



BILL HASLAM
GOVERNOR
STATE OF TENNESSEE

December 22, 2015

The Honorable Sylvia Mathews Burwell
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Dear Secretary Burwell:

Our TennCare Demonstration, which is entering its twenty-third year of operation, is due for renewal by June 30, 2016. TennCare has performed admirably in meeting the goals that were laid out when it was designed. Today we have a mature, well-functioning, and data-driven program that offers comprehensive health services to a sizeable number of people in Tennessee and that offers these services within a context of budget neutrality.

TennCare has achieved some major successes over the course of its operation, and upon approval of our extension we expect that TennCare will achieve even more successes in the years to come. As one important example, we are on the cusp of initiating payment reform—revising our payment structure to reward quality rather than quantity. Another example of a priority to the agency and state is moving forward on developing a new model for delivering managed Long-term Services and Supports to individuals with intellectual and developmental disabilities. We believe this model will be useful to other states seeking to modernize services for this important population.

TennCare has contributed greatly to the ongoing national discussion of Medicaid managed care, and we look forward to continuing our work and achieving new successes in the years ahead.

Sincerely,

A handwritten signature in blue ink, appearing to read "Bill Haslam".

Bill Haslam
Governor

**Tennessee Division of Health Care
Finance and Administration**

TennCare II (Project No. 11-W-00151/4)

Extension Request

December 22, 2015

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Executive Summary

TennCare is one of the longest-lasting and most comprehensive Medicaid managed care programs in the country. It began on January 1, 1994. “TennCare II,” the current phase of TennCare, has been in existence since July 1, 2002.

The program that exists today is a mature, data-driven managed care program with well-functioning component parts and a stable, established infrastructure that delivers high-quality health services to about one in five Tennesseans, including many of the state’s most vulnerable citizens—children from low-income families, pregnant women, and people with disabilities. TennCare today is quite a bit more sophisticated than the TennCare program that was launched on January 1, 1994. However, the core values of the program—broad access to care, improved health status of program participants, and cost effective use of resources—remain much the same.

The Tennessee Division of Health Care Finance and Administration (HCFA) is requesting a five-year extension of the current TennCare II Demonstration. The requested extension period is July 1, 2016, through June 30, 2021. The authority under which this extension is being sought is Section 1115(a) of the Social Security Act. HCFA is not requesting any changes to the Demonstration, other than the continuation of the waiver of retroactive eligibility that has been a component of the Demonstration since 1994. (*See page 25.*)

This document and its constituent sections are organized according to the topics listed at 42 C.F.R. § 431.412(c)(2), governing requests to extend existing Medicaid Demonstration projects. The topics addressed are: a historical narrative summary of the Demonstration, a description of any changes being requested, a list and description of the waivers and expenditure authorities being requested, summaries related to quality of and access to care, financial data demonstrating the state’s historical and projected expenditures, an interim evaluation report, and documentation of the state’s compliance with required public notice procedures.

Section I

Historical Narrative Summary of TennCare II

A. Background

On January 1, 2016, the TennCare Demonstration will begin its twenty-third year.

The early years of TennCare. With the large number of Medicaid managed care programs that exist today, it is sometimes difficult to recall that managed care was a relatively new concept for Medicaid programs in 1994. Only five states had Medicaid managed care programs in operation that year—Arizona, Hawaii, Oregon, Rhode Island, and Tennessee.¹ None of the other four states required that their entire Medicaid population participate in managed care, which has always been a feature of TennCare.² Unlike every other state, Tennessee does not have a fee-for-service (FFS) component of its Medicaid program.

At the time that the original Demonstration request was submitted to the Centers for Medicare and Medicaid Services (CMS), Tennessee’s experience with Medicaid managed care was limited to a single voluntary Primary Care Case Management (PCCM) program that offered only four Medicaid services to participants who lived in one of a handful of Tennessee counties. Yet the state made a tremendous leap virtually overnight, moving from a Medicaid managed care penetration rate of 3 percent on December 31, 1993, to a penetration rate of 100 percent on January 1, 1994.

The goal that drove so many to do so much to get TennCare off the ground so quickly was a common commitment to an innovative design to assist the uninsured. The new TennCare program opened up two important new Demonstration categories for people without insurance:

- ❖ The Uninsured category, for people without access to insurance as of a date set several months in the past.³
- ❖ The Uninsurable category, for people with a medical condition such that they were unable to purchase insurance. At the time, Tennessee had a High Risk Pool called TCHIP (Tennessee Comprehensive Health Insurance Program). TCHIP members, who by and large had higher incomes than most Medicaid eligibles and who would be contributing to the new program through payment of cost-sharing, were transitioned into the Uninsurable category in the new TennCare program.

¹ Kaiser Family Foundation, *Medicaid and Managed Care Policy Brief*, June 1995. Accessed online at <http://kff.org/medicaid/issue-brief/medicaid-and-managed-care-policy-brief> on October 5, 2015.

² TennCare has always required that all eligible persons participate in managed care, even though some individuals may receive certain services outside the Demonstration.

³ On January 1, 1994, applicants for the Uninsured category had to have been uninsured as of March 1, 1993. The reason for using a date in the past was to prevent people from dropping insurance to enroll in TennCare.

All Demonstration eligibles with incomes above 100 percent of the Federal Poverty Level (FPL) had cost-sharing requirements, including premiums, deductibles, and coinsurance. There was no upper limit on income. Individuals or families with incomes above 200 percent of the FPL had their choice of the regular plan or a high deductible plan. Premiums were set on a sliding scale, ranging from a low of \$2.74 per month for an individual premium at the lowest income threshold to a high of \$341.88 per month for a family premium at the highest income threshold in the regular plan, or \$170.83 per month for a family premium at the highest income threshold in the high deductible option. Coinsurance was set at 2, 4, 6, 8, or 10 percent of the cost of the service, depending upon income.

Near the end of TennCare's first year, it became clear that program funding could not keep up with enrollment growth. The state closed new enrollment into the Uninsured category on December 31, 1994, leaving new enrollment into the Uninsurable category open. Over the next few years, various efforts were made to re-open the program to new enrollment by certain groups of uninsured persons. Uninsured children under age eighteen were allowed to enroll beginning on April 1, 1997, and the age limit was extended to nineteen effective January 1, 1998. Also added effective January 1, 1998, were uninsured children who had access to insurance but whose parents could not afford it. The Tennessee General Assembly occasionally added eligibility groups, such as Dislocated Workers who had lost their insurance because of a plant closing. But the program continued to face financial challenges.

The early years of TennCare were characterized by a certain degree of volatility among the Managed Care Organizations (MCOs), some of which were formed for the express purpose of participating in TennCare. A few of these new MCOs were not sufficiently experienced or capitalized to be successful in the new program, which led to some turnover of plans during that period.

TennCare II. In 2002, the Tennessee General Assembly passed the TennCare Reform Act, which was intended to introduce new measures to bring stability to the program and to ensure that it could operate within budgetary limits. The TennCare Reform Act envisioned a new program called "TennCare II." TennCare II began on July 1, 2002, and continues today. Unless stated otherwise, all references to "TennCare" from this point on will be considered to mean "TennCare II."

Key leaders who have shaped TennCare II include the following people:

TennCare II (2002 – present)

| | |
|------------------------------|---|
| Governors: | Don Sundquist (2002 – 2003) Phil Bredesen (2003 – 2011) Bill Haslam (2011 – present) |
| TennCare Directors: | Manny Martins (2002 – 2004) J. D. Hickey (2004 – 2006) Darin Gordon (2006 – present) |
| CMS Project Officers: | Joe Millstone (2002 – 2005) Carolyn Milanowski (2005) Rachel DaCunha (2005 – 2006) Lane Terwilliger (2006) Mary Corddry (2007) Kelly Heilman (2007 – 2010) Paul Boben (2010 – 2011) Nicole Kaufman (2011 – 2012) Jessica Woodard (2012 – 2014) Megan Lepore (2015) Patrick Edwards (2015) Jessica Woodard (2015 – present) |

B. Approval Periods

There have been four separate approval periods since TennCare II began. (See Table 1.) Each period was authorized under a specific paragraph of Section 1115 of the Social Security Act.

Three of the four approval periods were for three years; one was for five years. The second approval period started after several short extensions of the first approval period. These extensions were required after the state was notified at the end of June 2007 that a cap would be placed on supplemental pool payments, effective July 1, 2007.

Table 1
Approval Periods During TennCare II

| Approval Period Number | Dates | Approval Authority under the Social Security Act |
|------------------------|---------------------------------|--|
| 1 | July 1, 2002 – October 4, 2007 | Section 1115(a) |
| 2 | October 5, 2007 – June 30, 2010 | Section 1115(a) |
| 3 | July 1, 2010 – June 30, 2013 | Section 1115(e) |

| Approval Period Number | Dates | Approval Authority under the Social Security Act |
|------------------------|------------------------------|--|
| 4 | July 1, 2013 – June 30, 2016 | Section 1115(f) |

Information about activities that occurred during each approval period will be discussed throughout this extension request. In order to provide a frame of reference for the reader, some highlights of each approval period are summarized below:

Approval Period #1.

- ❖ The TennCare population was divided into TennCare Medicaid (for Medicaid eligibles) and TennCare Standard (for Demonstration eligibles).
- ❖ A “Stabilization Plan” was implemented for an eighteen-month period of time to allow MCOs to operate temporarily on an Administrative Services Organization (ASO) basis and thereby gain time to stabilize their operations.
- ❖ TennCare Select began operating as a back-up plan to be available should an MCO have to leave the program unexpectedly.
- ❖ Pharmacy services were “carved out” to a Pharmacy Benefits Manager (PBM), and dental services were carved out to a Dental Benefits Manager (DBM).
- ❖ “TennCare Transformation,” which was a massive effort to restructure the program to maintain viability, occurred and was successful in allowing TennCare to continue to operate.
- ❖ By the end of 2006, all active MCOs had received accreditation from the National Committee for Quality Assurance (NCQA).
- ❖ A formal competitive procurement process was used to bring new MCOs to the Middle Tennessee Region.

Approval Period #2.

- ❖ The state extended the use of the formal competitive procurement process described above to bring new MCOs to the East and West Tennessee Regions.
- ❖ The carve-out for behavioral health and substance abuse treatment services that had been in operation since 1996 was phased out. Responsibility for delivering behavioral health and substance abuse treatment services, and for integrating these services with physical health services, was transitioned to the MCOs and brought into the overall continuum of care that they were providing.
- ❖ The CHOICES program, a Medicaid Managed Long-Term Services and Supports (MLTSS) program, was begun. Responsibility for LTSS provided to persons who were elderly and to adults with physical disabilities was transitioned to the MCOs. The state’s 1915(c) Home and Community Based Services (HCBS) waivers serving this population were closed.

Approval Period #3.

- ❖ Work was done on a model for serving dual eligibles, which was to be called “TennCare Plus.” The state’s proposal to the Center for Medicare and Medicaid

Innovation (CMMI) was ultimately withdrawn, but other coordination efforts were initiated, such as requiring the MCOs to establish D-SNPs (Dual Eligible Special Needs Plans) to promote aligned enrollment and coordination of Medicaid and Medicare services for their dually eligible members.

- ❖ Governor Haslam launched the Tennessee Health Care Innovation Initiative for the purpose of changing the way health care is paid for in Tennessee. Although the work of the Initiative extends beyond TennCare, TennCare is a critical component, and the Initiative staff is co-located with TennCare staff within the Division of Health Care Finance and Administration (HCFA)⁴ in Nashville. The early work of the Initiative was funded in part by a Round One State Innovation Model (SIM) grant. The Initiative is focused primarily on payment reform, moving from paying for volume to paying for value, and it encompasses strategies that enhance the role of the primary care provider, that align multi-payer models, that focus on improving quality and shifting payment in the LTSS system, and that can be translated into “episodes of care” when multiple providers are involved in a specific health care event.

Approval Period #4.

- ❖ TennCare developed a proposal named “Insure Tennessee,” which was an alternative model for providing services to persons in the Medicaid expansion population. See discussion of “Amendment 25” in the section below.
- ❖ The Tennessee Health Care Innovation Initiative received a \$65 million Round Two SIM grant to further support the goal of making health care in Tennessee a value-based system focused on efficiency, quality of care, and the patient experience.
- ❖ Planning was conducted for a new MLTSS program to serve persons with intellectual and developmental disabilities.
- ❖ The state transitioned to a statewide model of MCO service delivery, effective January 1, 2015. A new procurement process was organized to obtain MCOs that could operate on a statewide basis.

C. Authorities for the Demonstration

The Special Terms and Conditions (STCs), the Waivers, and the Expenditure Authorities that are approved by CMS as part of the Demonstration are considered the foundation documents and the primary authorities for the Demonstration. Amendments should also be considered part of the core documentation. They are unique documents that are state-specific and that are put together with painstaking attention to detail.

Prior to 2002, changes to the Demonstration were managed by correspondence between CMS and the state. Since 2002, the state has prepared twenty-nine Demonstration

⁴ HCFA is an organizational unit within the Tennessee Department of Finance & Administration, which is the Single State Agency specified in the Tennessee Medicaid State Plan. HCFA encompasses a number of health care-related programs and initiatives, including the Bureau of TennCare, CoverKids, AccessTN, CoverRx, the Strategic Planning and Innovation Group, and the Office of e-Health Initiatives. The Bureau of TennCare is the unit within HCFA responsible for administering the state’s Medicaid program, including the TennCare Demonstration.

amendments and filed twenty-seven. All twenty-nine Demonstration amendments are summarized in Attachment A. The two that were not submitted are as follows:

- ❖ Amendment #25 contained the “Insure Tennessee” proposal, which was a proposal for an alternative to the Medicaid expansion described in the Affordable Care Act (ACA). Insure Tennessee would have offered members a choice of purchasing employer-sponsored insurance through a program to be called the “Volunteer Plan,” or joining a “Healthy Incentives Plan” that would allow members to receive rewards for engaging in healthy behaviors. Insure Tennessee was discussed with CMS over a period of four months in 2014 but was not formally submitted to CMS because a committee of the Tennessee General Assembly voted against its implementation during a special legislative session on February 4, 2015. On March 31, 2015, during the regular legislative session, another committee of the Tennessee General Assembly voted against proceeding with implementation of Insure Tennessee.
- ❖ Amendment #29 was prepared in order to begin the benefit reductions that would have been required if Amendment #26 had not been approved. (Amendment #26 dealt with continuing the pool payments past December 31, 2015.) When the state received notice on December 11, 2015, that Amendment #26 had been approved, there was no need to move forward with Amendment #29.

D. Selected Issues: 2002 – 2015

The chronological history of the TennCare Demonstration has been documented by the state as well as CMS. The Bureau of TennCare maintains a timeline on its website.⁵ There is a fourteen-page summary of TennCare II on the CMS website that goes through mid-2014.⁶

Given the availability of these two chronologies, this document will focus on selected key issues in the Demonstration since 2002.

1. Key Issue: Program Innovation

One of the most appealing aspects of the Demonstration is the encouragement it provides for program innovation. Over the years, TennCare has responded to this encouragement in a number of ways.

Some of the most powerful innovations that have come about under TennCare II have been in the area of LTSS. The state currently has an MLTSS program for elderly persons and adults with physical disabilities (“CHOICES”) and, as of this writing, is in the process of developing a companion MLTSS program for persons with intellectual and developmental disabilities (“ECF CHOICES”).⁷

⁵ <http://www.tn.gov/tenncare/article/tenncare-timeline>.

⁶ <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/tn/tn-tenncare-ii-fs.pdf>.

⁷ “ECF” stands for “Employment and Community First.”

Highlights of current program innovations are listed below.

CHOICES (2008 – present). On June 17, 2008, the Long-Term Care Community Choices Act of 2008 was enacted. The Act, which passed unanimously in both houses of the Tennessee General Assembly, laid out the components of a proposed re-design of the TennCare LTSS system. In response to this Act, TennCare developed a concept paper for Amendment #7, which would bring LTSS for elderly persons and adults with physical disabilities under the managed care program and open up new opportunities for these individuals to receive HCBS. The concept paper was submitted to CMS on July 22, 2008, and on October 2, 2008, Amendment #7 was submitted. The state and CMS spent a great deal of time working through the issues in Amendment #7 before it was finally approved on July 22, 2009. The program began in Middle Tennessee about seven months later, on March 1, 2010. On August 1, 2010, the statewide implementation of CHOICES was completed, with program implementation beginning in both East and West Tennessee.

CHOICES has clearly opened up a whole new world of community supports and services for persons who are elderly or who have physical disabilities, while continuing to recognize the important role played by Nursing Facilities (NFs) in the continuum of care. Before CHOICES, 83 percent of TennCare’s LTSS population was served in NFs, with 17 percent served in HCBS settings. As of August 1, 2015, that balance was 57 percent being served in NFs and 44 percent served in HCBS.⁸

Dashboards for program monitoring (2008 – present). Tennessee has developed a set of program dashboards to enable managers to visualize, analyze, and act upon performance and fiscal data. The visual dashboard tool is regularly updated with a wide variety of data in such categories as enrollee demographics, MCO medical loss ratios (MLRs), claims accuracy, provider networks, appeals, MCO Report Cards, Quality Report Cards, and many other topics. “Buttons” on the dashboard use visual cues (e.g., red, yellow, green) to enable managers to easily identify areas needing attention, areas with potential need for additional follow-up or monitoring, and areas where performance is proceeding as expected.

Money Follows the Person (2011 – present). TennCare implemented its Money Follows the Person (MFP) Rebalancing Demonstration Grant program in October 2011. A unique incentive payment structure rewards MCOs that are successful in achieving the state’s transition, rebalancing, and related benchmarks established under the program. In addition to helping significant numbers of individuals transition from institutions to qualified residences in the community, TennCare is making use of rebalancing funds to increase housing capacity across the state, creating more affordable and accessible housing for individuals served in Medicaid. There are additional initiatives to increase the capacity and professionalism of the direct support workforce serving seniors and adults with disabilities. Improved access to housing and a better trained, more committed workforce increase quality of care and improve personal health outcomes for people served. In 2015, TennCare began implementing employment initiatives with the MFP rebalancing funds, and collecting employment data.

⁸ Patti Killingsworth, “State of Tennessee: Leveraging MLTSS to Accomplish System Objectives,” presentation to HCBS conference in Washington, DC, on September 1, 2015. Numbers may not add to exactly 100 percent due to rounding.

Previous member surveys revealed that approximately 20 percent of members surveyed wished to be employed in the community or involved in volunteer work. Integrated, competitive employment and volunteerism help people continue to feel connected to their communities and allow them to contribute in meaningful ways, increasing their overall quality of life.

Dental care for young children (2011 – present). On April 1, 2011, TennCare launched a new initiative to improve the dental health of enrollees who were three to five years old by offering reimbursement to non-traditional providers to conduct dental screens and apply fluoride varnish to teeth. “Non-traditional providers” were defined to include primary care physicians, pediatricians, physician assistants, nurse practitioners, and public health nurses.

SIM grants (2013 – present). In February 2013, Tennessee was one of sixteen states receiving a Round One Model Design Award under the SIM Initiative, which was authorized under Section 3021 of the Affordable Care Act (ACA). The announcement of the award said:

The State of Tennessee received up to \$756,000 to develop its State Health Care Innovation Plan. Tennessee proposed to develop and integrate specific and scalable purchasing strategies into the TennCare Medicaid managed care model. Specifically, the design process aimed to accelerate efforts to hold health care providers accountable for both cost and quality of care by identifying and rewarding the best-performing providers in accordance with federally-recognized quality metrics. The project identified evidence-based payment and service delivery models and decided how one or more of these models could best be used in Tennessee towards the effectiveness of patient-centered medical homes, [Accountable Care Organizations], and other integrated care models.⁹

In December 2014, Tennessee was awarded a Round Two SIM grant, this time for \$65 million. This grant award will further support efforts to make health care in Tennessee a value-based system focused on efficiency, quality of care, and the patient experience.

ECF CHOICES (Amendment #27). On May 30, 2014, the state published a concept paper for a joint proposal between TennCare and the Tennessee Department of Intellectual and Developmental Disabilities (DIDD) regarding the improvement of HCBS programs and services for individuals with intellectual and developmental disabilities. The concept paper—entitled “Renewal and Redesign of Tennessee’s Long-Term Services and Supports for Individuals with Intellectual Disabilities: A Concept Paper for Stakeholder Input and Review”—was developed following a series of statewide meetings with stakeholders held in late 2013 and early 2014. The document was shared with CMS on June 2, 2014, and then served as the basis for Amendment #27. It outlines a plan for launching a new MLTSS program known as ECF CHOICES, with the principal aim of promoting and supporting integrated, competitive employment and independent, integrated community living as the first and preferred option for individuals with intellectual and developmental disabilities (I/DD). ECF CHOICES will offer an array of benefits and supports related to employment and community living through a tiered benefit structure based on the needs of the individuals

⁹ <https://innovation.cms.gov/initiatives/State-Innovations-Model-Design>, Accessed online on October 23, 2015.

enrolled in the program. Establishing ECF CHOICES within the TennCare Demonstration will enable the state to provide HCBS and other Medicaid services to more people, including people currently on the waiting list for a Section 1915(c) waiver program and people with developmental disabilities who are not eligible for Tennessee’s existing Section 1915(c) waiver programs.

