	Jul – Sept 2014
EG1 Disabled, Type 1 State Plan eligibles	135,814	134,896	135,500
EG9 H-Disabled, Type 2 Demonstration Population	275	291	324
EG2 Over 65, Type 1 State Plan eligibles	19	24	26
EG10 H-Over 65, Type 2 Demonstration Population	0	0	0

Demonstration Populations	Total Number of TennCare Enrollees		
	Jan – Mar 2014	Apr – Jun 2014	Jul – Sept 2014
EG3 Children, Type 1 State Plan eligibles	655,192	667,448	681,230
EG4 Adults, Type 1 State Plan eligibles	298,598	316,441	332,388
EG5 Duals, Type 1 State Plan eligibles and EG11 H-Duals 65, Type 2 Demonstration Population	130,793	130,810	132,440
EG6E Expan Adult, Type 3 Demonstration Population	1,131	1,134	1,193
EG7E Expan Child, Type 3 Demonstration Population	64	64	63
EG8, Med Exp Child, Type 2 Demonstration Population, Optional Targeted Low Income Children funded by Title XIX	0	0	0
Med Exp Child, Title XXI Demonstration Population	19,553	19,523	19,499
EG12E Carryover, Type 3, Demonstration Population	6,621	6,960	6,783
TOTAL*	1,248,060	1,277,591	1,309,446

*** 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 seventy-seven 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, 2014

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

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

[2] UnitedHealthcare Community Plan, formerly known as "AmeriChoice," is operated by UnitedHealthcare Plan of the River Valley, Inc.

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

Benefits for Pregnant Women During a Period of Presumptive Eligibility ("Demonstration Amendment 23"). On July 28, 2014, the Bureau of TennCare submitted Demonstration Amendment 23 to CMS. Amendment 23 deals with the benefits a pregnant woman may receive from TennCare during a period of "presumptive eligibility," which is a period of temporary eligibility granted to low-income pregnant women who would likely qualify for TennCare coverage but who have not yet completed an application.

Federal regulations limit the Medicaid services that can be furnished to presumptively eligible pregnant women to ambulatory services only. TennCare has long taken the position that all Medicaid services—ambulatory as well as non-ambulatory—are "pregnancy-related services" and should be available to pregnant women to promote their health and the health of their unborn children. Amendment 23 was developed in concert with CMS as a way of resolving this issue and achieving the state's objectives. Most members of this population are "presumptives" for only a few short weeks before becoming fully TennCare eligible, when the issue of ambulatory versus non-ambulatory services becomes moot.

On September 5, 2014, CMS issued written approval of Amendment 23. As of the end of the July-September quarter, Bureau staff members were reviewing the updated waiver list, expenditure authorities, and Special Terms and Conditions that had accompanied CMS's approval letter in preparation for formally accepting these changes.

CHOICES Services ("Demonstration Amendment 24"). On July 23, 2014, the Bureau notified the public of another proposal to be submitted to CMS. Demonstration Amendment 24 would add two community-based residential alternative services to the menu of benefits covered by CHOICES, TennCare's program of long-term services and supports (LTSS) for individuals who are elderly or have physical disabilities. As of the end of the quarter, public comments on the proposed amendment were being reviewed.

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

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

resolved." During the July-September 2014 quarter, the Bureau received no notifications that a family with members enrolled in TennCare Standard had met its cost sharing limit. It should be noted that this is the seventh consecutive quarter since the plan was implemented in which no notifications have been received.

III. Innovative Activities to Assure Access

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

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

- Seasonal events. National Children's Dental Health Month in February, back-to-school events in August, and Child Health Week in October all have a profound influence on the focus and direction of outreach efforts during their respective quarters. TDH's communications strategy for each is based on an evaluation of past successes and current opportunities. During the 2013 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 2014 Compared to the Previous Two Quarters

Activities	Jan – Mar 2014	Apr – Jun 2014	Jul – Sept 2014
Number of outreach activities/events	3,096	2,789	2,903
Number of people made contact with (mostly face to face at outreach events)	123,317	135,734	159,165
Number of educational materials distributed	139,549	159,052	170,958
Number of coalitions/advisory board meetings attended or conducted	53	46	71
Number of attendees at coalitions/advisory board meetings	824	675	974
Number of educational preventive health radio/TV broadcasts	11,362	19,658	3,250
Number of educational preventive health newsletter/magazine articles	99	143	192
Number of educational preventive health billboards, scrolling billboards and bulletin boards	57,634	7,002[4]	7,769
Number of presentations made to enrollees/professional staff who work with enrollees	139	116	122
Number of individuals attending presentations	7,096	3,736	8,799
Number of attempted telephone calls regarding the importance of dental checkups	403	408	71
Number (approx) of completed telephone calls regarding the importance of immunizations and dental checkups	144	199	32
Number of attempted home visits (educational materials left with these families)	16,626	17,534	16,407
Number of home visits completed	8,763	7,609	6,511

