2025 QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT STRATEGY

Initial Strategy Available for Public Comment: November 3, 2025 – December 3, 2025

2025 Strategy Update Submitted to CMS for Review and Feedback: December 15, 20225

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Section I: Introduction

Background

On January 1, 1994, Tennessee implemented a new Medicaid reform program under the authority of a Section 1115 demonstration. This new program, known as TennCare, moved almost the entirety of Tennessee's Medicaid program into managed care. The TennCare 1115 demonstration has been renewed continuously by the state and CMS since 1994.

Since 1994, all (100 percent) of Medicaid beneficiaries in Tennessee have enrolled in managed care to receive most or all of their Medicaid benefits. Over time, Tennessee has worked toward more complete integration and more effective coordination of care to improve the member experience, support more cost-effective care delivery, and promote improved health outcomes. In 2009, Tennessee ended the separate carve-out for behavioral health services so that a single entity (the member's managed care organization or MCO) is responsible for administering and coordinating members' medical/surgical and behavioral health care. Long term services and supports (LTSS) for persons who are elderly or who have physical disabilities were carved into the MCO program with the creation of the CHOICES program in 2010, and in 2016, Tennessee integrated certain LTSS for individuals with intellectual and developmental disabilities into the MCO program with the implementation of Employment and Community First CHOICES.

In 2019, a new Katie Beckett Program was established under the demonstration, providing services and supports for children under age 18 with disabilities and/or complex medical needs who are not otherwise eligible for Medicaid because of their parents' income or assets.

On January 1, 2021, Tennessee transitioned its separate Children's Health Insurance Program (CHIP) program from fee-for-service to managed care, leveraging the state's existing managed care contracts and infrastructure to ensure close coordination and strategic alignment between Medicaid and CHIP. Because Tennessee uses the same managed care contractors to provide care to both its Medicaid and CHIP beneficiaries, this quality strategy addresses the steps taken to improve quality in both programs.

As noted above, Tennessee's managed care program encompasses all of the state's Medicaid and CHIP beneficiaries, and virtually all covered services. The state's managed care system currently consists of six managed care contractors (MCCs). The MCCs that the state contracts with are listed in Table 1. This Quality Assessment and Performance Improvement Strategy applies to all MCCs, and the populations served by TennCare.

Table 1. TennCare Managed Care Contractor Information

Plan Name	MCC Type	Managed Care Authority	Populations Served
UnitedHealthcare Plan of the River Valley, Inc. dba UnitedHealthcare Community Plan	MCO	1115; CHIP State Plan	Medicaid adults, children, and CHIP
Volunteer State Health Plan, Inc. dba BlueCare	MCO	1115; CHIP State Plan	Medicaid adults, children, and CHIP

Wellpoint	MCO	1115; CHIP State Plan	Medicaid adults, children, and CHIP
TennCare Select	PIHP	1115	Selected populations as specified in the state's 1115 demonstration
DentaQuest[1]	PAHP	1115	Medicaid adults and children
OptumRx	PAHP	1115	Medicaid adults and children with a pharmacy benefit (i.e., non-duals)

TennCare Quality Strategy Goals and Objectives

TennCare's commitment to quality and continuous improvement in the lives of Tennesseans is reflected in its vision and mission of a healthier Tennessee by improving lives through high-quality cost-effective care. TennCare has three goals that have served as the foundation of the program since its inception, with a fourth added in 2009 upon approval of LTSS integration.

1. Provide high-quality care that improves health outcomes
2. Ensure enrollee access to health care, including safety net providers
3. Ensure enrollees' satisfaction with services
4. Provide enrollees with appropriate and cost-effective Home and Community-Based Services (HCBS)

To provide high-quality care to enrollees that will improve health outcomes, TennCare will focus on improving the health and wellness of mothers and infants, increasing preventive services for the state's Medicaid and CHIP populations and improving chronic health conditions. In addition, TennCare will ensure that enrollees have improved access to care by maintaining robust member access to health services. TennCare will ensure enrollees' satisfaction with services by integrating patient-centered, holistic care into population health coordination for all members. TennCare will also improve the quality of life for members with LTSS needs by ensuring access to high-quality, cost-effective home and community-based services that allow members to meet their individualized goals and live the life of their choosing.

Progress toward TennCare's goals and associated objectives is measured through key physical health, behavioral health, long-term services and support performance measures. The objectives are drawn from nationally recognized and validated measure sets, as well as internal custom measures. Table 2 outlines TennCare's Quality Strategy Goals, the baseline performance, and the performance target where applicable.

Table 2. TennCare Quality Strategy Goals and Objectives

Objective	Objective description	Quality measure	Statewide performance baseline (MY 2024)	Statewide performance target for objective (MY 2027)
Goal 1: Improve the health and wellness of mothers and infants				
1.1	Increase the use of prenatal services	Timeliness of Prenatal Care (PPC-)	82.87%	85.87%

[1] TennCare contracted with a new dental benefit manager, Renaissance, effective November 1, 2025.

1.2	Increase the use of postpartum services	Postpartum Care (PPC-)	80.40%	83.40%
1.3	Increase the use of well-child visits in the first 15 months of life	Well-Child Visits in the 1st 30 Months of Life, 1st 15 Months (W30-CH)	70.09%	73.09%
Goal 2: Increase use of preventive care services for all members to reduce risk of chronic health conditions				
2.1	Increase child and adolescent well care visits	Child and Adolescent Well-Care Visits, Total Rate (WCV-CH)	59.33%	62.33%
2.2	Increase CMS-416 EPSDT screening rate	CMS-416 EPSDT Screening Rate	75%	80%
2.3	Increase child immunizations	Childhood Immunization Status – Combo10 (CIS-CH)	27.48%	30.48%
2.4	Improve high blood pressure control in adults	Controlling High Blood Pressure (CBP-AD)	70.59%	73.59%
2.5	Increase cervical cancer screening in adults	Cervical Cancer Screening (CCS-AD)	56.20%	59.20%
2.6	Increase dental sealant use in children	Sealant Recipient on Permanent First Molars, at least one sealant (SFM-CH)	55.97%	58.97%
2.7	Reduce rate of hospital readmissions	Plan All Cause Readmissions (PCR-AD)	1.1445	<1.0000
Goal 3: Integrate patient-centered, holistic care including non-medical risk factors into population health coordination for all members				
3.1	Maintain high member satisfaction with TennCare*	Percent of respondents indicating satisfaction with TennCare (UT survey)	NA*	NA*
3.2	Increase screening for non-medical risk factors	Percent of members screened by the MCO for non-medical risk factors (Custom)	1.56%	2.20%
3.3	Ensure CHOICES members receive person-centered care	Percent of Members whose service plan reflects their preferences and choices (NCI-AD, Q10 PCP)	81% (2023-2024)	83%
3.4	Ensure ECF CHOICES members receive person-centered care	Percent of members who report choosing services (POM, 19)	N/A	N/A
3.5	Ensure Katie Beckett members receive person-centered care	Percent of members/families who report feeling that supports and services have made a positive difference in the life of their child (NCI-CFS, Q 62)	100% (2022-2023)	100%
Goal 4: Improve positive outcomes for members with LTSS needs				
4.1	Maintain or improve quality of life for CHOICES members	Percent of members who report their paid service and supports help them live the life they want (NCI-AD, Q 90)	90% (2023-2024)	92%
4.2	Maintain or improve quality of life for individuals with I/DD	Percent of members reporting realizing goals (POM, 21)	N/A	N/A

4.3	Maintain or improve quality of life for eligible children in the Katie Beckett program	Percent of members who report services and supports are helping their child to live a good life. (NCI-CFS, Q 68)	99% (2022-2023)	100%
4.4	Increase percentage of older adults and adults with physical disabilities receiving LTSS in the community (HCBS) as compared to those receiving LTSS in an institution	CHOICES baseline data	39.9% (2023-2024)	41.9%
4.5	Increase percentage of individuals with I/DD receiving LTSS in the community (HCBS) as compared to those receiving LTSS in an institution	ECF CHOICES baseline data	84.8% (2023-2024)	86.6%
Goal 5: Provide additional support and follow-up for patients with behavioral health care needs				
5.1	Improve follow-up after hospitalization for mental illness in adults	Follow-up After Hospitalization for Mental Illness (FUH-AD), 30-Day Follow-up	56.42%	59.42%
5.2	Improve follow-up after hospitalization for mental illness in children	Follow-up After Hospitalization for Mental Illness (FUH-CH), 30-Day Follow-up	73.58%	76.58%
5.3	Increase the use of medication assisted treatment of opioid dependance and addiction	Use of Pharmacotherapy for OUD, Total Rate (OUD-AD)	55.43%	58.43%
Goal 6: Maintain robust member access to health care services				
6.1	Ensure members can access primary care according to time and distance standards	TennCare custom measure	100%	100%
6.2	Ensure adult members can access care, tests, or treatments timely	"Getting Needed Care" (CAHPS)	85.20%	88.20%
6.3	Ensure child members can access care, tests, or treatments timely	"Getting Needed Care" (CAHPS)	88.30%	91.30%
Goal 7: Maintain financial stewardship through increasing value-based payments and cost-effective care				
7.1	Maintain the percentage of TennCare members attributed to PCMH organizations	TennCare custom measure	45.0%	40.0%
7.2	Increase the percentage of TennCare members eligible for Tennessee Health Link (THL) who are actively enrolled in THL	TennCare custom measure	51.0%	53.0%
7.3	Increase the percentage of nursing facilities showing quality improvement	QuILTSS for NF	38.65%	39.42%
7.4	Increase the average Tier Score for facilities supporting members with ventilators or tracheostomies (Enhanced Respiratory Care)	TennCare custom measure	61.00%	62.22%

*Pending results from 2025 UT Annual Beneficiary Survey, will be updated.

** Baseline data will be provided in the 2026 Quality Strategy.

Selecting measures and determining performance targets

The TennCare Quality Strategy Goals and Objectives are established by the state to measure the health status of all populations served by the state's managed care plans.

To set statewide performance targets, TennCare statewide performance (Medicaid and CHIP combined) was set to show a three percent improvement.

LTSS quality is measured in many areas using data from the National Core Indicators – Aging and Disabilities (NCI-AD) survey, the NCI Child and Family Survey (NCI-CFS), and the Personal Outcome Measures (POM©) tool. POM©, a CMS-approved instrument aligned with the Access Rule HCBS Quality Measure Set, is now used for the IDD population, with data collection beginning in 2025 and baseline data coming in 2026. While Tennessee previously implemented the NCI In-Person Survey (NCI-IPS), it has since been discontinued due to vendor challenges. These tools collectively support TennCare's commitment to person-centered, outcomes-focused quality measurement and alignment with national standards.

Updating the Quality Strategy

TennCare values continuous improvement and will update its Quality Strategy annually. The state will include significant changes that have occurred as well as updated evaluation data. Significant changes are defined by the state as changes that: 1) alter the structure of the TennCare Program; 2) change benefits; and/or 3) include changes in MCCs. Updated interventions and activities will also be provided.

Every three years, TennCare will coordinate a comprehensive review and update to the Quality Strategy.[2] TennCare and its EQRO review and evaluate the implementation and effectiveness of the Quality Strategy annually by publishing the results of the evaluation in the EQR technical report. The most recent evaluation of the effectiveness of the quality strategy can be found https://www.tn.gov/tenncare/information-statistics/additional-tenncare-reports.html.[3] TennCare will update its quality strategy with recommendations identified in the EQRO's effectiveness evaluation. The Chief Quality Officer and Chief Medical Officer will review the recommendations and indicate which recommendations TennCare will adopt in the following year's Quality Strategy.[4]

Pursuant to 42 CFR § 438.340(c)(1), the state made a draft of this Quality Assessment and Performance Improvement Strategy available for public review and comment. The strategy was published on the TennCare website on November 3, 2025, and comments were accepted from November 3, through December 3, 2025. The strategy was also shared with the Medical Care Advisory Committee (MCAC) for review and comment. The state received one set of comments in response to its public notice. All comments were reviewed and considered by the state prior to the submission of the Strategy to CMS, no changes were made to the Strategy as a result of the feedback received. Tennessee has no federally recognized Indian tribes, Indian Health Programs, or Urban Indian Organizations that furnish health care services, and therefore did not consult with Tribes.

Quality Strategy Effectiveness Evaluation

TennCare acknowledges that there are several metrics outlined in our Quality Strategy where we did not meet the performance targets we set for ourselves during the most recent measurement year. These results are detailed in our *Quality Strategy Effectiveness Evaluation*.

TennCare intentionally sets aspirational targets for many of our quality measures. We believe that setting ambitious goals is essential to driving continuous improvement and innovation across our delivery system. While this approach may result in not meeting every target, it reflects our commitment to stretching ourselves and our partners to achieve the best possible outcomes for our members.

Compared to other Medicaid programs in our region, TennCare includes a broader and more comprehensive set of quality metrics in our Quality Strategy. As a result, it is expected that we may not meet every goal each year. However, this breadth reflects our commitment to a holistic and ambitious approach to quality improvement.

