TennCare Patient Centered Medical Home Provider Operating Manual 2025

Version 1.2
Released: March 2025

This operating manual outlines the PCMH program guidelines and policies effective January 1, 2025. The guidelines for 2024 are still valid for all claims with dates of service in 2024.

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All information included herein is subject to further updates and refinement from TennCare.

PCMH Provider Operating Manual Revisions for 2025

Section	Revision
3.1 Member Inclusion	Aligned D-SNP members will not be included in efficiency measure calculation
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5.8 Site Exemption from NCQA PCMH Recognition	New Section
6.3 Outcome Payments	Updated Outcome Payment language to reflect new pilot for outcome payment formula
8.2 Efficiency Thresholds	TennCare will set Efficiency thresholds
8.5 Value of Stars Earned	Updated to reflect new quality star gate
8.3 Cost Exclusion list	DDA claims will be excluded from TCOC
12 Care Coordination Reports	Updated with Care Coordination Reports
Throughout document	Removed references to High and Low volume

1. GENERAL INFORMATION

1.1 Objective of Patient Centered Medical Homes (PCMH) in Tennessee

PCMH is a comprehensive care delivery model designed to improve the quality of primary care services for TennCare members, the capabilities of and practice standards of primary care providers, and the overall value of health care delivered to the TennCare population.

To date, approximately 40% of TennCare Members are attributed to one of the PCMH-participating provider organizations throughout the state. PCMH providers commit to member centered access, team-based care, population health management, care management support, care coordination, performance measurement and quality improvement. Participating providers receive training and technical assistance, quarterly reports with actionable data, and access to the Care Coordination Reports. These providers are compensated with ongoing financial support and an opportunity for an annual outcome payment based on quality and efficiency performance.

1.2 Sources of Value

Successfully executed, the PCMH program will deliver a number of benefits to members, providers, and the system as a whole. A few of the most important benefits are outlined in Table 1.

TABLE Table 1– Sources of Value

Members	Practices	System
• Better access to primary care providers • Tailored care for those most in need • Care coordination services leading to improved quality and outcomes • Greater emphasis on primary and preventative care • Improved care coordination with behavioral health providers	• Support for performance improvement • Direct financial support for care coordination • Specialized training for practice transformation • Access to outcome payments • Input from other members of the care delivery team • Access to better information with which to make decisions • Improved workflows and processes that positively impact productivity and efficiency	• Higher quality care • Reduced total cost of care • Reduced utilization of secondary care through better management of chronic conditions • Reduced utilization of unnecessary procedures and visits (e.g., unnecessary emergency room visits) • More cost-conscious referrals • System shift towards greater coordination and information sharing

2. HOW DOES AN ORGANIZATION BECOME A PCMH?

2.1 Eligibility

TennCare PCMHs will be defined and measured at the Tax ID level. All primary care providers (PCP) serving Medicaid members under that Tax ID will be included in the PCMH. One PCMH may have multiple physical locations or sites.

All rules, processes, and requirements detailed herein apply only to the TennCare PCMH program. To be eligible for the program:

1. The entity must be a participating TennCare practice with one or more PCPs (including nurse practitioners) with any of the specialty types designated by TennCare as primary care practitioners including family medicine, internal medicine, and pediatrics.
2. The organization attests to commit to the goals of value-based payment including, but not limited to:
    - Increased care coordination,
    - Proactive management of the patient panel,
    - Focus on improving quality and performance outcomes identified in quarterly reports, and

- Integrated care across multidisciplinary provider teams.

3. The organization must designate a PCMH Director to serve as point of contact for the State, MCOs, and other parties.
4. Once designated as a TennCare PCMH, the organization must maintain PCMH recognition from the National Committee for Quality Assurance (NCQA) **OR** obtain NCQA's PCMH recognition (See Section 5 for details). If a participating PCMH organization opens or acquires a new primary care site, that site is expected to obtain or maintain PCMH recognition from NCQA (see Section 5.3 for more information).
5. The organization must also commit to the following PCMH activities:
    - Participate in practice transformation and support provided and managed by each MCO. This may include, but is not limited to, coaching sessions, participation in webinars, and attendance at statewide conferences.
    - Share best practices with other participating PCMH organizations and support other organizations in their practice transformation by participating in learning collaboratives on an ongoing basis.
    - It is expected that PCMH Organizations maintain regular communication with their assigned MCO coach. It is recommended that the PCMH meet with their coach at least quarterly, but no less than two times per year.

A participating organization remains enrolled in the PCMH program until any of the following occurs:

1. The organization withdraws;
2. The organization or provider becomes ineligible, is suspended, or removed from the TennCare program or the PCMH program;
3. The Managed Care Organization terminates its PCMH contract or contract amendment with the organization; or
4. Division of TennCare terminates the PCMH program.

To withdraw from the PCMH program, the participating organization must email intent to withdraw to payment.reform@tn.gov and to their contracted MCO(s).

2.2 Provider contracting

If selected to participate in TennCare PCMH, an organization must update its contract(s) with the relevant health plan(s). MCO contracting must be completed prior to the start of the performance period on the first of January each year. Organizations

will not be required to contract with health plans with which they do not have an existing contract.

An organization may not participate in two overlapping value-based payment programs with the same health plan simultaneously. The State and health plan will work together to determine if an organization's existing value-based payment arrangement with an MCO is duplicative of the TennCare PCMH program. Organizations may need to terminate existing value-based payment arrangements in order to participate in the TennCare PCMH to avoid duplication.

3. WHICH MEMBERS ARE IN A PCMH?

3.1 Member Inclusion

The intent of the PCMH program is to be as broad and inclusive as possible. As a result, all TennCare members enrolled with the MCO are eligible for the PCMH program, including adults and children. As of January 1, 2021, the PCMH program requires all CoverKids members who are assigned to a Primary Care Provider who is a part of a PCMH organization to be attributed to the PCMH program.

The program explicitly includes individuals that are dually eligible in Medicare and Medicaid if their D-SNP health plans are with the same MCO. Members may be enrolled in both a PCMH and a Tennessee Health Link (THL) organization simultaneously. THL is a program designed to coordinate health care services for TennCare members with the highest behavioral health needs.

All TennCare eligible members attributed to a PCMH are included in the calculation for the monthly activity per member per month (PMPM) payment. For the outcome payment calculation, some members are excluded from the provider panel and therefore not included in the performance evaluation calculation.

Members **are excluded** from the PCMH program performance evaluation under any of the following scenarios (i.e., these members are not counted in quality and efficiency metrics):

- **Member is dual-eligible but is not enrolled in an aligned D-SNP:** Members could be excluded from performance evaluation if they are dual eligible and not enrolled in an aligned D-SNP health plan (at the MCO's discretion). Being "aligned" means that the member is enrolled in a Medicare Advantage D-SNP plan with the same MCO participating in the TennCare Medicaid program. Examples of not being enrolled in an aligned D-SNP health plan include cases where the member is dual-eligible but enrolled in a Medicare Advantage health plan that is not a D-SNP, a D-SNP health plan with another insurer, or

Medicare fee-for-service. As of PY2025, all aligned D-SNP members will be excluded from efficiency metrics, but still included in quality metrics.

- **Member has or obtains third-party liability (TPL) coverage:** Members with a claim within the previous quarter indicating TPL coverage could be excluded from the PCMH program performance evaluation.

- **Member has a long-term nursing home stay:** Members with an active nursing home stay that covers ninety (90) or more consecutive days are not included in the PCMH program evaluation. Members must be discharged to home from a previous nursing home stay to regain PCMH program performance evaluation eligibility.

- **Member with long-term residential treatment facility stay:** Members with one or more residential treatment facility (RTF) claims that cover more than ninety (90) consecutive days that are ongoing as of the eligibility update start date are not included in the PCMH program evaluation. Members must be discharged to home from a previous RTF stay to regain PCMH program performance evaluation eligibility.

- **Member has less than nine (9) months of attribution with the same PCMH:** Only those members with at least nine (9) months of cumulative attribution to the PCMH are counted towards performance outcomes. These nine (9) months do not have to be consecutive. This policy is in place to ensure that the provider has had adequate time with the member to affect their quality and efficiency outcomes.

Once excluded, a member may become eligible again for the PCMH program if his or her exclusion status changes.

3.2 Member Attribution

Attribution uses the existing member to PCP assignment conducted by the MCOs today. Members are attributed each month to the PCMH associated with the member's active PCP. If the member's PCP is not part of an organization that participates in the PCMH program, the member will not be attributed to any PCMH for the month. The PCMH program is designed to incentivize providers to outreach to patients that aren't currently engaged in primary care. The PCMH program provides a per-member, per-month payment for every patient on your panel, regardless of whether the patient has been seen at the practice. Part of the purpose of those payments is to help support outreach.

3.3 Removal of Members from a Panel

The goal of the PCMH program is to provide a medical home for attributed TennCare members. However, TennCare recognizes there are some scenarios that necessitate the removal of members from panels. TennCare, in collaboration with the MCOs, has also developed a list of documentation required to remove a member from a panel. The list of approved scenarios and accompanying documentation are as follows:

1. **Safety of practice staff or other practice patients:** A patient may be moved to another provider if they have indicated violence or harm toward the staff or another patient at their primary care provider's office (via telephone, in person, portal messages etc.)
    a. Minimum documentation required:
        i. Certified letter
    b. Strongly recommended documentation:
        i. Recent office visit note outlining the violence.
        ii. Portal, text, or email message (if available) to inform patient.
2. **The patient has moved out of range of the provider.**
    a. Minimum documentation required:
        i. Member roster noting that member is out of range or alternative evidence that member is out of range.
        ii. Provider calls member per practice protocol and strongly encourages them to change their address with TennCare Connect and call MCO for new PCP assignment.
    b. Strongly recommended documentation:
        i. Letter, call, email, text, or portal message to patient to inform them of term from their provider and to advise them to go to TennCare Connect to change their address.
3. **Age:** If a pediatric group, the patient has aged out, or is above the age limit agreed upon with the MCO and has never been seen at the practice. It is the expectation that if an established patient has aged out and the pediatrician agrees to move the patient to an adult PCP then an appropriate transition of care takes place between the pediatrician and adult PCP.
    a. Minimum documentation required:
        i. If non-established patient that has aged out

1. Provider notifies MCO of a member that does not meet their age criteria that needs to be reassigned.

ii. If established patient that has aged out

1. Provider notifies MCO of a member that does not meet their age criteria that needs to be reassigned.

2. Letter and call to inform patient of transition, and practice provides transition assistance to new practice.

4. WHAT SERVICES WILL A PCMH PROVIDE?

The PCMH organizations will provide team-based care, patient-centered access, care coordination, and improved quality of care to their members. To ensure that these principles are being achieved, each PCMH will be required to maintain or achieve NCQA recognition (refer to Section 5 for further detail).