2. Key Issue: Integration of Care

Integration of care has been a primary focus of the TennCare program since its inception. Effective integration and coordination of care promotes a better experience for members, more cost effective service delivery, and improved health outcomes. Table 2 summarizes how various benefits have been offered outside (“carved out”) or integrated into (“carved in”) TennCare’s managed care program over time.

Table 2
History of Carve-Ins and Carve-Outs in TennCare

| Service | Carve In or Carve Out? |
|--|---|
| LTSS for persons who are elderly and/or physically disabled | <ul style="list-style-type: none"> • 1994: Originally administered by TennCare outside the managed care program • 2010: Carved in to the MCO program |
| Mental health services | <ul style="list-style-type: none"> • 1994: Services for persons with chronic mental illnesses provided outside the Demonstration by the Tennessee Department of Mental Health. Other mental health and substance abuse services provided by the MCOs. • 1996: All mental health and substance abuse treatment services brought into the Demonstration in 1996 but offered outside the MCOs by two Behavioral Health Organizations that were “partnered” with a certain number of MCOs. • 2009: Carved in to the MCO program |
| Dental services | <ul style="list-style-type: none"> • 1994: Originally part of the MCO program • 2002: Carved out (administered by DBM) |
| Pharmacy services | <ul style="list-style-type: none"> • 1994: Originally part of the MCO program • 1998: Behavioral health drugs were carved out of the BHO program and managed by TennCare • 2000: Drugs for dual eligibles were carved out of the MCO program and managed by TennCare • 2002: Entire pharmacy program carved out (administered by PBM) |
| HCBS for persons with intellectual and/or developmental disabilities | <ul style="list-style-type: none"> • 1994: Originally administered by TennCare and DIDD outside the managed care program • 2015: Plans are underway to carve in to the MCO program in 2016 |

As this summary indicates, TennCare has taken a number of steps to integrate care over time and continues to seek ways to better coordinate care for members. TennCare has elected to retain the PBM and DBM carve-outs (as noted in the table above) for several reasons. Dental services are sufficiently different from other health care services that it makes sense to keep that benefit separate at this time. The only dental services covered by TennCare are services for children. With respect to the PBM, during the time when each MCO had its own pharmacy program, TennCare observed that plans were having difficulty managing the benefit, with higher than anticipated expenditure trends. We received complaints from providers, who were having difficulty managing and keeping up with several different formularies offered by several different MCOs. Having only one entity created important efficiencies for the program, providers and enrollees.

Several integration of care models have been developed over the years, with members who are dually eligible for Medicare and Medicaid being a population of particular interest.

Integration of services for dual eligibles. In 2011, Tennessee submitted a request to the new CMMI for one of the \$1 million planning grants that were to be awarded to fifteen states to develop proposals for integrating care for Medicare-Medicaid dual eligibles. On April 5, 2011, the state was notified that the request had been approved.

A good deal of work was put into developing the model over the following year, culminating in a proposal for a new program to be called “TennCare Plus,” which was submitted to CMMI on May 17, 2012. Throughout the summer and the fall of 2012, CMMI continued to issue guidance regarding expectations for states submitting successful proposals. In the face of significant financial and programmatic concerns, including the adequacy of rates that would be paid to managed care plans under the demonstration and extremely short timeframes for readiness and implementation activities, the state withdrew its proposal on December 21, 2012.

Nevertheless, TennCare has remained committed to better integration and coordination of care for dually eligible members. Tennessee is leveraging Medicare Part C authority and the D-SNP (Dual Eligible Special Needs Plan) platform to help align members in the same health plan for Medicare and Medicaid benefits. As part of the MCO procurement process in 2013, the state began requiring each MCO to set up a companion D-SNP so that members would have the opportunity to choose to receive their Medicare and Medicaid services from the same entity. TennCare makes use of the MIPPA (Medicare Improvements for Patients and Providers Act) agreement to strengthen coordination requirements for D-SNPs—particularly those related to discharge planning, care transitions, and use of LTSS. TennCare has implemented extensive education efforts for Medicaid members attaining Medicare eligibility status, and is providing prospective enrollment information to MCOs to support seamless conversion of members into an aligned D-SNP upon Medicare enrollment.¹⁰

¹⁰ Two of TennCare’s three MCOs have permission from CMS to implement seamless conversion of Medicaid members attaining Medicare enrollment, including advance notice and opportunity for opt-out.

3. Key Issue: Access and Program Participation

Supplemental pools (1994 – present). One of the waivers in the original TennCare Demonstration was a waiver of Disproportionate Share Hospital (DSH) payments. The first of several supplemental funding pools (called the Unreimbursed Public Hospital Cost Pool for Certified Public Expenditures) was authorized at that time. Other pools were added in subsequent years. The purpose of most of the pools was to reduce uncompensated care provided by Tennessee hospitals, but two of the pools have had different purposes. The Graduate Medical Education (GME) pool has been used to support retention of primary care physicians being trained at four specific universities with medical schools. The Meharry Medical College Pool has been devoted to assisting Meharry with the operation of clinics that provide indigent care. TennCare currently includes the following pools:

- ❖ Graduate Medical Education Pool (authorized on December 6, 1995)
- ❖ Critical Access Hospital Pool (authorized on May 30, 2002)
- ❖ Meharry Medical College Pool (authorized on April 17, 2003)
- ❖ Essential Access Hospital Pool (authorized on March 31, 2006)
- ❖ DSH payments (authorized on March 31, 2006)
- ❖ Unreimbursed Hospital Cost Pool (authorized on June 30, 2010)
- ❖ Public Hospital Supplemental Payment Pool (authorized on June 20, 2010)

The supplemental pools have played a key role in contributing to both access and participation. They have helped hospitals meet the challenges of serving high levels of Medicaid patients, as well as patients requiring uncompensated care. The pools will be discussed in detail in the report being prepared in response to STC #69 that is due on February 29, 2016.

4. Key Issue: Program Sustainability

Managing a program as large and as complex as TennCare requires constant attention to detail, careful monitoring from many different vantage points, and quick action when issues are identified. Like most states, Tennessee cannot overspend its budget. There is a Constitutional requirement for the state to maintain a balanced budget each year.

Through the years, state leaders have used a number of strategies for ensuring program sustainability. Some of those are discussed below.

Stabilization Plan (2001 – 2002). In the early years of TennCare, there was volatility among some of the MCOs. One strategy the state used to deal with this issue was the imposition of a time-limited Stabilization Plan, whereby risk would be removed for a period of time and the MCOs would operate essentially as ASOs. This period allowed the MCOs to regroup and to strengthen their respective infrastructures. CMS approved the implementation of the Stabilization Plan in STC #27, as stated in a letter dated May 30, 2002, and approved the ending of the Plan in Amendment #1.

TennCare Select (2001 – present). Another strategy that the state used to deal with MCO volatility in the program's early years was to develop a separate managed care plan that would

in essence be the state's plan. This plan was called TennCare Select, and it has been administered by Volunteer State Health Plan since its beginning. It is a Prepaid Inpatient Health Plan (PIHP) rather than an MCO. Its initial purpose was to provide a back-up arrangement that would allow the state to transfer members from a problem MCO quickly if that MCO should have to leave the program unexpectedly.

As time went on, TennCare Select began to be used for other purposes as well. Most MCOs were not statewide in scope during the early years of TennCare, which posed a problem for children in state custody, who sometimes had to move on short notice and then be re-assigned to a new MCO. The state began requiring that all children in state custody be enrolled in TennCare Select to ensure continuity and coordination of care, regardless of where the child lived. Another population served by TennCare Select is individuals who are residing outside the state temporarily. TennCare Select also reimburses providers of emergency services delivered to undocumented immigrants; these payments are required by Section 1903(v) of the Social Security Act.

TennCare Transformation (2004 – 2006). In the late summer of 2003, a coalition of groups including BlueCross BlueShield of Tennessee, the Farm Bureau, Hospital Corporation of America, Vanderbilt University, and twenty-two hospitals within the Tennessee Hospital Association entered into a contract with McKinsey & Company, an international consulting firm, for the purpose of conducting an independent study to assess the viability of TennCare over the next five years and to identify strategic options for improving its financial sustainability.

On December 11, 2003, and February 11, 2003, McKinsey issued two reports, stating their assessment that TennCare as it was constructed at the time was not financially viable and, without reform, would consume most of the state's new revenues by 2008.

On February 17, 2004, Governor Phil Bredesen addressed the Tennessee General Assembly and announced plans to reform TennCare so that it could remain financially viable. A "TennCare Transformation Team" was assembled. State workers, providers, and advocates formed four policy teams and four organization teams to develop detailed plans for "TennCare Transformation," following the Governor's directive that coverage for children, pregnant women, and individuals with disabilities be protected to the greatest extent possible.

On August 19, 2004, a draft of a massive Demonstration amendment for TennCare Transformation was released for public comment. Presentations and "listening sessions" were conducted in various Tennessee communities. The state received over 2,000 electronic, written, or telephone comments, and on September 24, 2004, the Demonstration amendment was submitted to CMS.

As part of TennCare Transformation, the state had requested relief from several consent decrees affecting TennCare. There were a number of discussions on this topic during this period, but these discussions were ultimately unsuccessful. In light of this development and continuing budgetary issues, the Governor announced on November 10, 2004, that he was setting in motion a process to end TennCare and return to a traditional Medicaid program.

On January 10, 2005, after reaching the conclusion that the state could no longer afford TennCare in its present form, the Governor announced a proposal for a “third way”—namely, to retain TennCare and to do everything possible to keep children on the program, but to eliminate the Uninsured and Uninsurable categories for adults and to implement some benefit reductions.

CMS was responsive to the state’s situation. Initially, CMS officials requested that the state divide the large amendment submitted in September 2004 into smaller amendments so that the problem could be addressed in more manageable phases.

Phase I. The first phase was the review of eligibility of all individuals age nineteen and older in the Uninsured and Uninsurable categories, with the understanding that those who were not eligible for an open Medicaid category would be disenrolled. (See Amendment #2.) In addition, new enrollment into the non-pregnant adult Medically Needy program was closed.

Phase II. The second phase involved making some modifications in benefits. (See Amendments #3 and #4.) Pharmacy benefits for most adults were limited to five prescription drugs or refills per month, with no more than two being brand-name drugs. In addition, a \$3.00 copay on brand-name drugs was put in place for non-exempt individuals.

The result of these changes was continuation of the TennCare program, but not at a level that would require every dollar of new state revenues.

Essential Coverage Fee (2010 – present). In 2010, the Tennessee General Assembly passed a one-year Essential Coverage Fee, which was a 3.52 percent hospital assessment fee. Revenues from the fee were used to avert severe program reductions that would otherwise have been required. The fee has continued and was increased to 4.52 percent in subsequent years.

Recent statistics. Tennessee’s emphasis on careful fiscal management has been recognized in recent years. In June 2014, the Government Accounting Office (GAO) published a report indicating that Tennessee’s Medicaid spend per enrollee, which was nearly \$2,000 below the average per state, was the fourth lowest Medicaid spend per enrollee nationwide.¹¹ This statistic is more impressive in light of the percentage of Medicaid enrollees with disabilities, typically a more expensive population to serve. Tennessee ranked sixth in the percentage of its Medicaid population with disabilities. Tennessee’s percentage (23.2 percent) was about 5.6 percentage points above the average state percentage (16.6 percent).¹²

According to a Pew report dated October 2015, among all states Tennessee had the second lowest change in Medicaid spending as a share of own-source revenue between the years of 2003 and 2013. The change of 0.3 percentage points in Tennessee was far below the national average change of 4.7 percentage points.¹³

¹¹ GAO, “Assessment of Variation Among States in Per-Person Spending,” June 2014, page 41.

¹² Ibid., page 51.

¹³ Pew Charitable Trusts, *Fiscal 50: State Trends and Analysis*, an interactive resource, October 8, 2015.

5. Key Issue: Eligibility

Program enrollment is one of the most important factors in the TennCare program. A certain amount of enrollment growth is expected each year, but economic downturns and other events may cause spikes in enrollment.

TennCare covers all mandatory Medicaid categories and many optional ones. There are several demonstration categories as well. Changes that have occurred in eligibility over the course of TennCare II are outlined below.

Medicaid categories.

- ❖ **BCCP (category added in 2002).** When TennCare II was introduced, the state added a new optional Medicaid group—Women Needing Treatment for Breast and/or Cervical Cancer.
- ❖ **Non-pregnant Medically Needy adults (category revised in 2005; closed in 2007).** Approval of the Demonstration extension that began in 2007 enabled the state to begin to address the Medically Needy program for non-pregnant adults, which had been closed to new enrollment on April 29, 2005, pursuant to Amendment #2. Persons enrolled in this program when it closed in 2007 were reviewed for eligibility in the new “Standard Spend Down” program once it was open. (See Amendment #5.) By agreement with CMS, the state submitted a SPA to remove the Medically Needy category for non-pregnant adults from the Medicaid State Plan. The effective date of the SPA was October 5, 2007. The Medically Needy category remains open for pregnant women and children.
- ❖ ***Daniels* class members (group established as the result of a class action suit brought in 1979; reverifications began in 2009).** On January 8, 2009, the Federal District Court lifted an injunction that had been in place for years in a case called *Daniels*. The issue in the case was the state's ability to properly redetermine the eligibility of individuals who had lost Supplemental Security Income (SSI) benefits and who would therefore have to qualify in another Medicaid category in order to remain eligible for Medicaid. The redetermination procedures developed by the state were approved both by CMS and by the Court. As a result of this decision, the state began redetermining the eligibility of all 147,000 *Daniels* class members, some of whom had been enrolled in TennCare for years after losing SSI without having had their eligibility redetermined. Those who were not found eligible in any open TennCare category were disenrolled. A portion of these class members had Medicare as another source of coverage.
- ❖ **Former Foster Care Children (category added in 2014).** When the new eligibility requirements of ACA went into effect on January 1, 2014, the state added the Former Foster Care Children category, which is a mandatory Medicaid eligibility category.

Demonstration categories.

- ❖ **Uninsureds and Uninsurables (1994).** As has been stated earlier, beginning in 2005, all 323,000 persons in the Uninsured or Uninsurable (also called Medically Eligible) categories who were nineteen years of age or older were checked for eligibility in an open Medicaid category. Those who were not found eligible for any open category were disenrolled from TennCare. The only Uninsured and Medically Eligible people remaining on the program today are children under age nineteen who have lost eligibility for Medicaid and who fall into one of the following two Demonstration categories:
 - Uninsured children
 - Medically Eligible (uninsurable) children

- ❖ **Standard Spend Down Group (2006).** Members of this group are adults age twenty-one and older who meet criteria patterned after the Medically Needy program, specifically the aged, blind, and disabled category and the category for caretaker relatives of Medicaid-eligible children. Amendment #28, submitted on October 8, 2015, requests the removal of this eligibility category from the Demonstration.

- ❖ **217-Like HCBS Group (2009).** This is a CHOICES category. Members meet the level of care (LOC) criteria for NF care but are receiving HCBS in lieu of NF care.

- ❖ **At Risk Demonstration Group (2012).** This is a CHOICES category that opened when the state revised its LOC criteria for NF care in 2012. The purpose of this category was to preserve a pathway to eligibility based on institutional income standards for persons needing LTSS in order to comply with the maintenance of effort (MOE) requirements of ACA. New enrollment in this category was originally scheduled to end on December 31, 2013, but it was extended through June 30, 2015. (*See Amendment #20.*) Persons who applied for CHOICES by June 30, 2015, and who were enrolled in this category can continue their enrollment as long as they continue to meet the LOC criteria and financial income standards that were in place when they enrolled, and they remain continuously enrolled in the category.

- ❖ **CHOICES 1 and 2 Carryover Group (2012).** This is a CHOICES category that was set up when the state revised its LOC criteria for NF care. It consists of individuals who were enrolled in CHOICES 1 or CHOICES 2 as of June 30, 2012, but who no longer qualify for CHOICES enrollment due solely to the state's modification of its NF LOC criteria. They are allowed to continue their enrollment in this category as long as they continue to meet the LOC criteria that were in place when they enrolled, they continue to meet all of the eligibility criteria for the CHOICES program, and they remain continuously enrolled in their category.

- ❖ **PACE Carryover Group (2012).** This category was established when the state revised its LOC criteria for NF care. It consists of individuals who were enrolled in PACE as of June 30, 2012, but who no longer qualify for enrollment due solely to the state's modification of its NF LOC criteria. They are allowed to continue their

enrollment in this category as long as they continue to meet the LOC criteria that were in place when they enrolled, they continue to meet all of the eligibility criteria for PACE, and they remain continuously enrolled in their category.

The TennCare eligibility categories are described in Table 1a of the STCs. This table was developed by CMS and requires some updating in order to reflect the state's implementation of MAGI-based Medicaid eligibility standards on January 1, 2014. If requested, the state will be glad to assist CMS in updating Table 1a.

6. Key Issue: Benefits

One of the “levers” for managing a Medicaid program is benefits. Some benefits are mandatory for Medicaid programs; others are optional. Even optional benefits may be mandatory for certain populations, such as children.

The TennCare benefit package is quite comprehensive and covers many more benefits than the Medicaid program that preceded TennCare. There are very few limits on covered benefits other than that they be medically necessary. Key changes related to benefits that have been proposed over the course of TennCare II are outlined below.

- ❖ **Differential benefits (2002).** One of the biggest changes associated with the roll-out of TennCare II was segmenting enrollees into two groups: TennCare Medicaid (for Medicaid enrollees) and TennCare Standard (for Demonstration enrollees). The chief purpose of separating the two groups was to offer differential benefits, with more generous benefits being available for the Tennessee Medicaid population than were offered to the TennCare Standard population.

This concept never got off the ground, however. Differential benefits were scheduled to go into effect on January 1, 2003, but were stopped by action of the U.S. District Court for the Middle District of Tennessee on December 18, 2002. These changes were re-scheduled for implementation on April 1, 2003, but then postponed indefinitely due to efforts underway to reach new agreements with the plaintiffs in four separate lawsuits filed against the state—*Grier* (1979), addressing medical appeals issues; *John B.* (1998), having to do with the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program; *Newberry* (1998), dealing with the provision of home health care; and *Rosen* (1998), addressing disenrollment procedures for Demonstration eligibles.

- ❖ **Prescription drug limits and copays (2005, 2007, 2013).** On July 29, 2005, the U.S. District Court for the Middle District of Tennessee issued a ruling in the *Grier* Consent Decree that allowed the state to move forward with certain benefit changes. These included a new limit on prescription drug coverage for non-institutionalized adults and a new copay requirement on brand-name prescriptions for non-exempt adults.¹⁴ After receiving approval from CMS, the state implemented these changes, as well as eliminating the adult dental program and coverage of methadone clinic

¹⁴ Non-exempt adults are those listed in 42 CFR § 447.56.

services for adults mentioned below. (*See Amendment #3.*) A list of drugs that would not count against the limit, called the “Automatic Exemption List,” was put into effect.

In 2007, the state implemented a program of “soft limits,” which came to be called the “Prescriber Attestation Process.” The purpose of this process was to allow enrollees who were subject to a limit on outpatient drugs to obtain additional prescriptions in urgent situations. Over 600 medications were initially identified for this process. When an enrollee had reached his benefit limit for a given month and his prescriber contacted TennCare and attested that the enrollee had an urgent need for an otherwise covered drug that was in excess of the benefit limit, TennCare would pay for the medication.

In 2013, the state added a \$1.50 copay for generic drugs that was applicable to those persons who were already paying a \$3.00 copay for brand-name drugs.