It is also important to note that the redetermination process following the end of the Federal Public Health Emergency significantly changed the composition of our enrolled population. The resulting membership includes a higher proportion of individuals with chronic and complex medical needs, which has contributed to increased service utilization and impacted performance on certain quality measures.

Despite these challenges, TennCare remains focused on improving performance in these areas. Many of the lower-performing metrics are integrated into our provider incentive programs, including the Patient-Centered Medical Home (PCMH), Long-Term Services and Supports (LTSS), and Tennessee Health Link (THL) programs. We reevaluate the metrics used in these programs regularly and prioritize those that require additional attention and support.

TennCare has a contractual requirement for each Managed Care Organization (MCO) to achieve an 80% screening rate on the CMS-416 Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) measure. While we have seen steady progress in recent years, the statewide average has not yet reached the 80% target. To address this, we require each MCO to develop a detailed improvement plan, including targeted outreach strategies focused on low-performing age groups and counties.

Another example of TennCare's targeted quality improvement efforts is in the area of Follow-Up After Hospitalization for Mental Illness (FUH). In partnership with the Tennessee Hospital Association, TennCare has implemented a process to deliver daily Admission, Discharge, and Transfer (ADT) feeds to MCOs. These feeds enable more timely identification of members who have been hospitalized for behavioral health needs. To further enhance this process, TennCare is developing an incentive structure for hospitals to encourage the inclusion of more complete diagnosis and reason-for-visit information in the ADT feeds. With this enhanced data, MCO care coordinators will be better equipped to conduct timely and appropriate follow-up for individuals discharged from inpatient behavioral health settings.

In response to recommendation for more collaboration with MCOs, we have set up more oversight over some of their quality improvement strategies. For example, starting in 2025, each MCO prepared materials to reflect on improvements and opportunities in PCMH and THL quality metrics. This led to robust discussions about how MCOs and TennCare can partner on improving targeted measures.

[2] *42 CFR 438.340(b)(10) and (c)(3)(ii), applicable also to CHIP managed care programs per 42 CFR 457.1240(e).*

[3] *42 CFR 438.340(c)(2), 438.340(c)(2)(i), and 438.340(c)(2)(ii), applicable also to CHIP managed care programs per 42 CFR 457.1240(e).*

[4] *42 CFR 438.340(c)(2)(iii), applicable also to CHIP managed care programs per 42 CFR 457.1240(e), cross-referencing 438.364(a)(4) and 457.1250(a).*

Section II: Quality and Appropriateness of Care Assessment

State Requirements

Since TennCare's inception, continuous quality improvement has been a priority for TennCare and its partner MCOs. TennCare has instituted several process improvement efforts and requirements to ensure that quality improvement efforts remain in place and are refined over time. TennCare requires accreditation and specific distinctions of each of its MCOs. TennCare requires all MCOs to be National Committee for Quality Assurance (NCQA) health plan accredited, as well as to maintain distinction status in LTSS and Health Equity. MCOs are required, by contract, to provide TennCare with the accreditation survey and associated results. They are also required to submit to TennCare their annual NCQA Accreditation update. Accreditation information is available on the TennCare website: https://www.tn.gov/tenncare/members-applicants/managed-care-organizations.html

Additionally, the state's MCOs are required to report a full set of Healthcare Effectiveness Data and Information Set (HEDIS) and Consumer Assessment of Healthcare Providers and Systems (CAHPS) data as a part of the accreditation mandates in Tennessee. The HEDIS requirement is an integral part of the accreditation process of the NCQA and includes completion of all LTSS HEDIS Measures. This information is also provided to Health Services Advisory Group (HSAG), Tennessee's external quality review organization (EQRO), for review and trending. HSAG then prepares an annual report of findings for TennCare. TennCare publishes outcomes on all HEDIS measures to its website annually at the following website: https://www.tn.gov/tenncare/information-statistics/mco-quality-data.html [5]

TennCare also reports CMS Core performance measures for children and adults in Medicaid and CHIP. These measures encompass both the physical and mental health of Medicaid/CHIP members. Demonstrating a commitment to high quality care, historically, Tennessee measures and submits over 90 percent of the CMS performance measures for children and adults in Medicaid/CHIP each year. Beginning with FFY 2024, CMS rule mandates that all states report all Child and Behavioral Heath Adult Core Set Measures, therefore TennCare is reporting 100% of mandatory measures. TennCare aims to show improvement each year on the CMS Core Measures, and sets goals based on improvement or maintenance of the CMS national benchmarks and NCQA Quality Compass national benchmarks.

The state's DBM is required to have a written Quality Monitoring Program (QMP) that clearly defines its quality improvement structures, processes, and related activities. The DBM uses the results of the QMP activities to improve the quality of dental health with appropriate input from providers and members. The DBM is also incentivized to achieve defined preventive care targets for dental sealants and silver diamine fluoride or SDF.

TennCare involves the Pharmacy Benefit Administrator (PBA) to work closely with a Drug Utilization Review (DUR) Board, Pharmacy Advisory Committee, and CoverRx Clinical Advisory Committee which include multi-disciplinary healthcare professionals to monitor and evaluate new drugs and generics for safety and efficacy, provide opportunities for improved medication access, recommend drug interventions based on clinical information, and focus on influencing provider habits and utilization management strategies. The PBA also provides these services

[5] *42 CFR 438.340(b)(3)(i), applicable also to CHIP managed care programs per 42 CFR 457.1240(e).*

to CoverKids, Tennessee's CHIP Program, which utilizes a PBA commercial formulary. The PBA, through maintenance of the CoverKids formulary, oversight by the PBA's Pharmacy & Therapeutics (P&T) Committee, and operation of its utilization management programs, ensures the safety and efficacy of all medications offered through CoverKids Program thereby improving both medication access and appropriate medication utilization. Additionally, TennCare helps facilitate collaboration between the MCOs and PBA to enact change at the vendor level for the benefit of members.

The state's PBA utilizes an electronic Prospective Drug Utilization Review (ProDUR) monitoring system to screen prescriptions submitted for TennCare, CoverKids, and CoverRx members to identify potential problems and concerns based on the members past prescription claim history and medical conditions. Pharmacy claims identified through this ProDUR monitoring system are flagged at the dispensing pharmacy to address pharmacy related medical concerns. The PBA relies on the Pharmacists to use their clinical expertise and judgment for prompt resolution of these medical related concerns through consultation with the member and/or provider prior to dispensing the medication. The PBA further requires pharmacists to submit specific ProDUR edit codes or Professional Pharmacy Services (PPS) codes for members with specific needs, such as those with intellectual and/or developmental disabilities in the system to signify to the PBA that ProDUR edits have been resolved for the member. The PBA provides a reporting system to track outcomes of DUR which is used to develop educational outreach to providers to further identify patients who require specific medication needs. The TennCare Retrospective DUR Reporting System mainly focuses on improving quality of care. The system allows the PBA to track the impact of DUR initiatives by comparing specified data elements pre and post intervention. DUR metrics and interventions are used to support quality improvements in all population types and often become the catalyst for change during Committee meetings, or at the program level.

Quality Metrics and Performance Targets

Goal 1: Improve the health and wellness of mothers and infants

TennCare has several initiatives that aim to improve the health and wellness of mothers and infants. Since 2016, increasing access to most effective forms of contraception, such as long-acting reversible contraceptives (LARCs), has been a priority for TennCare. Three initiatives are in place to reduce barriers to LARCs: 1) TennCare supports reimbursement of immediate postpartum long-acting contraception in hospitals, 2) TennCare updated reimbursement policies to support reimbursement of same day LARC insertion as an office visit, and 3) TennCare partnered with a specialty pharmacy to support an inventory management program where LARC units are stocked in provider offices for point of care use. Increasing access to LARC may support patient-centered family planning and optimize interpregnancy intervals.

Providing maternal health care, including mental health, in the first year after delivery has been shown to have an outsized impact on early infant health and childhood development. TennCare continues to invest in women and children. In 2022, TennCare extended postpartum coverage and provided new dental coverage for members who have Medicaid during their pregnancy for the full 12 months. TennCare members who have Medicaid during their

pregnancy have continuous eligibly for 12 months following the end of a pregnancy and in 2023, TennCare began providing dental coverage for all adult members. Additionally in 2023, TennCare added a new outpatient benefit for mothers and infants to see a lactation provider both before and after delivery.

Table 3. Goal 1 Quality Metrics and Performance Targets

Improve the health and wellness of mothers and infants				
Metric Name	**Metric specifications**	**Baseline performance (MY2024)**	**Performance target (MY 2027)**	**Program**
Contraceptive Care – All women (CCW-AD and CCW-CH)*				
Long-acting reversible contraception, Ages 15-20	CMS Child Core Set	4.03%	N/A	Medicaid, CHIP, TennCare Select
Long-acting reversible contraception, Ages 21-44	CMS Adult Core Set	5.16%	N/A	Medicaid, CHIP, TennCare Select
Contraceptive Care – Postpartum Women (CCP-CH and CCP-AD)*				
Long-acting reversible contraception 3-day rate, Ages 15-20	CMS Child Core Set	3.17%	N/A	Medicaid, CHIP, TennCare Select
Long-acting reversible contraception 90-day rate Ages 15-20	CMS Child Core Set	24.23%	N/A	Medicaid, CHIP, TennCare Select
Long-acting reversible contraception 3-day rate, Ages 21-44	CMS Adult Core Set	2.41%	N/A	Medicaid, CHIP, TennCare Select
Long-acting reversible contraception 90-day rate, Ages 21-44	CMS Adult Core Set	17.89%	N/A	Medicaid, CHIP, TennCare Select
Well Child Visits in the first 30 months of life (W30-CH)				
1st 15 months	CMS Child Core Set	70.09%	73.09%	Medicaid, CHIP, TennCare Select
15-30 months	CMS Child Core Set	79.82%	79.82%	Medicaid, CHIP, TennCare Select

* TennCare encourages increasing access to LARCs, but it is voluntary and as such, TennCare wants to be sure that it is member driven. Therefore, these quality metrics do not have a specific performance target. Metrics are included for tracking purposes.

Goal 2: Increase use of preventive care services for all members to reduce risk of chronic health conditions

TennCare was one of the first states to require all its managed care organizations to have a comprehensive population health program and required clinical risk stratification of the population so that resources could be efficiently optimized to help provide care coordination in a sustainable way. These population health efforts have resulted in significant targeted care coordination and supports that have made meaningful and measurable impacts in high-risk members healthcare journey. The efforts also have identified and scaled cost-effective approaches to ensuring members' access to care.

TennCare began integrating non-medical risk factors supports into the population health strategy in 2019. TennCare has invested significant internal resources to improve the coordination around population health

and non-medical risk factors by collaborating with its MCOs to redesign the requirements of the population health programs to incorporate new emerging evidence and best practices. TennCare MCOs have now fully integrated assessments for non-medical risk factors into their population health model.

TennCare's MCOs are held accountable for EPSDT screening rates. TennCare holds an annual EPSDT strategy meeting with all three MCOs to identify high-priority target areas and a joint strategy to continually improve the screening rates across the state. The MCOs are then required to develop an annual EPSDT investment plan that identifies areas of low screening rates and focus on investing new resources to closing care gaps. The MCO investment plans have included strategies such as member and provider incentives, scheduling platforms, and partnerships with behavioral health providers.

During the COVID-19 Public Health Emergency (PHE), TennCare's MCOs were provided additional funding through the CDC COVID-19 Supplemental Funding Grant to engage in statewide events and outreach to improve well child visits and immunization rates. MCOs were able to leverage that funding in conjunction with their other funding sources to make substantial increases in TennCare's overall EPSDT screening rates.

In 2016, TennCare launched the Patient Centered Dental Home (PCDH), which is a dental practice that maintains an ongoing relationship between the dentist and the patient inclusive of all aspects of oral health care delivered in a comprehensive, continuously accessible and coordinated way. Modeled after TennCare's Patient Centered Medical Home (PCMH) program, all primary care dentists, which include general and pediatric dentists who participate in TennCare Medicaid and CoverKids are required to be a dental home. The PCDH is critical in achieving improvements in oral health outcomes. The PCDH requires the DBM to use various metrics to rank providers based on quality and to make new member assignments and reassignments to dental homes based on provider performance. TennCare tracks member utilization of dental services, utilization of oral disease prevention measures and minimally invasive dental treatments such as Silver Diamine Fluoride (SDF). In 2023, dental coverage became effective for all adult TennCare members.