1. To ensure patients receive enhanced patient-centered care, each PCMH will be required to offer the following functions: **Team-based care and practice organization:** The PCMH provides continuity of care; communicates roles and responsibilities of the medical home to patients/families/caregivers; and organizes and trains staff to work to the top of their license and ability to provide effective team-based care.

2. **Knowing and managing your patients:** The PCMH captures and analyzes information about the patients and communities it serves and uses the information to deliver evidence-based care that supports population needs and provision of culturally and linguistically appropriate services.

3. **Patient-centered access and continuity:** Patients/families/caregivers have 24/7 access to clinical advice and appropriate care facilitated by their designated clinician/care team and supported by access to their medical record. The PCMH considers the needs and preferences of the patient population when establishing and updating standards for access.

4. **Care management and support:** The PCMH identifies patient needs at the individual and population levels to effectively plan, manage, and coordinate patient care in partnership with patients/families/caregivers. Emphasis is placed on supporting patients at highest risk.

5. **Care coordination and transitions:** The PCMH tracks tests, referrals, and care transitions to ensure comprehensive care coordination and communication with specialists and other providers in the medical neighborhood.

6. **Performance measurement and quality improvement:** The PCMH collects reports and uses performance data to identify opportunities for quality improvement; sets goals and acts to improve clinical quality, efficiency, and patient experience; and engages the staff and patients/families/caregivers in the quality improvement activities.

5. NATIONAL COMMITTEE FOR QUALITY ASSURANCE (NCQA) PCMH REQUIREMENT

5.1 Overview

The National Committee for Quality Assurance's (NCQA) PCMH Recognition program is the most widely adopted PCMH evaluation program in the country,[1] and the TennCare PCMH program adheres to the process as put forth by NCQA.

NCQA PCMH-recognized organizations automatically meet the minimum requirements for TennCare's PCMH program as long as they maintain their recognition status. Organizations must renew each site's recognition annually using the most up to date NCQA PCMH program Standards and Guidelines by their current Anniversary date. Organizations without a previous NCQA PCMH recognition must obtain NCQA PCMH recognition for all their sites by the deadline set by the State.

NCQA's PCMH Program Standards and Guidelines are available online.

5.2 Required deadlines

Organizations should obtain NCQA PCMH recognition for all of their sites by the deadline set by the State or at the time of their current recognition Anniversary date, as outlined below.

- **PCMH organizations with no previous NCQA PCMH recognition**. Organizations that began program participation on January 1, 2024 (Wave 8), and have sites that do not have NCQA recognition, were expected to enroll in Q-PASS by May 31, 2024. They were expected to submit payment through the State's discount by June 30, 2024. Recognition is expected to be achieved by June 30, 2025 (12 months later).

[1] NCQA PCMH Program Overview

Organizations that begin program participation on January 1, 2025 (Wave 9), and have sites that do not have NCQA recognition, will be expected to enroll in Q-PASS by May 31, 2025. They will be expected to submit payment through the State's discount by June 30, 2025. Recognition is expected to be achieved by June 30, 2026 (12 months later).

- **PCMH Organizations with a current NCQA PCMH recognition.** An organization with current recognition is expected to renew each site's recognition by its Annual Reporting date. For example, an organization with a PCMH recognition that expires on October 30, 2025 must submit documentation for renewal no later than its Annual Reporting date of September 30, 2025. It is recommended that an organization start the renewal process at least six months prior to the October 30, 2025 expiration date, which is April 30, 2025.

Please note that TennCare has sole discretion to determine alternative deadlines for sites to achieve recognition under certain circumstances.

5.3 Acquisition of additional site locations

If a participating PCMH organization acquires or opens a site with primary care practitioners, including family medicine, internal medicine, and/or pediatrics at any point after beginning program participation, then the site is required to either maintain current NCQA recognition or pursue recognition under the NCQA PCMH recognition standards within 15 months of the effective date of operations under the participating PCMH tax identification number (TIN).

- **Example.** If an organization acquires a new site with an effective operational date of December 4, 2024, then the new site is required to achieve NCQA recognition no later than March 4, 2026 (15 months later).

5.4 Organizations with multiple site locations

It is important to note that NCQA recognition is evaluated at the site-level. Multi-site organizations with different recognition statuses for each site must obtain recognition for those sites whose recognition is set to expire and/or do not have current recognition. PCMH organizations are expected to notify the TennCare PCMH Program Lead and MCO Contacts of any site changes, including new site openings and closed sites within 30 days.

Below is an example of a multi-site organization with two sites that have different recognition statuses:

- Site one has NCQA PCMH recognition that expires December 22, 2025 and is in compliance with program requirements. It is expected to submit for renewal by the Annual Reporting date of November 22, 2025 in order to remain in compliance.

- Site two has never obtained NCQA recognition and will be expected to obtain NCQA PCMH recognition by the deadline set by the State (i.e., 15 months after the site became operational under the organization's TIN).

5.5 Funding associated with NCQA Recognition

TennCare will fund fees associated with the NCQA PCMH recognition process from the point of enrollment up through the third check-in. If an organization does not achieve recognition for a site(s) after the third check-in, then they must purchase an additional check-in. Please contact NCQA for pricing details.

Further, organizations may expect to pay for other fees that may be due under the NCQA PCMH recognition process such as requesting reconsideration and undergoing a Discretionary Review (previously referred to as the Discretionary Audit)

Please review NCQA's PCMH Standards and Guidelines for additional information on the fee schedule.

5.6 Discretionary Review

As part of the Annual Reporting process, NCQA will review a sample of practices to validate evidence, procedures, attestations, and other responses of a Q-PASS submission. NCQA reviews a sample of practices, either by specific criteria or at random. Discretionary Reviews may be completed by email, teleconference, webinar or other electronic means, or through onsite review.

If a discretionary review requires a virtual or on-site review, NCQA conducts the review within 30 calendar days of notifying the practice of its intent to conduct a discretionary review. If findings indicate that information submitted by the practice is incorrect or evidence does not meet the PCMH standards, the practice has 30 days from the time of the notification to correct the findings. If the practice does not correct the findings within 30 days, the application for NCQA Recognition may be denied, credits may be reduced, or additional evidence may be required. Failure to respond or comply with discretionary review process may result in loss of recognition status.

Practice sites selected for discretionary review are notified and sent instructions. Practices are responsible for the cost of the discretionary review. Fees correspond to the complexity and scope of the review and NCQA pricing policies in effect at the time of survey. For additional information about the discretionary review process and associated fees, please consult NCQA's Policies and Procedures.

5.7 Deadline Extension

TennCare will provide organizations with guidance on achieving recognition. Extensions are intended to allow additional time to organizations who are committed to PCMH but have not been able to achieve NCQA recognition because of outside circumstances. If an extension is necessary, an organization must submit a request for extension to TennCare no later than two (2) months before the deadline.

The extension request should include at a minimum the following:

- List of sites being requested for recognition extension;
- How much additional time is being requested per site;
- A clear explanation of the reason(s) for the request;
- Steps taken to date toward achieving recognition for your site(s);
- Steps the organization plans to take to achieve recognition within the timeline proposed in the request beyond State's set deadline; and
- A justified explanation from the organization and transformation coach for the delayed recognition.

5.8 Site Exemption from NCQA PCMH Recognition

TennCare will allow sites that *do not* accept TennCare to apply for an exemption request. TennCare still encourages all participating organizations to achieve and maintain NCQA PCMH recognition, as it ensures a high standard of care is provided to all patients. The intent of PCMH site exemption is to allow multisite organizations to apply for an exemption from the NCQA recognition component of the program for sites that DO NOT accept TennCare. If at any time through an organization's participation in the PCMH program the site begins accepting TennCare members, the site will be required to achieve and maintain NCQA PCMH recognition, in accordance with the timeline outlined in Section 5 of the PCMH Provider Operating Manual. TennCare will continue to offer the PCMH discount code to any eligible site that would like to achieve or maintain NCQA PCMH recognition, regardless of number TennCare membership. **PCMH site exemption does not remove members from panels, quality and efficiency metrics or total cost of care.** The instructions for application are as follows:

1. The site must verify they have less than 30 TennCare members cumulatively among all three Managed Care Organizations (MCOs) as of June 30, 2025.

2. The site seeking exemption must work with their assigned MCO coach to complete the from, prior to submitting to TennCare PCMH lead beginning July 1 and no later than July 31, 2025.

3. TennCare will notify the site of determination status within 30 days of receiving completed application.

4. To maintain the exemption, the practice must submit the application annually.

If an organization opens or acquires a new site throughout the program year and wishes to apply for an exemption, they must wait until the application period is open to submit a request. If the recognition deadline is prior to the application period, the site may submit an extension request to TennCare.

6. HOW WILL A PCMH BE PAID?

6.1 Fee-for-service

The current fee-for-service delivery model will remain unchanged under the PCMH program.

6.2 Activity Payments

Activity payments are per-member-per month (PMPM) payments made to the PCMH to support the delivery of care under the PCMH model. These payments are calculated retrospectively and paid on a monthly basis.

The activity payment is a *risk-adjusted* PMPM amount and will continue throughout the duration of the program. Each PCMH will receive their PMPM payment amount from the MCO based on the calculated risk values of their membership panel. The payments will primarily support the PCMH for the labor and time required to improve and support their care delivery models. PCMHs may hire new staff (e.g., care coordinators) or change responsibilities for existing staff to support the required care delivery changes.

Determination of risk-adjusted activity payment amounts

Activity payment amounts are risk-adjusted to account for differences in the degree of care coordination required for members with serious or chronic health conditions. Refer to Section 9 for further detail of the risk adjustment methodology.

While the payment amount per risk band is left to MCO discretion, the average payout across an MCO's contracted PCMH organizations must average at least $4 PMPM. No PMPM will be less than $1.

At the beginning of each performance period, a practice risk score will be calculated that will define the PCMH's risk for the year. The MCO will determine the PMPM amount based on that risk. The PCMH risk score will be updated annually before the start of the next performance period to account for changes in the PCMH risk over time.