- ❖ **Adult dental benefits (2005).** The state closed the limited adult dental program that had been in place. (*See Amendment #3.*)
- ❖ **Methadone clinic services (2005).** These services became non-covered for adults. (*See Amendment #3.*)
- ❖ **Home health and private duty nursing (2008).** One of the advantages of monitoring data closely is that program leadership can pinpoint when use of a particular benefit may require some modifications. This happened with TennCare’s private duty nursing and home health benefits in 2008. Encounter data indicated that expenditures for these services were growing dramatically, and so TennCare proposed some controls. (*See Amendment #6.*) These controls included placing a limit on the number of hours of home health that would be approved for adults and restricting the private duty nursing benefit for adults to situations where the patient was dependent on certain types of technology.
- ❖ **CHOICES benefits (2009, 2015).** Certain benefits were made available under CHOICES that had not been TennCare benefits previously. In some cases, these benefits were offered prior to CHOICES through the state’s 1915(c) HCBS waivers for persons who were elderly and adults with physical disabilities. These waivers were phased out when CHOICES was implemented. Benefits new to the TennCare Demonstration included:
 - Adult day care
 - Assistive technology
 - Attendant care
 - Community-based residential alternatives
 - Home-delivered meals
 - In-home respite care
 - Inpatient respite care
 - Minor home modifications

- Personal care visits
- Personal Emergency Response System
- Pest control

7. Key Issue: Managed Care Contractors

It would be difficult to overstate the importance of the Managed Care Contractors (MCCs) in any Medicaid managed care program. They are the workhorses that make the program go. They perform key functions with respect to members, providers, and the state. Those functions include the following:

For members, the MCOs:

- ❖ Enroll members who are sent to them by the state. (The MCOs do not determine eligibility for TennCare.)
- ❖ Are the chief communicators with members and the primary source of their members' information about the program.
- ❖ Ensure that they have an adequate number of geographically accessible providers to serve their members.
- ❖ Assist their members in establishing satisfactory relationships with providers, and they coordinate care.
- ❖ Are available twenty-four hours a day to any member who contacts them.

For providers, the MCOs:

- ❖ Are the face of the program with the provider community.
- ❖ Recruit providers for their plans, answer their questions, help with referrals, and provide payment for services.

For the state, the MCOs:

- ❖ Are responsible for carrying out all of their contractual obligations.
- ❖ Collect and maintain critical data used by the state for reporting and program planning.

TennCare's MCCs at present include three MCOs, one Prepaid Inpatient Health Plan (PIHP), and two Prepaid Ambulatory Health Plans (PAHPs). The PIHP is TennCare Select, and the two PAHPs are the PBM and the DBM.

The names of TennCare's current MCCs are listed in Table 3.

Table 3
TennCare Managed Care Contractors as of December 1, 2015

| Type of MCC | Current TennCare MCC |
|-------------------------------|---|
| Managed Care Organizations | Amerigroup BlueCare ¹⁵ UnitedHealthcare Community Plan ¹⁶ |
| Prepaid Inpatient Health Plan | TennCare Select ¹⁷ |
| Pharmacy Benefit Manager | Magellan Health Services |
| Dental Benefit Manager | DentaQuest |

The MCO procurement process. When TennCare started in 1994, there were twelve MCOs—eight Health Maintenance Organizations (HMOs) and four Preferred Provider Organizations (PPOs). MCOs were allowed to participate if they met the state’s criteria, but they could decide for themselves whether they wanted to be statewide, regional, or local. A number of the MCOs were start-ups that were organized for the express purpose of participating in TennCare.

By 2003, TennCare required all health plans to be HMOs and to serve all areas within one of three Grand Regions of the state.

The first competitive procurement process for MCOs was used in 2006, to procure MCOs to serve the Middle Tennessee Grant Region beginning in 2007. This process was subsequently used to procure MCOs to serve the East and West Tennessee Grand Regions as well. The procurement process was designed in such a way that a prospective MCO could not simply outsource the writing of the proposal to a contractor. Representatives of the MCOs had to be able to explain how their organizations worked and how they would be able to respond to the state’s requirements.

Following MCO selection but prior to the start date, there was a lengthy and detailed readiness review process to ensure that all MCOs would be ready to begin delivering services on the very first day of operation. This process continues to evolve and now includes review of distinct deliverables, on-site review of critical processes and operating functions, demonstration of critical MCO systems, and end-to-end systems testing. One of the readiness activities that Tennessee found particularly useful was to ensure that each MCO had the names of all enrollees with special circumstances, such as those enrollees who needed to be transported to dialysis on day one, to ensure that services would proceed without interruption when the new MCOs took over.

The most recent phase of MCO development has been the transition to a statewide service delivery model, which was accomplished effective January 1, 2015. TennCare built on prior learnings to help ensure continuity of care for members during the transition, including

¹⁵ BlueCare is operated by Volunteer State Health Plan, Inc. (VSHP), which is an independent licensee of the Blue Cross BlueShield Association and a licensed HMO affiliate of its parent company, BlueCross BlueShield of Tennessee.

¹⁶ UnitedHealthcare Community Plan is operated by UnitedHealthcare Plan of the River Valley, Inc.

¹⁷ TennCare Select is operated by Volunteer State Health Plan, Inc. (VSHP).

processes for exchanging transition of care data between MCOs. The TennCare MCOs today are experienced, well-capitalized health plans with national reputations.

Oversight of MCCs. The state cannot expect MCCs to function well without providing clear guidance and skillful, steady, and consistent oversight. This oversight starts with the contract, or the Contractor Risk Agreement (CRA), as it is called at TennCare. The CRA for the MCOs today is about four times the size of the original CRA in 1994.¹⁸ It contains many specifics that make it clear what the state’s expectations are.

Contract monitoring is another key function. The state has learned that a systematic process for receiving and tracking contract deliverables is important. Every required deliverable has a designated “owner” at TennCare and an automated system for tracking the status of the deliverable. At the beginning of TennCare, owners kept up with deliverables using a paper-and-pencil process, which sometimes got interrupted or sidetracked when there were personnel changes. In recent years, the entire process has been automated so that managers can readily determine if a particular deliverable has not been received or has not been reviewed timely.

Tennessee has found it helpful to involve other agencies in contract monitoring. On January 26, 1995, a separate TennCare Oversight Division was set up by Executive Order at the Tennessee Department of Commerce and Insurance. The TennCare Oversight Division is responsible for helping maintain the health and the integrity of the TennCare program by overseeing, examining, and monitoring the MCOs participating in the program (all of which are HMOs). This division ensures that the MCOs are in compliance with statutory and contractual requirements relating to their financial responsibility, stability and integrity. The monitoring carried out by the TennCare Oversight Division is complementary to the more programmatically oriented monitoring that occurs at TennCare.

One decision each state must make is how many MCCs are needed and how the MCCs will be distributed—whether on a regional or statewide basis, as an example. In Tennessee’s experience, the ideal configuration of MCOs is statewide, and while it makes sense to continue to have “carve-outs” for the PBM and the DBM, other carve-outs (such as a BHO for mental health and substance abuse services) are not necessary. TennCare today has three MCOs plus TennCare Select, one PBM, and one DBM. All MCOs are NCQA-accredited.

8. Key Issue: Quality Redesign

In December 2014, TennCare’s Division of Quality Oversight began a series of meetings to assess current quality activities across MCOs. MCO participants in the various meetings included Chief Medical Officers, Quality Directors, EPSDT Coordinators, and Population Health Directors. TennCare’s Quality Oversight Director and Assistant Director, along with the Chief Medical Officer, met with these groups and collaboratively worked on needed changes. The meetings and their results are as follows:

¹⁸ The original MCO CRA in 1994 was 115 pages without attachments. The current MCO CRA is 424 pages without attachments.

- ❖ December 12, 2014 – This meeting included a review of all current quality metrics with a discussion of both challenges and priorities for quality improvement.
- ❖ January 20, 2015 – This meeting included TennCare’s Pharmacy Director and the PBM. Participants discussed procedures for ensuring that case managers had access to the PBM when necessary to assist enrollees. Subsequently, MCOs submitted names of case managers to the PBM and obtained appropriate access.
- ❖ February 19, 2015 – The core group met with Population Health Directors and Quality Directors for each MCO. Meeting participants discussed the appropriateness of continuing various collaborative workgroups to address specific quality improvement topics. The ultimate decision was that two workgroups should continue. The maternity workgroup would continue until the joint Provider Toolkit was completed and distributed to providers. This toolkit has subsequently been printed and a pilot project involving its use has begun. It was also decided that the EPSDT workgroup, which had been dormant for a few months, would continue addressing innovative ways to reach TennCare’s “under twenty-one” population and would address topics to include in teen newsletters.
- ❖ March 3, 2015 – This meeting addressed the selection of quality measures to be included in pay for performance incentives for both the MCOs as well as their network providers. The group’s joint decision included nine HEDIS (Healthcare Effectiveness Data and Information Set) measures on which all three health plans scored at 25 percent of the National Medicaid Average. The selected measures included both adult and child measures. The tenth measure selected was an EPSDT screening ratio, with the goal of achieving screening ratios of 90 percent or above. These measures were subsequently included in the MCO CRA and in the MCOs’ network provider contracts as appropriate.
- ❖ April 15, 2015 – This meeting included the core group in addition to the EPSDT Coordinators from each MCO. All MCO contract requirements related to EPSDT were reviewed for effectiveness, and change recommendations were made. After review by a number of TennCare staff, some of the existing contract citations were removed while other requirements were added.
- ❖ July 9, 2015 – A meeting was held with the core group and included the EPSDT Coordinators from each MCO, as well as the EPSDT Director for the Tennessee Department of Health. Possible ways to collaborate on outreach were discussed and plans for a subsequent meeting were made.

E. Progress on Objectives

The TennCare Evaluation Plan, originally approved by CMS in 2008, is focused on the seven goals that appear in Section II of the STCs. The Evaluation Plan contains a number of performance measures that have been developed to help the state meet these goals. Section VI of this extension request identifies these goals and reports progress on performance

measures that have been established and regularly updated in the state's Quality Improvement Strategy (QIS).

Highlights from Section VI include the following:

- ❖ **Cost effectiveness:** TennCare provides services at a cost that does not exceed what would have been spent in a Medicaid FFS program.
- ❖ **Access to care:** Current statewide weighted HEDIS rates show substantial improvement since 2007 in access to primary care providers for children and adolescents ages 7-19 and to preventive/ambulatory health services for adults ages 20-65.
- ❖ **Access to care:** A high percentage of TennCare heads of households (94 percent) and TennCare children (97 percent) report that they go to a doctor or clinic when they are first seeking care, rather than to a hospital.
- ❖ **Quality of care:** Improvements have been noted since 2007 in the following statewide weighted HEDIS rates: adolescent well-child visits, timeliness of prenatal care, breast cancer screening, and cervical cancer screening.
- ❖ **Improved health care:** Improvements have been noted since 2007 in the following statewide HEDIS rates: HbA1c testing and controlling high blood pressure. Areas of emphasis in the future will be improvements in EPSDT screening rates and in the statewide weighted HEDIS rate for antidepressant medication management in both the acute phase and the continuation phase.
- ❖ **Enrollee satisfaction:** Currently, 95 percent of TennCare enrollees report that they are satisfied with their care (and satisfaction has remained over 92 percent for the past seven years). Other measures where improvement has been demonstrated since 2007 are the statewide averages for CAHPS (Consumer Assessment of Healthcare Providers and Systems) getting needed care, always or usually, and getting care quickly, always or usually.
- ❖ **Stability and viability of health plans:** At present, 100 percent of the TennCare MCOs have demonstrated compliance with statutory and/or contractual claim processing standards in at least ten out of twelve months in the past calendar year. In State Fiscal Year 2015, TennCare's MCOs reported a compliance rate of 93.2 percent for all contractual claims payment accuracy reports.

F. Future Goals of the Program (2016 – 2021)

The goals of the TennCare program for the next five years will continue to focus on using a managed care approach to provide services to Medicaid- and Demonstration-eligible enrollees that is cost effective, that assures appropriate access to high-quality care, and that ultimately improves health outcomes for program enrollees. Areas of special focus during the next

approval period will build on lessons learned over the course of the Demonstration, with emphasis on areas that have emerged as promising arenas for innovation.

A major focus of future effort will be the work being done by the Tennessee Health Care Innovation Initiative under the two SIM grants that are discussed earlier in this Section. (*See page 8.*) Particular areas of interest include the following:

- ❖ Development and implementation of new “episodes of care,” which are models for coordinating services provided by multiple providers for specific health events, such as hip and knee replacements, and using these models to pay for value rather than volume
- ❖ Primary care transformation, to include establishment of patient-centered medical homes and health homes for members with severe mental illnesses and a multi-payer shared care coordination tool that will allow primary care providers to implement better care coordination in their offices
- ❖ Development of new core quality metrics for adults and children
- ❖ Aligning payment with value and with outcomes in the delivery of HCBS

In implementing these initiatives, HCFA has sought and continues to solicit input from diverse stakeholders, including payers, providers, professional organizations, employers, and the public. As we move forward, this collaborative effort will allow us to effectively implement statewide change with broad consensus.

Another area where work has been done that has led to the development of new goals is in the area of MLTSS. Through the implementation of the CHOICES program, we have learned a great deal about delivering MLTSS to traditional NF populations, and we believe there is opportunity to develop MLTSS models to serve persons with other types of significant disabilities. We further believe that these models have the potential to offer supports more cost effectively, and to align incentives that will help to improve employment, health, and quality of life outcomes for persons served. (*See Amendment #27.*)

Better coordination of care for dual eligibles is an area we will continue to pursue, leveraging the D-SNP platform to align enrollment for Medicare and Medicaid, while hoping to ultimately have greater flexibility to serve these individuals in truly integrated programs of care.

An area which we explored in some depth in developing our Insure Tennessee proposal is encouraging enrollees to take more responsibility for their own health care and to manage their care appropriately. We are interested in developing new models for patient engagement, taking into consideration current research and best practices that have been identified in this area.

Finally, we are intrigued by the possibilities that could accompany strategic visions for the future regarding collecting, analyzing, and making use of data. We have a rich supply of data in Tennessee, and we are interested in ways that this data could be more useful not only in supporting program directions and decisions for Medicaid but also for driving actions in the larger health care system of which Medicaid is a part. We are also interested in exploring how

data can be made more accessible and comprehensible to providers and enrollees alike, and in particular how data could be used by TennCare members to help inform and support their engagement in decision-making that leads to more efficient utilization of health care, as well as improved outcomes and satisfaction with care.

Section II

Narrative Description of Change Being Requested

The state is requesting only one change in the Demonstration. This change is a request to continue an existing authority.

In Waiver #9, “Retroactive Eligibility,” we are asking that the last sentence be deleted. This sentence deals with the expiration of this waiver on June 30, 2016, “unless otherwise approved based on the requirements of paragraph 8 (Extension of the Demonstration) of the STCs.” The waiver of retroactive eligibility has been in place since the beginning of the TennCare program, and it is fundamental to the state’s ability to encourage individuals to seek care before they get sick and to prepare them for the time when they will be entering the world of Qualified Health Plans and commercial insurance, where retroactive eligibility does not exist.

The TennCare Demonstration was established as a program to “demonstrate” that a managed care approach can be successful in delivering appropriate care cost effectively. It is impossible to demonstrate the value of managed care principles when neither the state nor its contractors (the MCCs) can identify the individuals whose care they are attempting to manage, which is the case with retroactive eligibility. The waiver of retroactive eligibility in Tennessee has worked well for the past twenty-two years and should be continued.

STC #68 requires a study of TennCare eligibility determination processes and the relationship of these processes to retroactive eligibility. The state contracted with Manatt, Phelps, & Phillips, LLP, to conduct this study, which is currently being finalized.

Section III

Requested Waivers and Expenditure Authorities

The state is requesting the same waiver and expenditure authorities as those approved in the current Demonstration.

Section IV
Summaries of EQRO Reports, MCO and State Quality Assurance Monitoring, and Other Documentation of the Quality of and Access to Care Provided Under the Demonstration

Tennessee monitors the quality of and access to care provided under the Demonstration in multiple ways. First, all managed care contracts require monitoring and reporting to the state of key aspects of quality, member experience, and access. In addition, Tennessee has developed and regularly updates a QIS that addresses quality standards and processes. The state also retains an External Quality Review Organization (EQRO) to evaluate the measurement and quality improvement activities undertaken by the state’s MCCs. Overall, Tennessee maintains a robust quality management program for persons enrolled in the Demonstration.

Table 4 is a list of major reports/tools used by TennCare to measure quality of and access to care, including a brief summary of the most recent available data for each.

Table 4
Summary of Current Reports/Findings on Quality of and Access to Care

| Report | Most Recent Report | Summary of Major Findings |
|--|---------------------------|---|
| Annual Provider Network Adequacy and Benefit Delivery Review (ANA) | 2015 | <p><u>Network Adequacy:</u></p> <ul style="list-style-type: none"> – All MCOs scored between 99.4 percent and 100 percent. – The DBM scored 100 percent. <p><u>Benefit Delivery:</u></p> <ul style="list-style-type: none"> – All MCOs scored above 99.9 percent. – The DBM scored 97.8 percent. |
| Annual Quality Survey (AQS) | 2015 | <p><u>Quality Process (QP):</u></p> <ul style="list-style-type: none"> – All MCOs achieved 100 percent compliance on at least seven of eight QP standards, and earned five stars for all QP standard scores. – The DBM achieved 100 percent compliance on twelve of eighteen QP standards, and earned five stars for seventeen of eighteen QP standard scores. <p><u>Performance Activities (PAs):</u></p> <ul style="list-style-type: none"> – All MCOs achieved 100 percent compliance on a majority of PAs, and earned either four or five stars for all PA scores. |

| Report | Most Recent Report | Summary of Major Findings |
|---|--------------------|--|
| | | <ul style="list-style-type: none"> - The DBM achieved 100 percent compliance and earned five stars for all PAs. |
| Performance Improvement Project (PIP) Validation Report | 2015 | For 2014-2015, all PIPs that were in progress for at least one year were validated. Out of thirty-seven PIPs, thirty-four achieved a “Met” validation status. |
| EPSDT Summary Report | 2014 | <p>Strengths and Areas of Need were identified for each MCO in areas that included: member communication, member outreach, and program coordination.</p> <p>Several strengths were identified, but areas of need were also noted for DBM.</p> |
| Validation of Performance Measures (PMV) | 2015 | <p>In 2015 the measures validated by the EQRO were:</p> <ul style="list-style-type: none"> - Use of Multiple Concurrent Antipsychotics in Children and Adolescents, and - Metabolic Monitoring for Children and Adolescents on Antipsychotics. <p>All MCOs were in full compliance with all standards.</p> |
| Provider Data Validation | 2015 | <p>This quarterly report documents the accuracy rate for each audited provider data element: contract status, address, whether provider is credentialed, panel status (open or closed), provides services to patients under/over age twenty-one, provides primary care services, provides prenatal care services.</p> <p>Overall ratings for the most recent audit (second quarter 2015) ranged from 92.1 percent to 99.9 percent.</p> |
| HEDIS/CAHPS Report | 2015 | <p>Out of thirty-three HEDIS measures tracked since 2007, twenty-eight have shown improvement over time (85 percent). These include measures related to access and availability, prevention and screening, and effectiveness of care.</p> <p>From 2013 to 2015, sixty-four HEDIS measures have exhibited improvement.</p> |
| TennCare Beneficiary Survey | 2015 | Member satisfaction rates have been tracked since 1994 and have reached an all-time high rating of 95 percent based on the most recent beneficiary survey conducted by the University of Tennessee. |
| CMS-416 Reports | 2014 | These CMS-generated tables show that for Fiscal Year 2014, the screening ratio for Tennessee (total number of screens/expected number of screens for the eligible population) was 0.73. |

A. Summaries of EQRO Reports

TennCare's most recent (2015) EQRO Technical Report indicates that TennCare's MCCs are exhibiting a strong commitment to members by delivering timely, accessible, and high-quality care. The report notes:

All TennCare MCCs continue to achieve high compliance with all EQRO-related activities. Systems and processes are routinely evaluated and improved across all aspects of health plan operations. Provider networks are adequate, and all MCCs have timely access to services. Additionally, member and provider satisfaction scores continue to be high. The MCCs remain focused on members with special healthcare needs, including dual-eligible members.

These findings are similar to those reported in the 2014 EQRO Technical Report.

EQRO reports from 2015 include the following findings:

Performance Measure Validations. In 2015, all TennCare MCOs were determined to be compliant with HEDIS Information Systems Standards. Results from 2015 indicate that all MCOs passed the validation of performance measure (PMV) audit and were determined to be in full compliance with all standards. The EQRO report notes that the MCOs maintained extremely high standards for data validation to ensure accuracy and had well-documented policies and procedures regarding the receipt and use of data.

Performance Improvement Projects. For 2014-2015, TennCare's MCCs were engaged in a number of performance improvement projects (PIPs) related to a variety of topics. Designed by the MCCs and approved by TennCare, PIPs entail using quality indicators to identify areas for targeted quality improvement interventions, measuring the effectiveness of implemented interventions, and planning activities for sustaining or increasing improvement. In 2014-2015, TennCare elected to have its EQRO validate all PIPs being conducted by the MCCs that had been in progress for at least one year. Of the thirty-seven PIPs evaluated, thirty-four achieved a "Met" validation status.

Annual Network Adequacy. This annual EQRO report includes TennCare's Annual Network Adequacy (ANA) evaluation scores, which measure network adequacy and benefit delivery. Network adequacy includes the number and type of providers in each MCC's provider network and the proximity of those providers to members. Benefit delivery evaluates each MCC's delivery of covered benefits to its members and providers. In 2015, all TennCare MCCs except one achieved network adequacy ratings greater than 99.9 percent. (One MCC received a network adequacy rating of 99.4 percent.) For benefit delivery, all of TennCare's MCOs achieved ratings that were above 99.9 percent. TennCare's DBM achieved a benefit delivery rating of 97.8 percent in 2015.