Table 4. Goal 2 Quality Metrics and Performance Targets

Increase use of preventive care services for all members to reduce risk of chronic health conditions				
Metric Name	**Metric specifications**	**Baseline performance (MY 2024)**	**Performance target (MY2027)**	**Program**
Weight assessment and counseling for nutrition and physical activity for children/adolescents (WCC-CH)				
BMI percentile 3-11 years	CMS Child Core Set	84.07%	87.07%	Medicaid, CHIP, TennCare Select
BMI percentile 12-17 years	CMS Child Core Set	79.89%	82.89%	Medicaid, CHIP, TennCare Select
BMI percentile total	CMS Child Core Set	82.43%	85.43%	Medicaid, CHIP, TennCare Select
Immunizations for Children and Adolescents				
Childhood Immunization Status (CIS-CH) Combination 10	CMS Child Core Set	27.48%	30.48%	Medicaid, CHIP, TennCare Select

Immunization for Adolescents (IMA-CH) Combination 2	CMS Child Core Set	34.79%	37.79%	Medicaid, CHIP, TennCare Select
Breast Cancer Screening (BCS-E)				
Breast cancer screening (BCS-E)	CMS Adult Core Set	51.46%	54.46%	Medicaid, CHIP, TennCare Select
Dental measures				
Increase utilization of Silver Diamine Fluoride (SDF)	TennCare custom measure	56%	59%	Medicaid, CHIP
Increase the percentage of members 2-20 years of age who had one or more dental services annually	Partial enrollment adjusted ratio (PEAR), (Custom)	2.18%	5.18%	Medicaid, CHIP
Decrease Emergency Department Visits for Non-Traumatic Dental Conditions in Adults*^	DQA (ADA)	180.75	175.33	Medicaid, CHIP
Diabetes measures				
Glycemic Status <8% (GSD-AD)	CMS Adult Core Set	61.30%	64.30%	Medicaid, CHIP, TennCare Select
Glycemic Status >9% (GSD-AD) *	CMS Adult Core Set	30.64%	27.64%	Medicaid, CHIP, TennCare Select
Blood Pressure Control (BPD)	HEDIS	72.50%	75.50%	Medicaid, CHIP, TennCare Select
Eye Exam (EED)	HEDIS	55.27%	58.27%	Medicaid, CHIP, TennCare Select
Kidney Health Evaluation (KED)	HEDIS	40.02%	43.02%	Medicaid, CHIP, TennCare Select
Child and Adolescent Well-Care Visits (WCV-CH)				
Ages 3-11	CMS Child Core Set	66.97%	69.97%	Medicaid, CHIP, TennCare Select
Ages 12-17	CMS Child Core Set	56.17%	59.17%	Medicaid, CHIP, TennCare Select
Ages 18-21	CMS Child Core Set	31.89%	34.89%	Medicaid, CHIP, TennCare Select

*Lower rates are better.

*^Rate per 100,000 beneficiary months

Goal 3: Integrate patient-centered, holistic care including non-medical risk factors into population health coordination for all members

TennCare has a strong focus on patient-centered, holistic care that includes non-medical risk factors. The agency in partnership with its MCOs works to identify, evaluate, and reduce, to the extent practical, health disparities based on age, race/ethnicity, sex, primary language, and disability status in its member populations

Identification of health disparities and disability status

During the enrollment and eligibility reverification process demographic information, such as race/ethnicity, age, sex, primary language, and disability status is collected from TennCare applicants and members on a voluntary basis. Federal guidance states that individuals are not required to provide this demographic information.[6] Additional data collection efforts include TennCare's annual Consumer Assessment of Healthcare Providers and Systems ("CAHPS") surveys that meet National Committee Quality Assurance ("NCQA") requirements and Healthcare Effectiveness Data and Information Set ("HEDIS") measures. Pursuant to 42 U.S.C. § 300kk, TennCare and its MCOs and other contractors utilize the Office of Management and Budget (OMB) standards for the collection of Race/Ethnicity, Sex, Primary Language, and Disability Status data.

TennCare Medicaid benefits are available to any person who meets the financial and non-financial requirements of one of the available TennCare Medicaid categories. Eligibility for TennCare's programs and is determined by TennCare, with the assistance of the Social Security Administration ("SSA"). An individual is considered disabled if they meet the disability requirements of the Supplemental Security Income ("SSI") program. The SSA is responsible for determining the TennCare eligibility for individuals who receive benefits under the SSI program

Pursuant to the eligibility and enrollment data exchange requirements in CRA § A.2.23.5, the MCOs must receive, process, and update enrollment files that are sent by TennCare to the MCOs daily. Within twenty-four (24) hours of receipt of enrollment files, the MCOs must update the eligibility/enrollment databases.

As part of the initiative to improve health outcomes, the MCOs periodically collect data by conducting voluntary member and provider surveys and educational events on a variety of topics, which promote delivering high quality health care services to all TennCare members. MCO efforts to improve health outcomes for all members include analyzing data, conducting health needs assessments, holding outreach meetings and community events, and providing target health information to higher risk groups.

The MCOs and their providers and subcontractors that deliver services to members participate in TennCare's efforts to promote the delivery of services in a culturally competent manner that is free from discrimination to all enrollees, including those with Limited English Proficiency, disabilities, and diverse cultural and ethnic backgrounds regardless of a member's sex s. This includes the MCOs ensuring that network providers deliver services in a culturally competent manner that is free from discrimination. The MCOs are required to ensure that TennCare providers:

1) Have the capabilities to deliver services to members with physical or mental disabilities at locations that have physical access and accessible equipment,
2) Furnish reasonable accommodations, and
3) Furnish free language and communication assistance services, including accessible websites.

The MCOs are required to provide cultural and linguistically appropriate service ("CLAS") training to subcontractors and contracted providers which includes the potential impact of linguistic and cultural barriers

[6] Revisions to OMB's Statistical Policy Directive No. 15: Standards for Maintaining, Collecting, and Presenting Federal Data on Race and Ethnicity

on utilization, quality and satisfaction with care, and how and to deliver CLAS services appropriately during a service encounter.

Evaluation of health disparities

TennCare addresses disparities in healthcare through tracking the rates of illness and chronic conditions in relation to key demographic factors. TennCare contractually requires the MCOs to conduct QM/QI activities to address healthcare disparities identified through data collection and requires them to include the methodology utilized for collecting the data as well as interventions taken to enhance the accuracy of the data collected. Additionally, TennCare is directly working to reduce healthcare disparities through contractually requiring its MCOs to provide essential networks and services required to address disparity issues. These requirements include providing care coordination and direct support services for CHOICES HCBS enrollees and Employment and Community First CHOICES enrollees. Dual Eligible Special Needs Plans (D-SNPs) are also charged with coordinating non-medical risk factors supports that may impact dual eligible members' health-related behaviors and outcomes.

Reducing health disparities

Non-medical risk factors of health are conditions in the environment where TennCare members are born, live, learn, work, play, worship, and age that have an outsized impact on individuals' health. In Tennessee, risk factors directly related to an individual's social, economic, and physical environment are estimated to drive at least 40-60% of an individual's health. These risk factors affect a wide range of health, functioning, and quality-of-life outcomes. TennCare, as part of its 4-year strategic plan, has begun integrating whole-person health approaches to better address the non-medical risk factors of our TennCare members. These efforts, which TennCare refers to broadly as its "Health Starts Initiative," span a series of evidence-based and innovative initiatives that aim to provide clinical supports, resources, and technological enhancements to reduce the impact of non-medical risk factors.

On April 1, 2021, TennCare's MCOs began piloting efforts with key TennCare providers to determine how to consistently screen members for non-medical risk factors, refer members to community resources to meet identified needs, and ensure that the non-medical risk factor needs referral was completed. The provider partnerships are also designed to measure impact on the member and uncover best practices associated with addressing needs at the provider level. To date, over 40 organizations encompassing outpatient primary care, primary behavioral health, OB/GYN, hospital-based care, post-acute care, LTSS, and substance use providers have engaged in the program. The provider partnerships have continued to focus on supporting providers to systematically screen for non-medical risk factor needs such as food insecurity, housing supports, transportation, trauma supports, and job training and opportunities. The providers also created and strengthened partnerships with existing community and faith-based organizations to meet families' needs and support from TennCare's health plans will allow for longitudinal support to ensure recurrent needs may be met.

In June 2023, TennCare issued and launched a community health worker (CHW) grant program to Tennessee providers to support the implementation of evidence-based best practices. Eight provider organizations across the state were selected to receive technical support and facilitating sustainability efforts as these provider organizations hire and onboard CHW and CHW supervisors and provide CHW services to TennCare members. In

the first year of the grant, 51 CHWs and CHW supervisors were employed and served over 4,200 individuals. In June 2024, after assessing outcomes from the first round of grants, seven additional provider organizations were selected to participate in the CHW grant program. Each grant has continued for a minimum of two years. The first round of grants entered Year 3 In July 2025.The efforts of these organizations will directly support TennCare's ability to gather learnings and best practices to support the three-year goal of implementing a sustainable financial reimbursement model for community health worker services. Additionally, in June 2023, the Tennessee Community Health Worker Association (TNCHWA) was awarded a grant to build out program standards for CHW organizations and create the foundation to serve as an accrediting body for CHW organizations across the state. Since the start of the grant, TNCHWA, in collaboration with CHW subject-matter experts, has developed program standards to support the accreditation model and operationalize the accreditation process for CHW programs engaged in the TennCare Infrastructure Grant. So far, seven organizations have been awarded accreditation after a rigorous application process and site review. The accreditation serves as an attestation of high-fidelity alignment with evidence-based best practices and commitment to providing high-quality care.

TennCare is also integrating a statewide, Closed-Loop Referral System (CLRS), branded as Tennessee Community Compass, to provide enhanced support to providers and MCOs as they address non-medical risk factors in the TennCare population. The CLRS is a technology-based platform powered by findhelp, that facilitates systematic non-medical risk factor referrals and contains up-to-date community resource directories and referral outcomes tracking capabilities. The solution will serve as a repository of community-based resources to be utilized by the MCOs and healthcare providers. Non-medical risk factor assessments can be performed in the system and will serve as data to populate community resources for member referrals. The system also supports data analytics to understand the population health needs and other key health outcome metrics which will be used to further improve and refine existing efforts and expand the way TennCare meets non-medical risk factor needs and addresses non-medical risk factors. On March 31, 2025, TennCare's MCOs and provider partner, West Tennessee Health, launched TNCC within their case management and care models. Throughout the coming year, select Patient Centered Medical Home and Tennessee Health Link providers, one hospital, Tennessee Department of Health will launch TNCC.

In addition to programmatic efforts, TennCare MCOs are required to obtain and maintain NCQA's Health Equity Accreditation. The distinction is a representation of TennCare's commitment to offer culturally and linguistically appropriate services and provides an avenue to evaluate how well the MCOs comply with standards for collecting race/ethnicity and language data, provide language assistance, cultural responsiveness, quality improvement of CLAS, and reduction of health care disparities. All MCOs have obtained this accreditation and part of the accreditation requirements includes the collection and evaluation of data relevant to a person's race, ethnicity, language and sex data. Additionally, the requirements also include using the data to determine if health care disparities exist. NCQA allows the use of both direct and indirect methods for data collection. However, if an indirect method is used, the estimation methodology must be validated. NCQA's outlined methodology for organizations to determine if health care disparities exist includes analyzing valid measures of clinical performance by race/ethnicity, preferred language, and sex.

Patient-Centered Focus

TennCare is committed to ensuring enrollees' satisfaction with services. TennCare contracts with the University of Tennessee Boyd Center for Business and Economic Research to conduct an annual survey of 5,000 Tennessee households to gather information on insurance status, how individuals and families engage in the health care process and satisfaction with TennCare. The design for the survey is a "household sample," and the interview is conducted with the head of the household. The report, "The Impact of TennCare: A Survey of Recipients", allows comparison between responses from all households and households receiving TennCare. The most recent 2024 survey shows that 96 percent of TennCare recipients expressed satisfaction with the program's quality of care, making 2024 the 16th straight year in which satisfaction with TennCare exceed 90 percent. TennCare is proud of the growth in member satisfaction that has been achieved over time. This improvement reflects TennCare's commitment to high quality care and performance improvement.

Table 5. Goal 3 Quality Metrics and Performance Targets

Integrate patient-centered, holistic care including non-medical risk factors into population health coordination for all members				
Metric Name	**Metric specifications**	**Baseline performance (MY 2024)**	**Performance target (MY 2027)**	**Program**
Non-medical risk factors (Health Starts)				
Increase the number of authorized users using a statewide CLRS	TennCare Custom	435	1,074	Medicaid, CHIP, LTSS, TennCare Select
Increase the response rate for referrals to CBOs created by MCOs	TennCare Custom	19.1%	22.0%	Medicaid, CHIP, LTSS, TennCare Select
LTSS Member Satisfaction				
Increase the percentage of CHOICES members who report that people who are paid support staff show up and leave when they are supposed to	NCI-AD Q 29	82% (2023-2024)	84%	LTSS
Increase the percentage of ECF CHOICES members who report experiences of continuity, security, and respect in their services and supports.	POM, 7 *	N/A	N/A	LTSS
Increase the percentage of Katie Beckett member families satisfied with the services and supports their child currently receives	NCI-CFS Q 61	46% (2022-2023)	48%	LTSS

*Baseline data will be provided in the 2026 Quality Strategy

Goal 4: Improve positive outcomes for members with LTSS needs

Each of the MLTSS programs is specifically designed to support the achievement of specific outcomes.