Requirements for Activity Payment

- Initial eligibility: Requirements for payments will be contingent on enrollment in the PCMH program as defined in Section 2.2.

- Activity requirements: Organizations must perform all activities in order to continue receiving payments. The organization must commit to the following PCMH activities:
- Maintain NCQA PCMH recognition (Refer to Section 5),
- Share best practices with other participating PCMH organizations and support other organizations in their organization transformation by participating in learning collaboratives on an ongoing basis.

6.3 Outcome Payments

Outcome payments (awarded annually) are designed to reward the high performing PCMHs for providing high-quality care while effectively managing overall cost. For PCMH program year 2025 TennCare will be doing a one-year pilot, in which all organizations are evaluated on efficiency metric performance, what was historically known as the low-volume formula. The continuation of this pilot is not guaranteed past PY 2025. **Any modifications to outcome payments, including this one, are contingent on state budget approval. If the request for additional funding to accommodate this change is not approved, TennCare will provide further guidance.**

Outcome payments based on efficiency metric improvement

PCMH organizations may earn outcome payments for annual improvement on efficiency metrics compared to the performance on the same metrics in the previous year and/or by meeting standardized efficiency targets.

PCMH organizations are eligible for an outcome payment **only** if the PCMH earns a minimum number of quality stars: three (3) for pediatric and adult PCMHs, and five (5) for family PCMHs. Program performance and any subsequent outcome payments are calculated at the PCMH Tax Identification Number (TIN) level, not by site.

Outcome payments based on efficiency improvement

Organizations may earn outcome payments for annual improvement on efficiency metrics compared to the performance on the same metrics in the previous year. PCMH organizations are eligible for outcome payments only if they earned a minimum number of quality stars: (3) for pediatric and adult organizations, and five (5) for family organizations.

For PCMH organizations who qualify for an outcome payment by meeting minimum requirements outlined in previous sections, the outcome payment amount is calculated as follows:

The following subsections detail each component of this formula.

- Average total cost of care (TCOC): per member per month (PMPM)

This is the average total cost of care per member per month for members in PCMH across all of TennCare. The statewide average TCOC amount to be used is $242.

- Efficiency performance**:** Efficiency performance is calculated by adding the percentages earned from both efficiency improvement and efficiency stars. The maximum total efficiency performance percentage is 50.00%.

    a. Efficiency Improvement Percentage

    The efficiency improvement percentage will reward PCMH organizations which have improved relative to their previous year's performance. The efficiency improvement percentage is the average of improvement in each efficiency metric compared to previous year's performance for the PCMH. Efficiency improvement for a given metric is calculated as the following:

$$\begin{pmatrix} Efficiency \\ Improvement \\ Percentage \end{pmatrix} = \frac{\begin{pmatrix} Efficiency\ metric\ 1 \\ Prior\ year\ value \end{pmatrix} - \begin{pmatrix} Efficiency\ Metric\ 1 \\ Current\ value \end{pmatrix}}{\begin{pmatrix} Efficiency\ metric\ 1 \\ Prior\ year\ value \end{pmatrix}}$$

    If the efficiency metric value for the previous year could not be calculated, then the efficiency improvement for that given metric is considered to be zero. After calculating the efficiency improvement percentage for each efficiency metric, the average of the two (2) is taken.

Table 2 – Illustrative Example of Efficiency Improvement Percentage

Metric	Baseline (CY2024)	Since 1/1/25	Improvement (%)
ED Visits	78.10	76.00	2.69%
Inpatient Discharges	3.00	2.80	6.67%
Total Improvement	-	-	4.68%

Note: Values rounded to nearest hundredth decimal place

If the average of the efficiency improvement percentage results in a negative number, it will be set to 0 and if the average calculation exceeds 20% it will be capped at that value. In addition, each individual measure's efficiency improvement is capped at positive and negative 20.00%. In other words, if your organization sees a decrease in efficiency of 31.25%, your report will only show a decrease of 20.00%.

b. Efficiency Stars

Performance must meet or exceed the threshold to earn an efficiency star. Each efficiency star earned contributes 15.00% to the efficiency performance. These thresholds are set by each MCO and will be different for pediatric PCMH organizations and family PCMH organizations.

- Maximum share of savings

PCMH organizations may earn a maximum of 25.00% of the total savings achieved during a year.

- Quality performance

Performance must meet or exceed the threshold in order to earn a quality star. Each quality star earned by the PCMH organization contributes to the quality performance. The redistribution of quality star values may be applied under certain circumstances.

Most of the quality metrics are defined by HEDIS®[2]. HEDIS requires that an organization have at least thirty (30) observations in the denominator of any metric for it to be measured accurately. If an organization does not have at least thirty (30) observations during a calendar year for a given HEDIS metric, that organization is

[2] The Healthcare Effectiveness Data and Information Set (HEDIS®) is a registered trademark of NCQA. Information about HEDIS can be found online.

ineligible for that particular quality star. The potential value of each ineligible quality star will be redistributed. See Section 8.5 for details.

- Member months

Number of member months enrolled with the MCO for all members in the PCMH's outcome panel, as defined in Section 3.1.

Notes: Guidance on FQHC/RHC PPS system and a PCMH activity/outcome payments memo may be found in Section 14. Further information regarding FQHC and RHC provider reimbursements can be found online.

DISCLAIMER: Any modifications to outcome payments are contingent on budget approval. If the request for additional funding to accommodate this change is not approved, TennCare will provide further guidance.

6.4 PCMH Reconsiderations and Complaints

A reconsideration is a process that should be filed when the organization disagrees with the MCOs' determination related to the PCMH outcome payment. Reconsiderations should be submitted to your contracted MCO. Please see Section16 - Addendum for more information.

7. PCMH REMEDIATION PROCESS

The remediation process is initiated when a PCMH organization fails to meet deadlines and/or performance targets on required program activities. A PCMH may trigger probation, remediation, and/or removal under any of the following circumstances:

- Not meeting program requirements (e.g., NCQA recognition requirements)
- Failure to respond and meet with MCO and/or TennCare
- Poor quality and or efficiency performance as determined by the MCO

NCQA RECOGNITION REMEDIATION

If an organization fails to meet NCQA recognition requirements and the deadlines set by the State for sites with no previous recognition, the remediation process will take place in the three phases detailed below.

Phase One: Probation

Failure to meet NCQA recognition requirements: A PCMH organization is placed on probation by TennCare for not meeting NCQA recognition program requirements. TennCare will be in regular contact with clear communication regarding a PCMH organization's probation status.

A letter is issued by TennCare to a PCMH organization initiating probation and outlining the reason for the six-month probation period. An organization must obtain recognition by the end of the six-month probationary period, as outlined in the probation letter. TennCare will provide a copy of the letter to the MCO(s).

After receiving the probation letter, a PCMH organization will be required to work with the MCO(s) and those providing coaching to write a corrective action plan. The corrective action plan must be submitted to TennCare within thirty (30) calendar days of receiving the probation letter for review and approval. The corrective action plan developed in the probation phase should include a timeframe for each milestone necessary to achieve recognition by the deadline in the probation letter.

If a PCMH organization has not achieved recognition at the end of the six-month probation period, TennCare will issue a final probation letter to a PCMH organization within three (3) calendar days of confirming recognition status with NCQA. This letter signifies that the PCMH organization will be moved into the second phase of the remediation process. TennCare will provide a copy of the final probation letter to the MCO(s).

Failure to meet the minimum coaching requirements: A PCMH organization fails to meet with an MCO coach during a scheduled meeting two consecutive meetings in a row without rescheduling. A letter is issued by TennCare to a PCMH organization initiating probation and outlining the reason for the six-month probation period. An organization must meet quarterly with the MCO coach during the six-month probationary period, as outlined in the probation letter. TennCare will provide a copy of the letter to the MCO(s).

After receiving the probation letter, a PCMH organization will be required to work with the MCO(s) and those providing coaching to write a corrective action plan. The corrective action plan must be submitted to TennCare within thirty (30) calendar days of receiving the probation letter for review and approval.

The corrective action plan developed in the probation phase should include a timeframe for improved communication channels between the MCO and the organization.

Phase Two: Remediation

MCO(s) will stop practice activity payments to any organization in phase two. Also, during this phase, TennCare will evaluate the organization's recognition status. Following review, in its sole discretion, TennCare may move a PCMH organization from remediation to probation with a new recognition deadline. An organization moved back to phase one will be required to complete a revised corrective action plan.

Alternatively, TennCare may, at its discretion, move a PCMH organization from phase two to phase three – removal from the PCMH program. TennCare will notify the organization and MCO(s) within three (3) calendar days of their decision to move an organization to phase three – removal from the PCMH program.

Phase Three: Removal from the PCMH Program

After receiving a removal letter from TennCare, MCO(s) will terminate all PCMH related payment streams to the organization.

TennCare reserves the right to amend these phases due to extreme situations, such as a PCMH organization not reporting a site to TennCare in a timely manner.

SITE LAPSE OF NCQA RECOGNITION

The following remediation process applies to organizations with a site whose NCQA recognition is denied due to failure to renew by the required Anniversary date:

1. A site should submit for renewal by its Annual Reporting date (i.e., 30 days prior to the site's Anniversary date) to ensure that the review is completed by its Anniversary date. If a site misses its Anniversary date to renew, NCQA may deny recognition, and if this occurs, the PCMH organization would no longer be in compliance with TennCare PCMH Program or NCQA program requirements. At this point, the PCMH organization triggers the remediation process and TennCare will notify the organization via letter that they have triggered the remediation process. This letter will outline the remediation process explained below. A copy of this letter will be provided to the MCO(s).

   An organization that triggers the remediation process due to a loss of NCQA recognition has up to 90 calendar days from the Annual Reporting date to reinstate the recognition.

2. If the organization does not submit for NCQA-required Annual Reporting after 90 calendar days of the site's original reporting date, NCQA will cancel the site's recognition and TennCare will notify the organization that they must achieve recognition within 6 months in order to remain in the TennCare PCMH program. To achieve recognition, NCQA then requires the organization to submit for recognition under the accelerated renewal process and pay the full transformation fees noted in the NCQA PCMH Standards and Guidelines fee schedule at the time of the submission.