Annual Quality Survey. As part of the Annual Quality Survey (AQS) in 2015, all TennCare MCCs were assessed for compliance with quality process standards and performance activities based on contractual, regulatory, legislative, and judicial requirements. All MCOs

were determined to be compliant with quality process standards during the 2015 AQS. All MCOs achieved a compliance score of 100 percent for seven of the eight quality process standards and seven of the thirteen performance activities evaluated. The 2015 EQRO Report noted that TennCare’s MCCs demonstrated “exceptional” EPSDT program coordination efforts.

B. Summaries of MCO and State Quality Assurance Monitoring

HEDIS/CAHPS

Since 2006, TennCare has required all of its MCOs to be accredited by the NCQA. As part of the required NCQA accreditation, all TennCare MCOs report a full set of HEDIS measures.

Out of thirty-three HEDIS measures tracked since 2007, twenty-eight have shown improvement over time (85 percent). These include measures related to access and availability, prevention and screening, and effectiveness of care. From 2013 to 2015, improved statewide performance was noted for a total of sixty-four HEDIS measures.

Over the period of time from 2013 to 2015, improved statewide performance was noted for an array of child health measures, with many also exceeding the HEDIS National Medicaid Average for their respective year. Higher success rates were achieved on measures in all of the following HEDIS categories:

- ❖ Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents
- ❖ Childhood Immunization Status
- ❖ Immunizations for Adolescents
- ❖ Lead Screening in Children
- ❖ Appropriate Testing for Children with Pharyngitis
- ❖ Appropriate Treatment for Children with Upper Respiratory Infection
- ❖ Adolescent Well-Care Visits

From 2013 to 2015, improvement was also evident on measures in a variety of health categories applicable to adults, including Adults’ Access to Preventive/Ambulatory Health Services, Adult Body Mass Index (BMI) Assessment, Use of Appropriate Medications for Adults with Asthma, Medical Assistance with Smoking and Tobacco Use Cessation, Persistence of Beta-Blocker Treatment After a Heart Attack, Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis, and Pharmacotherapy Management of COPD Exacerbation.

Categories with special relevance to women’s health demonstrated progress over this time period as well: performance rose in both the Breast Cancer Screening and Human Papillomavirus Vaccine for Female Adolescents measures from 2013 to 2015.

HEDIS 2015 was the sixth year of statewide reporting of behavioral health measures following the integration of medical and behavioral health services among TennCare's health plans. Results superior to those in 2013 were achieved on measures in a number of behavioral health categories, including Antidepressant Medication Management, Follow-Up Care for Children Prescribed ADHD Medication, and Follow-Up After Hospitalization for Mental Illness.

Improvements have also been documented in statewide average CAHPS measures. From 2013 to 2015, improvements have been noted in a number of areas, including:

- ❖ Children (general), rating of all health care (rating of nine or ten)
- ❖ Children (general), rating of health plan (rating of nine or ten)
- ❖ Children with chronic conditions, getting care quickly (always or usually)
- ❖ Children with chronic conditions, rating of all health care (rating of nine or ten)
- ❖ Children with chronic conditions, rating of health plan (rating of nine or ten)
- ❖ Children with chronic conditions, coordination of care
- ❖ Adults, getting needed care (always or usually)
- ❖ Adults, getting care quickly (always or usually)
- ❖ Adults, rating of all health care (rating of nine or ten)
- ❖ Adults, rating of health plan (rating of nine or ten)

Beneficiary Survey

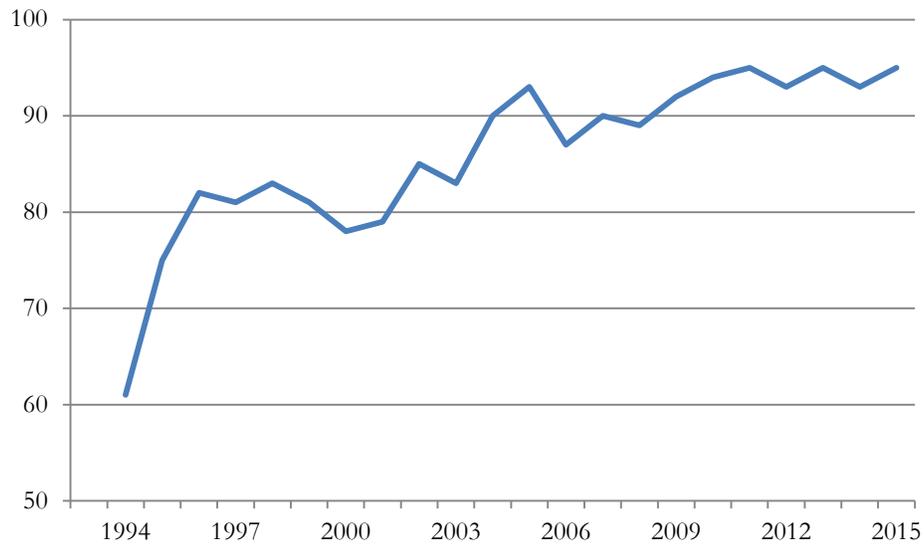
Every year since 1993, TennCare has contracted with the Center for Business and Economic Research (CBER) at the University of Tennessee to assess the opinions of TennCare enrollees about the health care they receive. Respondents provide feedback on a range of topics, including demographic information, perceptions of quality of care received, and behavior relevant to health care (the type of provider from whom an individual is most likely to seek initial care, the frequency with which care is sought, etc.). Survey findings from this Demonstration approval period have generally indicated high levels of enrollee satisfaction with TennCare. The percentage of respondents who reported being satisfied with the quality of care received from TennCare in 2015 was 95 percent. (2015 is the third time in the last five years that 95 percent satisfaction was achieved.)

The most recent (2015) beneficiary survey also indicated improvements in a number of areas, including:

- ❖ The percentage of respondents reporting that they sought initial medical care for themselves at hospitals (in non-emergency situations);
- ❖ The percentage of respondents reporting being able to get an appointment with a PCP for an illness quickly; and
- ❖ Respondents reporting receiving TennCare member materials at higher rates in 2015.

Figure 1 illustrates the reported level of member satisfaction with TennCare from 1994 to 2015.

Figure 1.
Percentage of Enrollees Reporting Satisfaction with TennCare, 1994-2015



C. Quality Improvement in CHOICES

TennCare implements a robust system of quality assurance and quality improvement strategies in the CHOICES program for adults who are elderly or who have physical disabilities. CHOICES quality assurance activities are continuously monitored and adjusted according to stakeholder input, contractor performance, programmatic changes, and continued evolution of the program. Current quality assurance activities include reports from contractors, contract compliance audits, care coordination monitoring, incident reporting and management, a concern and complaint process for members and providers, a CHOICES member satisfaction survey, HCBS settings and person-centered regulation compliance, annual quality assurance surveys of community living supports (CLS) and CLS-family model providers, and a CLS ombudsman. Information gathered from quality assurance activities is utilized to ensure timely remediation of individual issues and to systematically improve quality across the program.

In addition to the more “routine” aspects of TennCare’s LTSS quality improvement processes (e.g., readiness reviews, training and technical assistance, progressive sanctions, the CRA amendment process), TennCare has also undertaken an array of quality improvement initiatives around payment reform, person-centered planning and HCBS settings compliance, and the development of CHOICES program dashboards and report cards.

In 2013, TennCare was awarded a grant from the Robert Wood Johnson Foundation’s State Quality and Value Strategies Program to fund technical assistance in the state’s Quality Improvement in Long-Term Services and Supports (QuILTSS) value-based purchasing initiative. As part of the QuILTSS initiative, TennCare has developed a new payment approach based in part on a quality framework, including a core set of quality domains and

quality performance measures that will be collected to measure the quality of services provided by LTSS providers, both NFs and HCBS providers. The quality data are used in the calculation of payments in order to properly align incentives, enhance the customer experience of care, support better health and improved health outcomes for persons receiving LTSS, and improve quality performance over time.

Examples of the quality improvements already seen as a result of QuILTSS include:

- ❖ Ninety-eight percent of facilities are now conducting resident satisfaction surveys; 96 percent are conducting family satisfaction surveys; and 95 percent are conducting staff satisfaction surveys—up from 61 percent, 54 percent, and 63 percent, respectively, in the baseline measurement period when QuILTSS began.
- ❖ More importantly, the overwhelming majority of facilities are now using the information obtained through these survey processes to initiate specific quality improvement activities designed to improve satisfaction. Eighty-eight percent of facilities undertook quality improvement efforts related to resident satisfaction; 85 percent undertook quality improvement efforts targeted at family satisfaction; and 84 percent engaged in quality improvement efforts related to staff satisfaction—up from 45 percent, 34 percent, and 48 percent, respectively, in the baseline measurement period when QuILTSS began.
- ❖ The percentage of facilities conducting person-centered care or culture change assessments has increased from 15 percent to 85 percent since the QuILTSS initiative began. Moreover, the percentage of facilities undertaking specific quality improvement activities designed to support culture change and improve person-centered practices in their facilities has increased from just 7 percent to 81 percent.

TennCare systematically monitors the MCOs to identify and address potential gaps in care provided to CHOICES members. For example, during the twelve-month period from October 1, 2014, through September 30, 2015, more than 95 percent of all scheduled in-home case visits were completed, except for reasons initiated by the member. During this same time period, more than 99.5 percent of home care visits provided were on time, except for reasons initiated by the member.

Section V

Financial Data

With respect to budget neutrality assumptions and projections for the extension of the Demonstration, we have largely continued the trends as defined in the current approval period. A financial spreadsheet illustrating the state's projected expenditures for the requested period of the extension is presented in the Exhibit, which is being provided under separate cover.

Section VI

Interim Evaluation Report

The heart of TennCare's program evaluation involves outcome measures designed to determine whether program goals and objectives contained in the TennCare Evaluation Plan submitted to CMS and approved on March 31, 2008, have been met. Performance measures are those specified in the state's QIS. Progress toward these goals is gauged by physical and behavioral health performance measures implemented in 2007, with other measures added over time as needed.

The goals specified in the TennCare Evaluation Plan are taken from Section II of the STCs of the TennCare Demonstration agreement. They are:

- ❖ Use a managed care approach to provide services to Medicaid state plan and demonstration enrollees at a cost that does not exceed what would have been spent in a Medicaid fee-for-service program.
- ❖ Assure appropriate access to care for enrollees.
- ❖ Provide quality care to enrollees.
- ❖ Assure enrollees' satisfaction with services.
- ❖ Improve health care for program enrollees.
- ❖ Assure that participating health plans maintain stability and viability, while meeting all contract and program requirements.

After the TennCare CHOICES program was implemented in 2010, a seventh goal was added to the TennCare Demonstration:

- ❖ Provide appropriate and cost effective home and community based services that will improve the quality of life for persons who qualify for nursing facility care, as well as for persons who do not qualify for nursing facility care but who are "at risk" of institutional placement and that will help to rebalance long-term services and supports expenditures.

In this section, we describe progress toward these goals and their related performance measures. For purposes of this discussion, the program goals listed above have been organized into three groups. First, we discuss those goals related to medical and behavioral health. Then, we address measures related to efficiency, stability, and viability. Finally, we address the CHOICES program.

Table 5
Medical and Behavioral Health Measures

| Performance Measure | Baseline (2007) | 2015 Result | Status |
|--|--|--|-----------------------|
| <i>Goal 1: Assure appropriate access to care for enrollees.</i> | | | |
| 1.1 By 2016, the statewide weighted HEDIS rate for adults' access to preventive/ambulatory health services will increase to 83.4% for enrollees 20-44 years old and the rate for enrollees 45-64 years old will be maintained at 88.6% or above. | 70% for ages 20-44 74% for ages 45-64 | 77.03% for ages 20-44 87.95% for ages 45-64 | Objective in progress |
| 1.2 By 2016, the statewide weighted HEDIS rate for children and adolescents' access to PCPs will increase to 95.3% for enrollees 7-11 years old and 93.09% for enrollees 12-19 years old. | 87% for ages 7-11 82% for ages 12-19 | 93.55% for ages 7-11 89.96% for ages 12-19 | Objective in progress |
| 1.3 By 2016, 97% of TennCare heads of household and 98% or greater of TennCare children will go to a doctor or clinic when they are first seeking care rather than a hospital (emergency room). | 94% for heads of household 97% for children | 94% for heads of household 97% for children | Objective in progress |
| <i>Goal 2: Provide quality care to enrollees.</i> | | | |
| 2.1 By 2016, the statewide weighted HEDIS rate for adolescent well-care visits will increase to 47.20% | 35% | 47.18% | Objective in progress |
| 2.2 By 2016, the statewide weighted HEDIS rate for timeliness of prenatal care will be maintained at 82.7% or above. | 78% | 80.23% | Objective in progress |
| 2.3 By 2016, the statewide weighted HEDIS rate for breast cancer screening will increase to 46.9%. | 44% | 54.08% | Objective achieved |
| 2.4 By 2016, the statewide weighted HEDIS rate for cervical cancer screening will increase to 71.29%. | 63% | 64.83% | Objective in progress |
| <i>Goal 3: Assure enrollees' satisfaction with services.</i> | | | |
| 3.1 By 2016, 95% of TennCare enrollees will be satisfied with TennCare. | 90% | 95% | Objective achieved |
| 3.2 By 2016, the statewide average for adult CAHPS getting needed care always or usually will increase to 87.05%. | 78% | 84.87% | Objective in progress |
| 3.3 By 2016, the statewide average for child CAHPS getting care quickly always or usually will increase to 92.42%. | 79% | 91.77% | Objective in progress |
| <i>Goal 4: Improve health care for program enrollees.</i> | | | |
| 4.1 By 2016, the statewide weighted HEDIS rate for HbA1c testing will be increased to 83.51%. | 79% | 81.88% | Objective in progress |
| 4.2 By 2016, the statewide weighted HEDIS rate for controlling high blood pressure will increase to 59.14%. | 50% | 54.99% | Objective in progress |

| Performance Measure | Baseline (2007) | 2015 Result | Status |
|--|---|---|-----------------------|
| 4.3 By the end of each demonstration year, the state will achieve a total statewide EPSDT screening rate of at least 80%. | 77% | 73% ¹⁹ | Objective in progress |
| 4.4 By 2016, the statewide weighted HEDIS rate for antidepressant medication management will be increased to 52.04% for acute phase and 32.64% for continuation phase. | 50.11% for acute phase 32.03% for continuation phase | 48.62% for acute phase 31.39% for continuation phase | Objective in progress |

**Table 6
Efficiency, Stability and Viability Measures**

| Performance Measure | Baseline (2007) | 2015 Result | Status |
|---|-----------------|-------------|-----------------------|
| <i>Goal 1: Use a managed care approach to provide services to Medicaid State Plan and Demonstration eligibles at a cost that does not exceed what would have been spent in a Medicaid fee-for-service program.</i> | | | |
| During the course of the Demonstration, budget neutrality has been successfully maintained and reported in each Quarterly Progress Report submitted to CMS in accordance with STC #45. | | | |
| <i>Goal 2: Assure that health plans maintain stability and viability while meeting all contract and program requirements.</i> | | | |
| 2.1 By 2016, 100% of the TennCare MCOs will have demonstrated compliance with statutory and/or contractual claims processing timeliness standards in at least 10 out of 12 months in a calendar year. | 80% | 100% | Objective achieved |
| 2.2 By 2016, the MCOs will report a compliance rate of 95% for all contractual claims payment accuracy reports. | 91.5% | 93.2% | Objective in progress |

CHOICES

Since 2010, the CHOICES program has provided LTSS for TennCare members who are elderly or who are adults with physical disabilities. Some key outcomes achieved to date in the CHOICES program include:

- ❖ Since the program began, the total number of persons receiving HCBS in CHOICES has increased by nearly 170 percent (from 4,861 to 13,032, as of November 1, 2015).
- ❖ During the same period of time, the number of persons receiving NF services in CHOICES has declined by nearly 6,000 people (from 23,076 to 17,248).

¹⁹ EPSDT screening rate for 2014. The EPSDT screening rate for 2015 is not yet available.

- ❖ The percentage of persons coming into LTSS in a NF declined from 81.34 percent in the year immediately preceding CHOICES implementation to 47.93 percent as of June 30, 2014, with more than half of people choosing HCBS upon enrollment in CHOICES for each of the past two years.
- ❖ The average CHOICES member's length of stay in a NF has declined from 285 days to 250 days as of June 30, 2014.
- ❖ More than 2,500 individuals have transitioned from NFs to HCBS as of June 30, 2014, an average of 646 individuals per year, compared to 129 people in the baseline year immediately preceding CHOICES implementation.
- ❖ More than 10 percent of CHOICES members receiving HCBS (1,475) are actively participating in Consumer Direction for some or all of their HCBS, with more than 300 additional persons in various phases of the referral process. Consumer direction options were not available for this population prior to CHOICES implementation.

Because CHOICES did not exist when the TennCare Evaluation Plan was approved by CMS on March 31, 2008, the plan did not contain any goals specific to TennCare's LTSS program. STC #67 was added to the Demonstration after CHOICES began; it required that the state design and implement a special CHOICES study as one of the Demonstration's evaluation activities.

The CHOICES special study examined shifts in statewide use of NF services and HCBS, NF and HCBS expenditures, transitions from NF services to HCBS, and related issues. Overall, the data for 2011 through 2013 show a decrease in the number of NF service recipients, and an increase in HCBS participation over this time period, leading to a rebalancing of LTSS enrollment, as well as progress in rebalancing overall LTSS spending. The study also documents the cost effectiveness of HCBS versus NF services.

The CHOICES program expanded access to HCBS in a system where there had previously been fewer alternatives to NF placement. Once more cost effective HCBS were made widely available to TennCare members, participation in and expenditures for HCBS increased, resulting in an overall decrease in monthly spending on each CHOICES member during the period of time from 2011 to 2013. The data also indicate that transitions from NFs to HCBS increased over the two years studied.

By expanding access to HCBS, CHOICES has catalyzed a shift in utilization of and expenditures for NF services to HCBS. CHOICES has also helped the state avoid expenditures by promoting the use of less expensive HCBS when appropriate, while still providing NF care for individuals who require those services, allowing significantly more people to be served over time. It also follows that the increased participation in HCBS will delay or prevent the need for institutional placement for some individuals.

Additional information about the CHOICES special study, including more detail about the measures used in the study, is available in the CHOICES Special Study Report, which is included as Attachment B.

Section VII

Documentation of the State's Compliance with the Public Notice Process

The state has used multiple mechanisms for notifying interested parties about this application to extend the TennCare Demonstration and for soliciting public input on the application. These public notice and public input procedures are informed by—and comply with—the requirements specified at 42 C.F.R. § 431.408.

A. Public Notice and Input Procedures

The state's public notice and comment period began on November 12, 2015. A comprehensive description of the extension application to be submitted to CMS was made available for public review and comment on an extension-specific webpage on the TennCare website on that day. An easily identifiable link on TennCare's homepage referred users to the extension webpage. This extension-specific webpage, which was maintained and updated throughout the public comment and review process, included all of the following:

- ❖ The physical locations and internet address where copies of the extension application were available for public review;
- ❖ A mailing address and email address available for receiving public comments on the extension (along with instructions for requesting copies of public comments received);
- ❖ The locations, dates, and times of two public hearings to seek public comment on the extension; and
- ❖ Information about the state's public notice process, public input process, and a link to the relevant demonstration page on CMS's website.

Furthermore, the state developed an abbreviated public notice that included a summary description of the TennCare Demonstration; the locations, dates, and times of two public hearings; and a link to the full public notice on the state's extension-specific webpage. This abbreviated public notice was published in *The Tennessee Administrative Register* and in the newspapers of widest circulation in Tennessee cities with a population of 50,000 or more.

HCFA used several additional mechanisms to inform interested parties of the extension application process. HCFA staff made a presentation about the application to the state's Medical Care Advisory Committee (MCAC) on June 17, 2015, and again on December 16, 2015. On November 6, 2015, HCFA sent information about the application to more than 1,800 health care providers throughout the state via TennCare's provider listserv. On November 10, 2015, HCFA provided information about the application in an electronic newsletter disseminated to approximately fifty advocates, many of whom represent statewide advocacy associations, such as the Tennessee Disability Coalition, the Rural Health

Association of Tennessee, and the Tennessee Mental Health Consumers Organization. HCFA disseminated information about the extension application—including a link to the extension webpage—via Facebook and Twitter to individuals who have elected to receive updates about the TennCare program through these social networking media.