CHOICES

The CHOICES program provides Home and Community-based Services (HCBS) for elderly and/or physically disabled persons who would otherwise require Nursing Facility (NF) services. TennCare provides these services for individuals at a cost that does not exceed the individual cost neutrality test used in a Section 1915(c) waiver. Through improved coordination of care and use of more cost-effective home and community-based alternatives, TennCare expands access to home and community-based services for persons who do not yet meet a NF level of care, but who are "at risk" of needing NF services, thereby delaying or preventing the need for more expensive institutional care.

Employment and Community First CHOICES

The Employment and Community First CHOICES program is a tiered benefit structure based on the needs of individuals enrolled in the program and allows the state to provide HCBS and other Medicaid services more cost-effectively so that more people who need HCBS can receive them. This includes people with ID who would otherwise be on the waiting list for a section 1915(c) waiver and people with other DD who are not eligible for Tennessee's current section 1915(c) waivers. The development of a benefit structure and the alignment of financial incentives specifically geared toward promoting integrated competitive employment and integrated community living will result in improved employment and quality of life outcomes.

Katie Beckett

The Katie Beckett program was designed for children under the age of 18 with disabilities or complex medical needs. The program supports children with disabilities and complex medical needs to grow and thrive in their homes and communities, including planning and preparing the child for transition to employment and community living with as much independence as possible. The program also supports and empowers families caring for a child with disabilities or complex medical needs at home and keeps families together and sustains family caregivers. The program provides services in the most cost-effective manner possible in order to serve as many children as possible within approved program funding.

Identification of persons who need LTSS or require special health care needs[7]

The state provides LTSS benefits through managed care. The MCOs are contractually required to make a best effort to conduct an initial screening of each member's needs, within ninety (90) days of the effective date of enrollment for all new members to assess member's health risk utilizing a health risk assessment or a comprehensive health risk assessment. The MCO must make subsequent attempts to conduct an initial screening of each member's needs if the initial attempt to contact the member is unsuccessful. The information collected

[7] *42 CFR 438.340(b)(8), applicable also to CHIP managed care programs per 42 CFR 457.1240(e), cross-referencing 438.208(c)(1) and 457.1230(c).*

from these health assessments will be used to align individual members with appropriate intervention approaches and maximize the impact of the services provided.

At time of enrollment and annually thereafter, the MCO must make a reasonable attempt to assess the member's health. The comprehensive health risk assessment required by Level 2 Population Health programs, CHOICES, ECF CHOICES, Katie Beckett, Dual Special Needs Program (D-SNP), Select Community, and Department of Children's Services (DCS) can be used in lieu of the approved health assessment required by the contract. The completed approved health assessment or comprehensive health risk assessment data may be shared among TennCare MCOs and used to meet the annual requirement. Upon request, the MCO shares with TennCare, or other MCCs serving the member, the results of any identification and assessment of that member's needs to assist in facilitating the administration of health-related services and to prevent duplication of those activities.

The MCO conducts a comprehensive Health Risk Assessment (HRA) for all members enrolled in the Chronic Care Management, Complex Case Management, and High-Risk Maternity Programs. The HRA should include screening for physical conditions, mental health, and substance abuse for all members. For members considered high risk, the assessment includes documenting the individual health history, determining each member's health literacy status, identifying substance abuse and behavioral issues/problems, identifying needs and gathering information, when appropriate, from other sources (e.g., family members, medical providers, and educators). The MCO also conducts an assessment for the need of a face-to-face visit for members considered to have high health risks that are enrolled in the Chronic Care Management, Complex Case Management, or High-Risk Maternity programs. The MCO will assess the need for a face-to-face visit using the standard assessment criteria provided by TennCare. If needed, such a visit will be conducted following consent of the member.

The PBA also identifies persons with special health care needs by updating its eligibility file on a daily basis. The PBA receives daily MMIS eligibility file updates from TennCare and includes the general TennCare and CoverKids members and those identified by a unique indicator as being in a special needs' program including CHOICES, ECF CHOICES, Department of Children's Services (DCS) Select Community, and dual eligible Medicare/Medicaid members. Katie Beckett members are included in the daily file, but they are not identified by an indicator. Rather a separate monthly file from TennCare is provided to the PBA with the Katie Beckett members identified, which is uploaded to the PBA's system.

Table 6. Goal 4 Quality Metrics and Performance Targets

Improve positive outcomes for members with LTSS needs[8]				
Metric Name	**Metric specifications**	**Baseline performance MY 2024**	**Performance target MY 2027**	**Program**
Quality of Life				
Increase percentage of CHOICES members who report they feel like they have more choice and control over their life than 12 months ago.	NCI-AD (Q TN-5)	17% (2022-2024)	19%	LTSS
Percent of ECF CHOICES members who report experiences of rights, fairness, and environmental access in their daily schedule.	POM (5, 7, 8)*	N/A	N/A	LTSS
Increase percentage of parents/families who report feeling that services and supports have improved their ability to care for their child	NCI-CFS (Q 64)	98% (2022-2023)	100%	LTSS
Community Integration				
Increase percentage of working age adults with I/DD enrolled in HCBS who are employed in an integrated setting earning at or above minimum wage	ECF CHOICES baseline data	21.6% (2023-2024)	23.6%	LTSS
Increase the percentage of older adults and adults with physical disabilities who report being as active in their community they would like.	NCI-AD (Q 53)	58% (2023-2024)	62%	LTSS
Increase the percentage of individuals with I/DD who report meaningful participation and inclusion in community.	NCI-IPS (Q 56, 58, 59, 61) OM(9,10 11)*	N/A	N/A	LTSS
Increase the percentage of children participating in activities in the community	NCI-CFS (Q 40)	88% (2022-2023)	90%	LTSS
Rebalancing				
Increase HCBS expenditures for older adults and adults with physical disabilities as a percentage of total LTSS expenditures	CHOICES baseline data	20.02% (2023-2024)	22.02%	LTSS
Increase HCBS expenditures for individuals with I/DD as a percentage of total LTSS expenditures	ECF CHOICES baseline data	47.1% (2023-2024)	49.1%	LTSS
LTSS HEDIS Measures – Comprehensive Assessments and Care Plans				
Comprehensive Assessment and Update (LTSS-CAU)				

[8] *42 CFR 438.340(b)(3)(i), applicable also to CHIP managed care programs per 42 CFR 457.1240(e), cross-referencing 438.330(c)(1)(ii).*

Assessment of Core Elements	HEDIS	96.19%	99.19%	LTSS
Assessment of Supplemental Elements	HEDIS	95.86%	98.86%	LTSS
Comprehensive Care Plan and Update (LTSS-CPU)				
Care Plan with Core Elements Documented	HEDIS	95.78%	98.78%	LTSS
Care Plan with Supplemental Elements Documented	HEDIS	95.70%	98.70%	LTSS
Reassessment/Care Plan Update after Inpatient Discharge (LTSS-RAC)				
Reassessment after Inpatient Discharge	HEDIS	63.50%	66.50%	LTSS
Reassessment and Care Plan Update after Inpatient Discharge	HEDIS	57.99%	60.99%	LTSS
Shared Care Plan with Primary Care Practitioner (LTSS-SCP)				
Shared Care Plan with Primary Care Practitioner	HEDIS	90.92%	93.92%	LTSS

*Baseline data will be available for the 2026 Quality Strategy.

Goal 5: Provide additional support and follow-up for patients with behavioral health care needs

TennCare and its contracted MCOs operate two statewide behavioral health programs where the focus is on improving healthcare quality outcomes and care coordination for members with severe and persistent mental illness (SPMI) and/or substance use disorders (SUD).

Tennessee Health Link (THL) coordinates health care services for TennCare members with the highest behavioral health needs. Through better coordinated behavioral and physical health services, the Health Link program is meant to produce improved member outcomes, greater provider accountability and multidisciplinary care coordination when it comes to the delivery of appropriate care for each individual, and improved cost control for the state. For more information about THL, see goal 7.

Buprenorphine Enhanced Medication Assisted Recovery and Treatment (BESMART) Program was developed in 2019 to be a specialized provider network focused on contracting with high quality medication assisted treatment (MAT) providers to provide comprehensive care to TennCare members with SUD. BESMART providers commit to providing best practice clinical standards of comprehensive medication for Opioid Use Disorder, counseling, care coordination, and behavioral health support.

Table 7. Goal 5 Quality Metrics and Performance Targets

Provide additional support and follow-up for patients with behavioral health care needs				
Metric Name	**Metric specifications**	**Baseline performance MY 2024**	**Performance target MY 2027**	**Program**
Use of Opioids at High Dosage in Persons without Cancer (OHD-AD)				

Use of Opioids at High Dosage in Persons without Cancer*	CMS Adult Core Set	4.40%	1.40%	Medicaid
Concurrent Use of Opioids and Benzodiazepines (COB-AD)				
Concurrent Use of Opioids and Benzodiazepines*	CMS Adult Core Set	13.33%	10.33%	Medicaid
Follow-up After Hospitalization for Mental Illness (FUH-AD)				
7-day rate	CMS Adult Core Set	36.27%	39.27%	Medicaid, CHIP, TennCare Select
30-day rate	CMS Adult Core Set	56.42%	59.42%	Medicaid, CHIP, TennCare Select
Follow-up After Hospitalization for Mental Illness (FUH-CH)				
7-day rate	CMS Child Core Set	51.39%	54.39%	Medicaid, CHIP, TennCare Select
30-day rate	CMS Child Core Set	73.58%	76.58%	Medicaid, CHIP, TennCare Select
Use of Pharmacotherapy for OUD (OUD-AD)				
Total Rate	CMS Adult Core Set	55.43%	58.43%	Pharmacy
Buprenorphine	CMS Adult Core Set	47.06%	50.06%	Pharmacy

*Lower rates are better.

Goal 6: Maintain robust member access to health care services

TennCare monitors MCO General Network Access, Specialty Network Access, Behavioral Health Network Access and Long-Term Services & Supports. The standards can be accessed at https://www.tn.gov/content/dam/tn/tenncare/documents/MCOStatewideContract.pdf All TennCare Network Access Requirements are located in Attachment III (General Access), Attachment IV (Specialty) and Attachment V (Behavioral Health) of the contractor risk agreement (CRA). TennCare has historically maintained 100% network access with its contracted MCOs for many years. As new standards have been developed over the years, TennCare sets benchmarks over several months that MCOs must meet prior to go live.

The state's MCCs are contractually required to provide available and accessible, adequate numbers of contracted providers for the provision of TennCare covered services. The Division of TennCare uses Quest Analytics software as to monitor enrollee access to care. These software applications and other measures are utilized to identify potential deficiencies in each MCC's provider network. Geo Reports are routinely prepared for each MCC monthly. If a potential network deficiency is identified, the MCC is notified and is requested to address the deficiency.

Transition of Care

TennCare maintains a transition of care policy that addresses transfers between managed care contractors and that ensures continued access to services during any transition between managed care contractors.[9] This transition of care policy specifies that transferring enrollees continue to have access to services consistent with their prior access, including the ability to retain their current provider for a period of time if that provider is not in the new managed care contractor's network. In addition, the transition of care policy ensures that the enrollee is

[9] *42 CFR 438.340(b)(5), applicable also to CHIP managed care programs per 42 CFR 457.1240(e), cross-referencing 438.62(b).*

referred to appropriate providers of services that are in the new managed care contractor's network. Under the state's transition of care policy, the enrollee's old managed care contractor must fully and timely comply with appropriate information requests from the enrollee's new managed care contractor, including requests for historical utilization data. In addition, the enrollee's new providers are able to obtain copies of the enrollee's medical records, consistent with federal and state law. The transition of care policy also includes a process for the electronic exchange of specified data classes and elements. The transition of care policy is available on the TennCare website:

https://www.tn.gov/content/dam/tn/tenncare/documents2/con19001.pdf

Table 8. Goal 6 Quality Metrics and Performance Targets

Maintain robust member access to health care services				
Metric Name	**Metric specifications**	**Baseline performance MY 2024**	**Performance target MY 2027**	**Program**
Adult Access to Preventive/Ambulatory Health Services (AAP)				
Ages 20-44	HEDIS	79.99%	82.99%	Medicaid, CHIP, TennCare Select
Ages 45-64	HEDIS	86.76%	89.76%	Medicaid, CHIP, TennCare Select
General Network Access Time and Distance Standards				
Maintain high compliance for adult members	General Network Access Time and Distance standards	100%	100%	Medicaid, CHIP, LTSS
Specialty Network Access Time and Distance Standards				
Maintain high compliance for adult members	Specialty Network Access Time and Distance standards	100%	100%	Medicaid, CHIP
Behavioral Network Access Time and Distance Standards				
Maintain high compliance for adult members	Behavioral Health Network Access Time and Distance standards	99.9%	100%	Medicaid, CHIP
General Dental Network Access Time and Distance Standards				
Maintain high compliance for adult members	General Dental Network Access Time and Distance standards	100%	100%	Medicaid, CHIP, LTSS
Maintain high compliance for pediatric members	General Dental Network Access Time and Distance standards	100%	100%	Medicaid, CHIP, LTSS
Maintain high compliance for ECF CHOICES members	General Dental Network Access Time and Distance standards	100%	100%	LTSS
Pharmacy Network Access Time and Distance Standards				