3. If recognition is not achieved after that 6-month period, TennCare will then determine if the organization will be removed from the program. TennCare will notify the organization and MCO(s) within three (3) business days of their decision to remove an organization from the program.

   Example: If an organization has a site with an Anniversary date of June 1, 2025 and an Annual Reporting date of May 1, 2025 and does not renew by the Anniversary date, then the remediation process is triggered. The organization then has until July 30, 2025 (i.e., 90 calendar days from the Annual Reporting date) to submit the site for renewal.

   If, after July 30, 2025, the site has not submitted for renewal, then the NCQA recognition status of that site is cancelled. Upon recognition of being cancelled, the organization must pay the site's full transformation fees noted in the fee schedule and achieve recognition no later than January 30, 2026 (6 months) after the recognition status is cancelled. If recognition is not timely obtained, the organization will be removed from the program.

An organization that is in remediation will be responsible for paying all fees to NCQA associated with reinstatement, and full transformation recognition. TennCare will not pay for the organization's fees during the remediation process.

POOR PERFORMANCE REMEDIATION PROCESSES

Each MCO will manage their own remediation process for organizations identified as having poor performance. Each MCO will define the parameters for what is deemed as poor performance and issue communication tor providers.

OTHER GROUNDS FOR REMOVAL

TennCare reserves the right to remove a PCMH organization from the program in extreme circumstances, including failing to respond and meet with TennCare and the MCO(s). The decision to remove an organization from the PCMH program in extreme circumstances is at TennCare's sole discretion.

8. HOW WILL QUALITY AND EFFICIENCY BE MEASURED?

8.1 Quality Metrics

Quality metrics are tracked to ensure that PCMHs are meeting specified quality performance levels and to provide them with information they can use to improve the quality of care they provide.

There are three (3) types of PCMH organizations for purposes of determining performance: pediatric, adult, and family. For the purpose of organization type setting, members aged 21 or younger are considered to be children, and all other members are considered to be adults. PCMH organization type is determined based on the percentage and number of adults and children on an organization's panel.

Practice type is defined in two (2) steps:

1. If a member panel has more than 500 pediatric members and more than 500 adult members attributed, it is a family organization. If the organization does not meet this requirement (has less than 500 children and 500 adult members, the following calculation is used to determine practice type.
2. Determine the percentage of adults and children in an organization's panel.
    a. If the organization's attribution from that MCO is 70% or more children, the organization may be a pediatric organization.
    b. If the organization's attribution from that MCO is 70% or greater adults, the practice may be an adult organization.
    c. If the organization's attribution from that MCO has a mixture of adults and children that does not meet one of the above criteria, it is a family organization.

The organization type of each PCMH is determined at the beginning of each performance year, and an organization's type remains constant for the duration of the performance period.

Various quality performance metrics are used across the three (3) types of organizations. Adult and pediatric organizations will be evaluated on five (5) quality metrics, while family organizations will be evaluated on ten (10) quality metrics, as shown in Table 3.

Core quality metrics that will be used to determine outcome payment levels are shown in Table 3. Some measures are grouped into composites. Each composite is worth one quality star. All eligible sub-measures within a composite must meet or exceed the threshold in order for a practice to earn that star. Additional reporting only metrics will also be provided on reports. There is a more detailed table with sources and descriptions in Section 13 – Appendix: Quality and Efficiency Metrics – Tables 7 and 8.

TABLE 3 – Quality Metrics by PCMH Organization Type

Adult Organization Core Quality Metrics
Breast Cancer Screening-Electronic (BCS-E)
Blood Pressure Control for Patients With Diabetes (BPD)
Eye Exam for Patients With Diabetes (EED)
Glycemic Status Assessment for Patients with Diabetes (GSD) Glycemic Status <8.0%
Child and Adolescent Well-Care Visits (WCV) Ages 12 – 17 years Ages 18 – 21 years

Family Organization Core Quality Metrics
Breast Cancer Screening- Electronic (BCS-E)
Blood Pressure Control for Patients With Diabetes (BPD)
Controlling High Blood Pressure (CBP)
Cervical Cancer Screening (CCS-E)
Childhood Immunization Status - Combination 10 (CIS-E)
Eye Exam for Patients With Diabetes (EED)
Glycemic Status Assessment for Patients with Diabetes (GSD)
Glycemic Status <8.0%
Immunizations for Adolescents - Combination (IMA-E)
Child and Adolescent Well-Care Visits (WCV) **Ages 3-11 years** **Ages 12-17 years** **Ages 18-21 years**
Well-Child Visits in the First 30 Months of Life (W30) **Well-Child Visits in the First 15 Months** **Well-Child Visits for Age 15 Months – 30 Months**

8.2 Efficiency Metrics

Efficiency metrics are tracked to ensure that PCMHs are meeting specified efficiency performance levels and to provide them with information they can use to improve the quality of care they provide. Core efficiency metrics that will be used to determine outcome payment levels are shown in Table 4. Additional reporting only metrics will also be provided on reports. Each organization type (adult, family, and pediatric) will

be held to a separate threshold for each efficiency metric. The thresholds will be set by TennCare. There is a more detailed table with sources and descriptions in Section 13 – Appendix: Quality and Efficiency Metrics - Table 7.

TABLE 4– PCMH Efficiency Metrics

PCMH Efficiency Metrics per 1,000 member months

1. Ambulatory care - ED visits
2. Inpatient discharges - Total inpatient

8.3 Total Cost of Care (TCOC) Calculation

Total cost of care (TCOC) refers to average total spending of the members in a PCMH's panel, adjusted for the member months during which the member was eligible for TennCare. At the end of each quarter, the TCOC is generated for the PCMH report, based on each PCMH's member panel for performance. The following calculations are displayed in each PCMH report:

- Non-risk adjusted TCOC
- Risk-adjusted TCOC
- Non-risk adjusted TCOC for behavioral health

For PY2025, TCOC amounts will be displayed for informational purposes only. Each of these TCOC calculations is discussed in greater detail in the sections that follow.

Definition of Total Cost of Care

The total cost of care is meant to capture the total cost of an average member in a PCMH's organization. Using this, the MCOs, TennCare, and Organizations can better understand if the program has assisted in lowering cost of care for the members they serve. For purposes of the PCMH program, there are nine (9) categories of spending excluded from TCOC calculation:

1. Dental
2. Transportation
3. NICU and nursery
4. Any spending during the first month of life
5. Mobile Crisis Capitation payments

6. Medication Therapy Management (MTM) payments for CY2021
7. Gain-sharing payment made to the PCMH as a Principal Accountable Provider (i.e., Quarterback) of episode-based payment models
8. Upper Payment Limit (UPL) payments for CY2022
9. Payments made to Department of Children's Services (DCS) or Department of Disability and Aging (DDA) directly billed to MCO

In addition to traditional claims-based payments, there are two (2) types of spending incorporated into the TCOC calculation:

1. PCMH activity payments are considered a cost associated with delivering care. As a result, the activity payments from the prior quarter are added to TCOC at the member level.
2. Tennessee Health Link support payments are also considered a cost associated with delivering care. Tennessee Health Link payments from the previous quarter are added to TCOC at the member level.

Actual Total Cost of Care

Actual total cost of care for a PCMH is calculated as a per-member-per-month metric, on a separate basis for each MCO with which the PCMH contracts.

Non-risk adjusted TCOC is defined as the sum of spend included in TCOC divided by the sum of the number of enrollment months with the MCO, for all the members in the PCMH's panel. In other words, across all members of the PCMH's panel within an MCO.

Risk adjusted TCOC reflects the risk score of the members in the PCMH's panel, and includes a maximum spend cap of $100,000 annually per person to remove the impact of outliers. Risk-adjusted TCOC for a PCMH organization is calculated by summing the included spend for all members in the PCMH's outcome payments panel, capped at a set amount per member (to be provided with State thresholds), and dividing by the sum of each member's risk score multiplied by the number of months each member was enrolled with the MCO during the year. In other words, across all members of the PCMH's panel within an MCO.

Non-risk adjusted TCOC for behavioral health is defined analogously with the non-risk adjusted TCOC above but taking into account only the Behavioral Health spend. For non-risk adjusted TCOC for behavioral health, spend included is spend that meets the Behavioral Health spend definition as well as the TCOC definition.

8.4 Earning Stars

In each quarterly report, PCMH organizations earn stars based on their performance across the core quality and efficiency metrics. There are five (5) quality stars and two (2) efficiency stars for a total of seven (7) stars for adult only and pediatric only PCMH organizations, and ten (10) quality stars and two (2) efficiency stars for a total of twelve (12) stars for family PCMH organizations.

- For adult organizations, each adult organization quality metric that equals or outperforms the state threshold translates into one (1) quality star.
- For pediatric organizations, each pediatric organization quality metric that equals or outperforms the state threshold translates into one (1) quality star.
- For family organizations, each family organization quality metric that equals or outperforms the state threshold translates into one (1) quality star.
- For all organization types, each efficiency metric that equals or outperforms the MCO thresholds set based on the methodology defined by the State translates into one efficiency star.

Family, adult, and pediatric core quality and efficiency metrics are defined in Sections 8.1 and 8.2 and further detailed in Section 13 – Appendix: Quality and Efficiency Metrics - Tables 7 and 8.

Quality and efficiency metrics are calculated for all PCMH organizations regardless of the number of observations in the denominator of a given metric. PCMH organizations can earn stars for quality metrics that meet a minimum number of thirty (30) observations in the metric's denominator.
PCMHs must meet the minimum quality star requirement in the performance report at the end of year to qualify for outcome payments. The minimum quality star requirement is three (3) stars for adult only and pediatric only PCMH organizations, and five (5) stars for family PCMH organizations.

8.5 Value of Stars Earned

Redistribution of quality values may be applied under certain circumstances. Most of the quality metrics are defined by HEDIS. HEDIS requires that an organization have at least thirty (30) observations in the denominator of any metric for it to be measured accurately. If an organization does not have at least thirty (30) observations during a calendar year for a given HEDIS metric, that organization is ineligible for that particular quality star. The potential value of each ineligible quality star will be redistributed.

The guidelines for this quality value redistribution are as follows:

- The fully calculated (not rounded) value of each star will be used.

- Quality Gate: Organizations must still meet or exceed the quality gate to qualify for an outcome payment.