HCFA held two public hearings to seek public comment on the extension application. The first hearing took place on November 18, 2015, at 10:00 a.m. Central Time in the Auditorium of the Nashville Public Library, 615 Church Street in Nashville. The second public hearing took place on November 23, 2015, at 1:00 p.m. Central Time in Room 16 of Legislative Plaza, 301 6th Avenue North in Nashville. The times, dates, and locations of both public hearings were included in the state’s public notice and abbreviated public notice. Telephonic access to both hearings was made available for individuals unable to attend in person. Persons who wished to attend either hearing but who needed language or communication assistance, such as individuals with limited English proficiency or persons with disabilities, were encouraged to contact the HCFA Office of Civil Rights Compliance to ensure that appropriate accommodations could be made for them.

Tennessee has no federally recognized Indian tribes, Indian health programs, or urban Indian health organizations with which to consult or from which to seek advice.

Table 7 summarizes the state’s public notice and public input processes for this extension application.

Table 7
Summary of Public Notice and Input Processes

| Public Notice and Input Component | Date | Requirement |
|--|-------------------|--|
| Presentation on extension application made to MCAC | June 17, 2015 | 42 CFR 431.408(a)(2)(iii) |
| Information about extension application transmitted to health care providers via provider listserv | November 6, 2015 | 42 CFR 431.408(a)(2)(iii) |
| Information about extension application transmitted to state advocacy organizations via electronic newsletter | November 10, 2015 | 42 CFR 431.408(a)(2)(iii) |
| Public notice and comment period begins Extension-specific website launched, including a comprehensive description of the extension application, the state’s public notice and public input processes, and other required information | November 12, 2015 | 42 CFR 431.408(a)(1); 42 CFR 431.408(a)(2)(i) |
| Abbreviated public notice transmitted to the state’s administrative record (i.e., the Tennessee Administrative Register) | November 12, 2015 | 42 CFR 431.408(a)(2)(ii) |
| Abbreviated public notice sent to newspapers for publication | November 12, 2015 | 42 CFR 431.408(a)(2)(ii) |

| Public Notice and Input Component | Date | Requirement |
|---|-------------------|---------------------------|
| TennCare Facebook friends and Twitter followers notified of extension application | November 12, 2015 | 42 CFR 431.408(a)(2)(iii) |
| First public hearing held | November 18, 2015 | 42 CFR 431.408(a)(3) |
| Second public hearing held | November 23, 2015 | 42 CFR 431.408(a)(3) |
| Public notice and comment period ended | December 14, 2015 | 42 CFR 431.408(a)(1) |
| Presentation on extension application made to MCAC | December 16, 2015 | 42 CFR 431.408(a)(2)(iii) |

Materials documenting the state’s compliance with public notice and input requirements are available upon request.

B. Issues Raised by the Public During the Public Notice and Input Period

HCFA’s public notice and comment period began on November 12, 2015, and lasted through December 14, 2015. During this time, a draft of the extension application to be submitted to CMS was available for public review and comment on an extension-specific webpage. HCFA accepted written public comments by mail and e-mail and spoken and/or written public comments at two public hearings.

Three comments were received and are summarized in Table 8 below. Efforts were made to contact each writer who expressed concerns about his situation or that of another person to determine if there were ways that TennCare could help.

**Table 8
Comments Received**

| Commenter | Date | Vehicle for Comment | Substance of Comment |
|-----------|-------------------|----------------------------------|---|
| #1 | November 18, 2015 | Verbal comment at public hearing | The commenter said he was “grateful” that TennCare intended to extend the Demonstration and that he was in favor of all waivers—especially those with sensitive deadlines—being extended. |
| #2 | November 24, 2015 | e-mail | This woman and her son are on TennCare. Due to financial issues, she needs help. She has looked into the help offered by the Marketplace but has found it to be too expensive. She likes TennCare. “It is really quite a piece [sic] of mind knowing I can go to a doctor when I need to and be healthy so I can work.” |
| #3 | November 30, 2015 | e-mail | The writer’s brother is 63 years old and is receiving Social Security. He has no Medicare benefits at present. She |

| Commenter | Date | Vehicle for Comment | Substance of Comment |
|-----------|------|---------------------|------------------------|
| | | | requested information. |

C. Post-Award Public Input Process

HCFA will comply with all post-award public input requirements. Within six months of the renewal of the TennCare Demonstration (anticipated to begin on July 1, 2016), HCFA will hold a public forum to solicit comments on the progress of the Demonstration. After this first public forum, HCFA will convene a similar forum at least annually throughout the extension period. HCFA will publish the date, time, and location of each public forum on its public website at least thirty days prior to the forum date. Summaries of the comments received at each public forum will be included in the appropriate quarterly reports to CMS and in each annual report to CMS.

Attachments

Attachment A
TennCare II Demonstration Amendments

TennCare II Demonstration Amendments to Date

***Note regarding Amendments #9, #12, #15, #17, and #21:** In 2010, the Tennessee General Assembly passed a one-year hospital assessment fee, which was used in part to avoid significant reductions in program operations that would have been required without the fee. Each year since 2010, this fee has come up for renewal in the General Assembly, and each time it has been approved for one more year. Because the state did not know whether the fee would be approved in any given year, and because massive program reductions would have been required by July 1 if the fee had not been renewed, the state was required to file Amendments with CMS to be ready if the reductions were necessary. (CMS generally requires 120 days to review Demonstration Amendments.) Each of these five Amendments was withdrawn following the passage of the hospital assessment fee for the year in which the Amendment was requested. The state did not file a similar Amendment in 2015 because of early indications that the fee would continue.*

| Number | Date Submitted to CMS | Major Changes Requested | Date Approved by CMS |
|--------|-----------------------|--|----------------------|
| #1 | March 27, 2003 | Remove the Stabilization Neutrality Cap implemented as part of the stabilization period in which MCOs would operate under non-risk contracts. | April 29, 2003 |
| #2 | February 18, 2005 | <p>Close new enrollment into the Medically Needy category by non-pregnant adults and move those currently in the category at the end of their twelve month period of eligibility into another Medicaid category, if there was one for which they qualified.</p> <p>Close new enrollment into the Uninsured and Uninsurable categories for adults aged nineteen and older and move those currently in these categories into a Medicaid category, if there was one for which they qualified.</p> <p>Stop the practice of allowing TennCare adults aged nineteen and older who were leaving Medicaid to “roll over” into TennCare Standard if they qualified.</p> | March 24, 2005 |
| #3 | February 18, 2005 | <p>Eliminate pharmacy coverage for TennCare Standard adults.</p> <p>Implement a “soft limit” on pharmacy coverage for non-institutionalized TennCare Medicaid adults of five prescriptions or refills per month, of which no more than two may be brand name drugs.</p> | June 8, 2005 |

| Number | Date Submitted to CMS | Major Changes Requested | Date Approved by CMS |
|--------|-----------------------|--|----------------------|
| | | <p>Implement a nominal copay of \$3.00 per brand name prescription or refill for TennCare Medicaid adults not in an exempt group.</p> <p>Remove the out-of-pocket maximum applied to copays paid by TennCare Standard enrollees with incomes above poverty.</p> <p>Eliminate adult dental coverage.</p> <p>Eliminate coverage of methadone clinic services for adults.</p> | |
| #4 | September 1, 2005 | <p>Re-establish an annual MCO change period.</p> <p>Eliminate coverage of benzodiazepines and barbiturates for adults.²⁰</p> <p>Implement a practice of suspending persons from TennCare for one year if they had been convicted of a TennCare crime such as selling drugs obtained through TennCare. <i>[No action by CMS on this request.]</i></p> | March 31, 2006 |
| #5 | May 21, 2006 | Add a Standard Spend Down (SSD) Demonstration population of non-pregnant adults aged twenty-one or older who are aged, blind, disabled, or the caretaker relatives of Medicaid-eligible children (capped at 105,000 enrollees). | November 14, 2006 |
| #6 | May 19, 2008 | Implement limitations on the coverage of home health and private duty nursing services for adults. | July 22, 2008 |
| #7 | October 2, 2008 | Implement the CHOICES program offering managed LTSS to elderly adults and adults aged twenty-one or older with physical disabilities. | July 22, 2009 |
| #8 | September 28, 2009 | Remove lifetime limits on inpatient and outpatient substance abuse treatment services, in order to ensure compliance with the Mental Health Parity requirements of the Emergency Economic Stabilization Act of 2008. | December 15, 2009 |

²⁰ Coverage of benzodiazepines and barbiturates for adults resumed on January 1, 2014, in accordance with Section 2502 of the Affordable Care Act.

| Number | Date Submitted to CMS | Major Changes Requested | Date Approved by CMS |
|--------|-----------------------|--|----------------------|
| #9 | February 3, 2010 | Implement program reductions that would be needed without the passage of a hospital assessment fee for State Fiscal Year 2010-2011. <i>Withdrawn by the state upon passage of the hospital assessment fee and approval of Amendment #10.</i> | Withdrawn |
| #10 | May 14, 2010 | Add two new pools to be called the Unreimbursed Hospital Cost (UHC) Pool and the Public Hospital Supplemental Payment (PHSP) Pool. The Regional Medical Center in Memphis was originally the only participant in the PHSP. | June 30, 2010 |
| #11 | July 21, 2010 | Add a second hospital—Metro General Hospital in Nashville—to the list of participants in the PHSP Pool. (See Amendment #10.) | December 16, 2010 |
| #12 | February 28, 2011 | Implement program reductions that would be needed without the passage of a hospital assessment fee for State Fiscal Year 2011-2012. <i>Withdrawn by the state on May 5, 2011, after passage of the hospital assessment fee.</i> | Withdrawn |
| #13 | December 15, 2011 | Increase the enrollment cap of CHOICES 2 to a range of 8,500 to 12,500 in Demonstration Year 10 ²¹ and a range of 11,000 to 15,000 in Demonstration Year 11. ²² <i>On March 1, 2012, the part of this amendment that dealt with DY 10 was withdrawn. The part dealing with DY 11 was combined with Amendment #14.</i> | Withdrawn |
| #14 | March 1, 2012 | Open an Interim CHOICES 3 group ²³ in order to be able to preserve a pathway to eligibility for persons needing LTSS and to ensure compliance with the MOE provisions of ACA when the state revises its LOC criteria for NF admission. | June 15, 2012 |

²¹ DY 10 corresponds to the state's Fiscal Year 2011-2012.

²² DY 11 corresponds to the state's Fiscal Year 2012-2013.

²³ "Interim CHOICES 3" was a new category requested in Amendment #14. This category was composed of persons who were elderly and adults with physical disabilities who met the criteria for Nursing Facility placement that were in effect on June 30, 2012, but who did not meet the LOC criteria in effect on July 1, 2012.

| Number | Date Submitted to CMS | Major Changes Requested | Date Approved by CMS |
|--------|-----------------------|---|---|
| #15 | March 1, 2012 | Implement program reductions that would be needed without the passage of a hospital assessment fee for State Fiscal Year 2012-2013. <i>Withdrawn by the state on April 26, 2012, after passage of the hospital assessment fee.</i> | Withdrawn |
| #16 | April 13, 2012 | Ensure that the state is able to draw down the full Congressional Disproportionate Share Hospital (DSH) appropriation each year. | June 15, 2012 |
| #17 | February 4, 2013 | Implement program reductions that would be needed without the passage of a hospital assessment fee for State Fiscal Year 2013-2014. <i>Withdrawn by the state on April 26, 2013, after passage of the hospital assessment fee.</i> | Withdrawn |
| #18 | March 7, 2013 | Add Assisted Care Living Facility (ACLF) services under certain circumstances to the list of benefits available to member of CHOICES 3 (including members of Interim CHOICES 3). | June 24, 2015 |
| #19 | April 26, 2013 | Implement a nominal copayment of \$1.50 per generic prescription or refill for TennCare Medicaid and TennCare Standard enrollees who were already subject to a \$3.00 copayment for brand name prescriptions. | July 16, 2013 |
| #20 | December 17, 2013 | Extend the end date for open enrollment in Interim CHOICES 3 from December 31, 2013, to June 30, 2015. Remove the Essential Access Hospital (EAH) pool from the list of pool payments subject to the annual cap of \$540 million, and increase the EAH pool to compensate for the end of Tennessee's DSH allotment. Add a third hospital—Erlanger Medical Center in Chattanooga—to the list of participants in the PHSP Pool. (See Amendments #10 and #11.) | Approval for Interim CHOICES 3 component: December 30, 2013 Approval for DSH and PHSP components: March 28, 2014 |
| #21 | January 27, 2014 | Implement program reductions that would be needed without the passage of a hospital | Withdrawn |

| Number | Date Submitted to CMS | Major Changes Requested | Date Approved by CMS |
|--------|-----------------------|---|----------------------|
| | | assessment fee for State Fiscal Year 2014-2015. <i>Withdrawn by the state on April 25, 2014, after passage of the hospital assessment fee.</i> | |
| #22 | May 8, 2014 | Implement maximum allowable copayments for inpatient stays (\$75), outpatient visits (\$4), and non-emergency use of the Emergency Department (\$8). ²⁴ There was also a request to be able to limit adult diapers to 200 per person per month, but the state agreed to address this issue through the MCOs' prior approval processes. | Pending |
| #23 | July 28, 2014 | Provide non-ambulatory services to presumptively eligible pregnant women and postpartum women. | September 5, 2014 |
| #24 | March 4, 2015 | Add two new community-based residential alternative services to the menu of benefits covered by CHOICES: Community Living Supports (CLS) and Community Living Supports-Family Model (CLS-FM). | June 24, 2015 |
| #25 | Not submitted | Implement Tennessee Governor Bill Haslam's "Insure Tennessee" proposal, a two-year pilot program to extend coverage to low-income adults between the ages of 19 and 65. | N/A |
| #26 | April 8, 2015 | Extend the expenditure authority for hospital pool payments (i.e., Expenditure Authority #4 of the TennCare Demonstration) from December 31, 2015, to June 30, 2016. | December 11, 2015 |
| #27 | June 23, 2015 | Implement Employment and Community First CHOICES, a new program of managed LTSS that delivers Home and Community Based Services (HCBS) to individuals with intellectual and developmental disabilities. | Pending |
| #28 | October 8, 2015 | End the SSD category and assist enrollees in that category in finding other coverage. | Pending |
| #29 | Not submitted | Implement benefit reductions that would be required if Amendment #26 is not approved. | N/A |

²⁴ These maximum amounts are applicable in managed care states that do not have fee-for-service payment rates.

Attachment B
CHOICES Special Study Report

CHOICES Special Study Report

Baseline, Re-Measurement Period 1 and Re-Measurement Period 2 Data

December 2015

**Division of Long Term Services & Supports
Bureau of TennCare
310 Great Circle Road
Nashville, Tennessee 37243**

Primary Special Study Question

What effects did the CHOICES program have on the use of institutional versus home and community-based services?

Background

CHOICES is an integrated Medicaid Managed Long Term Services and Supports (MMLTSS) program. The goals of the CHOICES program are to expand access to Home and Community Based Services (HCBS), rebalance LTSS expenditures between Nursing Facility (NF) services and HCBS, provide cost-effective HCBS as an alternative to institutional care, and delay or prevent the need for institutional placement.

In the CHOICES program, at-risk Managed Care Organizations (MCOs) coordinate physical and behavioral health and long-term services and supports for eligible members. Upon implementation in 2010, there were two groups comprising the total CHOICES population: Group 1, consisting of persons who received Medicaid-reimbursed care in a NF; and Group 2, consisting of persons age sixty-five (65) and older and adults age twenty-one (21) and older with physical disabilities who also met NF level of care, but elected to remain in the community and receive HCBS as an alternative to NF care.

CHOICES Group 3 was added on July 1, 2012 and consisted of persons age sixty-five (65) and older and adults age twenty-one (21) and older with physical disabilities that did not meet NF level of care but, in the absence of HCBS, were found to be “at-risk” of needing NF placement. Group 3 was implemented when the State changed its NF level of care (i.e., medical eligibility) criteria, targeting the more expensive NF benefit to individuals with higher acuity of need. The same standard which had previously been sufficient for approval of NF level of care—a single significant deficiency in activities of daily living—became the threshold for a new “At Risk” level of care—qualifying for HCBS, but not for NF services.

CHOICES Group 1 defines the entire population of NF care recipients. CHOICES Groups 2 and 3 define the population of HCBS recipients.

In Tennessee, there are three MCOs contracted with the Bureau of TennCare to provide long-term services and supports to CHOICES enrollees: Amerigroup, BlueCare, and United Healthcare Community Plan. During the study period, Amerigroup operated only in the middle region of the state. BlueCare operated in the eastern and western regions of the state. United Healthcare Community Plan operated in all 3 regions. Thus, there were two MCOs operating in each region.¹

¹ At the end of calendar year 2013, TennCare completed a competitive procurement, awarding three (3) statewide MCO contracts. Effective January 1, 2015, Amerigroup, BlueCare and United Healthcare Community Plan, all incumbents who won the procurement, operate statewide.

Evaluation Focus

This evaluation examines the impact of the CHOICES program on the Tennessee's long-term services and supports system during calendar years 2011, 2012 and 2013. This study reviewed the effects of CHOICES on rebalancing nursing facility (NF) and home and community based services (HCBS) participants, rebalancing NF and HCBS expenditures, the cost-effectiveness of HCBS versus NF services, and transitions from NF to HCBS as well as transitions from HCBS to NF. The study focuses on statewide changes in these areas as well as a comparison of performance across the TennCare MCOs over time.

Evaluation Design

The TennCare Division of Quality Oversight developed five separate study indicators to gather information about the effects of CHOICES on rebalancing NF and HCBS participants and expenditures and on transitions (see Attachment 1). The study indicators addressed Group 1 (NF residents) and Group 2 (HCBS recipients) CHOICES users during 1/1/11 – 12/31/11 (Baseline), and included Group 3 (HCBS recipients) CHOICES users for the last six months of 1/1/12 – 12/31/12 (Re-measurement Period 1) and 1/1/13 – 12/31/13 (Re-measurement Period 2). To be included in this study as a CHOICES user, individuals had to be members enrolled in CHOICES for a minimum of thirty (30) continuous days and continuously enrolled in the health plan during the measurement period with no more than one thirty (30) day gap in enrollment during each measurement period. TennCare obtained statewide and MCO information from interChange, the state's Medicaid Management Information System of record.

Results

1. NF vs. HCBS Participants

a. Member Months for NF Recipients

Statewide, member months for NF recipients as a percentage of all CHOICES member months decreased 15.76% and member months for HCBS participants as a percentage of all CHOICES member months increased 41.23% between 2011 and 2013 (see Attachment 2 for full data tables showing numerator and denominator values for each of the study indicators).² The average number of NF member months out of all CHOICES member months decreased from 72.35% to 60.95% within two years (-15.76%). Per MCO, decreases in the number of NF member months varied from 11.43% (BlueCare East) to 17.50% (UHC West) and 20.09% (BlueCare West) during this time period.

1a: Member months of eligible CHOICES NF users at the date of measurement ÷ Member months of all eligible CHOICES users at date of measurement

| | Baseline | Year 1 | % Change 2011-2012 | Year 2 | % Change 2011-2013 |
|------------------|---------------------|---------------------|-----------------------|---------------------|-----------------------|
| | 1/1/2011-12/31/2011 | 1/1/2012-12/31/2012 | | 1/1/2013-12/31/2013 | |
| | Metric | Metric | | Metric | |
| Statewide | 72.35% | 66.33% | -8.32% | 60.95% | -15.76% |
| Amerigroup | 70.42% | 64.92% | -7.81% | 59.38% | -15.68% |
| BlueCare East | 69.67% | 66.23% | -4.94% | 61.71% | -11.43% |
| BlueCare West | 71.27% | 62.51% | -12.29% | 56.95% | -20.09% |
| UHC East | 75.56% | 70.17% | -7.13% | 65.22% | -13.68% |
| UHC Middle | 71.15% | 64.48% | -9.37% | 58.87% | -17.26% |
| UHC West | 75.56% | 68.43% | -9.44% | 62.34% | -17.50% |

NOTE—All instances of “% Change” utilized the formula of (B-A)/A where “A” represents the initial year of measurement. The formula represents the amount of increase or decrease from the starting point.

² Note that the table depicts, as described in the narrative, member months by service setting as a percentage of total CHOICES member months, and not the percentage increase or decrease in each population, which for HCBS in particular, would be *significantly* higher. The CHOICES Baseline Data Report to CMS (reported on a program, rather than calendar year) shows a greater than 150% increase in HCBS participants during the first three program years (as of June 30, 2013), and a 15.8% decline in NF residents.

b. Member Months for NF Recipients

Following implementation in July 2012, Group 3 increased participation in HCBS for those individuals at risk of being placed in a NF during the latter half of 2012 and all of 2013. There was a corresponding increase in the percentage of HCBS member months out of all CHOICES member months, statewide (41.23%) and per MCO (ranging from 26.24%-BlueCare East to 49.84%-BlueCare West and 54.09%-UHC West).