Maintain high compliance for adult members	Pharmacy Network Access Time and Distance standards	99.99%	100%	Medicaid, CHIP
Maintain high compliance for pediatric members	Pharmacy Network Access Time and Distance standards	99.99%	100%	Medicaid, CHIP
LTSS Network Access Time and Distance Standards				
Maintain high compliance for CHOICES HCBS members	MLTSS Network Adequacy Time and Distance Scores	99.99%	100%	LTSS
Maintain high compliance for ECF CHOICES members	MLTSS Network Adequacy Time and Distance Scores	100%	100%	LTSS

Goal 7: Maintain financial stewardship through increasing value-based payments and cost-effective care

Patient-Centered Medical Homes

TennCare's Patient Centered Medical Home (PCMH) program aims to improve the quality of primary care services for members, the capabilities and reach of primary care providers, and the overall quality of health care delivered to the TennCare population. TennCare believes that a strong primary care system is the backbone of a thriving health care delivery system. Primary care transformation focuses on the role of the primary care provider: preventing illness, managing chronic illnesses, coordinating care with other providers, and engaging members in the community. As part of Tennessee's Health Care Innovation Initiative, the state has committed to moving away from paying for volume to paying for value. The mission is to reward health care providers for improving health outcomes by providing high quality and efficient treatment of medical conditions and maintaining people's health over time. This strategy includes PCMH for the general population of adults and children, and a Tennessee Health Link (THL) model for TennCare members with high behavioral health needs. The PCMH program launched in January 2017 and serves both children and adults through our accredited 75+ PCMH organizations across 450+ sites statewide.

Across program years 2021, 2022 and 2023, TennCare observed improved quality in 13 of 14 measures. TennCare utilizes the National Committee for Quality Assurance (NCQA) HEDIS® measures for the majority of PCMH Core Quality Measures. In the first three years of the program, the largest improvement was seen in the metric for Comprehensive Diabetes Care: Blood Pressure Control (<140/90), which had improved by 12 percentage points. From 2021 to 2023, the program again exceeded targets on this metric, further improving by seven percentage points. In addition, two other metrics regarding diabetes care realized similar improvements: eye exams and glycemic status (<8%) for patients with diabetes both increased by an average of eight percentage points. Across the same measurement period, Well-child visit screening rates for children in the PCMH program increased for ages3 – 11, four percentage points for ages 12 – 17, and three percentage points for ages 18 – 21.

Tennessee Health Link

The primary objective of THL is to coordinate health care services for TennCare members with the highest behavioral health needs. Through better coordinated behavioral and physical health services, the Health Link program is meant to produce improved member outcomes, greater provider accountability and flexibility when it comes to the delivery of appropriate care for each individual, and improved cost control for the state. There are 18 agencies who provide THL services across the state.

Health Link providers commit to providing comprehensive care management, care coordination, referrals to non-medical risk factor supports, member and family support, transitional care, health promotion, and population health management. Participating providers receive training and technical assistance, quarterly, bi-weekly, weekly, and daily reports with actionable data. These providers are compensated with financial support in the form of activity payments and an opportunity for an annual outcome payment based on quality and efficiency performance.

Episodes of Care

TennCare's Episodes of Care program strives to transform the way specialty and acute healthcare services are delivered in Tennessee by incentivizing high-quality, cost-effective care; encouraging provider coordination; and disincentivizing ineffective and/or inappropriate care. An episode of care includes all the relevant health care services a patient receives during a specified period for the treatment of a physical or behavioral health condition. For each episode of care, a principle accountable provider (or "quarterback") is defined and held accountable for the quality and cost of care delivered during the entire episode. With regards to promoting quality, these "quarterbacks" are given quarterly reports outlining how that provider has performed on the gain-sharing quality metrics (i.e., metrics tied to financial accountability) and informational quality metrics of the episodes they are responsible for. If the "quarterback" meets cost and quality thresholds for a given episode, that provider then becomes eligible for a reward payment, based on shared savings. Tennessee is committed to providing quality data for episodes on an annual basis. A full summary of each gain-sharing quality metric and its year-over-year performance in the program can be found under the "Results" section at the following link: https://www.tn.gov/tenncare/health-care-innovation/episodes-of-care/results-changes.html. Quality metrics are reviewed and updated annually as part of regular program operations. If TennCare identifies a quality metric that has undergone a significant decrease in performance, the state works alongside its MCO partners to analyze the data, identify potential reasons for the change (e.g., updated practice guidelines, new medical codes, etc.), and update an episode's design if applicable.

Quality Improvement in Long-Term Services and Supports (QuILTSS)

Nursing Facilities

Quality Improvement in Long-Term Services and Supports (QuILTSS) is the name given to TennCare's value-based purchasing and delivery system transformation (VBP/DST) approach for LTSS. QuILTSS encompasses a number of initiatives focused on promoting a person-centered approach to service planning and delivery, improving quality of care and quality of life, and shifting payment to be outcomes driven and other VBP approaches, with a primary emphasis on improving the member's experience of care across services and settings, including nursing facilities (NFs) and home and community- based services (HCBS).

Working in partnership with stakeholders, Tennessee is continuing to implement quality- and acuity-based payment and delivery system reform for Long-Term Services and Supports Nursing Facility services. Successes already realized from this work include a nursing home payment structure that takes into account the acuity of residents and the quality of care provided as well as a 25 percent reduction in payments to nursing homes for complex respiratory care with more people weaned from the ventilator and reductions in adverse outcomes (infections, hospitalizations, deaths).

Home and Community Based Services (HCBS)

HCBS QuILTSS also encompasses a number of different VBP/DST initiatives across TennCare's HCBS programs and authorities. The Systems of Support (SOS) model was implemented in early 2016 as a new model of support for the delivery of behavioral crisis prevention, intervention, and stabilization services for individuals with intellectual and developmental disabilities (I/DD). Delivered under the managed care program, the service focuses on crisis prevention, in-home stabilization, sustained community living, and improved quality of life for individuals with challenging behaviors that place themselves and others at risk. The VBP approach utilizes a monthly case rate aligned to support improvement and increased independence over time as the provider is successful in helping paid or unpaid caregivers increase their capacity to provide needed support in order to prevent and/or manage crises. A second VBP component introduced in 2019 added outcome-based deliverables in order to receive monthly payments. Learnings from this initiative helped to inform the design of new Groups 7 and 8 in Employment and Community First CHOICES (described below), including the VBP/DST approach and data collection process (which was launched before the collection of non-claims-based SOS measurement data).

Employment and Community First CHOICES is a managed LTSS program designed to promote integrated employment and community living as the first and preferred outcome for individuals with I/DD. Employment benefits designed in consultation with experts from the federal Office of Disability Employment Policy create a pathway to employment, even for people with severe disabilities. Reimbursement for employment benefits in this program reflects a variety of value-based approaches including outcome-based reimbursement for up-front services leading to employment, tiered outcome-based reimbursement for Job Development and Self-Employment Start-Up based on the member's "acuity" level and paid in phases to support tenure, and tiered reimbursement for Job Coaching also based on the member's acuity, but taking into account the length of time the person has held the job and the amount of paid support required as a percentage of hours worked (which helps to incentivize greater independence in the workplace, the development of natural supports, and the fading of paid supports over time).

New Groups 7 and 8 targeted specifically to children and adults, respectively, with I/DD and severe co-occurring psychiatric conditions or challenging behavior support needs, were implemented in September 2019. Building on the lessons learned from the SOS model, the VBP approach for the primary benefit in each group— Intensive Behavioral Family-Centered Treatment, Stabilization and Support and Intensive Behavioral Community Transition and Stabilization Services, respectively— combines outcome-based deliverables with a monthly case rate aligned to support improvement and increased independence over time.

LTSS Workforce Incentives

In 2022, TennCare launched a multi-faceted initiative to strengthen the competency of Direct Support Professionals (DSPs) by partnering with the National Alliance for Direct Support Professionals (NADSP). This initiative aimed to enhance the skills of DSPs, Frontline Supervisors (FLS), and Home and Community-Based Services (HCBS) providers through nationally accredited, competency-based training. The program also incorporated milestone-based incentive payments to encourage participation and achievement.

As of June 30, 2025, a total of 455 DSPs and FLSs from 47 provider agencies across East, Middle, and West Tennessee were enrolled in the NADSP E-Badge Academy. Of those enrolled 437 DSPs and 44 FLSs successfully earned badges, marking significant progress in workforce development.

TennCare has actively promoted the E-Badge Academy through a variety of outreach methods, including printed and digital materials (e.g., flyers, brochures, social media), stakeholder presentations, newsletters, and direct engagement with HCBS providers.

To assess the program's impact, TennCare developed evaluation tools focused on recruitment and retention metrics. Preliminary findings indicate:

- The majority of participants are between the ages of 45 and 54.
- Most participants have 3–5 years of experience in the field, followed closely by those with 6–10 years.
- A significant portion of participants reported no intention to leave their current positions within the next six months.

Participant feedback on the program's value includes aspirations such as:

- Gaining a sense of accomplishment.
- Improving managerial skills to better support staff and operations.
- Enhancing knowledge to provide higher-quality care to individuals served.

The NADSP E-Badge Academy is expected to improve service delivery, support career advancement in a traditionally low-wage field, and contribute to long-term workforce stability through professionalization and skill development.

Goal 8: Performance Improvement Projects (PIP) and PIP interventions[10]

In accordance with the contractor risk agreements (CRAs) with TennCare, MCOs must conduct one clinical and one non-clinical performance improvement projects (PIPs). The DBM and PBA must conduct at least one clinical and one non-clinical PIP, respectively. For MCOs, the non-clinical PIP must be conducted in the area of long-term care focusing on one of the HEDIS LTSS measures, or other efforts to drive quality performance and improvement in person-centered planning or person-centered support plans. In addition, MCOs must conduct an additional PIP on

[10] *42 CFR 438.340(b)(3)(ii), applicable also to CHIP managed care programs per 42 CFR 457.1240(e), cross-referencing 438.330(d) and 457.1240(b).*

Early and Periodic Screening, Diagnostic and Treatment (EPSDT) screening and outreach if their overall CMS-416 rates are below 80%. Each of the PIPs tie into the Quality Strategy and advance at least one of the state's goals and objectives. See Appendix 2 for the full listing of PIPs for each MCC.

Section III: Monitoring and Compliance

Network adequacy and availability of services[11]

TennCare's MCCs consistently maintain adequate networks. Remediation efforts (e.g., CAP, ORR, or RFI) are rarely required to address a deficiency. Additionally, TennCare maintains high compliance scores for access and availability for its MCOs and the DBM.

TennCare provides the state's MCO network adequacy and availability of services standards within the Contractor Risk Agreement (CRA), which can be found at:
https://www.tn.gov/content/dam/tn/tenncare/documents/MCOStatewideContract.pdf.
All TennCare Network Access Requirements are located in Attachment III (General Access), Attachment IV (Specialty) and Attachment V (Behavioral Health) of the CRA. The standards apply for Medicaid, CHIP and LTSS members.

General Network Access (Attachment III of CRA). See pages 649-650

TennCare MCOs provide available, accessible, and adequate numbers of institutional facilities, service locations, service sites, professional, allied, and paramedical personnel for the provision of covered services, including all emergency services, on a 24-hour-a-day, 7-day-a-week basis for all members (adults and children) as outlined in the General Network Access requirements.

Specialty Network Access (Attachment IV of CRA). See pages 652-654

TennCare MCOs adhere to Specialty Network Access requirements to ensure access and availability to specialists for all members (adults and children) who are not dually eligible for Medicare and TennCare (non-dual members). For the purpose of assessing specialty provider network adequacy, TennCare evaluates the MCO's provider network with monitoring these 17 specialties: Allergy, Cardiology, Chiropractic, Dermatology, Endocrinology, Otolaryngology, Gastroenterology, General Surgery, Nephrology, Neurology, Neurosurgery, Oncology/Hematology, Ophthalmology, Orthopedics, Psychiatry (adult), Psychiatry (child and adolescent), and Urology.

Behavioral Health Network Access (Attachment V of CRA). See pages 656-658

TennCare MCOs adhere to the following Behavioral Health Network Access requirements to ensure access and availability to behavioral health services for all members (adults and children). For the purpose of assessing behavioral health provider network adequacy, TennCare evaluates the MCO's provider network relative to the contractual requirements. Providers serving adults are evaluated separately from those serving children.