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

[4] In the April-June 2014 quarter, TDH changed its methodology for measuring use of scrolling billboards: rather than counting the number of times TENNderCare messages flashed or scrolled on a particular billboard, the total number of billboards was used.

Table 5
Tennessee Department of Health
TENNderCare Call Center Activity
July – September 2014 Compared to the
Previous Two Quarters

Activities	Jan – Mar 2014	Apr – Jun 2014	Jul – Sept 2014
Number of families reached	41,470	26,791	28,410[5]
Number of families who were assisted in scheduling an EPSDT exam for their children	2,219	907	137
Number of families who were assisted in arranging for transportation	53	15	8

IV. Collection and Verification of Encounter and Enrollment Data

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

Table 6
Number of Initial Encounters Received by TennCare During the July – September 2014 Quarter, and Percentage that Passed Systems Edits, Compared to the Previous Two Quarters

	Jan – Mar 2014	Apr – Jun 2014	Jul – Sept 2014
No. of encounters received by TennCare (initial submission)	14,755,963[6]	12,854,531	13,358,785
No. of encounters rejected by Edifecs upon initial submission	19,323	25,686	46,570
Percentage of encounters that were compliant with State standards (including HIPAA) upon initial submission	99.87%	99.80%	99.65%

[5] This total includes families reached through a TDH special project that focused on educating enrollees about the importance of back-to-school immunizations and/or well-child examinations (as age-appropriate).
[6] Encounter totals were higher than average during the January-March 2014 quarter as the result of Magellan Health Services' reprocessing of claims pertaining to certain generic drugs.

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

A. CHOICES

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

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

	Statewide Enrollment Targets and Reserve Capacity[7]	Enrollment and Reserve Slots Being Held as of the End of Each Quarter		
		Jan – Mar 2014	Apr – Jun 2014	Jul – Sept 2014
CHOICES 1	Not applicable	18,462	18,018	17,943
CHOICES 2	12,500	8,802	8,729	8,600
Interim CHOICES 3	Not applicable	4,014	4,321	4,688
Total CHOICES	Not applicable	31,278	31,068	31,231
Reserve capacity	300	300	300	300

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

Data and trends of the designated CHOICES data elements: STC 43.d. requires the State to submit to CMS periodic statistical reports about the use of LTSS by TennCare enrollees. Seven separate reports—spanning the period of August 2011 through August 2014—had been submitted by the conclusion of the July-September 2014 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 relatively consistent use of NF services over time, with placement in institutional settings decreasing somewhat from 21,530 individuals on June 30, 2011, to 18,018 individuals on June 30, 2014. The aggregate number of TennCare enrollees accessing HCBS, by comparison, grew from 6,226 in the twelve-month period preceding CHOICES implementation to 15,311 after CHOICES had been in place for three years. This trend was mirrored in point-in-time data as

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

well: on the day prior to CHOICES implementation, 4,861 individuals were using HCBS, but the number had grown to 13,050 by June 30, 2014. 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), 7/1/12 – 6/30/13	Percent increase over a four-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 6/30/14	Percent increase from the day before CHOICES implementa-tion to 6/30/14
6,226	15,311	146%	4,861	13,050	168%

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

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

During the period from July 1, 2014, through September 30, 2014, NF PreAdmission Evaluations were approved for 105 individuals with acuity scores lower than 9, and 63 of these individuals were subsequently enrolled in CHOICES 1 during the reporting period. Reasons that the remaining individuals were approved for—but not yet enrolled in—CHOICES 1 include:

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

In the same reporting period, HCBS PreAdmission Evaluations were approved for 26 individuals with acuity scores lower than 9, and 25 of the individuals were subsequently enrolled in CHOICES Group 2. The remaining applicant did not meet Medicaid financial eligibility requirements or otherwise failed to qualify for, or proceed with, enrollment in CHOICES 2.