1b: Member months of eligible CHOICES HCBS users at date of measurement ÷ Member months of all eligible CHOICES users at date of measurement

| | Baseline | Year 1 | % Change 2011-2012 | Year 2 | % Change 2011-2013 |
|------------------|---------------------|---------------------|-----------------------|---------------------|-----------------------|
| | 1/1/2011-12/31/2011 | 1/1/2012-12/31/2012 | | 1/1/2013-12/31/2013 | |
| | Metric | Metric | | Metric | |
| Statewide | 27.65% | 33.67% | 21.77% | 39.05% | 41.23% |
| Amerigroup | 29.58% | 35.08% | 18.59% | 40.62% | 37.32% |
| BlueCare East | 30.33% | 33.77% | 11.34% | 38.29% | 26.24% |
| BlueCare West | 28.73% | 37.49% | 30.49% | 43.05% | 49.84% |
| UHC East | 24.44% | 29.83% | 22.05% | 34.78% | 42.31% |
| UHC Middle | 28.85% | 35.52% | 23.12% | 41.13% | 42.56% |
| UHC West | 24.44% | 31.57% | 29.17% | 37.66% | 54.09% |

2. NF vs. HCBS Expenditures

NF services accounted for 87.67% of total long term care expenditures in Tennessee during 2011, and decreased to 78.23% of total long term care expenditures in 2013, amounting to a 10.77% shift from NF to HCBS expenditures over two years. Among the MCOs, the shift in expenditures from NF to HCBS varied from 7.98% (UHC East) to 11.62% (UHC West) and 14.58% (BlueCare West) from Baseline to Year 2.

2a: Dollar amount of all CHOICES expenditures for NF services ÷ Total dollar amount of CHOICES expenditures for both NF and HCBS services

| | Baseline | Year 1 | % Change 2011-2012 | Year 2 | % Change 2011-2013 |
|------------------|---------------------|---------------------|-----------------------|---------------------|-----------------------|
| | 1/1/2011-12/31/2011 | 1/1/2012-12/31/2012 | | 1/1/2013-12/31/2013 | |
| | Metric | Metric | | Metric | |
| Statewide | 87.67% | 82.35% | -6.07% | 78.23% | -10.77% |
| Amerigroup | 85.33% | 78.70% | -7.77% | 75.49% | -11.53% |
| BlueCare East | 87.96% | 83.63% | -4.92% | 80.85% | -8.08% |
| BlueCare West | 86.70% | 77.58% | -10.52% | 74.06% | -14.58% |
| UHC East | 90.06% | 86.49% | -3.96% | 82.87% | -7.98% |
| UHC Middle | 86.73% | 82.19% | -5.23% | 76.78% | -11.47% |
| UHC West | 88.32% | 84.13% | -4.74% | 78.06% | -11.62% |

There were corresponding increases in HCBS expenditures statewide (76.56%) and per MCO (ranging from 59.05%-UHC East to 87.84%-UHC West and 95.04%-BlueCare West). The addition of Group 3 in July 2012 catalyzed a shift toward HCBS in the way long term care dollars were spent in Tennessee during the measurement period.

2b: Dollar amount of all CHOICES expenditures for HCBS services ÷ Total dollar amount of CHOICES expenditures for both NF and HCBS services

| | Baseline | Year 1 | % Change 2011-2012 | Year 2 | % Change 2011-2013 |
|------------------|---------------------|---------------------|-----------------------|---------------------|-----------------------|
| | 1/1/2011-12/31/2011 | 1/1/2012-12/31/2012 | | 1/1/2013-12/31/2013 | |
| | Metric | Metric | | Metric | |
| Statewide | 12.33% | 17.65% | 43.15% | 21.77% | 76.56% |
| Amerigroup | 14.67% | 21.30% | 45.19% | 24.51% | 67.08% |
| BlueCare East | 12.04% | 16.37% | 35.96% | 19.15% | 59.05% |
| BlueCare West | 13.30% | 22.42% | 68.57% | 25.94% | 95.04% |
| UHC East | 9.94% | 13.51% | 35.92% | 17.13% | 72.33% |
| UHC Middle | 13.27% | 17.81% | 34.21% | 23.22% | 74.98% |
| UHC West | 11.68% | 15.87% | 35.87% | 21.94% | 87.84% |

3. NF vs. HCBS Cost Effectiveness

a. NF and HCBS Combined Per Member Per Month (PMPM) Expenditures

Statewide, an average of \$2,895.53 was spent per month per CHOICES member (expenditures for both NF and HCBS combined) in 2011. This amount decreased to \$2,775.56 in 2013, representing an overall decrease of \$119.97 (or 4.14% reduction) in monthly spending on each CHOICES member over two years.³

Among the MCOs, average savings per CHOICES member (NF and HCBS) combined ranged from \$101.87 PMPM (BlueCare East, with a 3.60% decrease in expenditures over two years) to \$194.97 (UHC Middle, with a 6.70% decrease in expenditures over two years). Only one MCO, Amerigroup, had an increased PMPM expenditure of \$126.01, or a 4.65% change in total expenditures between 2011 and 2013. Amerigroup demonstrated the largest increase in expenditures for NF, HCBS, and total expenditures (NF + HCBS); however, they began at a lower cost per person and with the exception of HCBS, were more in line with other MCOs during the second measurement period.

3a: Total dollar amount of CHOICES expenditures for NF and HCBS services ÷ Member months of all eligible CHOICES users at time of measurement

| | Baseline | Year 1 | % Change 2011-2012 | Year 2 | % Change 2011-2013 |
|------------------|---------------------|---------------------|-----------------------|---------------------|-----------------------|
| | 1/1/2011-12/31/2011 | 1/1/2012-12/31/2012 | | 1/1/2013-12/31/2013 | |
| | Metric | Metric | | Metric | |
| Statewide | \$ 2,895.53 | \$ 2,792.43 | -3.56% | \$ 2,775.56 | -4.14% |
| Amerigroup | \$ 2,709.71 | \$ 2,886.51 | 6.52% | \$ 2,835.72 | 4.65% |
| BlueCare East | \$ 2,826.99 | \$ 2,711.72 | -4.08% | \$ 2,725.12 | -3.60% |
| BlueCare West | \$ 3,005.30 | \$ 2,849.33 | -5.19% | \$ 2,813.76 | -6.37% |
| UHC East | \$ 2,903.47 | \$ 2,761.43 | -4.89% | \$ 2,720.41 | -6.30% |
| UHC Middle | \$ 2,908.46 | \$ 2,715.80 | -6.62% | \$ 2,713.49 | -6.70% |
| UHC West | \$ 3,061.54 | \$ 2,859.89 | -6.59% | \$ 2,871.67 | -6.20% |

³ Both NF and HCBS rates of reimbursement are set by the State, so reductions would be based on changes in utilization of LTSS—primarily, members choosing more cost-effective HCBS over NF services.

b. NF PMPM Expenditures Only

An average of \$3,508.68 was spent per month per NF member in 2011. This amount decreased to \$3,466.98 in 2012 but increased to \$3,562.54 in 2013, representing an increase of \$53.86 (or 1.54%) in spending from 2011 to 2013 per month for each NF member. During this time, there were fewer individuals receiving NF services, but the cost of providing NF services to those individuals was higher. This is a function of the cost-based reimbursement system for NF services, and the higher costs that are ostensibly related to higher acuity levels of persons served in NFs.⁴

NF service expenditures varied less than 1% between 2011 and 2013 for all MCOs except for Amerigroup, who experienced an increase of 9.81%. It is possible that Amerigroup members who left the NF to receive HCBS were mostly short term stay patients or those with lesser support needs, leaving those with very high acuity behind.

3b: Dollar amount of all CHOICES expenditures for NF services ÷ Member months of eligible CHOICES NF users at the date of measurement

| | Baseline | Year 1 | % Change 2011-2012 | Year 2 | % Change 2011-2013 |
|------------------|---------------------|---------------------|-----------------------|---------------------|-----------------------|
| | 1/1/2011-12/31/2011 | 1/1/2012-12/31/2012 | | 1/1/2013-12/31/2013 | |
| | Metric | Metric | | Metric | |
| Statewide | \$ 3,508.68 | \$ 3,466.98 | -1.19% | \$ 3,562.54 | 1.54% |
| Amerigroup | \$ 3,283.21 | \$ 3,499.49 | 6.59% | \$ 3,605.30 | 9.81% |
| BlueCare East | \$ 3,569.09 | \$ 3,424.16 | -4.06% | \$ 3,570.28 | 0.03% |
| BlueCare West | \$ 3,655.77 | \$ 3,536.49 | -3.26% | \$ 3,659.53 | 0.10% |
| UHC East | \$ 3,460.80 | \$ 3,403.56 | -1.65% | \$ 3,456.75 | -0.12% |
| UHC Middle | \$ 3,545.31 | \$ 3,461.74 | -2.36% | \$ 3,538.84 | -0.18% |
| UHC West | \$ 3,578.50 | \$ 3,515.60 | -1.76% | \$ 3,595.96 | 0.49% |

⁴ The increase in acuity of persons served in NFs is attributable both to effective diversion and transition practices implemented in CHOICES, as well as changes in NF level of care criteria effective July 1, 2012, that were specifically intended to target NF services to persons with higher acuity of need, while offering HCBS to persons “at risk” of NF placement.

c. HCBS PMPM Expenditures Only

An average of \$1,291.29 was spent per month per HCBS member in 2011. This amount increased to \$1,463.55 in 2012 (13.34%) and then to \$1,547.43 in 2013, representing an overall increase of \$256.14, or 19.84%, over a two-year period. Individuals diverted from the NF during Year 1 may have been those individuals with fairly low needs for supports in the community, who could be assisted with low to moderate growth in the cost of service provision.

During Year 2, TennCare raised its NF level of care criteria, targeting NF services to persons with higher acuity of need, and diverting nearly 20% of persons who would have formerly been served in a NF to the community. Thus, members participating in HCBS had higher acuity of need, and required more expensive or additional supports than those targeted for diversion the previous year. The new standards were effective on July 1, 2012, or half of the measurement period in Year 1 and all of the measurement period in Year 2. Amerigroup had the largest per member HCBS expenditure growth (27.29%) followed by BlueCare (24.48%-East and 21.83%-West). UHC had the smallest increase in per member HCBS expenditures (13.46%-East, 14.31%-West, and 14.51%-Middle).

3c: Dollar amount of all CHOICES expenditures for HCBS services ÷ Member months of eligible CHOICES HCBS users at the date of measurement

| | Baseline | Year 1 | % Change 2011-2012 | Year 2 | % Change 2011-2013 |
|------------------|---------------------|---------------------|-----------------------|---------------------|-----------------------|
| | 1/1/2011-12/31/2011 | 1/1/2012-12/31/2012 | | 1/1/2013-12/31/2013 | |
| | Metric | Metric | | Metric | |
| Statewide | \$ 1,291.29 | \$ 1,463.55 | 13.34% | \$ 1,547.43 | 19.84% |
| Amerigroup | \$ 1,344.14 | \$ 1,752.32 | 30.37% | \$ 1,710.90 | 27.29% |
| BlueCare East | \$ 1,122.02 | \$ 1,314.53 | 17.16% | \$ 1,363.06 | 21.48% |
| BlueCare West | \$ 1,391.31 | \$ 1,703.69 | 22.45% | \$ 1,695.08 | 21.83% |
| UHC East | \$ 1,180.74 | \$ 1,250.62 | 5.92% | \$ 1,339.65 | 13.46% |
| UHC Middle | \$ 1,337.89 | \$ 1,361.57 | 1.77% | \$ 1,532.02 | 14.51% |
| UHC West | \$ 1,463.42 | \$ 1,438.27 | -1.72% | \$ 1,672.86 | 14.31% |

d. NF vs HCBS Cost-Effectiveness Comparisons

1) PMPM Expenditure Savings in HCBS

Across all of the MCOs and across all measured years, HCBS were more cost-effective than NF services. With changes in NF level of care beginning the second half of Year 1 that diverted members with higher acuity from a NF to the community, the difference between NF and HCBS expenditures decreased; however, statewide and for most of the MCOs, the PMPM NF expenditures exceeded HCBS expenditures by more than \$2,000 in each of the measured years. The exception was for the MCOs in the west that had NF expenditures exceeding HCBS expenditures by more than \$1,800 PMPM in Year 1 and Year 2.

3d: Dollar amount difference between the PMPM cost of NF services and HCBS (NF PMPM–HCBS PMPM)

| | Baseline | Year 1 | % Change 2011-2012 | Year 2 | % Change 2011-2013 |
|------------------|---------------------|---------------------|-----------------------|---------------------|-----------------------|
| | 1/1/2011-12/31/2011 | 1/1/2012-12/31/2012 | | 1/1/2013-12/31/2013 | |
| | Metric | Metric | | Metric | |
| Statewide | \$2,217.39 | \$2,003.43 | -9.65% | \$2,015.11 | -9.12% |
| Amerigroup | \$1,939.07 | \$1,747.17 | -9.90% | \$1,894.40 | -2.30% |
| BlueCare East | \$2,447.07 | \$2,109.63 | -13.79% | \$2,207.22 | -9.80% |
| BlueCare West | \$2,264.46 | \$1,832.80 | -19.06% | \$1,964.45 | -13.25% |
| UHC East | \$2,280.06 | \$2,152.94 | -5.58% | \$2,117.10 | -7.15% |
| UHC Middle | \$2,207.42 | \$2,100.17 | -4.86% | \$2,006.82 | -9.09% |
| UHC West | \$2,115.08 | \$2,077.33 | -1.78% | \$1,923.10 | -9.08% |

2) Percentage of PMPM Expenditure Savings in HCBS

CHOICES NF PMPM expenditures exceeded HCBS PMPM expenditures by a significant amount. With only a single exception, in all measured years and across all MCOs, NF PMPM expenditures were more than twice the amount of HCBS expenditures (NF > 100% higher than HCBS). In Year 1 for Amerigroup, NF PMPM expenditures were less than one half of one percent shy of doubling HCBS expenditures. The percentage of NF PMPM expenditures over HCBS expenditures decreased in Year 1 with the diversion of individuals with higher acuity needs to HCBS, but NF PMPM expenditures were still greater than 130% higher than HCBS expenditures in both Years 1 and 2.

3e: Percentage by which PMPM NF expenditures exceeded PMPM HCBS expenditures {metric= (NF-HCBS)/HCBS}

| | Baseline | Year 1 | % Change 2011-2012 | Year 2 | % Change 2011-2013 |
|------------------|---------------------|---------------------|-----------------------|---------------------|-----------------------|
| | 1/1/2011-12/31/2011 | 1/1/2012-12/31/2012 | | 1/1/2013-12/31/2013 | |
| | Metric | Metric | | Metric | |
| Statewide | 171.72% | 136.89% | -20.28% | 130.22% | -24.17% |
| Amerigroup | 144.26% | 99.71% | -30.88% | 110.73% | -23.25% |
| BlueCare East | 218.10% | 160.49% | -26.41% | 161.93% | -25.75% |
| BlueCare West | 162.76% | 107.58% | -33.90% | 115.89% | -28.80% |
| UHC East | 193.10% | 172.15% | -10.85% | 158.03% | -18.16% |
| UHC Middle | 164.99% | 154.25% | -6.51% | 130.99% | -20.61% |
| UHC West | 144.53% | 144.43% | -0.07% | 114.96% | -20.46% |

4. NF to HCBS Transitions

a. All NF to HCBS Transitions

Transitions of NF members to HCBS increased over time on a statewide basis. Of NF members, transitions to HCBS increased from 3.42% during 2011 to 4.10% of those eligible for CHOICES NF services during 2012, and then to 4.18% during 2013. Between 2011 and 2013, there was a 22.22% increase in the transitions from NF residents to HCBS.

The increase in NF to HCBS transitions during the special study period is largely accounted for by the performance of BlueCare East and BlueCare West. Among the MCOs, BlueCare East increased their transitions 55.50% during Year 1, and 106.50% by Year 2. However, Blue Care East started with the lowest number of transitions (79) during 2011 (see Attachment A), so it had farther to go in order to reach the transition levels achieved by the other MCOs. BlueCare West had the second highest percentage of change for both years, at 30.82% and 24.26%, respectively. It also had a low number of transitions during the baseline year (87). Amerigroup’s transition increases (20.95% in 2011 and 19.83% in 2012) were very close to the statewide increases over time (19.88% after Year 1 and 22.22% after Year 2). UHC Middle increased their transitions by 29.48% between 2011 and 2012 but only increased 0.74% between 2011 and 2013, which likely constrained the total increase of NF to HCBS transitions over this time period. During Year 1, UHC Middle actually had more transitions from NF to HCBS out of all NF eligible members than the other MCOs. The following year, they had returned to the baseline transition rate. The remainder of the UHC Middle NF members in 2012 may not have been appropriate for transition following a very thorough campaign to transition individuals to HCBS during 2011.

4a: Number of unique CHOICES users who transitioned from NF to HCBS ÷ Average number of unique users eligible for CHOICES NF services during the measurement period

| | Baseline | Year 1 | % Change 2011-2012 | Year 2 | % Change 2011-2013 |
|------------------|---------------------|---------------------|-----------------------|---------------------|-----------------------|
| | 1/1/2011-12/31/2011 | 1/1/2012-12/31/2012 | | 1/1/2013-12/31/2013 | |
| | Metric | Metric | | Metric | |
| Statewide | 3.42% | 4.10% | 19.88% | 4.18% | 22.22% |
| Amerigroup | 3.58% | 4.33% | 20.95% | 4.29% | 19.83% |
| BlueCare East | 2.00% | 3.11% | 55.50% | 4.13% | 106.50% |
| BlueCare West | 3.05% | 3.99% | 30.82% | 3.79% | 24.26% |
| UHC East | 3.72% | 4.01% | 7.80% | 4.37% | 17.47% |
| UHC Middle | 4.07% | 5.27% | 29.48% | 4.10% | 0.74% |
| UHC West | 3.99% | 3.86% | -3.26% | 4.31% | 8.02% |

b. NF to HCBS Transitions with a Minimum 90-day Retention in the Community

Of those CHOICES members who transitioned from a NF to HCBS *and* received HCBS for 90 days or longer, the percentage of transitions to HCBS statewide increased from 2.13% to 2.61% during the first year and returned to 2.13% during the second year. Over the study period, the percentage of HCBS members remaining in the community for 90 days or longer increased 22.54% on a statewide basis between 2011 and 2012, and did not change between 2011 and 2013. This may have resulted from the population of members eligible for NF services declining over time and the acuity of remaining residents increasing, resulting in individuals with more complex care needs transitioning.

After Year 1, transitions from a NF to HCBS for 90 days or longer increased by a range of 12.37% (BlueCare West) to 49.22% (UHC Middle) for all but one MCO (UHC West), who only experienced a 0.74% increase. Following Year 2, only BlueCare East showed an increase (85.27%) since 2011. Of BlueCare East NF members, transitions to HCBS lasting for 90 days or longer increased from 1.29% to 1.52% between 2011 and 2012, and then increased to 2.39% out of those eligible for NF services. BlueCare West had a 1.61% increase and UHC East had a 1.48% decrease in the number of members with transitions to HCBS lasting 90 days or longer. Amerigroup, UHC Middle, and UHC West all experienced decreases from 2011 to 2013 (12.29%, 12.40%, and 20.45%, respectively). This may have resulted from some MCOs selecting the most obvious candidates for successful transition during the first year, and later (particularly once NF level of care criteria changed and more people were diverted from NF placement to the community) finding that the remaining population had more complex requirements for community support.

4b: Number of CHOICES users who transition from NF to HCBS and remain in HCBS for 90 days or longer ÷ Average number of unique users eligible for CHOICES NF services during the measurement period

| | Baseline | Year 1 | % Change 2011-2012 | Year 2 | % Change 2011-2013 |
|------------------|---------------------|---------------------|-----------------------|---------------------|-----------------------|
| | 1/1/2011-12/31/2011 | 1/1/2012-12/31/2012 | | 1/1/2013-12/31/2013 | |
| | Metric | Metric | | Metric | |
| Statewide | 2.13% | 2.61% | 22.54% | 2.13% | 0.00% |
| Amerigroup | 2.36% | 2.75% | 16.53% | 2.07% | -12.29% |
| BlueCare East | 1.29% | 1.52% | 17.83% | 2.39% | 85.27% |
| BlueCare West | 1.86% | 2.09% | 12.37% | 1.89% | 1.61% |
| UHC East | 2.03% | 2.64% | 30.05% | 2.00% | -1.48% |
| UHC Middle | 2.58% | 3.85% | 49.22% | 2.26% | -12.40% |
| UHC West | 2.69% | 2.71% | 0.74% | 2.14% | -20.45% |

5. HCBS to NF Transitions

a. ALL HCBS to NF Transitions

Statewide, HCBS to NF transitions decreased 9.01% between 2011 and 2012, but increased 13.25% between 2011 and 2013. Some of this increase may be attributed to the certain operational practices that were part of implementing NF level of care criteria changes and the new CHOICES Group 3 population of persons “at risk” of NF placement. At the inception of the new CHOICES 3 at-risk group, if a NF applicant was found not to meet NF level of care, but met the at-risk level of care criteria, he or she was approved for HCBS and enrolled in CHOICES Group 3, subject to all other applicable enrollment criteria. If, during the initial comprehensive assessment by an MCO (or anytime thereafter) a determination was made that the person’s needs could not be safely met in the community, a transition to NF was then completed.⁵

With this caveat, only Amerigroup improved in terms of HCBS to NF transitions over time, experiencing a decrease of 4.48% between 2011 and 2013. Of the Amerigroup HCBS members, 12.94% transitioned to NFs in 2011 while 12.36% transitioned in 2013. BlueCare East, BlueCare West, and UHC East experienced the greatest increase transitions from HCBS to NF from 2011 to 2013, at 22.50%, 23.20%, and 28.37%, respectively. UHC Middle and UHC West experienced the smallest increases (8.11% and 11.34%, respectively) among the MCOs after two years.