MLTSS Network Access (Section A.2.11.7 of the CRA). See pages 310-317

In addition to the General Network Access standards above, TennCare has established specific MCO standards

[11] *42 CFR 438.340(b)(1), applicable also to CHIP managed care programs per 42 CFR 457.1240(e), cross-referencing 438.68, 438.206, 457.1218, and 457.1230(a).*

regarding network adequacy for MLTSS providers to include time and distance standards for LTSS provider types in which an enrollee must travel to the provider to receive services.[12] Additionally, TennCare has MCO network adequacy standards other than time and distance standards for LTSS provider types that travel to the enrollee to deliver services. For services provided in the member's home, MCOs must ensure a choice of providers for every HCBS and a sufficient number of providers to initiate services as specified in the person-centered support plan ensuring continuity of services without gaps in care. MCO standards also apply for special populations, specifically that individuals with I/DD have a network of providers with appropriate experience and expertise in serving people with I/DD and in achieving important program outcomes, such as employment.

General Dental Services (Amendment #3 Section A.200.d.3.(i)). See PDF page 137
The DBM makes services, service locations and service sites available and accessible so that transport distance/time to general dental, oral surgery services, orthodontic services, pediatric dental services and dental specialty providers will be the usual and customary, not to exceed the network access standards as outlined in the Dental Benefit Managers contract, found at:
https://www.tn.gov/content/dam/tn/tenncare/documents2/DentaQuest59802.pdf.

Pharmacy Benefit Services (Section A.49.b). See page 101
The PBA provides available, accessible, and adequate numbers of pharmacies to meet the pharmacy network access standards as outlined in the Pharmacy Benefits Administrator's contract, found at
https://www.tn.gov/content/dam/tn/tenncare/documents2/Optum3186500600.pdf.

Clinical practice guidelines[13]

The state requires MCOs to utilize evidence-based clinical practice guidelines required by 42 CFR 438.236 in its Population Health Programs. Wherever possible, MCOs utilize nationally recognized clinical practice guidelines. For example, all three MCOs use the nationally recognized Guidelines for Perinatal Care (American Academy of Pediatrics & American Congress of Obstetrics and Gynecology) and the Global Strategy for the Diagnosis, Management and Prevention of Chronic Obstructive Pulmonary Disease (Global Initiative for Chronic Obstructive Lung Disease (GOLD)). On occasion, tools for standardized specifications for care to assist practitioners and patient decisions about appropriate care for specific clinical circumstances are developed through a formal process and are based on authoritative sources that include clinical literature and expert consensus. The guidelines must be reviewed and revised whenever the guidelines change and at least every two years. The MCO is required to maintain an archive of its clinical practice guidelines for a period of five years. Such archives must contain each clinical guideline as originally issued so that the actual guidelines for prior years are retained for program integrity purposes. MCOs are required to be NCQA accredited. As part of the accreditation survey, files are reviewed to ensure that the NCQA requirements for clinical practice guidelines are met.

TennCare prioritizes the use of evidence-based practice and clinical interventions that have demonstrated safety

[12] *Pursuant to 42 CFR 438.68(2), in addition to the requirements in Section A.2.11.1 and Attachment III of the CRA. See CRA Section A.2.11.7.*
[13] *42 CFR 438.340(b)(1), applicable also to CHIP managed care programs per 42 CFR 457.1240(e), cross-referencing 438.236 and 457.1233(c).*

and effectiveness assist consumers in achieving their desired goals of health and wellness.

For additional information on each MCOs clinical practice guidelines, please see the following websites:

BlueCare
https://provider.bcbst.com/tools-resources/manuals-policies-guidelines

UnitedHealthcare
https://www.uhcprovider.com/en/health-plans-by-state/tennessee-health-plans/tn-comm-plan-home/tn-cp-policies.html

Wellpoint
https://provider.amerigroup.com/docs/gpp/TN_CAID_ClinicalPracticeGuidelinesMatrix.pdf?v=202106011539

Intermediate sanctions[14]

Tennessee's managed care contracts include the use of intermediate sanctions against managed care contractors for failure to meet performance standards. Consistent with federal regulations, these sanctions may be imposed upon a reasonable determination by the state that the contractor is deficient in the performance of its obligations, which include (but may not be limited to):

- Fails substantially to provide medically necessary covered services;
- Imposes on members cost sharing responsibilities that are in excess of the cost sharing permitted by TennCare;
- Acts to discriminate among enrollees on the basis of health status or need for health care services;
- Misrepresents or falsifies information that it furnishes to CMS or to the State;
- Misrepresents or falsifies information furnished to a member, potential member, or provider;
- Fails to comply with the requirements for physician incentive plans as listed in 42 CFR 438.6(h);
- Has distributed directly, or indirectly through any agent or independent contractor, marketing or member materials that have not been approved by the state or that contain false or materially misleading information; and
- Has violated any of the other applicable requirements of Sections 1903(m) or 1932 of the Social Security Act and any implementing regulations.

Intermediate sanctions imposed by the state against a contractor may include the development and implementation of corrective action plans, liquidated damages, suspension of enrollment, disenrollment of members, limitation of the contractor's service area, civil monetary penalties (as provided for in 42 CFR 438.704), appointment of temporary management (as provided for in 42 CFR 438.706), or suspension of payment for members enrolled after the effective date of the sanction until the state is satisfied that the issue has been resolved. These remedies provide the state with a range of administrative mechanisms to address performance

[14] *42 CFR 438.340(b)(7), applicable also to CHIP managed care programs per 42 CFR 457.1240(e), cross-referencing Part 438 Subpart I*

issues. The disposition of any corrective action depends upon the nature, severity and duration of a deficiency or non-compliance.

Compliance with Federal LTSS Requirements[15]

While populations served through LTSS programs are included in the performance objectives listed above, TennCare has also outlined the compliance measures specific to LTSS populations given the unique needs of those served. These measures specific to CHOICES were established based on section 1915(c) waiver assurances and sub-assurances, including level of care, service plan, qualified providers, health and welfare, administrative authority, and participant rights—largely measures of compliance with federal and/or state requirements.

Upon implementation of Employment and Community First CHOICES and Katie Beckett, these measures were expanded to encompass the new programs. In addition, TennCare incorporated quality components of the Medicaid Managed Care Rule specified in 42 C.F.R. § 438.330. More recently, STC 52 to the TennCare III Demonstration, Quality Improvement Strategy for 1915(c) or 1915(i)-approvable HCBS Services, requires that "the state's Quality Assessment and Performance Improvement Plan must encompass LTSS-specific measures set forth in the federal rule and should also reflect how the state will assess and improve performance to demonstrate compliance with applicable federal waiver assurances set forth in 42 CFR 441.301 and 441.302." Appendix 3 outlines compliance measurement goals and objectives for the State's three MLTSS programs – CHOICES, Employment and Community First CHOICES, and Katie Beckett Part A Programs.

[15] TennCare III Demonstration, STC 51: Quality Improvement Systems and Strategy for the CHOICES, ECF CHOICES, and Katie Beckett (Part A) Programs. TennCare III Demonstration, STC 52: Quality Improvement Strategy for 1915(c) or 1915(i) approvable HCBS Services.

Section IV: External Quality Review Arrangements

EQR arrangements[16]

Tennessee contracts with Health Services Advisory Group (HSAG) to provide all External Quality Review (EQR) activities. The contract is effective January 15, 2024, and ends on January 14, 2027. The contract may be extended with the state reserving the right to execute two (2) one-year renewal options extending the contract term no longer than January 14, 2029. The services to be provided under this contract include multiple tasks and deliverables that are consistent with applicable federal EQR regulations and protocols for Medicaid Managed Care Organizations and state-specific requirements. The contract allows the state to be compliant with Federal EQR regulations and rules and to measure MCC-specific compliance with the TennCare Section 1115 Waiver.

HSAG conducts independent reviews of the quality outcomes, timeliness of and access to the services covered under each MCC. The Annual Quality Survey reviews the MCOs' compliance with Medicaid and CHIP Managed Care regulations. It includes a review of enrollee rights and protections, quality assessment and performance improvement, structure and operation standards, measurement and improvement standards, and compliance with the appeal process. The survey process includes document review, interviews with key MCC personnel, and an assessment of the adequacy of information management systems. According to 42 CFR §438.358, a state or its EQRO must conduct a review within a three-year period to determine Medicaid MCC's compliance with the federal standards. Beginning with the 2025 AQS reviews, TennCare elected to review one-third of the MCC standards. AQS reviews will include approximately one-third of the required standards each year to ensure that all required compliance standards are reviewed at least once within a three-year period.

In addition to this survey, HSAG conducts Performance Improvement Project validations, Network Adequacy Validation, and Performance Measure Validation in accordance with federal requirements. HSAG also conducts an Annual Network Adequacy survey to determine the extent to which the MCCs' networks are compliant with contractual requirements. The EQRO provides these reviews for all the MCOs, DBM, and PBA. Tennessee contracts with FIDE-SNPs that are fully aligned with the MCOs. These plans and their members are included in the state's EQR activities and in the annual EQR technical report.

EQR non-duplication option[17]

The CMS External Quality Review (EQR) Protocols[18] dated February 2023 indicated that nonduplication for mandatory EQR-related activities is intended to lessen the administrative burden on states and MCCs while still ensuring that information concerning those activities is available to the EQRO to include the results in the technical

[16] *42 CFR 438.340(b)(4), applicable to CHIP managed care programs per 42 CFR 457.1240(e), cross-referencing 438.350, which is applicable to CHIP per 42 CFR 457.1250*

[17] *42 CFR 438.340(b)(9), applicable also to CHIP managed care programs per 42 CFR 457.1240(e), cross-referencing 438.360(c), which is applicable to CHIP per 42 CFR 457.1250(a)*

[18] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *External Quality Review (EQR) Protocols, February 2023*. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Sep 27, 2024.

report as required in 438.364(a).[19] States are allowed to use information from Medicare or private accreditation reviews when the requirements are comparable to federal and state requirements. TennCare has elected to allow deeming for the MCOs, since they are required to be accredited by NCQA, and the DBM since the organization received NCQA accreditation for the credentialing standard included in the compliance activity. To be eligible for deeming, a score of 100% must be obtained for the NCQA element that matches the associated requirement in the federal and state regulations. TennCare allows deeming for two mandatory activities: compliance reviews and performance measure validation.

Review of Compliance with Medicaid and CHIP Managed Care Regulations

As required in 42 CFR 438.358(b)(1)(iii)[20], HSAG conducts Tennessee compliance reviews within a three-year period to determine the MCOs' and DentaQuest's compliance with federal and state requirements. The compliance assessment tools, titled Annual Quality Survey (AQS) for TennCare, and the compliance review activity comply with the requirements found in Protocol 3. Review of Compliance with Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity.[21]

Annually, HSAG reviews the requirements found in the applicable contract between TennCare and the MCCs to determine the contract revisions that may need to be included in the review. HSAG then compares the elements in the compliance tools and their associated federal and state requirement to the NCQA standards to determine which elements can be deemed to prevent duplication. TennCare uses the rates to assist in evaluating the MCOs' performance concerning the quality, timeliness, and access to care for Medicaid enrollees. TennCare also uses the rates to determine progress in meeting the goals established in the state's Quality Strategy. The full list can be deemed during the 2025 review of compliance with Medicaid and CHIP managed care regulations is found in Appendix 4. TennCare will provide the full list of items that can be deemed for each corresponding calendar year.

Validation of Performance Measures

As required in 42 CFR 438.358(b)(1)(ii)[22], HSAG conducts performance measure validation and uses the HEDIS rates submitted by the NCQA accredited MCOs to ensure nonduplication of efforts for this mandatory activity.

[19] U. S. Government Publishing Office. (2024). *Electronic Code of Federal Regulations*. Available at: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-438/subpart-E/section-438.364#p-438.364(a)(2)(i). Accessed on: Sep 27, 2024.

[20] U. S. Government Publishing Office. (2024). *Electronic Code of Federal Regulations*. Available at: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-438/subpart-E/section-438.358. Accessed on: Sep 27, 2024.

[21] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, February 2023. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Sep 27, 2024.

[22] U. S. Government Publishing Office. (2024). *Electronic Code of Federal Regulations*. Available at: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-438/subpart-E/section-438.358. Accessed on: Sep 27, 2024.

The performance measure validation activity complies with the requirements found in Protocol 2. Validation of Performance Measures: A Mandatory EQR-Related Activity.[23]

The MCOs contract with independent certified HEDIS compliance auditors to generate the rates submitted for the HEDIS measures. To complete the performance measure activity, HSAG receives the final audit reports, information systems compliance tools, and the interactive data submission system files approved by an NCQA-licensed organization from each MCO. HSAG uses the information to generate annual reports that include statewide rates, a comparison of the MCO HEDIS rates, and trending of the rates over time. TennCare uses the rates to assist in evaluating the MCOs' performance concerning measures that affect the quality, timeliness, and access to care for Medicaid enrollees. TennCare also uses the rates to determine progress in meeting the goals established in the state's Quality Strategy.