  Pediatric/Adult= 3 star minimum;

  Family = 5 star minimum

- Maximum redistribution: Values can only be distributed up to a certain maximum.
    - The value of up to three (3) stars may be redistributed for PCMH pediatric and adult only organizations.
    - The value of up to five (5) stars may be redistributed for PCMH family organizations.
    - The value of the ineligible stars (maximum of 3 or 5) is redistributed evenly among the remaining measures regardless of the denominator of those remaining measures.
- Composite measures are defined as quality measures which consist of two (2) or more sub-metrics. For example, child and adolescent well-care visits is a composite measure with three sub-metrics, broken down by age (ages 3-11, 12-17, and 18-21).
    - The value of composite measures will be redistributed when the minimum denominator is not met for all of its sub-metrics. In other words, the only way a composite measure's star value is redistributed is if the organization does not meet all of the sub-metric denominators.
    - If an organization has an eligible denominator for at least one (1) of the composite's sub-metrics, that organization will be measured against the threshold(s) and may be eligible to earn a star. In other words, organizations will be measured on their performance, and therefore eligible for a star, for any metric for which they have a sufficient denominator in at least one sub-metric.
    - Organizations must meet or exceed the threshold for every eligible sub-metric to earn a star.

Composite Measure Chart
See below charts for further guidance on when a composite star is redistributed and when a star is earned.

If all denominators are met
If all denominators are met & no thresholds are met → Do not earn star
If all denominators are met & some thresholds are met → Do not earn star

If all denominators are met
If all denominators are met & all thresholds met → Earn star

Some denominators are met
If some denominators are met & no thresholds are met→ Do not earn Star
If some denominators are met & some thresholds are met→ Earn star if thresholds for all denominators >30 are met
If some denominators are met & all thresholds are met→ Earn star

No denominators met
Do not evaluate metric→ Star values are redistributed, and provider report shows as N/A

The following charts display the value of each quality star under different circumstances. To calculate the value of a star, first determine the number of stars an organization is eligible for using the guidelines above. Then, determine how many stars are awarded (i.e., how many measure thresholds were met or exceeded). Please note that a minimum number of stars (i.e., three for pediatric and adult organizations and five for family organizations) must be met before the value is applied. The maximum value for all organizations is 50%.

TABLE 5 - Pediatric or Adult Only PCMH

Number of Stars Earned	Eligible for 1 star	Eligible for 2 stars	Eligible for 3 stars	Eligible for 4 stars	Eligible for 5 stars
1	0.00%	0.00%	0.00%	0.00%	0.00%
2	-	33.33%	33.33%	0.00%	0.00%
3	-	-	50.00%	37.50%	30.00%
4	-	-	-	50.00%	40.00%
5	-	-	-	-	50.00%

*****Redistributed star values are not rounded.

TABLE 6 - Family PCMH

Stars Earned	Eligible for 1 star	Eligible for 2 stars	Eligible for 3 stars	Eligible for 4 stars	Eligible for 5 stars	Eligible for 6 stars	Eligible for 7 stars	Eligible for 8 stars	Eligible for 9 stars	Eligible for 10 stars
1	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
2	-	0%	0%	0%	0%	0%	0%	0%	0%	0%
3	-	-	0%	25.00%	25.00%	25.00%	0%	0%	0%	0%
4	-	-	-	33.33%	33.33%	33.33%	28.57%	25.00%	0%	0%
5	-	-	-	-	41.67%	41.67%	35.71%	31.25%	27.78%	25.00%
6	-	-	-	-	-	50.00%	42.86%	37.50%	33.33%	30.00%
7	-	-	-	-	-	-	50.00%	43.75%	38.89%	35.00%
8	-	-	-	-	-	-	-	50.00%	44.45%	40.00%
9	-	-	-	-	-	-	-	-	50.00%	45.00%
10	-	-	-	-	-	-	-	-	-	50.00%

*Redistributed star values are not rounded.

9. RISK ADJUSTMENT

Risk adjustment is an essential analytic element of the PCMH program. Risk adjustment will be used in the TennCare PCMH program in two (2) ways:

- Risk adjustment of the activity payments PMPM; and
- Risk adjustment of total cost of care

The TennCare PCMH program utilizes the Combined Chronic Illness and Pharmacy Payment System (CDPS+Rx) for risk adjustment.

CDPS is a diagnosis-based risk assessment and classification system that supports health status-based capitated payments for Medicaid and Medicare populations. The CDPS model was first developed in 2000 by the University of California, San Diego (UCSD), and has since been expanded to include diagnostic and pharmacy risk assessment models. The CDPS model has the option to run in either prospective or concurrent mode.

9.1 Risk adjustment for practice support payments

The CDPS prospective model is used to calculate risk score for activity payments. The prospective model was chosen because these risk scores are being calculated at the beginning of the year and will be used for the rest of the year. Based on the risk score generated for each member, the PCMH organization's average risk score is assigned to a risk band, which determines the level of the activities PMPM payment for each member in the practice. This risk-adjusted activity payment amount will be recalculated each year to account for any change in the members' risk in that practice. CDPS +Rx version 7.0 will be used to calculate the risk score for activity payments for PY2025.

9.2 Risk adjustment for Total Cost of Care (TCOC)

The CDPS concurrent model is used to calculate risk score for TCOC. The concurrent model was chosen because it is calibrated to reflect realized risk during a historical period. For this purpose, CDPS will be run at the end of each quarter, taking into account a claims run-out period of ninety (90) days. CDPS +Rx version 7.0 will be used to calculate the risk score for TCOC for PY2025.

10. REPORTING

PCMH providers will be sent quarterly reports detailing their efficiency and quality stars, total cost of care, and potential payments for the relevant performance period. Each MCO will send providers reports quarterly. These quarterly reports aim to provide PCMHs an interim view of the member panels that they will be held accountable for during the performance period.

There are two (2) types of quarterly provider reports:

- Preview reports; and
- Performance reports.

Preview Reports

Initially, when organizations first join the program, PCMH providers will receive preview reports on their performance until the first claims run-out is complete, after which they will start to receive quarterly performance reports. These preview reports will give PCMHs a sense of how they were performing before the program launched. MCO(s) will also send providers a final annual report seven to eight months after the end of Q4 which will calculate the annual outcome payment. Only data from January 1st to December 31st of a full performance year will be included in a performance evaluation.

Performance Reports

Each quarterly performance report will provide a summary of the PCMH's total cost of care performance from the beginning of the performance period to the end of each quarter and will incorporate ninety (90) days of claims run out after the end of each quarter. Each performance report will also include the most recent data available for performance on quality and efficiency metrics. The final performance report will calculate the outcome payment. This final report will incorporate one hundred and eighty (180) days of claims run out for total cost of care (TCOC) and ninety days (90) of claims run out for performance on quality and efficiency metrics after the end of the year. Nine-month attribution will be displayed in the May report and final August report.

The following table represents the timeframes of data that will be included in each report.

TABLE 7 – Data Timeframes for Quarterly Reports in Program Year 2025

Release Date	Q1 February	Q2 May	Q3 August	Q3 August	Q4 November
Performance Year	PY2024 Report 3	PY2024 Report 4	PY2024 Final Report 5	PY2025 Report 1	PY2025 Report 2
TCOC Data	Jan 1 – Sep 30, 2024	Jan 1 – Dec 31, 2024 + Runout	Jan 1 – Dec 31, 2024 + Runout	Jan 1 – Mar 31, 2025	Jan 1 – Jun 30, 2025
Quality & Efficiency Data	Jan 1 – Dec 31, 2024	Jan 1 – Dec 31, 2024	Jan 1 – Dec 31, 2024	Jan 1 – Jun 31, 2025	Jan 1 – Sep 30, 2025

10.1 Panel size

Panel size refers to the number of unique attributed members in the panel. The methodology used to calculate the outcome savings percentage is based on the number of quality and efficiency stars. This percentage is then used to calculate outcome payments for participants.

The report will contain the following sections (A-D and Appendices):

A. Quality Performance: This section summarizes the quality stars earned by the provider as of the end of the given quarter. Adult and pediatric PCMH organizations will view the 5 applicable adult/pediatric quality metrics, with each quality star contributing 10% to the outcome saving percentage. Family PCMH organizations will see all ten (10) applicable quality metrics, with each quality star contributing 5% to the outcome savings percentage.

The redistribution of quality values may be applied under certain circumstances. Most of the quality metrics are defined by HEDIS. HEDIS requires that an organization have at least thirty (30) observations in the denominator of any metric for it to be measured accurately. If an organization does not have at least thirty (30) observations during a calendar year for a given HEDIS metric, that organization is ineligible for that particular quality star. The potential value of each ineligible quality star will be redistributed. See Section 8.5 for more information.

B. Efficiency Performance: This section summarizes the efficiency stars and efficiency improvement score, an input of the outcome payment calculation. Performance must meet or exceed the benchmark in order to earn an efficiency star. Each efficiency star earned contributes 15% to the efficiency performance. For the efficiency improvement score, the provider's current performance (year to date) on the two (2) efficiency metrics is compared to a performance from the prior year to determine the PCMH improvement. The improvement percentages for each metric are averaged together to generate the total efficiency score. If the average efficiency improvement percentage results in a negative number, it will be set to 0 and if the calculation exceeds 20% it will be capped at that value.

C. Outcome Payment: This section provides information on potential (or actual, if it is the annual report) outcome payments. It lists the amount of the potential payment, and details of the calculation of that amount. The outcome payment is calculated as detailed in Section 6.3.

D. Total Cost of Care (TCOC) (for reporting only): This section offers provider TCOC information by care category. The provider TCOC figures are provided on a non-risk-adjusted basis for both TCOC and behavioral health specific cost of care. This section also shows providers how they compare to other Medicaid primary care organizations throughout the state.

Appendix: Quality Comparison: This section contains more detail on the quality metrics performance, including a short description of each quality metric and a visual depiction of the provider performance on each metric as compared to other providers and as compared to the metric threshold for earning a star.

Appendix: Quality and Efficiency Measures for Reporting Only: This section provides information about a set of quality and efficiency metrics that are for reporting-only purposes. In addition to the short description of each measure, there is a visual depiction of the provider performance on each metric as compared to the NCQA Quality Compass national benchmark.

11. PROVIDER TRAINING

MCO transformation coaches will deliver provider training and technical assistance services to PCMH providers across the State. The MCO transformation coaches will help providers make the needed investments in practice transformation across all their sites. This training investment is intended as a co-investment with PCMH organizations and not as full coverage for the time, infrastructure, and other investments that practices will need to make.