5a: Number of unique CHOICES users who transitioned from HCBS to NF ÷ Average number of unique users eligible at any time for CHOICES HCBS during the measurement period

| | Baseline | Year 1 | % Change 2011-2012 | Year 2 | % Change 2011-2013 |
|------------------|---------------------|---------------------|-----------------------|---------------------|-----------------------|
| | 1/1/2011-12/31/2011 | 1/1/2012-12/31/2012 | | 1/1/2013-12/31/2013 | |
| | Metric | Metric | | Metric | |
| Statewide | 11.32% | 10.30% | -9.01% | 12.82% | 13.25% |
| Amerigroup | 12.94% | 7.91% | -38.87% | 12.36% | -4.48% |
| BlueCare East | 11.60% | 13.97% | 20.43% | 14.21% | 22.50% |
| BlueCare West | 8.45% | 8.99% | 6.39% | 10.41% | 23.20% |
| UHC East | 13.43% | 11.05% | -17.72% | 17.24% | 28.37% |
| UHC Middle | 10.85% | 10.40% | -4.15% | 11.73% | 8.11% |
| UHC West | 9.35% | 9.13% | -2.35% | 10.41% | 11.34% |

⁵ Changes were implemented in 2014 that include the assessment of safety *before* determining level of care, helping to ensure the most appropriate services and setting prior to initial enrollment in CHOICES. In addition, since 2014, persons are only enrolled into Group 3 after indicating that they do, in fact, want to begin receiving HCBS.

b. HCBS to NF Transitions with a Less Than 90-day NF Stay

While transitions from HCBS to short-term (i.e., less than 90-day) NF stays statewide increased slightly (2.36%) between 2011 and 2012, they ultimately increased 16.51% between 2011 and 2013. Across MCOs, there was great variance between 2011 and 2012, ranging from an increase of 37.86% (BlueCare East) to a decrease of 32.63% (Amerigroup). Between 2011 and 2013, there was an increase for all MCOs except Amerigroup (with a decrease since 2011 of 8.64%), from 14.35% (UHC Middle) to 51.18% (UHC West). With the increase of 51.18%, UHC West contributed significantly to the increase of these transitions. This data suggests both that MCOs may be making effective use of short-term NF stays to address post-acute care needs with transition back to HCBS as soon as possible, and also that individuals may be remaining in the community for as long as possible before being placed in a NF—when their care needs dictate a more intensive setting at end of life.

5b: Number of unique CHOICES users who transitioned from HCBS to NF for and remained in NF for less than 90 days ÷ Average number of unique users eligible at any time for CHOICES HCBS during the measurement period

| | Baseline | Year 1 | % Change 2011-2012 | Year 2 | % Change 2011-2013 |
|------------------|---------------------|---------------------|-----------------------|---------------------|-----------------------|
| | 1/1/2011-12/31/2011 | 1/1/2012-12/31/2012 | | 1/1/2013-12/31/2013 | |
| | Metric | Metric | | Metric | |
| Statewide | 4.24% | 4.34% | 2.36% | 4.94% | 16.51% |
| Amerigroup | 5.21% | 3.51% | -32.63% | 4.76% | -8.64% |
| BlueCare East | 4.20% | 5.79% | 37.86% | 5.32% | 26.67% |
| BlueCare West | 2.96% | 3.84% | 29.73% | 3.49% | 17.91% |
| UHC East | 5.27% | 4.54% | -13.85% | 6.61% | 25.43% |
| UHC Middle | 4.18% | 4.47% | 6.94% | 4.78% | 14.35% |
| UHC West | 2.97% | 3.70% | 24.58% | 4.49% | 51.18% |

c. HCBS to NF Transitions with a 90 to 179-day NF Stay

Statewide, transitions from HCBS to NF resulting in NF stays between 90 and 179 days (an intermediate-term stay) decreased by 18.95% between 2011 and 2012 and increased 4.90% from 2011 to 2013. Among the MCOs, all three UHC regions experienced decreased transitions of this type between 2011 and 2012, and increased transitions between 2011 and 2013 (although UHC Middle’s increase was very small at 1.00% versus UHC West at 8.70% and UHC East at 18.11%). BlueCare East experienced increased transitions from HCBS to intermediate NF stays during both years (an increase of 28.62% between 2011 and 2012 and 18.52% between 2011 and 2013). BlueCare West and Amerigroup experienced decreases in transitions to intermediate NF stays during both periods (35.14% and 12.16% for BlueCare West and 44.74% and 5.26% for Amerigroup). As previously noted, this may have resulted from the higher acuity of persons being served in the community over the study period.

5c: Number of unique CHOICES users who transitioned from HCBS to NF and remained in NF between 90 and 179 days ÷ Average number of unique users eligible at any time for CHOICES HCBS during the measurement period

| | Baseline | Year 1 | % Change 2011-2012 | Year 2 | % Change 2011-2013 |
|------------------|---------------------|---------------------|-----------------------|-------------------------|-----------------------|
| | 1/1/2011-12/31/2011 | 1/1/2012-12/31/2012 | | 1/1/2013- 12/31/2013 | |
| | Metric | Metric | | Metric | |
| Statewide | 3.06% | 2.48% | -18.95% | 3.21% | 4.90% |
| Amerigroup | 3.04% | 1.68% | -44.74% | 2.88% | -5.26% |
| BlueCare East | 2.97% | 3.82% | 28.62% | 3.52% | 18.52% |
| BlueCare West | 2.96% | 1.92% | -35.14% | 2.60% | -12.16% |
| UHC East | 3.70% | 2.62% | -29.19% | 4.37% | 18.11% |
| UHC Middle | 2.99% | 2.53% | -15.38% | 3.02% | 1.00% |
| UHC West | 2.53% | 2.23% | -11.86% | 2.75% | 8.70% |

d. HCBS to NF Transitions with a greater than 180-day NF Stay

The change between 2011 and 2012 on a statewide basis for those transitioning from HCBS to NF and staying for 180 days or longer (a long-term stay) was a decrease of 13.32%. Between 2011 and 2013, there was an increase of 16.21%. Among the MCOs, Amerigroup experienced a decrease of 42.00% between 2011 and 2012 and a nominal (0.64%) increase between 2011 and 2013. BlueCare West was the only MCO that experienced an increase in transitions to long term NF stays during both Years 1 and 2, with an increase of 28.06% between 2011 and 2012 and 70.75% between 2011 and 2013, contributing to the overall increase of these transitions over time. BlueCare East experienced a decrease of 1.81% over the first year and an increase of 21.22% between Baseline and Year 2. All of the UHC regions experienced a decrease during the first year (ranging from 7.61%-UHC Middle, 12.78%-UHC East, and UHC West-16.93%), but only UHC West experienced a decrease after the second year (17.45%). UHC Middle and UHC East experienced increases, 6.52% and 40.46%, respectively.

5d: Number of unique CHOICES users who transitioned from HCBS to NF and remained in NF for 180 days or longer ÷ Average number of unique users eligible at any time for CHOICES HCBS during the measurement period

| | Baseline | Year 1 | % Change 2011-2012 | Year 2 | % Change 2011-2013 |
|------------------|---------------------|---------------------|-----------------------|-------------------------|-----------------------|
| | 1/1/2011-12/31/2011 | 1/1/2012-12/31/2012 | | 1/1/2013- 12/31/2013 | |
| | Metric | Metric | | Metric | |
| Statewide | 4.01% | 3.48% | -13.32% | 4.66% | 16.21% |
| Amerigroup | 4.69% | 2.72% | -42.00% | 4.72% | 0.64% |
| BlueCare East | 4.43% | 4.35% | -1.81% | 5.37% | 21.22% |
| BlueCare West | 2.53% | 3.24% | 28.06% | 4.32% | 70.75% |
| UHC East | 4.46% | 3.89% | -12.78% | 6.26% | 40.46% |
| UHC Middle | 3.68% | 3.40% | -7.61% | 3.92% | 6.52% |
| UHC West | 3.84% | 3.19% | -16.93% | 3.17% | -17.45% |

Conclusions

For most of the study indicators, the effects of the CHOICES program on the use of institutional versus home and community-based services produced the expected results. The introduction of changes in NF level of care criteria (to be more in line with other states) midway through Year 1 of the study period impacted certain measures by increasing the acuity of need of persons served in NFs and in the community; but nonetheless, helped move the program forward in advancing its goals.

The data for 2011 through 2013 shows a decrease in member months for NF services and an increase in member months for HCBS over this time period, leading to a rebalancing of LTSS spending. Member months for NF recipients as a percentage of all CHOICES member months decreased by 15.76% among CHOICES members from 2011 to 2013. Member months for HCBS increased by 41.23% during the study period. Total expenditures for NF services decreased 10.77% while those for HCBS increased 76.56% over the course of the study period.

The CHOICES program expanded access to HCBS in a system where there had previously been fewer alternatives to NF placement. Once more cost-effective HCBS were made widely available to TennCare members, participation in and expenditures for HCBS increased, resulting in an overall decrease of \$119.97 in monthly spending on each CHOICES member during this time period, including NF residents, even though the average PMPM cost of providing NF services increased. The savings were achieved not by reducing the amount of services that people in HCBS receive, but rather by serving more people, based on their setting of preference, in more cost-effective HCBS rather than in a NF.

Across all of the MCOs and across all measured years, HCBS were more cost-effective than NF services. Statewide and for most of the MCOs, the NF PMPM expenditures exceeded HCBS expenditures by more than \$2,000 in each of the measured years. For the remaining MCOs, NF expenditures exceeded HCBS expenditures by more than \$1,800. With only a single exception, in all measured years and across all MCOs, NF PMPM expenditures were more than twice the amount of HCBS expenditures (NF>100% higher than HCBS).

The data also indicates that transitions from NFs to HCBS increased 22.22% over two years. During 2012, MCOs ostensibly chose individuals who were more easily transitioned to HCBS, reflecting a statewide increase in the number of transitions to HCBS lasting for 90 days or more. During 2013, that percentage returned to 2011 levels, as those members still residing in the NFs, presumably with higher acuity, comprised the available population from which MCOs could transition their members. This phenomenon also impacted HCBS to NF transitions, causing a statewide decrease during 2012, and an increase during 2013, with transitions from HCBS to NF increasing 13.25% from 2011 to 2013.

By expanding access to Home and Community Based Services (HCBS), CHOICES has catalyzed a shift in utilization and expenditures for NF services to HCBS. CHOICES also helped the state avoid expenditures by promoting the use of less-expensive HCBS while still providing NF care for individuals who require those services, allowing significantly more people to be served over time. It also follows that the increased participation in HCBS will delay or prevent the need for institutional placement. We anticipate that CHOICES will continue to rebalance LTSS delivery in the future away from NF services and toward HCBS, as more people choose to receive cost-effective care in the community.

Attachment 1: Measurement Methodologies

The five study indicators were as follows:

1. NF Service Recipients vs. HCBS Participants
 - a. $\frac{\text{Member months of eligible CHOICES users in Group 1 at the date of measurement}}{\text{Member months of all eligible CHOICES users at date of measurement}}$
 - b. $\frac{\text{Member months of eligible CHOICES users in Group 2 and 3 at date of measurement}}{\text{Member months of all eligible CHOICES users at date of measurement}}$
2. NF vs. HCBS Expenditures
 - a. $\frac{\text{Dollar amount of all CHOICES expenditures for Group 1 services to Group 1 users}}{\text{Total dollar amount of CHOICES expenditures for Group 1, 2, and 3 services to CHOICES users}}$
 - b. $\frac{\text{Dollar amount of all CHOICES expenditures for Group 2 and 3 services to Group 2 and 3 users}}{\text{Total dollar amount of CHOICES expenditures for Group 1, 2, and 3 services to CHOICES users}}$
3. NF vs. HCBS Cost Effectiveness
 - a. $\frac{\text{Total dollar amount of CHOICES expenditures for Group 1, 2, and 3 users}}{\text{Member months of all eligible CHOICES users at time of measurement}}$
 - b. $\frac{\text{Dollar amount of all CHOICES expenditures for Group 1 services to Group 1 users}}{\text{Member months of eligible CHOICES users in Group 1 at the date of measurement}}$
 - c. $\frac{\text{Dollar amount of all CHOICES expenditures for Group 2 and 3 services to Group 2 and 3 users}}{\text{Member months of eligible CHOICES users in Group 2 and 3 at the date of measurement}}$
 - d. Dollar amount of the PMPM cost of NF services – the PMPM cost of HCBS
 - e. $\frac{\text{Dollar amount of the PMPM cost of NF services}}{\text{the PMPM cost of HCBS}}$
4. HCBS to NF Transitions
 - a. $\frac{\text{Number of unique CHOICES users who transitioned from Group 1 to Group 2 and 3}}{\text{Average number of unique CHOICES Group 1 members during the measurement period}}$
 - b. $\frac{\text{Number of unique CHOICES users who transitioned from Group 1 to Group 2 and 3 and remain in Group 2 or 3 for 90 days or longer}}{\text{Average number of unique CHOICES Group 1 members during the measurement period}}$
5. NF to HCBS Transitions
 - a. $\frac{\text{Number of unique CHOICES users who transitioned from Group 2 and 3 to Group 1}}{\text{Average number of unique CHOICES Group 2 and 3 members during the measurement period}}$
 - b. $\frac{\text{Number of unique CHOICES users who transitioned from Group 2 and 3 to Group 1 and remained in Group 1 for less than 90 days}}{\text{Average number of unique CHOICES Group 2 and 3 members during the measurement period}}$
 - c. $\frac{\text{Number of unique CHOICES users who transitioned from Group 2 and 3 to Group 1 and remained in Group 1 between 90 and 179 days}}{\text{Average number of unique CHOICES Group 2 and 3 members during the measurement period}}$
 - d. $\frac{\text{Number of unique CHOICES users who transitioned from Group 2 and 3 to Group 1 and remained in Group 1 for 180 days or longer}}{\text{Average number of unique CHOICES Group 2 and 3 members during the measurement period}}$

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Attachment 2: Full Data Tables

1a: Member months of eligible CHOICES users in NF at the date of measurement ÷ Member months of all eligible CHOICES users at date of measurement

| | Baseline | | | Year 1 | | | % Change 2011-2012 | Year 2 | | | % Change 2011-2013 |
|------------------|---------------------|----------------|---------------|---------------------|----------------|---------------|-----------------------|---------------------|----------------|---------------|-----------------------|
| | 1/1/2011-12/31/2011 | | | 1/1/2012-12/31/2012 | | | | 1/1/2013-12/31/2013 | | | |
| | Num | Den | Metric | Num | Den | Metric | | Num | Den | Metric | |
| Statewide | 273,814 | 378,467 | 72.35% | 261,627 | 394,430 | 66.33% | -8.32% | 239,786 | 393,440 | 60.95% | -15.76% |
| Amerigroup | 43,291 | 61,472 | 70.42% | 42,396 | 65,309 | 64.92% | -7.81% | 38,307 | 64,516 | 59.38% | -15.68% |
| BlueCare East | 47,310 | 67,902 | 69.67% | 44,316 | 66,913 | 66.23% | -4.94% | 40,703 | 65,959 | 61.71% | -11.43% |
| BlueCare West | 34,182 | 47,958 | 71.27% | 33,381 | 53,403 | 62.51% | -12.29% | 32,316 | 56,748 | 56.95% | -20.09% |
| UHC East | 59,101 | 78,221 | 75.56% | 55,948 | 79,727 | 70.17% | -7.13% | 51,027 | 78,239 | 65.22% | -13.68% |
| UHC Middle | 47,476 | 66,727 | 71.15% | 44,831 | 69,525 | 64.48% | -9.37% | 39,848 | 67,685 | 58.87% | -17.26% |
| UHC West | 42,454 | 56,187 | 75.56% | 40,755 | 59,553 | 68.43% | -9.44% | 37,585 | 60,293 | 62.34% | -17.50% |

1b: Member months of eligible CHOICES users in HCBS at date of measurement ÷ Member months of all eligible CHOICES users at date of measurement

| | Baseline | | | Year 1 | | | % Change 2011-2012 | Year 2 | | | % Change 2011-2013 |
|------------------|---------------------|----------------|---------------|---------------------|----------------|---------------|-----------------------|---------------------|----------------|---------------|-----------------------|
| | 1/1/2011-12/31/2011 | | | 1/1/2012-12/31/2012 | | | | 1/1/2013-12/31/2013 | | | |
| | Num | Den | Metric | Num | Den | Metric | | Num | Den | Metric | |
| Statewide | 104,653 | 378,467 | 27.65% | 132,803 | 394,430 | 33.67% | 21.77% | 153,654 | 393,440 | 39.05% | 41.23% |
| Amerigroup | 18,181 | 61,472 | 29.58% | 22,913 | 65,309 | 35.08% | 18.59% | 26,209 | 64,516 | 40.62% | 37.32% |
| BlueCare East | 20,592 | 67,902 | 30.33% | 22,597 | 66,913 | 33.77% | 11.34% | 25,256 | 65,959 | 38.29% | 26.24% |
| BlueCare West | 13,776 | 47,958 | 28.73% | 20,022 | 53,403 | 37.49% | 30.49% | 24,432 | 56,748 | 43.05% | 49.84% |
| UHC East | 19,120 | 78,221 | 24.44% | 23,779 | 79,727 | 29.83% | 22.05% | 27,212 | 78,239 | 34.78% | 42.31% |
| UHC Middle | 19,251 | 66,727 | 28.85% | 24,694 | 69,525 | 35.52% | 23.12% | 27,837 | 67,685 | 41.13% | 42.56% |
| UHC West | 13,733 | 56,187 | 24.44% | 18,798 | 59,553 | 31.57% | 29.17% | 22,708 | 60,293 | 37.66% | 54.09% |

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2a: Dollar amount of all CHOICES expenditures for NF services ÷ Total dollar amount of CHOICES expenditures for NF and HCBS services

| | Baseline | | | Year 1 | | | % Change 2011-2012 | Year 2 | | | % Change 2011-2013 |
|------------------|---------------------|------------------|--------|---------------------|------------------|--------|--------------------|---------------------|------------------|--------|--------------------|
| | 1/1/2011-12/31/2011 | | | 1/1/2012-12/31/2012 | | | | 1/1/2013-12/31/2013 | | | |
| | Num | Den | Metric | Num | Den | Metric | | Num | Den | Metric | |
| Statewide | \$ 960,724,460 | \$ 1,095,862,034 | 87.67% | \$ 907,054,461 | \$ 1,101,418,718 | 82.35% | -6.07% | \$ 854,248,058 | \$ 1,092,017,382 | 78.23% | -10.77% |
| Amerigroup | \$ 142,133,357 | \$ 166,571,146 | 85.33% | \$ 148,364,224 | \$ 188,515,060 | 78.70% | -7.77% | \$ 138,108,091 | \$ 182,949,129 | 75.49% | -11.53% |
| BlueCare East | \$ 168,853,674 | \$ 191,958,243 | 87.96% | \$ 151,745,164 | \$ 181,449,616 | 83.63% | -4.92% | \$ 145,321,118 | \$ 179,746,459 | 80.85% | -8.08% |
| BlueCare West | \$ 124,961,445 | \$ 144,128,089 | 86.70% | \$ 118,051,527 | \$ 152,162,749 | 77.58% | -10.52% | \$ 118,261,217 | \$ 159,675,317 | 74.06% | -14.58% |
| UHC East | \$ 204,536,985 | \$ 227,112,708 | 90.06% | \$ 190,422,099 | \$ 220,160,644 | 86.49% | -3.96% | \$ 176,387,739 | \$ 212,842,365 | 82.87% | -7.98% |
| UHC Middle | \$ 168,317,158 | \$ 194,072,863 | 86.73% | \$ 155,193,111 | \$ 188,815,677 | 82.19% | -5.23% | \$ 141,015,828 | \$ 183,662,659 | 76.78% | -11.47% |
| UHC West | \$ 151,921,841 | \$ 172,018,985 | 88.32% | \$ 143,278,336 | \$ 170,314,972 | 84.13% | -4.74% | \$ 135,154,065 | \$ 173,141,453 | 78.06% | -11.62% |