Section V: Directed Payments

Since the implementation of the 2016 Medicaid and CHIP Managed Care Final Rule, TennCare has pursued approval on a variety of directed payments. In accordance with §438.6(c)(2)(i)(C) of the Code of Federal Regulations, TennCare has designed its directed payment programs so that they advance at least one goal or objective in the quality strategy. Appendix 5 provides additional details and outlines the goals that are being advanced by each directed payment.

[23] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 2. Validation of Performance Measures: A Mandatory EQR-Related Activity*, February 2023. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Apr 7, 2023.

Section VI: Appendix

Appendix 1: Acronyms

AAP	American Academy of Pediatrics
AAP	Ambulatory Health Services
ANA	Provider Annual Network Adequacy Benefit Delivery Review
AQS	Annual Quality Survey
ARPA FMAP	American Rescue Plan Act Federal Medical Assistance Percentage
BCBST	BlueCross BlueShield of Tennessee
BESMART	Buprenorphine Enhanced Medication Assisted Recovery and Treatment
BMI	Body Mass Index
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CAP	Corrective Action Plan
CCT	Care Coordination Teams
CDC	Centers for Disease Control and Prevention
CFR	Code of Federal Regulations
CHIP	Children's Health Insurance Program
CHW	Community Health Worker
CLAS	Culturally and linguistically appropriate services
CLRS	Closed-Loop Referral System
CMS	Centers for Medicare & Medicaid Services
COVID-19	Coronavirus Disease 2019
CRA	Contractor Risk Agreement
DBM	Dental Benefits Manager
DCS	Department of Children's Services
DD	Developmental Disabilities
DDA	Department of Disability and Aging
DSP	Direct Support Professionals
DST	Delivery System Transformation
D-SNPs	Dual Eligible Special Needs Plans
DSW	Direct Support Worker/Workforce
ECF CHOICES	Employment and Community First CHOICES

ED	Emergency Department
EPSDT	Early and Periodic Screening, Diagnostic and Treatment
EQR	External Quality Review
EQRO	External Quality Review Organization
FIDE SNP	Fully Integrated Dual Eligible Special Needs Population
FY	Fiscal Year
HCBS	Home and Community-Based Services
HEDIS	Healthcare Effectiveness Data and Information Set
HRA	Health Risk Assessment
I/DD	Intellectual and/or Developmental Disabilities
ICF/IID	Immediate Care Facility for Individuals with Intellectual Disabilities
LARC	Long- Acting Reversible Contraceptives
LOC	Level of Care
LTSS	Long Term Services and Supports
MAC	Medicaid Advisory Commitee
MAT	Medication Assisted Treatment
MCC	Managed Care Contractor
MCO	Managed Care Organization
MDS	Minimum Data Set
MLTSS	Medicaid Managed Long Term Services and Supports
MMIS	Medicaid Management Information System
MRR	Medical Record Review
NCI	National Core Indicators
NCI-AD	National Core Indicators – Aging and Disabilities
NCI-CFS	National Core Indicators – Child and Family Surveys
NCI-IPS	National Core Indicators – In Person Surveys
NCQA	National Committee for Quality Assurance
NEMT	Non-Emergency Medical Transportation
NF	Nursing Facility
OUD	Opioid Use Disorder
ORR	On Request Report
PAE	Pre-Admission Evaluation

PAHP	Prepaid Ambulatory Health Plan
PBA	Pharmacy Benefits Administrator
PCDH	Patient Centered Dental Home
PCMH	Patient Centered Medical Home
PCP	Primary Care Provider or Practitioner
PCSP	Person-Centered Support Plan
PH	Population Health
PHE	Public Health Emergency
PIHP	Prepaid Inpatient Health Plan
PIP	Performance Improvement Project
POM	Personal Outcome Measures
PPC	Prenatal and Postpartum Care
QA	Quality Assurance
QI	Quality Improvement
QI/UM	Quality Improvement/Utilization Management
QM/QI	Quality Management/Quality Improvement
QuILTSS	Quality Improvement in Long Term Services and Supports
RFI	Request for Information
REM	Reportable Event Management
SDF	Silver Diamine Fluoride
SDOH	Social Determinants of Health
SIM	State Innovation Model (grant)
SPMI	Severe and Persistent Mental Illness
SOS	System of Support
STC	Special Terms and Conditions
SUD	Substance Use Disorder
TCS	TennCare Select
THL	Tennessee Health Link
UM	Utilization Management
VBP	Value Based Purchasing
VLARC	Voluntary Long Acting Removable Contraceptives
WFD	Workforce Development

Appendix 2: TennCare PIP Summary

In accordance with the contractor risk agreements (CRAs) with TennCare, MCOs must conduct one clinical and one non-clinical PIP. The DBM and PBA must conduct at least one clinical and one non-clinical PIP, respectively. For MCOs, the non-clinical PIP must be conducted in the area of long-term care. In addition, MCOs must conduct a PIP on Early and Periodic Screening, Diagnostic and Treatment (EPSDT) screening and outreach if their overall CMS-416 rates are below 80%.

Note: Verbiage quoted from the MCCs' PIP Summary Forms appears in italics and is included to capture MCCs' aims and strategies in their own words. Each PIP is linked to a specific goal in the Quality Strategy (QS) as indicated in the first column. Also included in the table are each PIP's measurement year (Baseline [B]; Remeasurement 1 [R1]; Remeasurement 2 [R2]; Remeasurement 3 [R3]; Remeasurement 4 [R4]; Remeasurement 5 [R5]) and classification as clinical (C) or non-clinical (NC).

Table 9. TennCare 2025 Performance Improvement Projects

2025 Performance Improvement Projects					
QS	**Year**	**C/NC**	**Topic**	**PIP Aim Statement**	**Improvement Strategies**
Wellpoint					
2	R1	C	*EPSDT – Improve HPV Vaccination of Adolescents by Their 13th Birthday*	*Will targeted interventions improve the percentage of adolescent members 13 years of age who have completed the human papillomavirus (HPV) vaccine series by their 13th birthday over each measurement year of the PIP lifecycle statewide?*	♦ Added a monetary incentive for providers for MY 2025 based on CPT code use for HPV administration ♦ Enhanced member use of the plan's Healthy Rewards Incentive for HPV vaccination involves offering a monetary incentive to adolescents aged 9 to 13 who complete the HPV series
2	B	C	*Improve Diabetic Retinal Eye Exam Screenings in the PCMH Clinical Setting*	*Will targeted interventions improve retinal eye exam screenings for members with type 1 or type 2 diabetes ages 18-75 years in the Patient-Centered Medical Home (PCMH) Adult and Family core metric provider populations over each measurement year of the PIP lifecycle statewide?*	♦ Implemented an enhanced incentive program for providers focusing on the use of Category II (CAT II) codes for the administration of the diabetic retinal eye exam (EED) ♦ Provided direct telephonic provider education on appropriate coding of EED results with a request for resubmission of claims to close gap-in-care for EED HEDIS® measure for all PCMH adult providers

2025 Performance Improvement Projects					
QS	**Year**	**C/NC**	**Topic**	**PIP Aim Statement**	**Improvement Strategies**
4	R3	NC	*Improve Timeliness of Reassessment and Care Plan Updates for LTSS Members*	*Will targeted interventions for established LTSS members 18 years of age and over in Groups 2 through 8, improve the LTSS RAC rate for the completion of re-assessments and care plan updates with the 18 core elements over each measurement year?*	♦ Enhanced training program to prepare staff to implement LTSS HEDIS measures with an emphasis on post-discharge Reassessment and Care Plan Updates (RAC). Staff will be trained to promptly document and update the Person-Centered Support Plan (PCSP) and improve care coordination after discharge
BlueCare					
4	R3	NC	*Long-Term Services and Supports Reassessment/Care Plan Update After Inpatient Discharge (RAC)*	*Will targeted data interventions improve the rate of completion of a reassessment/care plan update for CHOICES/ECF CHOICES members 18 years and older within 30 days of inpatient discharge, over each remeasurement year?*	♦ Created Admission Discharge Transfer feeds/notifications into the documentation platform to autogenerate task alerts for Car/Support Coordinators ♦ Utilized a web-based application, AutoAudit, in combination with an LTSS Quality Monitoring dashboard to better assist the plan with identifying components of HEDIS LTSS measures
2	B	C	*Improving Glycemic Status Assessment for Patients with Diabetes (GSD) <8.0%*	*Will targeted interventions improve the percentage of members 18 to 75 years of age with diabetes (Types 1 and 2) whose most recent glycemic status was <8.0% for the BlueCare Statewide population during the remeasurement period?"*	♦ Created the Diabetes Care Program for High-Risk Members with Diabetes to help with member communication and education.
TennCare*Select*					
2	B	NC	*Improving Psychotropic Medication Management*	*Will targeted interventions decrease the percentage of psychotropic medications prescribed for TennCareSelect Department of Children Services (DCS) children and adolescents who are 20 years of age or younger over each measurement year?*	♦ Provided support and consultation on psychotropic medication prescribing practices for children in state custody through partnership with Vanderbilt Center of Excellence (COE) ♦ Developed the Behavioral Healthcare in Pediatrics (BeHIP) training program with various partners

2025 Performance Improvement Projects					
QS	**Year**	**C/NC**	**Topic**	**PIP Aim Statement**	**Improvement Strategies**
2	R1	NC	*Improving Early Periodic Screening Diagnosis & Treatment (EPSDT)*	*Will targeted interventions improve EPSDT rates for TennCareSelect members under the age of 21, over each remeasurement period?*	♦ Provided training and technical support to providers with low EPSDT rates with a focus on rural Middle and West Tennessee through partnership with the Tennessee chapter of the American Academy of Pediatrics (TNAAP)
3	B	C	*Improving Follow-Up After Hospitalization for Mental Illness 7-Day (FUH)*	*Will targeted interventions improve the rate of follow-up within 7 days after hospitalization for mental illness in members, ages 6 years and older, in the TennCareSelect Department of Children's Services (DCS) population over each remeasurement period?*	♦ Created the Behavioral Health Care Transitions Initiative to coordinate member BH needs by addressing barriers to discharge from inpatient care and assisting with connection to post discharge outpatient care with appropriate provider within 7-days
UnitedHealthcare					
5	R2	C	*Follow-Up After Emergency Department (ED) Visit for Mental Illness 7-Day (FUM)*	*Will targeted interventions increase FUM 7-day adherence for members 6 years of age and older who were seen in the ED with principal diagnosis of mental illness or intentional self-harm during the measurement year over each measurement period?*	♦ Peer Recovery Telephonic Outreach
4	R3	NC	*LTSS HEDIS Process Improvement for Reassessment and Care Plan Updates Within 30 days After Inpatient Discharge*	*Will targeted interventions improve the rates of completion for both components of the HEDIS LTSS-Reassessment and Care Plan (RAC) measure including the 9 core elements for each and the additional 9 care plan supplemental elements when applicable, for all eligible LTSS members over each remeasurement period?*	♦ Reported actual discharge date to coordination staff to improve compliance for Post Inpatient Stay Assessment and Car Planning
DentaQuest					
2	R1	C	*Oral Health Disparities*	*Will the use of targeted interventions increase the percentage of Black Non-Hispanic members ages 6-9, with 90 days continuous enrollment, who receive a preventative visit (CDT codes D1000-D1999) during the remeasurement period?*	♦ Targeted Text Message including information about why preventive dental care is important to overall health

2025 Performance Improvement Projects					
QS	**Year**	**C/NC**	**Topic**	**PIP Aim Statement**	**Improvement Strategies**
1	R1	NC	*Pregnant & Postpartum Dental Utilization*	*Will the use of targeted interventions increase the percentage of Tennessee Adult Medicaid Pregnant and Postpartum women over the age of 20, with 90 days continuous enrollment, who received any dental service (CDT codes D0001-D9999) during remeasurement year 1/1/2024 to 12/31/2024?*	♦ Targeted Text Message including information about why dental care is important during pregnancy, encouraging members to visit their Dental Home, and how to access transportation services
OptumRx					
7	R2	C	*Schizophrenia Medication Compliance Improvement Plan*	*Will increasing the utilization of long-acting atypical antipsychotic injectables (LAI) reduce frequency and costs associated with psychotic breaks (e.g., inpatient psychiatric hospitalizations, including medical-pharmacy claims, and emergency room (ER) visits) in patients with schizophrenia who have been non-compliant on oral antipsychotics over each remeasurement year?*	♦ Outreached to prescribers on benefits of switching to a long-acting injectable (LAI) to improve compliance for schizophrenic patients to utilize
7	D	NC	*Reducing Rejected Claims*	*Does the targeted intervention decrease rejected OTC claims for TennCare members less than 21 years of age during the remeasurement year?*	♦ PBM has not progressed to reporting improvement strategies.