Frequency and use of MCO-distributed transition allowances (CHOICES approval letter dated February 26, 2010): The allocation of CHOICES transition allowance funds is detailed in Table 9. Distribution of such funds increased during the July-September 2014 quarter as the result of the MCOs' renewed efforts to maximize appropriate use of HCBS within the CHOICES population.

Table 9
TennCare CHOICES Transition Allowances
for July – September 2014 Compared to the Previous Two Quarters

	Frequency and Use of Transition Allowances					
	Jan – Mar 2014		**Apr – Jun 2014**		**Jul – Sept 2014**	
Grand Region	# Distributed	Total Amount	# Distributed	Total Amount	# Distributed	Total Amount
East	4	$2,555	5	$2,885	5	$3,626
Middle	1	$45	2	$1,599	4	$4,767
West	6	$9,036	7	$8,065	15	$20,211
Statewide Total	11	$11,636	14	$12,549	24	$28,604

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

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

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

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

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

During this quarter, the MCOs submitted their National Association of Insurance Commissioners (NAIC) Second Quarter 2014 Financial Statements. As of June 30, 2014, TennCare MCOs reported net worth as indicated in the table below.[8]

Table 10
Net Worth Reported by MCOs as of June 30, 2014

	Net Worth Requirement	Reported Net Worth	Excess/ (Deficiency)
Amerigroup Tennessee	$17,550,992	$116,111,714	$98,560,722
UnitedHealthcare Plan of the River Valley (UnitedHealthcare Community Plan)	$64,885,278	$517,337,683	$452,452,405
Volunteer State Health Plan (BlueCare & TennCare Select)	$34,942,038	$294,561,107	$259,619,069

[8] The "Net Worth Requirement" and "Reported Net Worth" figures in the table are based on the MCOs' company-wide operations, not merely their TennCare operations. Amerigroup, for instance, operates a Medicare Advantage Plan in Middle Tennessee, while UnitedHealthcare has several lines of business in Illinois, Iowa, Virginia, and Tennessee. Volunteer State Health Plan, by contrast, operates solely on TennCare's behalf.

All TennCare MCOs met their minimum net worth requirements as of June 30, 2014.

C. *Wilson v. Gordon*

On July 23, 2014, attorneys with the Tennessee Justice Center, the Southern Poverty Law Center, and the National Health Law Program filed a class action lawsuit in the U.S. District Court for the Middle District of Tennessee against TennCare, the Tennessee Department of Finance and Administration, and the Tennessee Department of Human Services. In spite of the fact that more than 125,000 applications for TennCare were approved in the first eight months of 2014, the suit made the following allegations (among others):

- Applications for TennCare were not being resolved in a timely manner, and affected applicants were not being granted hearings regarding the delay in the resolution of their applications;
- Individuals were not afforded a method of submitting an application directly to TennCare; and
- Tennessee had not implemented a system by which hospitals could enroll certain groups of people (such as pregnant women or children) who would likely meet eligibility criteria.

In response to the suit, attorneys representing the State pointed out that the Bureau had foreseen the problem and had quickly developed a mitigation plan to assure that eligible Tennesseans could access TennCare services. Under this plan, the State obtained permission from the federal government to have most TennCare applications processed by the Federally Facilitated Marketplace (FFM) for a temporary period of time until the State's own eligibility determination system was operational. The fact that information from individual applications was in the possession of the FFM and had not been forwarded to the State meant that the State's ability to respond to appeals was severely limited.

On September 2, 2014, U.S. District Judge Todd Campbell issued two orders: 1) a preliminary injunction ordering the State to provide "delay hearings" to persons who have been waiting for an eligibility determination from the FFM for more than 45 days (or more than 90 days for disability cases); and 2) a class certification order granting "class action" status to the case. TennCare took immediate action to comply with the provisions of Judge Campbell's orders but also filed an appeal with the U.S. Court of Appeals for the Sixth Circuit in Cincinnati.

D. MCO Readiness

In December 2013, the Bureau announced that the three health plans already comprising TennCare's managed care network—Amerigroup, BlueCare, and UnitedHealthcare—had submitted successful bids to deliver physical health services, behavioral health services, and

LTSS[9] in all three of Tennessee's grand regions beginning on January 1, 2015. During the July-September 2014 quarter, TennCare continued to coordinate with the MCOs to ensure a seamless transition to this statewide service delivery model. The efforts this quarter focused on preparations for the reassignment of approximately one-third of TennCare's members from one plan to another on January 1, 2015, and on April 1, 2015. Topics discussed have included transfer of enrollee data—such as treatment histories, claims histories, and impending surgery dates—that would accompany every reassignment. Furthermore, as the quarter concluded, TennCare finalized letters to certain members of the CHOICES population notifying them of their upcoming reassignment. Establishing contact with affected enrollees a full quarter ahead of the January 1, 2015, implementation date is expected not only to minimize transition difficulties but also to open lines of communication and build rapport between health plans and the individuals they serve. As part of the reassignment process, enrollees who are not satisfied with the new MCO to which they are transferred will have a temporary option to return to the MCO in which they were enrolled on December 31, 2014.