11.1 Scope of provider training

The MCO transformation coaches will conduct an initial assessment of each newly participating PCMH practice that identifies current capabilities. The results of this assessment will allow the transformation coach to create a custom curriculum for each organization to help in meeting transformation milestones. The custom plan will be refined periodically through semi-annual assessments.

The PCMH curriculum will focus on building health care provider capabilities for effective patient population health management to reduce the rate of growth in total cost of care while improving health, quality of care, and patient experience.

This curriculum will include content in the following areas:

a. Delivering integrated physical and behavioral health services;
b. Team-based care and care coordination;
c. Organization workflow redesign and management;
d. Risk stratified and tailored care delivery;
e. Enhanced patient access (e.g., flexible scheduling, expanded hours);
f. Evidence-informed and shared decision making;
g. Developing an integrated care plan;
h. Patient and family engagement (e.g., motivational interviewing);
i. Making meaningful use of Health Information Technology (HIT)/ Health Information Exchange (HIE);
j. Making meaningful use of provider reports;
k. Business support; and
l. Clinical workflow management.

Providers will be encouraged to access this curriculum in various ways including:

- **Coaching**: On-site and/or virtual coaching for practice staff, e.g., one-on-one coaching sessions with small groups of organization staff including physicians, office managers, care coordinators and/or PCMH Directors.

- **Small format in-person trainings**: Small-format collaboratives, available in each of the Tennessee Grand Regions.

- **Live webinars**: Live, hosted webinars with live Q&A.

- **Recorded trainings**: Recorded video trainings available to providers online on a self-serve basis.

- **Compendium of resources**: A library of documents and resources available online.

MCOs may choose to supplement this in-kind training with new or existing programs geared toward PCMH training. The MCOs will coordinate support to minimize duplication and maximize efficiency for the MCO, vendor, and providers alike.

11.2 Timeline of provider training

MCO transformation coaches will begin scheduling initial assessments for Wave 9 PCMHs after contracting is completed with MCOs. Onsite coaching sessions will begin once the initial assessments are complete.

11.3 Duration of provider training

MCOs will develop individualized curricula for PCMH organization's transformation through December 2025.

12. CARE COORDINATION REPORTS IN MCO PORTALS

TennCare and our MCOs have partnered to create standardized reports for the PCMH & THL programs in areas that are critical for program management and care coordination. MCOs will be uploading provider reports to their respective portals on a scheduled cadence and in a standardized layout for Member Attribution, Gap-in-Care reports, and admission/discharge/transfer (ADT) reports.

12.1 Data in the Reports

- **Admission/discharge/transfer Reports:** These reports are provided daily (Monday-Friday) are populated by ADT feeds from hospitals across the state. They contain data such as basic member information, provider information, hospital event details, and data load details.
- **Member Attribution List:** This report is provided once per week and contains a full list of your attributed members by the respective MCO. The report contains attributed provider information and basic and detailed member information.
- **Gap-in-Care/Performance Report:** This report is produced twice per month and contains detailed information each attributed member's associated measures, whether status is Met or Not, and if Met how it was closed. Additionally, the Practice Performance tab provides information on each metric's numerator, denominator, performance percentage and target, report period, and run date.

12.2 Delivery Cadence

The delivery cadence varies by report, however, each MCO follows the same cadence listed below to ensure you can expect the same report to be available in each of the MCO's portal on the same day.

TABLE 8 – Care Coordination Report Delivery Cadence

Report	Delivery Cadence
ADT (Admission, discharge, transfer)	Daily (Monday-Friday)
Member Attribution	Weekly (Mondays)
Gaps-in-Care & Practice Performance	Bi-weekly (2nd & last Friday of each month)

Member Attribution reports will be delayed until the next business day if a holiday falls on a Friday.

12.3 Training Materials

A recording and slide deck of the webinar reviewing the contents and delivery cadence of the ADT, Member Attribution, and Gap-in-Care reports are available on the PCMH & THL Learning and Training webpage. Additionally, an Excel data dictionary is available, if you are interested in receiving this, please reach out to TennCare.CCT@tn.gov.

12.4 Troubleshooting and Access Issues

If you have questions or need assistance accessing reports in an MCO's portal, please contact your representative at the respective MCO. Each MCO has different training materials and assistance available to individuals trying to access these reports in their respective portal. If you have tried to resolve an issue with an MCO and have been unsuccessful after multiple attempts, please notify us for further assistance at TennCare.CCT@tn.gov.

13. APPENDIX: QUALITY AND EFFICIENCY METRICS

Quality metrics are tracked to ensure that PCMHs are meeting specified quality performance levels and to provide them with information they can use to improve the quality of care they provide. TennCare has selected a group of core quality metrics for the PCMH program; the number and type of metrics vary across the three types of organizations: adult, pediatric, and family. Adult and pediatric organizations will be evaluated on five (5) quality metrics, while family organizations will be evaluated on ten (10) quality metrics.

The descriptions for HEDIS measures, below, are based on the most recently released HEDIS Calendar Year 2025 specifications. Organizations will always be measured on the most recent HEDIS specifications available.

TABLE 9 – Core quality metrics for adult practices

Adult Core Metrics	Description	Threshold
1. Breast Cancer Screening – Electronic	The percentage of members 50–74 years of age who were recommended for routine breast cancer screening and had a mammogram to screen for breast cancer.	≥ 47.00%

Adult Core Metrics	Description	Threshold
(HEDIS BCS-E)		
2. Blood Pressure Control for Patients with Diabetes **(HEDIS BPD)**	% of members 18- 75 years of age with diabetes (type 1 and type 2), whose blood pressure was adequately controlled (<140/90 mm Hg).	≥ 62.00%
3. Eye Exam for Patients with Diabetes **(HEDIS EED)**	% of members 18- 75 years of age with diabetes (type 1 and type 2) who had a retinal eye exam.	≥ 51.00%
4. Glycemic Status Assessment for Patients with Diabetes **(HEDIS GSD)** • Glycemic Status <8.0%	The percentage of members 18–75 years of age with diabetes (types 1 and 2) whose most recent glycemic status (hemoglobin A1c [HbA1c] or glucose management indicator [GMI]) was at the following levels during the measurement year: Glycemic Status <8.0%.	≥ 47.00%
5a. Child and Adolescent Well-Care Visits 12-21 years **(HEDIS WCV)** • Ages 12-17 years	% of members 12-17 years of age who had at least one comprehensive well-care visit with a PCP or OB/GYN practitioner during the measurement year.	≥ 57.00%
5b. Child and Adolescent Well-Care Visits 12-21 years **(HEDIS WCV)** • Ages 18-21 years	% of members 18-21 years of age who had at least one comprehensive well-care visit. with a PCP or OB/GYN practitioner during the measurement year.	≥ 39.00%

TABLE 10 – Core quality metrics for pediatric practices

Pediatric Core Metrics	Description	Threshold
1. Childhood Immunization Status – Electronic – Combination 10 **HEDIS CIS-E**	% children 2 years of age who had 4 DTaP, 3 polio, 1 MMR, 3 HiB, 3 HepB, 1 VZV, 4 PCV, 1 HepA, 2 or 3 RV, and 2 influenza vaccines by their second birthday.	≥ 42.00%
2. Immunizations for Adolescents – Total rate-Electronic -Combination 2 **HEDIS IMA-E**	% of adolescents 13 years of age who had one dose of meningococcal vaccine, one Tdap vaccine, and have completed the human papillomavirus (HPV) vaccine series by their 13th birthday.	≥ 26.00%
3. Upper Respiratory Infection **HEDIS URI** • 3 months–17 years	The percentage of episodes for members 3 months of age and older with a diagnosis of upper respiratory infection (URI) that did not result in an antibiotic dispensing event.	≥ 93.00%
4a. Child and Adolescent Well-Care Visits **HEDIS WCV** • Ages 3 – 11 years	% of members 3-11 years of age who had at least one comprehensive well-care visit with a PCP or OB/GYN practitioner during the measurement year.	≥ 65.00%
4b. Child and Adolescent Well-Care Visits **HEDIS WCV** • Ages 12 – 17 years	% of members 12-17 years of age who had at least one comprehensive well-care visit with a PCP or OB/GYN practitioner during the measurement year.	≥ 57.00%
4c. Child and Adolescent Well-Care Visits **HEDIS WCV** • Ages 18 – 21 years	% of members 18-21 years of age who had at least one comprehensive well-care visit with a PCP or OB/GYN practitioner during the measurement year.	≥ 39.00%
5a. Well-Child Visits in the First 30 Months of Life **HEDIS W30** • Well-Child Visits in the First 15 Months	% of members who had the following number of well-child visits with a PCP during the last 15 months. Children who turned 15 months old during the measurement year: Six or more well-child visits.	≥ 61.00%
5b. Well-Child Visits in the First 30 Months of Life • Well-Child Visits for Age 15 Months – 30 Months	% of members who had the following number of well-child visits with a PCP during the last 15 months. Children who turned 30 months old during the measurement year: Two or more well-child visits.	≥ 71.00%

TABLE 11 – Core quality metrics for family practices

Family Core Metrics	Description	Threshold
1. Breast Cancer Screening – Electronic **HEDIS BCS-E**	The percentage of members 50–74 years of age who were recommended for routine breast cancer screening and had a mammogram to screen for breast cancer.	≥ 47.00%
2. Blood Pressure Control for Patients with Diabetes **HEDIS BPD**	% of members 18- 75 years of age with diabetes (type 1 and type 2), whose blood pressure was adequately controlled (<140/90 mm Hg).	≥ 62.00%
3. Controlling High Blood Pressure **HEDIS CBP**	% of members 18–85 years of age who had a diagnosis of hypertension (HTN) and whose Blood Pressure (BP) was adequately controlled (<140/90 mm Hg) during the measurement year.	≥ 60.00%
4. Cervical Cancer Screening – Electronic **HEDIS CCS-E**	% of members 21–64 years of age who were recommended for routine cervical cancer screening who were screened for cervical cancer	≥ 52.00%
5. Childhood Immunization Status – Electronic – Combination 10 **HEDIS CIS-E**	% children 2 years of age who had 4 DTaP, 3 polio, 1 MMR, 3 HiB, 3 HepB, 1 VZV, 4 PCV, 1 HepA, 2 or 3 RV, and 2 influenza vaccines by their second birthday.	≥ 42.00%
6. Eye Exam for Patients with Diabetes **HEDIS EED**	% of members 18- 75 years of age with diabetes (type 1 and type 2) who had a retinal eye exam.	≥ 51.00%
7. Glycemic Status Assessment for Patients with Diabetes **HEDIS GSD** • Glycemic Status <8.0%	The percentage of members 18–75 years of age with diabetes (types 1 and 2) whose most recent glycemic status (hemoglobin A1c [HbA1c] or glucose management indicator [GMI]) was at the following levels during the measurement year: Glycemic Status <8.0%.	≥ 47.00%
8. Immunizations for Adolescents – Total rate- Electronic - Combination 2 **HEDIS IMA-E**	% of adolescents 13 years of age who had one dose of meningococcal vaccine, one Tdap vaccine, and have completed the human papillomavirus (HPV) vaccine series by their 13th birthday.	≥ 26.00%
9a. Child and Adolescent Well-Care Visits 12-21 years **HEDIS WCV**	% of members 3-11 years of age who had at least one comprehensive well-care visit with a PCP or OB/GYN practitioner during the measurement year.	≥ 65.00%