Appendix 3: MLTSS Compliance Measurement Goals

Table 10. MLTSS Compliance Measurement Goals

Metric name/Objective	Metric Specifications	Baseline performance	Performance target (MY 2027)
1. Maintain the percent of CHOICES Group 2 members who are offered a choice between institutional services and HCBS	Member Record Review	99% (2023-2024)	100%
2. Ensure CHOICES, Employment and Community First CHOICES, and Katie Beckett Part A members will have a level of care determination indicating the need for institutional services or being "At-Risk" for institutional placement, as applicable, prior to enrollment in CHOICES, Employment and Community First CHOICES, or Katie Beckett, as applicable, and receipt of Medicaid-reimbursed HCBS.	MMIS system standards[24]	100% (2023)	100%
3. Ensure that all PCSPs for CHOICES Groups 2 and 3, Employment and Community First (ECF) CHOICES, and Katie Beckett Part A members include documented strengths and interests; authorized HCBS services and supports with clearly defined amount, frequency, duration, and scope; and person-centered SMART goals that reflect the member's needs, preferences, and desired outcomes, including employment and community living goals where applicable	Member Record Review	94% (2023-2024)	96%
4. Ensure that CHOICES Groups 2 and 3, Employment and Community First (ECF) CHOICES, and Katie Beckett Part A members have a PCSP that meets requirements specified by the CRA and/or TennCare protocol, including being updated and signed annually by the member or their representative, as applicable, and the Care/Support Coordinator, and any time the member experiences a significant change in needs or circumstances.	Member Record Review	100% (2023-2024)	100%
5. Ensure CHOICES Group 2 and 3, Employment and Community First CHOICES, and Katie Beckett Part A member records document that the member (or their family member/authorized representative, as applicable) receive education/information at least annually regarding how to identify and report abuse, neglect and exploitation.	Member Record Review	91% (2023-2024)	100%
6. Ensure that Reportable Event records for CHOICES Groups 2 and 3, Employment and Community First (ECF) CHOICES, and Katie Beckett members demonstrate that incidents are reported, investigated, resolved, and any necessary corrective actions are completed within timeframes specified in the REM	PERLSS REM System[25]	97.6% (2024)	99.6%

[24] As a practical matter, TennCare cannot enroll anyone in the MMIS unless there is a LOC determination in PERLSS. This is completed as part of the process 100% of the time.

[25] In 2021, all critical incident reporting across LTSS was aligned with DDA through the implementation of the One System REM Protocol, rendering the previous metric obsolete. In April 2024, CMS released the Access Rule, formally titled the Ensuring Access to Medicaid Services Final Rule (CMS-2442-F), which establishes standardized annual reporting requirements for states regarding the timely initiation, resolution, and completion of corrective actions for critical incidents in HCBS programs. In parallel, LTSS is currently developing a new REM reporting system, expected to launch in 2026. In light of the Access Rule requirements and the upcoming system changes, this metric has been revised.

[25] While the PERLSS system is under development, this metric will be calculated using data directly from the monthly REM reports submitted by DDA.

7. Ensure CHOICES Group 2 and 3, Employment and Community First CHOICES, and Katie Beckett Part A member records in which HCBS were denied, reduced, suspended, or terminated as evidenced in the PCSP as applicable document that the member was informed of and afforded the right to request a Fair Hearing as determined by the presence of a notice of action..	Member Record Review	99% (2023-2024)	100%

Appendix 4: EQR Nonduplication

During the 2025 Annual Quality Survey (AQS), each MCO will be evaluated for deeming based on the NCQA elements for which it received accreditation. Elements that score 100 percent on the applicable NCQA elements will be deemed. Elements will not be partially deemed. For example, for Coordination and Continuity of Care, Element 2, Coordination of Services, MED 5 A, QI 3 A-D, LTSS 1 A, and LTSS 3 A-C must have a score of 100 percent, otherwise the element cannot be deemed, and all required documentation should be provided.

AQS Tool Element	AQS Tool Element Name	CFR Reference(s)	2023 NCQA Element(s)	2024 NCQA Element(s)
Coordination and Continuity of Care				
1.	Coordination of Ongoing Care	*§438.208(b)(1) §457.1230(c)*	MED 5 A NET 1 B NET 2 A PHM 5 A PHM 5 E LTSS 1 A LTSS 1 B–I	MED 5 A NET 1 B NET 2 A PHM 5 A PHM 5 E LTSS 1 A LTSS 1 B–M
2.	Coordination of Services	*§438.208(b)(2)* *§457.1230(c)*	MED 5 A QI 3 A–D LTSS 1 A LTSS 3 A–C	MED 5 A QI 3 A–D LTSS 1 A LTSS 3 A–C
3.	Coordination of Care	*§438.208(b)(4)*	MED 6 B	MED 6 B
4.	Record Maintenance	*§438.208(b)(5) §457.1230(c)*	MED 5 B	MED 5 B
5.	Confidentiality	*§438.208(b)(6)*	MED 4 A-C	MED 4 A-C
6.	Comprehensive Assessment	*§438.208(b)(3) §457.1230(c)*	MED 6 A	MED 6 A

AQS Tool Element	AQS Tool Element Name	CFR Reference(s)	2023 NCQA Element(s)	2024 NCQA Element(s)
8.	LTSS Assessment Mechanisms	*§438.208(c)(2)* *§457.1230(c)*	LTSS 1 A–D	LTSS 1 A LTSS 1 F–H
9.	Treatment Plans	*§438.208(c)(3)* *§457.1230(c)*	MED 5 C LTSS 1 E–G, I LTSS 3 A	MED 5 C LTSS 1 I–K, M LTSS 3 A
10.	Treatment Plan Requirements	*§438.208(c)(3)(i-iv)* *§441.301(c)(1-2)* *§457.1230(c)*	MED 5 C LTSS 1 E–G, I LTSS 3 A	MED 5 C LTSS 1 I–K, M LTSS 3 A
12.	Access to Specialists	*§438.208(c)(4)* *§457.1230(c)*	MED 1 A MED 1 B	MED 1 A MED 1 B
Emergency and Poststabilization Service				
1.	Emergency Medical Condition	*§438.114(a)*	MED 9 D	MED 9 D
2.	Emergency Services	*§438.114(a)*	MED 9 D	MED 9 D
3.	Poststabilization Care Services	*§438.114(a)*	MED 9 D	MED 9 D
4.	Emergency Services—Coverage and Payment	*§438.114(c)(1)*	MED 9 D	MED 9 D
5.	Emergency Service Limitations	*§438.114(d)(1)*	MED 9 D	MED 9 D
6.	Subsequent Treatment	*§438.114(d)(2)*	MED 9 D	MED 9 D
7.	Transfer or Discharge	*§438.114(d)(3)*	MED 9 D	MED 9 D
Health Information Systems				

AQS Tool Element	AQS Tool Element Name	CFR Reference(s)	2023 NCQA Element(s)	2024 NCQA Element(s)
1.	Basic Requirements	*§438.242(a)*	MCO's ability to report HEDIS and generate UM and QI reports indicate that these required systems are in place.	MCO's ability to report HEDIS and generate UM and QI reports indicate that these required systems are in place.
3.	Collection of Member and Provider Data	*§438.242(b)(2)*	MCO's ability to report HEDIS and generate UM and QI reports indicate that these required systems are in place.	MCO's ability to report HEDIS and generate UM and QI reports indicate that these required systems are in place.
4.	Data Accuracy and Completeness	*§438.242(b)(3)*	Certified HEDIS Audit	Certified HEDIS Audit
5.	Data Available to TennCare and CMS	*§438.242(b)(4)*	A copy of the MCO's HEDIS Data Submission Tool (DST) submitted to the State.	A copy of the MCO's HEDIS Data Submission Tool (DST) was submitted to the State.
Practice Guidelines				
1.	Adoption of Practice Guidelines	*438.236(b)(1) 457.1233(c)*	MED 2 A	MED 2 A
2.	Guidelines Consider the Needs of the Members	*§438.236(b)(2) §457.1233(c)*	MED 2 A	MED 2 A
3.	Adoption of Practice Guidelines in Consultation with Network Providers	*§438.236(b)(3)*	MED 2 A	MED 2 A
4.	Review and Update to Practice Guidelines	*§438.236(b)(4) §457.1233(c)*	MED 2 A	MED 2 A
5.	Dissemination of Guidelines	*§438.236(c) §457.1233(c)*	MED 2 B	MED 2 B

AQS Tool Element	AQS Tool Element Name	CFR Reference(s)	2023 NCQA Element(s)	2024 NCQA Element(s)
6.	Application of Guidelines	*§438.236(d) §457.1233(c)*	MED 2 A MED 2 C UM 2 C	MED 2 A MED 2 C UM 2 C
Quality Assessment and Performance Improvement (QAPI)				
1.	QAPI Program	*§438.330(a)(1)*	QI 1 A QI 1 B	QI 1 A QI 1 B
3.	Utilization and Special Health Care Needs	*§438.330(b)(3)* *§438.330(b)(4)*	MED 7 A	MED 7 A
4.	LTSS Requirements	*§438.330(b)(5)* *§438.330(b)(5)(ii)*	MED 7 A LTSS 1 H LTSS 2 A LTSS 2 E	MED 7 A LTSS 1 L LTSS 2 A LTSS 2 E

Appendix 5: Tennessee Directed Payment Programs

Table 11. 438.6(c) Directed Payment Programs Overview

	Directed Payment Description	Payment Type	Quality Strategy Goals	Quality Strategy Objectives
1	Fee Schedules ("Sweeper")	Fee Schedule	Goal 3: Integrate patient-centered, holistic care including non-medical risk factors into population health coordination for all members Goal 4: Improve positive outcomes for members with LTSS needs Goal 6: Maintain robust member access to health care services	Objective(s): 3.3-3.5 Ensure CHOICES, ECF CHOICES, and Katie Beckett members receive holistic care 4.1-4.3 Maintain or improve quality of life for CHOICES, ECF CHOICES and Katie Beckett members 6.1 Ensure all members can access care according to time and distance standards
2	Hospital ACR Uniform Percentage Increase	Fee Schedule & Value-Based Purchasing	Goal 2: Increase use of preventive care services for all members to reduce risk of chronic health conditions Goal 3: Integrate patient centered, holistic care including non-medical risk factors into population health coordination for all members	Objective(s): 2.8 Reduce rate of hospital readmissions 3.2 Increase screening for non-medical risk factors
3	Emergency Medical Services (ground ambulance) Uniform Dollar Increase	Fee Schedule	Goal 6: Maintain robust member access to health care services	Objective(s): 6.2 Ensure adult members can access care, tests, or treatments timely 6.3 Ensure child members can access care, tests, or treatments timely
4	Patient Centered Medical Homes (PCMH)	Fee Schedule & Value-Based Purchasing	Goal 1: Improve the health and wellness of new mothers and infants Goal 2: Increase use of preventive care services for all members to reduce risk of chronic health conditions Goal 7: Maintain financial stewardship through increasing value-based payments and cost-effective care	Objective(s): 1.3 Increase the use of well-child visits in the first 30 months 2.1 Increase child and adolescent well care visits 2.3 Increase child immunizations 2.4 Improve high blood pressure control in adults 2.5 Increase cervical cancer screening in adults

				2.7 Decrease emergency department utilization for children 7.1 Maintain the percentage of TennCare members attributed to PCMH organizations
5	Academic Affiliated Physicians' Upper Payment Limit Initiative for Tennessee (UPLIFT)	Fee Schedule & Value-Based Purchasing	Goal 1: Improve the health and wellness of new mothers and infants Goal 2: Increase use of preventive care services for all members to reduce risk of chronic health conditions Goal 5: Provide additional support and follow-up for patients with behavioral health care needs	Objective(s) 1.2 Increase the use of postpartum services 2.3 Increase child immunizations 2.8 Reduce the rate of hospital readmissions 5.1 Improve follow-up after hospitalization for mental illness in adults 5.2 Improve follow-up after hospitalization for mental illness in children
6	Tennessee Health Link (THL)	Value-Based Purchasing	Goal 5: Provide additional support and follow-up for patients with behavioral health care needs Goal 7: Maintain financial stewardship through increasing value-based payments and cost-effective care	Objective(s): 2.1 Increase child and adolescent well care visits 2.4 Improve high blood pressure control in adults 2.7 Decrease Emergency Department utilization for children 5.1 Improve follow-up after hospitalization for mental illness in adults 5.2 Improve follow-up after hospitalization for mental illness in children 7.2 Increase the number of TennCare members who are active in the Tennessee Health Link program
7	Emergency Medical Services (ground ambulance) Minimum Fee Schedule	Fee Schedule (State Plan Amendment)	Goal 6: Maintain robust member access to health care services	Objective(s):

				6.2 Ensure adult members can access care, tests, or treatments timely 6.3 Ensure child members can access care, tests, or treatments timely
	Nursing Facility Stability	Fee Schedule	Goal 4: Improve positive outcomes for members with LTSS needs	Objective(s): 4.1 Maintain or improve quality of life for CHOICES members