E. Electronic Health Record Incentive Program

The Electronic Health Record (EHR) Incentive Program is a partnership between federal and state governments that grew out of the Health Information Technology for Economic and Clinical Health (HITECH) Act. The purpose of the program is to provide financial incentives to Medicaid providers[10] to replace outdated, often paper-based approaches to medical record-keeping with electronic systems that meet rigorous certification criteria and that can improve health care delivery and quality. The federal government provides 100 percent of the funding for the incentive payments and 90 percent of the administrative costs.

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

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

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

[9] The term "LTSS" in this instance does not include ICF/IID services, HCBS waiver services for individuals with intellectual and developmental disabilities, or services furnished through the Program of All-Inclusive Care for the Elderly (PACE). All of these services are delivered outside the TennCare Demonstration.

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

Table 11
EHR Payments
Quarterly and Cumulative

Payment Type	No. of Providers Paid During the Quarter	Quarterly Amount Paid (Jul-Sept 2014)	Cumulative Amount Paid To Date
First-year payments	53[11]	$2,327,175	$143,843,049
Second-year payments	72	$1,298,282	$40,824,988
Third-year payments	34	$286,167	$4,394,134

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

- Participation throughout the quarter in five Southeast Regional Collaboration for HIT/HIE (SERCH) calls;
- Telephone assistance throughout the quarter for eligible professionals attesting to Meaningful Use (with particular emphasis on the EHR final rule that was to take effect on October 1, 2014);
- Attendance at the CMS Regional EHR Incentive Program Meeting on September 16 and 17;
- Responding to more than 500 inquiries submitted to the EHR Meaningful Use email box;
- Monthly newsletters distributed by the Bureau's EHR ListServ; and
- A quarterly reminder issued through the Provider Incentive Payment Program ("PIPP") system to Tennessee providers who had registered at the federal level but who have not registered or attested at the state level.

A variety of events are already planned for the October-December 2014 quarter, including participation in six workshops hosted by the Tennessee Medical Association during the month of October.

VI. Action Plans for Addressing Any Issues Identified

As reported in Section V, TennCare has taken immediate steps to respond to Orders issued in the *Wilson v. Gordon* court action.

[11] Of the 53 providers receiving first-year payments in the July-September 2014 quarter, 10 earned their incentives by successfully attesting to meaningful use of EHR technology in their first year of participation in the program.

VII. Financial/Budget Neutrality Development Issues

Total state and local revenue collections were higher in all three months of the July-September 2014 quarter than they had been during the corresponding months of 2013. September 2014 proved especially successful in this regard, with total revenues exceeding those from September 2013 by more than 6 percent.[12] With regard to the subject of jobs, the unemployment rate rose from 6.6 percent to 7.1 percent during July, and further still to 7.4 percent in August, before dipping slightly to 7.3 percent in September. While unemployment was lower in the July-September 2014 quarter than in the July-September 2013 quarter, Tennessee's rate nonetheless exceeded the national rate by an average of more than 1 percentage point throughout the quarter.[13]

VIII. Member Month Reporting

Tables 12 and 13 below present the member month reporting by eligibility group for each month in the quarter.

Table 12
Member Month Reporting for Use in Budget Neutrality Calculations
July – September 2014

Eligibility Group	July 2014	August 2014	September 2014	Sum for Quarter Ending 9/30/14
Medicaid eligibles (Type 1)				
EG1 Disabled, Type 1 State Plan eligibles	135,261	135,142	134,697	405,100
EG2 Over 65, Type 1 State Plan eligibles	24	23	27	74
EG3 Children, Type 1 State Plan eligibles	671,991	676,297	679,505	2,027,793
EG4 Adults, Type 1 State Plan eligibles	320,911	326,289	331,516	978,716
EG5 Duals, Type 1 State Plan eligibles	124,583	124,839	125,090	374,512
Demonstration eligibles (Type 2)				