Family Core Metrics	Description	Threshold
• Ages 3-11 years		
9b. Child and Adolescent Well-Care Visits 12-21 years **HEDIS WCV** • Ages 12-17 years	% of members 12-17 years of age who had at least one comprehensive well-care visit. with a PCP or OB/GYN practitioner during the measurement year.	≥ 57.00%
9c. Child and Adolescent Well-Care Visits **HEDIS WCV** Ages 18 – 21 years	% of members 18-21 years of age who had at least one comprehensive well-care visit with a PCP or OB/GYN practitioner during the measurement year.	≥ 39.00%
10a. Well-Child Visits in the First 30 Months of Life **HEDIS W30** • Well-Child Visits in the First 15 Months	% of members who had the following number of well-child visits with a PCP during the last 15 months. Children who turned 15 months old during the measurement year: Six or more well-child visits.	≥ 61.00%
10b. Well-Child Visits in the First 30 Months of Life • Well-Child Visits for Age 15 Months – 30 Months	% of members who had the following number of well-child visits with a PCP during the last 15 months. Children who turned 30 months old during the measurement year: Two or more well-child visits.	≥ 71.00%

TABLE 12 – Core Efficiency Metrics

TennCare will set thresholds for core efficiency metrics for each organization type in 2025.

Category	Core metric	Source	Description	Threshold
Efficiency metrics for Adult Organizations	**Ambulatory care - ED visits per 1,000 member months**	HEDIS (AMB)	Number of ED visits per 1,000 member months	58.30
Efficiency metrics for Adult Organizations	**Inpatient discharges per 1,000 member months – Total inpatient**	HEDIS (IPU)	Number of acute inpatient discharges per 1,000 member months	7.10
Efficiency metrics for Family Organizations	**Ambulatory care - ED visits per 1,000 member months**	HEDIS (AMB)	Number of ED visits per 1,000 member months	48.00
Efficiency metrics for Family Organizations	**Inpatient discharges per 1,000 member months – Total inpatient**	HEDIS (IPU)	Number of acute inpatient discharges per 1,000 member months	4.95
Efficiency metrics for Pediatric Organizations	**Ambulatory care - ED visits per 1,000 member months**	HEDIS (AMB)	Number of ED visits per 1,000 member months	37.00
Efficiency metrics for	**Inpatient discharges per 1,000 member months – Total inpatient**	HEDIS (IPU)	Number of acute inpatient discharges per 1,000 member months	1.50

TABLE 13 – Total Cost of Care Categories

Each PCMH organization will receive a breakdown of their TCOC by category in each quarterly report.

Category	Description
Inpatient facility	All services provided during an inpatient facility stay including room and board, recovery room, operating room, and other services.
Emergency department or observation	All services delivered in an Emergency Department or Observation Room setting including facility and professional services.
Outpatient facility	All services delivered by a facility during an outpatient surgical encounter, including operating and recovery room and other services.
Inpatient professional	Services delivered by a professional provider during an inpatient hospital stay, including patient visits and consultations, surgery, and diagnostic tests.
Outpatient laboratory	All laboratory services in an inpatient, outpatient, or professional setting.
Outpatient radiology	All radiology services such as MRI, X-Ray, CT and PET scan performed in an inpatient, outpatient, or professional setting.
Outpatient professional	Uncategorized professional claims such as evaluation and management, health screenings, and specialist visits.
Pharmacy	Any pharmacy claims billed under the pharmacy or medical benefit with a valid National Drug Code.
Other	PCMH support payments, DME, Home health, and any remaining uncategorized claims.

For purposes of the PCMH program, there are nine (9) categories of spending excluded from the TCOC calculation:

- Dental
- Transportation
- NICU and nursery
- Any spending during the first month of life
- Mobile Crisis Capitation payments
- Medication Therapy Management (MTM) payments for CY2021
- Gain-sharing payment made to the PCMH as a Principal Accountable Provider (i.e., Quarterback) of episode-based payment models
- Uplift (UPL) payments
- Payments made to Department of Children's Services (DCS) or Department of Disability and Aging (DDA) directly billed to MCO

Quality and Efficiency Metrics for Reporting-Only

Each PCMH organization will see a set of quality and efficiency metrics in the preview or performance reports that are for reporting-only purposes.

TABLE 14 – Pediatric Reporting-Only Quality Metrics

Pediatric Reporting-Only Quality Metrics	Description
Antibiotic Utilization for Respiratory Conditions **HEDIS AXR**	The percentage of episodes for members 3 months of age and older with a diagnosis of a respiratory condition that resulted in an antibiotic dispensing event.
Childhood Immunization Status – Electronic – Combo 7 **HEDIS CIS-E**	The % children 2 years of age who had DTaP, IPV, MMR, HiB, hepatitis B, VZV, pneumococcal, hepatitis A and rotavirus vaccines by their second birthday.
Childhood Immunization Status – Electronic – Influenza **HEDIS CIS-E**	The % of members who received at least two influenza vaccinations with different dates of service before their second birthday.
Depression Screening and Follow-up for Adolescents and Adults – Electronic - Depression Screening **HEDIS DSF-E**	The % of members 12 years of age and older who were screened for clinical depression using a standardized instrument and, if screened positive, received follow-up care.
Depression Screening and Follow-up for Adolescents and Adults – Electronic - Follow-Up on Positive Screening **HEDIS DSF-E**	The % of members 12 years of age and older who were screened for clinical depression using a standardized instrument and, if screened positive, received follow-up care.
Social Needs Screening and Intervention – Electronic – Food Screening **HEDIS SNS-E**	The % of members who were screened, using prespecified instruments, at least once during the measurement period for unmet food, housing and transportation needs, and received a corresponding intervention if they screened positive.
Social Needs Screening and Intervention – Electronic – Food Intervention **HEDIS SNS-E**	The % of members who were screened, using prespecified instruments, at least once during the measurement period for unmet food, housing and transportation needs, and received a corresponding intervention if they screened positive.
Social Needs Screening and Intervention – Electronic – Housing Screening **HEDIS SNS-E**	The % of members who were screened, using prespecified instruments, at least once during the measurement period for unmet food, housing and

Pediatric Reporting-Only Quality Metrics	Description
	transportation needs, and received a corresponding intervention if they screened positive.
Social Needs Screening and Intervention – Electronic – Housing Intervention **HEDIS SNS-E**	The % of members who were screened, using prespecified instruments, at least once during the measurement period for unmet food, housing and transportation needs, and received a corresponding intervention if they screened positive.
Social Needs Screening and Intervention – Electronic – Transportation Screening **HEDIS SNS-E**	The % of members who were screened, using prespecified instruments, at least once during the measurement period for unmet food, housing and transportation needs, and received a corresponding intervention if they screened positive.
Social Needs Screening and Intervention – Electronic – Transportation Intervention **HEDIS SNS-E**	The % of members who were screened, using prespecified instruments, at least once during the measurement period for unmet food, housing and transportation needs, and received a corresponding intervention if they screened positive.
Topical Fluoride for Children **HEDIS SNS-E**	The % of members 1-4 years of age who received at least two fluoride varnish applications during the measurement year.

TABLE 15 – Family Reporting-Only Quality Metrics

Family Reporting-Only Quality Metric	Description
Antibiotic Utilization for Respiratory Conditions **HEDIS AXR**	The percentage of episodes for members 3 months of age and older with a diagnosis of a respiratory condition that resulted in an antibiotic dispensing event.
Blood Pressure Control for Patients with Hypertension – Electronic **HEDIS BPC-E**	The % of members 18–85 years of age who had a diagnosis of hypertension (HTN) and whose most recent blood pressure (BP) was <140/90 mm Hg during the measurement period.
Childhood Immunization Status – Electronic – Combo 7 **HEDIS CIS-E**	The % children 2 years of age who had DTaP, IPV, MMR, HiB, hepatitis B, VZV, pneumococcal, hepatitis A and rotavirus vaccines by their second birthday.

Family Reporting-Only Quality Metric	Description
Childhood Immunization Status – Electronic – Influenza **HEDIS CIS-E**	The % of members who received at least two influenza vaccinations with different dates of service before their second birthday.
Colorectal Cancer Screening – Electronic **HEDIS COL-E**	The % of members 45-75 years of age who had appropriate screening for colorectal cancer.
Depression Screening and Follow-up for Adolescents and Adults - Electronic – Depression Screening **HEDIS DSF-E**	The % of members 12 years of age and older who were screened for clinical depression using a standardized instrument and, if screened positive, received follow-up care.
Depression Screening and Follow-up for Adolescents and Adults - Electronic – Follow-Up on Positive Screening **HEDIS DSF-E**	The % of members 12 years of age and older who were screened for clinical depression using a standardized instrument and, if screened positive, received follow-up care.
Kidney Health Evaluation for Patients with Diabetes **HEDIS KED**	The % of members 18-85 years of age with diabetes (type 1 and type 2) who received a kidney health evaluation, defined by an estimated glomerular filtration rate (eGFR) ***and*** a urine albumin-creatinine ratio (uACR), during the measurement year.
Social Needs Screening and Intervention – Electronic – Food Screening **HEDIS SNS-E**	The % of members who were screened, using prespecified instruments, at least once during the measurement period for unmet food, housing and transportation needs, and received a corresponding intervention if they screened positive.
Social Needs Screening and Intervention – Electronic – Food Intervention **HEDIS SNS-E**	The % of members who were screened, using prespecified instruments, at least once during the measurement period for unmet food, housing and transportation needs, and received a corresponding intervention if they screened positive.
Social Needs Screening and Intervention – Electronic – Housing Screening **HEDIS SNS-E**	The % of members who were screened, using prespecified instruments, at least once during the measurement period for unmet food, housing and transportation needs, and received a corresponding intervention if they screened positive.
Social Needs Screening and Intervention – Electronic – Housing Intervention **HEDIS SNS-E**	The % of members who were screened, using prespecified instruments, at least once during the measurement period for unmet food, housing and transportation needs, and received a corresponding intervention if they screened positive.
Social Needs Screening and Intervention – Electronic – Transportation Screening **HEDIS SNS-E**	The % of members who were screened, using prespecified instruments, at least once during the measurement period for unmet food, housing and transportation needs, and received a corresponding intervention if they screened positive.