2b: Dollar amount of all CHOICES expenditures for HCBS services ÷ Total dollar amount of CHOICES expenditures for NF services and HCBS

| | Baseline | | | Year 1 | | | % Change 2011-2012 | Year 2 | | | % Change 2011-2013 |
|------------------|---------------------|------------------|--------|---------------------|------------------|--------|--------------------|---------------------|------------------|--------|--------------------|
| | 1/1/2011-12/31/2011 | | | 1/1/2012-12/31/2012 | | | | 1/1/2013-12/31/2013 | | | |
| | Num | Den | Metric | Num | Den | Metric | | Num | Den | Metric | |
| Statewide | \$ 135,137,575 | \$ 1,095,862,034 | 12.33% | \$ 194,364,258 | \$ 1,101,418,718 | 17.65% | 43.15% | \$ 237,769,323 | \$ 1,092,017,382 | 21.77% | 76.56% |
| Amerigroup | \$ 24,437,789 | \$ 166,571,146 | 14.67% | \$ 40,150,836 | \$ 188,515,060 | 21.30% | 45.19% | \$ 44,841,038 | \$ 182,949,129 | 24.51% | 67.08% |
| BlueCare East | \$ 23,104,569 | \$ 191,958,243 | 12.04% | \$ 29,704,452 | \$ 181,449,616 | 16.37% | 35.96% | \$ 34,425,340 | \$ 179,746,459 | 19.15% | 59.05% |
| BlueCare West | \$ 19,166,644 | \$ 144,128,089 | 13.30% | \$ 34,111,222 | \$ 152,162,749 | 22.42% | 68.57% | \$ 41,414,101 | \$ 159,675,317 | 25.94% | 95.04% |
| UHC East | \$ 22,575,724 | \$ 227,112,708 | 9.94% | \$ 29,738,545 | \$ 220,160,644 | 13.51% | 35.92% | \$ 36,454,626 | \$ 212,842,365 | 17.13% | 72.33% |
| UHC Middle | \$ 25,755,705 | \$ 194,072,863 | 13.27% | \$ 33,622,567 | \$ 188,815,677 | 17.81% | 34.21% | \$ 42,646,831 | \$ 183,662,659 | 23.22% | 74.98% |
| UHC West | \$ 20,097,144 | \$ 172,018,985 | 11.68% | \$ 27,036,636 | \$ 170,314,972 | 15.87% | 35.87% | \$ 37,987,387 | \$ 173,141,453 | 21.94% | 87.84% |

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3a: Total dollar amount of CHOICES expenditures for NF services and HCBS ÷ Member months of all eligible CHOICES NF users at time of measurement

| | Baseline | | | Year 1 | | | % Change 2011-2012 | Year 2 | | | % Change 2011-2013 |
|------------------|-------------------------|----------------|--------------------|-------------------------|----------------|--------------------|--------------------|-------------------------|----------------|--------------------|--------------------|
| | 1/1/2011-12/31/2011 | | | 1/1/2012-12/31/2012 | | | | 1/1/2013-12/31/2013 | | | |
| | Num | Den | Metric | Num | Den | Metric | | Num | Den | Metric | |
| Statewide | \$ 1,095,862,035 | 378,467 | \$ 2,895.53 | \$ 1,101,418,719 | 394,430 | \$ 2,792.43 | -3.56% | \$ 1,092,017,381 | 393,440 | \$ 2,775.56 | -4.14% |
| Amerigroup | \$ 166,571,146 | 61,472 | \$ 2,709.71 | \$ 188,515,060 | 65,309 | \$ 2,886.51 | 6.52% | \$ 182,949,129 | 64,516 | \$ 2,835.72 | 4.65% |
| BlueCare East | \$ 191,958,243 | 67,902 | \$ 2,826.99 | \$ 181,449,616 | 66,913 | \$ 2,711.72 | -4.08% | \$ 179,746,458 | 65,959 | \$ 2,725.12 | -3.60% |
| BlueCare West | \$ 144,128,089 | 47,958 | \$ 3,005.30 | \$ 152,162,749 | 53,403 | \$ 2,849.33 | -5.19% | \$ 159,675,318 | 56,748 | \$ 2,813.76 | -6.37% |
| UHC East | \$ 227,112,709 | 78,221 | \$ 2,903.47 | \$ 220,160,644 | 79,727 | \$ 2,761.43 | -4.89% | \$ 212,842,365 | 78,239 | \$ 2,720.41 | -6.30% |
| UHC Middle | \$ 194,072,863 | 66,727 | \$ 2,908.46 | \$ 188,815,678 | 69,525 | \$ 2,715.80 | -6.62% | \$ 183,662,659 | 67,685 | \$ 2,713.49 | -6.70% |
| UHC West | \$ 172,018,985 | 56,187 | \$ 3,061.54 | \$ 170,314,972 | 59,553 | \$ 2,859.89 | -6.59% | \$ 173,141,452 | 60,293 | \$ 2,871.67 | -6.20% |

3b: Dollar amount of all CHOICES expenditures for NF services ÷ Member months of eligible CHOICES NF users at the date of measurement

| | Baseline | | | Year 1 | | | % Change 2011-2012 | Year 2 | | | % Change 2011-2013 |
|------------------|-----------------------|----------------|--------------------|-----------------------|----------------|--------------------|--------------------|-----------------------|----------------|--------------------|--------------------|
| | 1/1/2011-12/31/2011 | | | 1/1/2012-12/31/2012 | | | | 1/1/2013-12/31/2013 | | | |
| | Num | Den | Metric | Num | Den | Metric | | Num | Den | Metric | |
| Statewide | \$ 960,724,460 | 273,814 | \$ 3,508.68 | \$ 907,054,461 | 261,627 | \$ 3,466.98 | -1.19% | \$ 854,248,058 | 239,786 | \$ 3,562.54 | 1.54% |
| Amerigroup | \$ 142,133,357 | 43,291 | \$ 3,283.21 | \$ 148,364,224 | 42,396 | \$ 3,499.49 | 6.59% | \$ 138,108,091 | 38,307 | \$ 3,605.30 | 9.81% |
| BlueCare East | \$ 168,853,674 | 47,310 | \$ 3,569.09 | \$ 151,745,164 | 44,316 | \$ 3,424.16 | -4.06% | \$ 145,321,118 | 40,703 | \$ 3,570.28 | 0.03% |
| BlueCare West | \$ 124,961,445 | 34,182 | \$ 3,655.77 | \$ 118,051,527 | 33,381 | \$ 3,536.49 | -3.26% | \$ 118,261,217 | 32,316 | \$ 3,659.53 | 0.10% |
| UHC East | \$ 204,536,985 | 59,101 | \$ 3,460.80 | \$ 190,422,099 | 55,948 | \$ 3,403.56 | -1.65% | \$ 176,387,739 | 51,027 | \$ 3,456.75 | -0.12% |
| UHC Middle | \$ 168,317,158 | 47,476 | \$ 3,545.31 | \$ 155,193,111 | 44,831 | \$ 3,461.74 | -2.36% | \$ 141,015,828 | 39,848 | \$ 3,538.84 | -0.18% |
| UHC West | \$ 151,921,841 | 42,454 | \$ 3,578.50 | \$ 143,278,336 | 40,755 | \$ 3,515.60 | -1.76% | \$ 135,154,065 | 37,585 | \$ 3,595.96 | 0.49% |

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3c: Dollar amount of all CHOICES expenditures for HCBS services ÷ Member months of eligible CHOICES HCBS at the date of measurement

| | Baseline | | | Year 1 | | | % Change 2011-2012 | Year 2 | | | % Change 2011-2013 |
|------------------|---------------------|---------|-------------|---------------------|---------|-------------|--------------------|---------------------|---------|-------------|--------------------|
| | 1/1/2011-12/31/2011 | | | 1/1/2012-12/31/2012 | | | | 1/1/2013-12/31/2013 | | | |
| | Num | Den | Metric | Num | Den | Metric | | Num | Den | Metric | |
| Statewide | \$ 135,137,575 | 104,653 | \$ 1,291.29 | \$ 194,364,258 | 132,803 | \$ 1,463.55 | 13.34% | \$ 237,769,323 | 153,654 | \$ 1,547.43 | 19.84% |
| Amerigroup | \$ 24,437,789 | 18,181 | \$ 1,344.14 | \$ 40,150,836 | 22,913 | \$ 1,752.32 | 30.37% | \$ 44,841,038 | 26,209 | \$ 1,710.90 | 27.29% |
| BlueCare East | \$ 23,104,569 | 20,592 | \$ 1,122.02 | \$ 29,704,452 | 22,597 | \$ 1,314.53 | 17.16% | \$ 34,425,340 | 25,256 | \$ 1,363.06 | 21.48% |
| BlueCare West | \$ 19,166,644 | 13,776 | \$ 1,391.31 | \$ 34,111,222 | 20,022 | \$ 1,703.69 | 22.45% | \$ 41,414,101 | 24,432 | \$ 1,695.08 | 21.83% |
| UHC East | \$ 22,575,724 | 19,120 | \$ 1,180.74 | \$ 29,738,545 | 23,779 | \$ 1,250.62 | 5.92% | \$ 36,454,626 | 27,212 | \$ 1,339.65 | 13.46% |
| UHC Middle | \$ 25,755,705 | 19,251 | \$ 1,337.89 | \$ 33,622,567 | 24,694 | \$ 1,361.57 | 1.77% | \$ 42,646,831 | 27,837 | \$ 1,532.02 | 14.51% |
| UHC West | \$ 20,097,144 | 13,733 | \$ 1,463.42 | \$ 27,036,636 | 18,798 | \$ 1,438.27 | -1.72% | \$ 37,987,387 | 22,708 | \$ 1,672.86 | 14.31% |

4a: Number of unique CHOICES members who transitioned from NF to HCBS ÷ Average number of unique members eligible for CHOICES NF services during the measurement period

| | Baseline | | | Year 1 | | | % Change 2011-2012 | Year 2 | | | % Change 2011-2013 |
|------------------|---------------------|---------------|--------------|---------------------|---------------|--------------|--------------------|---------------------|---------------|--------------|--------------------|
| | 1/1/2011-12/31/2011 | | | 1/1/2012-12/31/2012 | | | | 1/1/2013-12/31/2013 | | | |
| | Num | Den | Metric | Num | Den | Metric | | Num | Den | Metric | |
| Statewide | 780 | 22,818 | 3.42% | 894 | 21,802 | 4.10% | 19.88% | 836 | 19,982 | 4.18% | 22.22% |
| Amerigroup | 129 | 3,608 | 3.58% | 153 | 3,533 | 4.33% | 20.95% | 137 | 3,192 | 4.29% | 19.83% |
| BlueCare East | 79 | 3,943 | 2.00% | 115 | 3,693 | 3.11% | 55.50% | 140 | 3,392 | 4.13% | 106.50% |
| BlueCare West | 87 | 2,849 | 3.05% | 111 | 2,782 | 3.99% | 30.82% | 102 | 2,693 | 3.79% | 24.26% |
| UHC East | 183 | 4,925 | 3.72% | 187 | 4,662 | 4.01% | 7.80% | 186 | 4,252 | 4.37% | 17.47% |
| UHC Middle | 161 | 3,956 | 4.07% | 197 | 3,736 | 5.27% | 29.48% | 136 | 3,321 | 4.10% | 0.74% |
| UHC West | 141 | 3,538 | 3.99% | 131 | 3,396 | 3.86% | -3.26% | 135 | 3,132 | 4.31% | 8.02% |

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4b: Number of CHOICES members who transition from NF to HCBS and remain in HCBS for 90 days or longer ÷ Average number of unique members eligible for CHOICES NF services during the measurement period

| | Baseline | | | Year 1 | | | % Change 2011-2012 | Year 2 | | | % Change 2011-2013 |
|------------------|---------------------|---------------|--------------|---------------------|---------------|--------------|-----------------------|---------------------|---------------|--------------|-----------------------|
| | 1/1/2011-12/31/2011 | | | 1/1/2012-12/31/2012 | | | | 1/1/2013-12/31/2013 | | | |
| | Num | Den | Metric | Num | Den | Metric | | Num | Den | Metric | |
| Statewide | 486 | 22,818 | 2.13% | 570 | 21,802 | 2.61% | 22.54% | 425 | 19,982 | 2.13% | -0.00% |
| Amerigroup | 85 | 3,608 | 2.36% | 97 | 3,533 | 2.75% | 16.53% | 66 | 3,192 | 2.07% | -12.29% |
| BlueCare East | 51 | 3,943 | 1.29% | 56 | 3,693 | 1.52% | 17.83% | 81 | 3,392 | 2.39% | 85.27% |
| BlueCare West | 53 | 2,849 | 1.86% | 58 | 2,782 | 2.09% | 12.37 | 51 | 2,693 | 1.89% | 1.61% |
| UHC East | 100 | 4,925 | 2.03% | 123 | 4,662 | 2.64% | 30.05% | 85 | 4,252 | 2.00% | -1.48% |
| UHC Middle | 102 | 3,956 | 2.58% | 144 | 3,736 | 3.85% | 49.22% | 75 | 3,321 | 2.26% | -12.40% |
| UHC West | 95 | 3,538 | 2.69% | 92 | 3,396 | 2.71% | 0.74% | 67 | 3,132 | 2.14% | -20.45% |

5a: Number of unique CHOICES members who transitioned from HCBS to NF ÷ Average number of unique members eligible at any time for CHOICES HCBS during the measurement period

| | Baseline | | | Year 1 | | | % Change 2011-2012 | Year 2 | | | % Change 2011-2013 |
|------------------|---------------------|--------------|---------------|---------------------|---------------|---------------|-----------------------|---------------------|---------------|---------------|-----------------------|
| | 1/1/2011-12/31/2011 | | | 1/1/2012-12/31/2012 | | | | 1/1/2013-12/31/2013 | | | |
| | Num | Den | Metric | Num | Den | Metric | | Num | Den | Metric | |
| Statewide | 987 | 8,721 | 11.32% | 1,140 | 11,067 | 10.30% | -9.01% | 1,641 | 12,805 | 12.82% | 13.25% |
| Amerigroup | 196 | 1,515 | 12.94% | 151 | 1,909 | 7.91% | -38.87% | 270 | 2,184 | 12.36% | -4.48% |
| BlueCare East | 199 | 1,716 | 11.60% | 263 | 1,883 | 13.97% | 20.43% | 299 | 2,105 | 14.21% | 22.50% |
| BlueCare West | 97 | 1,148 | 8.45% | 150 | 1,669 | 8.99% | 6.39% | 212 | 2,036 | 10.41% | 23.20% |
| UHC East | 214 | 1,593 | 13.43% | 219 | 1,982 | 11.05% | -17.72% | 391 | 2,268 | 17.24% | 28.37% |
| UHC Middle | 174 | 1,604 | 10.85% | 214 | 2,058 | 10.40% | -4.15% | 272 | 2,320 | 11.73% | 8.11% |
| UHC West | 107 | 1,144 | 9.35% | 143 | 1,567 | 9.13% | -2.35% | 197 | 1,892 | 10.41% | 11.34% |

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5b: Number of CHOICES users who transitioned from HCBS to NF and remained in NF for less than 90 days ÷ Average number of unique members eligible at any time for CHOICES HCBS during the measurement period

| | Baseline | | | Year 1 | | | % Change 2011-2012 | Year 2 | | | % Change 2011-2013 |
|------------------|---------------------|--------------|--------------|---------------------|---------------|--------------|-----------------------|---------------------|---------------|--------------|-----------------------|
| | 1/1/2011-12/31/2011 | | | 1/1/2012-12/31/2012 | | | | 1/1/2013-12/31/2013 | | | |
| | Num | Den | Metric | Num | Den | Metric | | Num | Den | Metric | |
| Statewide | 370 | 8,721 | 4.24% | 480 | 11,067 | 4.34% | 2.36% | 633 | 12,805 | 4.94% | 16.51% |
| Amerigroup | 79 | 1,515 | 5.21% | 67 | 1,909 | 3.51% | -32.63% | 104 | 2,184 | 4.76% | -8.64% |
| BlueCare East | 72 | 1,716 | 4.20% | 109 | 1,883 | 5.79% | 37.86% | 112 | 2,105 | 5.32% | 26.67% |
| BlueCare West | 34 | 1,148 | 2.96% | 64 | 1,669 | 3.84% | 29.73% | 71 | 2,036 | 3.49% | 17.91% |
| UHC East | 84 | 1,593 | 5.27% | 90 | 1,982 | 4.54% | -13.85% | 150 | 2,268 | 6.61% | 25.43% |
| UHC Middle | 67 | 1,604 | 4.18% | 92 | 2,058 | 4.47% | 6.94% | 111 | 2,320 | 4.78% | 14.35% |
| UHC West | 34 | 1,144 | 2.97% | 58 | 1,567 | 3.70% | 24.58% | 85 | 1,892 | 4.49% | 51.18% |

5c: Number of CHOICES users who transitioned from HCBS to NF and remained in NF between 90 and 179 days ÷ Average number of unique members eligible at any time for CHOICES HCBS during the measurement period

| | Baseline | | | Year 1 | | | % Change 2011-2012 | Year 2 | | | % Change 2011-2013 |
|------------------|---------------------|--------------|--------------|---------------------|---------------|--------------|-----------------------|---------------------|---------------|--------------|-----------------------|
| | 1/1/2011-12/31/2011 | | | 1/1/2012-12/31/2012 | | | | 1/1/2013-12/31/2013 | | | |
| | Num | Den | Metric | Num | Den | Metric | | Num | Den | Metric | |
| Statewide | 267 | 8,721 | 3.06% | 275 | 11,067 | 2.48% | -18.84% | 411 | 12,805 | 3.21% | 4.90% |
| Amerigroup | 46 | 1,515 | 3.04% | 32 | 1,909 | 1.68% | -44.74% | 63 | 2,184 | 2.88% | -5.26% |
| BlueCare East | 51 | 1,716 | 2.97% | 72 | 1,883 | 3.82% | 28.62% | 74 | 2,105 | 3.52% | 18.52% |
| BlueCare West | 34 | 1,148 | 2.96% | 32 | 1,669 | 1.92% | -35.14% | 53 | 2,036 | 2.60% | -12.16% |
| UHC East | 59 | 1,593 | 3.70% | 52 | 1,982 | 2.62% | -29.19% | 99 | 2,268 | 4.37% | 18.11% |
| UHC Middle | 48 | 1,604 | 2.99% | 52 | 2,058 | 2.53% | -15.38% | 70 | 2,320 | 3.02% | 1.00% |
| UHC West | 29 | 1,144 | 2.53% | 35 | 1,567 | 2.23% | -11.8683% | 52 | 1,892 | 2.75% | 8.70% |

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5d: Number of CHOICES users who transitioned from HCBS to NF and remained in NF for 180 days or longer ÷ Average number of unique members eligible at any time for CHOICES HCBS during the measurement period

| | Baseline | | | Year 1 | | | % Change 2011-2012 | Year 2 | | | % Change 2011-2013 |
|------------------|---------------------|--------------|--------------|---------------------|---------------|--------------|-----------------------|---------------------|---------------|--------------|-----------------------|
| | 1/1/2011-12/31/2011 | | | 1/1/2012-12/31/2012 | | | | 1/1/2013-12/31/2013 | | | |
| | Num | Den | Metric | Num | Den | Metric | | Num | Den | Metric | |
| Statewide | 350 | 8,721 | 4.01% | 385 | 11,067 | 3.48% | -13.32% | 597 | 12,805 | 4.66% | 16.21% |
| Amerigroup | 71 | 1,515 | 4.69% | 52 | 1,909 | 2.72% | -42.00% | 103 | 2,184 | 4.72% | 0.64% |
| BlueCare East | 76 | 1,716 | 4.43% | 82 | 1,883 | 4.35% | -1.81% | 113 | 2,105 | 5.37% | 21.22% |
| BlueCare West | 29 | 1,148 | 2.53% | 54 | 1,669 | 3.24% | 28.06% | 88 | 2,036 | 4.32% | 70.75% |
| UHC East | 71 | 1,593 | 4.46% | 77 | 1,982 | 3.89% | -12.78% | 142 | 2,268 | 6.26% | 40.36% |
| UHC Middle | 59 | 1,604 | 3.68% | 70 | 2,058 | 3.40% | -7.61% | 91 | 2,320 | 3.92% | 6.52% |
| UHC West | 44 | 1,144 | 3.84% | 50 | 1,567 | 3.19% | -16.93% | 60 | 1,892 | 3.17% | -17.45% |