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

Eligibility Group	July 2014	August 2014	September 2014	Sum for Quarter Ending 9/30/14
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	273	298	322	893
EG10 H-Over 65, Type 2 Demonstration Population	0	0	0	0
EG11 H-Duals, Type 2 Demonstration Population	5,424	5,519	5,645	16,588
TOTAL	1,258,467	1,268,407	1,276,802	3,803,676

Table 13
Member Month Reporting Not Used in Budget Neutrality Calculations
July – September 2014

Eligibility Group	July 2014	August 2014	September 2014	Sum for Quarter Ending 9/30/14
EG6E Expan Adult, Type 3, Demonstration Population	1,126	1,149	1,188	3,463
EG7E Expan Child, Type 3, Demonstration Population	64	64	64	192
Med Exp Child, Title XXI Demonstration Population	19,530	19,525	19,480	58,535
EG12E Carryover, Type 3, Demonstration Population	6,772	6,713	6,633	20,118
TOTAL	27,492	27,451	27,365	82,308

IX. Consumer Issues

Eligibility Appeals. Tennessee is currently a "determination" state, meaning that MAGI-based eligibility decisions are made by FFM rather than by the State.

When the FFM denies an application, it has the responsibility of providing the applicant with an appeal of its decision; current regulations give the applicant a choice, if he would prefer that the State hear his appeal. The State's ability to process an appeal, however, is dependent upon its having access to the information that the FFM used to deny the application. For a period of time, the FFM was unable to provide this information to the State. As a result, and after

discussions with CMS, the State sent all MAGI-based appeals received during this period to the FFM to process with the information the FFM had in its possession.

On June 30, 2014, the last day of the previous quarter, CMS outlined a plan to—

- Contact appellants who had indicated a preference that their appeals be heard by the State and offer to conduct those appeals via the Office of Marketplace Eligibility Appeals (OMEA), the FFM's designated appeals entity; and
- Provide information for the State to use in conducting appeals for individuals who did not elect the FFM appeal option.

As of the end of the July-September 2014 quarter, the State had not received any MAGI-based eligibility appeals from the FFM but had nonetheless begun processing eligibility appeals submitted by applicants and enrollees directly to TennCare.

Eligibility appeals concerning non-MAGI eligibility categories continued to be processed by the Tennessee Department of Human Services during the July-September 2014 quarter. Table 14 presents a summary of the number and types of eligibility appeals handled during the quarter, compared to the previous two quarters. The noticeable decline in the number of appeals from the January-March 2014 quarter to the April-June 2014 quarter was the result of the suspension of "termination of enrollment" notices that began in December 2013.

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

	Jan – Mar 2014	Apr – Jun 2014	Jul – Sept 2014
TennCare Medicaid			
No. of appeals received	1,466	496	486
No. of appeals resolved or withdrawn	1,084	323	469
No. of appeals taken to hearing	623	102	140
No. of appeals that did not involve a valid factual dispute	718	296	569
Appeals previously heard that were decided in the State's favor	594	66	74
Appeals previously heard that were decided in the appellant's favor	124	16	25
TennCare Standard			
No. of appeals received	11	3	2
No. of appeals resolved or withdrawn	10	3	0
No. of appeals taken to hearing	28	1	0
No. of appeals that did not involve a valid factual dispute	19	1	4

	Jan – Mar 2014	Apr – Jun 2014	Jul – Sept 2014
Appeals previously heard that were decided in the State's favor	23	0	0
Appeals previously heard that were decided in the appellant's favor	2	0	0

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

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

	Jan – Mar 2014	Apr – Jun 2014[14]	Jul – Sept 2014
No. of appeals received	901	1,602	1,832
No. of appeals resolved	829	1,384	1,672
• Resolved at the MCC level	274	704	883
• Resolved at the TSU level	108	100	114
• Resolved at the LSU level	447	580	675
No. of appeals that did not involve a valid factual dispute	227	276	243
No. of directives issued	163	169	195
No. of appeals taken to hearing	447	580	675
No. of appeals that were withdrawn by the enrollee at or prior to the hearing	157	212	229
Appeals that went to hearing and were decided in the State's favor	123	149	193
Appeals that went to hearing and were decided in the appellant's favor	22	31	29

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.

[14] The increase in medical service appeals that began in the April-June 2014 quarter has been attributed largely to an increase in dental appeals, which in turn is attributed in part to outreach conducted by TennCare in partnership with the Tennessee Dental Association on the subject of how participating providers should properly file appeals on behalf of TennCare enrollees.