Family Reporting-Only Quality Metric	Description
Social Needs Screening and Intervention – Electronic – Transportation Intervention **HEDIS SNS-E**	The % of members who were screened, using prespecified instruments, at least once during the measurement period for unmet food, housing and transportation needs, and received a corresponding intervention if they screened positive.
Topical Fluoride for Children **HEDIS TFC**	The % of members 1-4 years of age who received at least two fluoride varnish applications during the measurement year.
Appropriate Treatment for Upper Respiratory Infection, Ages 3 months – 17 years **HEDIS URI**	The % episodes for members 3 months–17 years of age with a diagnosis of upper respiratory infection (URI) that did not result in an antibiotic dispensing event.

TABLE 16 – Adult Reporting-Only Quality Metrics

Adult Reporting-Only Quality Metrics	Description
Antibiotic Utilization for Respiratory Conditions **HEDIS AXR**	The percentage of episodes for members 3 months of age and older with a diagnosis of a respiratory condition that resulted in an antibiotic dispensing event.
Blood Pressure Control for Patients with Hypertension – Electronic **HEDIS BPC-E**	The % of members 18–85 years of age who had a diagnosis of hypertension (HTN) and whose most recent blood pressure (BP) was <140/90 mm Hg during the measurement period.
Cervical Cancer Screening – Electronic **HEDIS-CCE**	The % members 21–64 years of age who were recommended for routine cervical cancer screening and were screened for cervical cancer using any of the following criteria: had cervical cytology performed with the last 3 years.
Colorectal Cancer Screening – Electronic **HEDIS COL-E**	The % of members 45-75 years of age who had appropriate screening for colorectal cancer.
Depression Screening and Follow-up for Adolescents and Adults - Electronic – Depression Screening **HEDIS DSF-E**	The % of members 12 years of age and older who were screened for clinical depression using a standardized instrument and, if screened positive, received follow-up care.

Adult Reporting-Only Quality Metrics	Description
Depression Screening and Follow-up for Adolescents and Adults - Electronic – Follow-Up on Positive Screening **HEDIS DSF-E**	The % of members 12 years of age and older who were screened for clinical depression using a standardized instrument and, if screened positive, received follow-up care.
Kidney Health Evaluation for Patients with Diabetes **HEDIS KED**	The % of members 18-85 years of age with diabetes (type 1 and type 2) who received a kidney health evaluation, defined by an estimated glomerular filtration rate (eGFR) ***and*** a urine albumin-creatinine ratio (uACR), during the measurement year.
Social Needs Screening and Intervention – Electronic – Food Screening **HEDIS SNS-E**	The % of members who were screened, using prespecified instruments, at least once during the measurement period for unmet food, housing and transportation needs, and received a corresponding intervention if they screened positive.
Social Needs Screening and Intervention – Electronic – Food Intervention **HEDIS SNS-E**	The % of members who were screened, using prespecified instruments, at least once during the measurement period for unmet food, housing and transportation needs, and received a corresponding intervention if they screened positive.
Social Needs Screening and Intervention – Electronic – Housing Screening **HEDIS SNS-E**	The % of members who were screened, using prespecified instruments, at least once during the measurement period for unmet food, housing and transportation needs, and received a corresponding intervention if they screened positive.
Social Needs Screening and Intervention – Electronic – Housing Intervention **HEDIS SNS-E**	The % of members who were screened, using prespecified instruments, at least once during the measurement period for unmet food, housing and transportation needs, and received a corresponding intervention if they screened positive.
Social Needs Screening and Intervention – Electronic – Transportation Screening **HEDIS SNS-E**	The % of members who were screened, using prespecified instruments, at least once during the measurement period for unmet food, housing and transportation needs, and received a corresponding intervention if they screened positive.
Social Needs Screening and Intervention – Electronic – Transportation Intervention **HEDIS SNS-E**	The % of members who were screened, using prespecified instruments, at least once during the measurement period for unmet food, housing and transportation needs, and received a corresponding intervention if they screened positive.

TABLE 17 – Reporting-Only Efficiency Metrics

Reporting-Only Efficiency Metric	Source	Description
Inpatient Average Length of Stay	HEDIS (IPU)	The inpatient average length of stay for all patients, excluding newborns.
Plan All-Cause Readmissions	HEDIS (PCR)	For members 18-64 years of age, the number of acute inpatient stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission.
Diagnosed Mental Health Disorders	HEDIS (DMH)	The percentage of members 1 year of age and older who were diagnosed with a mental health disorder during the measurement year.
Avoidable ED Visits per 1,000 Member Months	TennCare, adapted from IOM/ Michigan	The number of ED visits for ambulatory care sensitive conditions, per 1,000 member months, based on ACSCs as defined by the Institute of Medicine.
Inpatient Utilization (IU-HH) Adult, Family, & Pediatrics	Health Homes	The rate of inpatient care and services (total) per 1,000 member months

14. FQHC/RHC PPS REIMBURSEMENT SYSTEM AND PCMH ACTIVITY/OUTCOME PAYMENTS MEMO

Division of TennCare

To: Medicaid Participating Federally Qualified Health Centers and Rural Health Clinics
From: Zane Seals, Deputy Chief Financial Officer, Bureau of TennCare
Date: October 5, 2018

Subject: FQHC/RHC PPS reimbursement system and PCMH activity/outcome payments

TennCare and the Comptroller have received several questions about how revenue received as part of the state's payment reform initiatives should be reported for the purposes of the PPS reimbursement system. In general, services associated with payment reform initiatives are outside the scope of the PPS system. Specifically, the payments related to the following initiatives should not be reported when submitting information to the Comptroller:

- Patient Centered Medical Home (PCMH) activity payments,
- Patient Centered Medical Home (PCMH) outcome payments, and
- Health Link activity and outcome payments

For questions, please contact Zane Seals, Deputy Chief Financial Officer at zane.seals@tn.gov.

Fiscal Division/Business Sectors • 310 Great Circle Road • Nashville, TN 37243 Tel: 615-507-6345 • tn.gov/agency

Note: Further information regarding reimbursements for FQHC and RHC Providers can be found online.

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16. ADDENDUM – FAQ PCMH RECONSIDERATIONS AND COMPLAINTS

Q: What is a PCMH reconsideration?

A: A reconsideration is a process that should be filed when the organization disagrees with the MCOs' determination related to the Patient Centered Medical Home outcome payment. Reconsiderations should be submitted to your contracted MCO. Please see end of document for additional information for each MCO.

Q: What constitutes a PCMH reconsideration?

A: The five items an organization can file a reconsideration for are:

- Quality Metric Performance
- Efficiency Metric Performance
- Efficiency Improvement Percentage
- Total Cost of Care Savings Amount
- Calculation of the Final Outcome Payment amount

Q: How do you file a PCMH reconsideration?

A: Reconsideration requests need to be sent in writing to the MCO via mail or email. Provider must also provide a detailed rationale to support the reconsideration request and include:

- Identification of each performance result (payment and metrics) to be considered.
- Identification of the contested result calculated.

- A detailed explanation of why the provider believes the determination is incorrect, including the specific members involved per measure in question.
- Any other relevant information to support the provider's reconsideration request.

Q: How many days does an organization have to file a reconsideration? Please note there may be some differences across MCOs.

A: BlueCare and Wellpoint (formerly Amerigroup): Providers have 30 calendar days from the delivery of the final performance report. UnitedHealthcare: Providers have 20 business days from the delivery of the final performance report

Q: How many days do the MCOs have to complete their review? Please note there may be some differences across MCOs.

A: BlueCare and Wellpoint will respond to the reconsideration within 30 calendar days after the submission date. UnitedHealthcare will respond to the reconsideration within 20 calendar days after the submission date.

Q: What can an organization do if they don't agree with the reconsideration decision?

A: They are encouraged to speak with the respective MCO to review the data utilized in the decision-making process before filing a complaint.

Q: Where can organizations share concerns or complaints about the PCMH program?

A: If an organization has a concern regarding the program design and/or implementation it should be directed to TennCare. Please email these concerns to payment.reform@tn.gov.

Q: What other options are available for organizations?

A: Organizations may file a request with the Commissioner of Commerce and Insurance for an independent review pursuant to the TennCare Provider Independent Review of Disputed Claims process, which shall be available to organizations to resolve disputes, as provided in T.C.A. 56-32-126. It is understood that in the event PCMH organizations file such a request with the Commissioner of Commerce

and Insurance for Independent Review, such dispute shall be governed by T.C.A. 56-32-126(b).

Sample copies of the Request to Commissioner of Commerce and Insurance for Independent Review of Disputed TennCare Claim form, instructions for completing the form, and frequently asked questions developed by the State of Tennessee Department of Commerce and Insurance can be obtained on the state's website.

For questions about the independent review process, call the State of Tennessee at (615) 741-2677.

Q: Where can organizations find additional information related to PCMH reconsiderations?

A: Wellpoint

Reconsideration requests need to be sent in writing to Wellpoint via mail or email:

Mail:
Wellpoint Community Care
Attn: Provider Relations — Patient-Centered Medical Home
22 Century Blvd., Suite 220
Nashville, TN 37214

Email: TNPCMH@Wellpoint.com

Web address where reconsideration information will be housed online.

BlueCare

BlueCare PMCH Provider Dispute Resolution Process

BlueCare PCMH Reconsideration Form

UnitedHealthcare

Reconsideration questions and submissions shall be submitted to the following: tnpcmh@uhc.com