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

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

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

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

	Jan – Mar 2014	Apr – Jun 2014	Jul – Sept 2014
No. of appeals of PreAdmission Evaluation (PAE) denials	326	302	356
No. of appeals of PASRR determinations	5	5	8
No. of appeals of denial for enrollment into CHOICES	8	11	10
No. of appeals of involuntary disenrollment from CHOICES	5	4	6
No. of appeals of denial of Consumer Direction	1	1	0
No. of appeals of involuntary withdrawal of Consumer Direction	0	0	0
No. of appeals of involuntary disenrollment from an HCBS waiver for individuals with intellectual disabilities	0	1	0
No. of appeals resolved in appellant's favor prior to hearing	156	159	174
No. of appeals withdrawn prior to hearing	27	23	24

	Jan – Mar 2014	Apr – Jun 2014	Jul – Sept 2014
No. of appeals dismissed at hearing	86	72	61
No. of appeals continued at hearing	5	11	3
No. of appeals that went to hearing and were decided in the State's favor	50	26	13
No. of appeals that went to hearing and were decided in the appellant's favor	10	6	6

X. Quality Assurance/Monitoring Activity

Population Health. "Population Health" (PH) is the model of targeted health care interventions implemented by TennCare in the months leading up to—and culminating on—July 1, 2013. Advantages of PH 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 2014 quarter is provided in Table 17. Data for the period of July through September 2014 will be provided in the next Quarterly Progress Report.

Table 17
Population Health Data*, April – June 2014

Risk Level	Intervention Type	Intervention Goal(s)	Number of Unique Members at End of Quarter
Level 0: no identified risk	Wellness Program	Keep members healthy as long as possible	576,013
Level 1: low or moderate risk	Maternity Program	Engage pregnant women in timely prenatal care and deliver a healthy, term infant without complications	18,270
	Health Risk	Prevent, reduce, or delay exacerbation	630,737

Risk Level	Intervention Type	Intervention Goal(s)	Number of Unique Members at End of Quarter
	Management	and complications of a condition or health risk behavior	
	Care Coordination	Assure that members receive the services they need to reduce the risk of an adverse health outcome	21,852
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	3,041
	High Risk Pregnancy Management	Engage pregnant women in timely prenatal care and deliver a healthy, term infant without complications	2,722
	Complex Case Management	Move members to optimal levels of health and well-being through timely coordination of quality services and self-management support	1,405
Total PH Enrollment			**1,254,040**

*** 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. TennCare's External Quality Review Organization (EQRO), Qsource, published the results of its provider data validation survey for the April-June 2014 quarter. Qsource took a sample of provider data files from TennCare's MCCs[15] and reviewed each for accuracy in the following categories:

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

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

The validity of such information is one measure of providers' availability and accessibility to TennCare enrollees. Qsource's report concluded that "[o]verall, the MCCs' accuracy rates have maintained a high level," especially in the categories of "active contract status with MCC" (98.4 percent accuracy), "provider credentialed specialty / behavioral health service code" (98.8 percent accuracy), "primary care services" (99.4 percent accuracy), and "prenatal care services" (99.9 percent accuracy).

While the results were comparable to the overall scores obtained last quarter and one year ago, to ensure improvement in these and other areas (such as "services to patients age 21 or older," which demonstrated only 92.3 percent accuracy), TennCare required each of its MCCs to submit a Corrective Action Plan no later than September 5, 2014. The Bureau, in turn, had received, reviewed, and accepted all of the plans by September 11, 2014. Results for the July-September 2014 quarter will be discussed in the next Quarterly Progress Report.

XI. Demonstration Evaluation

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

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

Furthermore, in November 2013, the State submitted its annual update of the strategy to evaluate and improve the quality and accessibility of care offered to enrollees through the managed care network. The document, entitled *2013 Annual Update Report: Quality Assessment and Performance Improvement Strategy*, was approved by CMS on March 17, 2014.

XII. Essential Access Hospital Pool[16]

A. Safety Net Hospitals

Vanderbilt University Hospital
Regional Medical Center at Memphis (The MED)
Erlanger Medical Center

[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.

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

D. Other Acute Care Hospitals

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

NorthCrest Medical Center
Southern Hills Medical Center
LeConte Medical Center
Horizon Medical Center
Sumner Regional Medical Center
Tennova Healthcare – Newport Medical Center
Takoma Regional Hospital
Methodist Medical Center of Oak Ridge
Heritage Medical Center
Baptist Memorial Hospital – Tipton
StoneCrest Medical Center
Summit Medical Center
Tennova Healthcare – LaFollette Medical Center
Dyersburg Regional Medical Center
Morristown – Hamblen Healthcare System
Henry County Medical Center
Sweetwater Hospital Association
Sycamore Shoals Hospital
Harton Regional Medical Center
Grandview Medical Center
Indian Path Medical Center
Regional Hospital of Jackson
Baptist Memorial Hospital – Union City
Lakeway Regional Hospital
Jellico Community Hospital
Wellmont Hawkins County Memorial Hospital
Hardin Medical Center
Crockett Hospital
Athens Regional Medical Center
River Park Hospital
Southern Tennessee Medical Center
Livingston Regional Hospital
Tennova Healthcare – Jefferson Memorial Hospital
Henderson County Community Hospital
McNairy Regional Hospital
Roane Medical Center
Skyridge Medical Center – Westside
Bolivar General Hospital
McKenzie Regional Hospital
Claiborne County Hospital
Hillside Hospital
Volunteer Community Hospital
United Regional Medical Center
Jamestown Regional Medical Center

Wayne Medical Center
Methodist Healthcare – Fayette
Erlanger Health System – East Campus
DeKalb Community Hospital
Baptist Memorial Hospital – Huntingdon
White County Community Hospital
Emerald Hodgson Hospital

XIII. Graduate Medical Education (GME) Hospitals

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

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

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

XIV. Critical Access Hospitals

Camden General Hospital
Copper Basin Medical Center

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

State Contact:

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

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

Date Submitted to CMS: November 28, 2014

Attachment A

Budget Neutrality Calculations for the Quarter

Actual TennCare Budget Neutrality (July - September 2014)

I. The Extension of the Baseline

Baseline PMPM

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

Actual Member months of Groups I and II

1-Disabled (can be any ages)	405,993
2-Child <=18	2,027,793
3-Adult >= 65	74
4-Adult <= 64	978,716
Duals (17)	391,100
Total	3,803,676

Ceiling without DSH	**Baseline * MM**
1-Disabled (can be any ages)	$666,272,944
2-Child <=18	$982,246,336
3-Adult >= 65	$79,120
4-Adult <= 64	$942,271,399
17s	$267,130,606
Total	**$2,858,000,406**

DSH	**DSH Adjustment (Quarterly)**	$115,999,213

Total Ceiling	**Budget Neutrality Cap**	
	Total w/DSH Adj.	**$2,973,999,619**

II. Actual Expenditures

Group 1 and 2

1-Disabled (can be any ages)	$	539,746,607
2-Child <=18	$	412,274,601
3-Adult >= 65	$	53,461
4-Adult <= 64	$	361,091,005

Duals (17)	$	275,496,807
Total		**1,588,662,481**

Group 3

1-Disabled (can be any ages)		
2-Child <=18	$	12,298,592
3-Adult >= 65	$	77,221,464
4-Adult <= 64	$	1,705,744
Duals (17)		
Total		**91,225,800**

Pool Payments and Admin

Total Pool Payments		$395,045,008

Admin	$	92,271,326

Quarterly Drug Rebates	$	124,423,404
Quarterly Premium Collections	$	213
Total Net Quarterly Expenditures	**$**	**2,042,780,998**

III. Surplus/(Deficit)

	$931,218,621
Federal Share	**$607,992,638**

HCI Result	MM201407	MM201408	MM201409	TOTAL	HCI ASO	HCI Rx	HCI DTL	HCI MCO CAP (TCS Admin)	UNK Allocation	TOTAL
EG1-TYPE1 (disabled, type1 state plan eligibles)	135,261	135,142	134,697	405,100	$81,118,040	$101,521,355	$1,869,842	$352,154,768	(996,707)	$535,667,298
EG1-TYPE2 (disabled, type2 transition group)	0	0	0	-				$0	-	$0
EG2-TYPE1 (over 65, type1 state plan eligibles)	24	23	27	74	$14,807	$5,627	$0	$33,121	(94)	$53,461
EG2-TYPE2 (over 65, type2 state plan eligibles)	0	0	0	-				$0	-	$0
EG3-TYPE1 (children, type1 state plan eligibles)	671,991	676,297	679,505	2,027,793	$12,493,898	$58,561,329	$33,676,112	$308,314,548	(771,286)	$412,274,601
Med Exp Child (Title XXI Demo Pop; EG3-Type2)	19,530	19,525	19,480	58,535	$46,338	$3,137,708	$1,314,474	$7,775,394	(22,760)	$12,251,154
EG4-TYPE1 (adults, type1 State plan eligibles)	320,911	326,289	331,516	978,716	$747,413	$55,631,944	$2,789,219	$302,581,133	(658,705)	$361,091,005
EG4-TYPE2 (adults, type2 demonstration pop)	0	0	0	-				$0	-	$0
EG5-TYPE1 (duals, state plan eligibles)	124,583	124,839	125,090	374,512	$879,632	$961,217	$700,694	$231,780,730	(432,303)	$233,889,970
EG6E-TYPE3 (Expan adult, type3 demonstration p	1,126	1,149	1,188	3,463		$393,202	$4,599	$1,311,522	(3,580)	$1,705,744
EG7E-TYPE3 (Expan child, type3 demonstration p	64	64	64	192		$18,897	$2,809	$25,821	(89)	$47,438
EG8-TYPE2 (emd exp child)	0	0	0	-		$0		$0	-	$0
EG9 H-Disabled (TYPE 2 Eligibles)	273	298	322	893		$240,083	$0	$3,847,736	(8,509)	$4,079,310
EG11H, H-Dual	5,424	5,519	5,645	16,588		$9,571	$10,196	$41,672,211	(85,141)	$41,606,838
EG12E, Carryovers	6,772	6,713	6,633	20,118		$266,745	$10,857	$77,067,454	(123,592)	$77,221,464
Total	**1,285,959**	**1,295,858**	**1,304,167**	**3,885,984**	**$95,300,128**	**$220,747,678**	**$40,378,802**	**$1,326,564,438**	**-$3,102,552**	**$1,679,888,495**

HCI Result	MM201407	MM201408	MM201409	TOTAL	HCI ASO PMPM	HCI Rx PMPM	HCI DTL PMPM	HCI MCO CAP (TCS Admin)	UNK Allocation	TOTAL
EG1-TYPE1 (disabled, type1 state plan eligibles)	135,261	135,142	134,697	405,100	$200.24	$250.61	$4.62	$869.30	-$2.46	$1,322.31
EG1-TYPE2 (disabled, type2 transition group)	0	0	0	-						
EG2-TYPE1 (over 65, type1 state plan eligibles)	24	23	27	74	$200.10	$76.04	$0.00	$447.57	-$1.27	$722.44
EG2-TYPE2 (over 65, type2 state plan eligibles)	0	0	0	-	-	-	-	-	-	-
EG3-TYPE1 (children, type1 state plan eligibles)	671,991	676,297	679,505	2,027,793	$6.16	$28.88	$16.61	$152.04	-$0.38	$203.31
Med Exp Child (Title XXI Demo Pop; EG3-Type2)	19,530	19,525	19,480	58,535	$0.79	$53.60	$22.46	$132.83	-$0.39	$209.30
EG4-TYPE1 (adults, type1 State plan eligibles)	320,911	326,289	331,516	978,716	$0.76	$56.84	$2.85	$309.16	-$0.67	$368.94
EG4-TYPE2 (adults, type2 demonstration pop)	0	0	0	-						
EG5-TYPE1 (duals, state plan eligibles)	124,583	124,839	125,090	374,512	$2.35	$2.57	$1.87	$618.89	-$1.15	$624.52
EG6E-TYPE3 (Expan adult, type3 demonstration p	1,126	1,149	1,188	3,463	$0.00	$113.54	$1.33	$378.72	-$1.03	$492.56
EG7E-TYPE3 (Expan child, type3 demonstration p	64	64	64	192	$0.00	$98.42	$14.63	$134.49	-$0.46	$247.07
EG8-TYPE2 (emd exp child)	0	0	0	-						
EG9 H-Disabled (TYPE 2 Eligibles)	273	298	322	893	$0.00	$268.85	$0.00	$4,308.77	-$9.53	$4,568.10
EG11H, H-Dual	5,424	5,519	5,645	16,588	$0.00	$0.58	$0.61	$2,512.19	-$5.13	$2,508.25
EG12E, Carryovers	6,772	6,713	6,633	20,118	$0.00	$13.26	$0.54	$3,830.77	-$6.14	$3,838.43
Total	**1,285,959**	**1,295,858**	**1,304,167**	**3,885,984**	**$24.52**	**$56.81**	**$10.39**	**$341.37**	**-$0.80**	**$432.29**

* Unknown allocation was performed within the Service category totals.