Division of TennCare

Tennessee Department of Finance & Administration

Division of TennCare

TennCare III Demonstration

Project No. 11-W-00369/4

Annual Monitoring Report

(For the period January – December 2021)

April 7, 2022

TennCare III Annual Monitoring Report

Tennessee operates its Medicaid program under the authority of an 1115 demonstration known as TennCare. TennCare is a comprehensive Medicaid reform project, consisting of innovations in a number of aspects of the Medicaid program, including eligibility, benefits, and service delivery systems. The primary goals of the TennCare demonstration include providing high-quality care to enrollees, improving health outcomes for enrollees, and providing enrollees with access to safe and appropriate HCBS. As a means of advancing these goals, the TennCare Demonstration authorizes a number of programmatic flexibilities, including extending eligibility to certain groups that would not be eligible for Medicaid under the State Plan; covering a more robust package of benefits than that authorized under the Medicaid State Plan; operating a single, statewide managed care service delivery system; operating a number of HCBS programs for persons with physical, intellectual, and/or developmental disabilities; and various operational efficiencies. Through the TennCare Demonstration, the State demonstrates that the careful use of a single, statewide managed care service delivery system can enable the State to deliver high-quality care to all enrollees without spending more than would have been spent had the State continued its Medicaid program.

Key Dates of the Demonstration Quarter

Key dates of approval/operation for the TennCare Demonstration during the October-December 2021 quarter, together with the corresponding Special Terms and Conditions (STCs), if applicable, are presented in Table 1. A summary of key activities that occurred with respect to the STCs throughout DY 1 is presented in Attachment A to this report.

Table 1
Key Dates of Approval/Operation in the Quarter

Date	Action	STC #
10/28/21	The Monthly Call for October, which would have been held on this date, was cancelled.	60
11/25/21	The Monthly Call for November, which would have been held on this date, was cancelled.	60
12/6/21	The State submitted the Quarterly Monitoring Report for the July – September 2021 quarter to CMS.	56
12/7/21	The State notified the public of its intent to submit to CMS an amendment to the TennCare III Demonstration. Amendment 2 would extend TennCare coverage to children adopted from state custody who do not receive federal or state adoption assistance.	7, 12
12/13/21	The State submitted to CMS an emergency amendment to the TennCare III Demonstration. The amendment would give the State temporary flexibilities to assist certain members of the CHOICES program and the	N/A

Date	Action	STC #
	Employment and Community First CHOICES program during the COVID-19 public health emergency.	
12/23/21	The Monthly Call for December, which would have been held on this date, was cancelled.	60

I. Operational Updates

Progress Towards Milestones During Demonstration Year 1

The TennCare III Demonstration continues a number of program components from the prior iteration of the TennCare Demonstration that are already in operation. In addition, TennCare III includes some new programmatic flexibilities and authorities. In terms of new flexibilities authorized under TennCare III, the State has completed various milestones during Demonstration Year 1, including the submission of the Shared Savings Quality Measures Protocol on March 8, 2021; the submission of the Draft Implementation Plan on April 8, 2021; the submission of the Demonstration Monitoring Protocol on June 7, 2021; and the submission of the DSIP Claiming Protocol on June 30, 2021. The State is awaiting CMS approval of each of these deliverables.

The State has not yet implemented certain flexibilities authorized under the TennCare Demonstration. Specifically, the State has not implemented any new policies related to coverage of prescription drugs or any new policies related to suspension of members convicted of TennCare fraud. The State will work closely with CMS prior to implementing any new policies in these areas.

Additional Program Developments During Demonstration Year 1

During DY 1, a number of other programs were underway. These include the following:

Demonstration Amendment 1. On March 31, 2021, the State submitted Demonstration Amendment 1 to CMS. The purpose of Amendment 1 is to improve the alignment between the various types of care that TennCare enrollees with intellectual disabilities receive. Currently, these enrollees receive their medical/surgical and behavioral healthcare from MCOs through the managed care program authorized under the Demonstration, and their LTSS outside of managed care. Specifically, Amendment 1 entails the following modifications to the TennCare program:

- Integration of services for members with intellectual disabilities into the TennCare managed care program[1];
- Transitioning the care of children receiving Supplemental Security Income (SSI) benefits from the TennCare Select health plan to one of the other health plans that serves TennCare members; and

[1] Specific services to be integrated are intermediate care facility services for individuals with intellectual disabilities (ICF/IID services) and 1915(c) waiver home- and community-based services (HCBS).

- Assigning to the TennCare Select health plan certain inmates of public institutions who receive inpatient services in a setting located outside the public institution.

As of the end of DY 1, the State was awaiting CMS approval of Amendment 1.

Enhancements to Home and Community Based Services. On August 2, 2021, the State received partial approval of its plan to enhance, expand, and strengthen Medicaid HCBS under Section 9817 of the American Rescue Plan Act, and full CMS approval was received on September 22, 2021. The State's HCBS Spending Plan includes a number of enhancements to the HCBS programs authorized under the Demonstration, including expanding the number of individuals receiving HCBS under the Demonstration, enhancing the benefits available to persons receiving HCBS through the Demonstration, and initiatives to strengthen the HCBS workforce. The implementation of the State's HCBS Spending Plan is discussed in more detail below.

Demonstration Amendment 2. On December 7, 2021, the State launched a public notice and comment period regarding Demonstration Amendment 2. The purpose of Amendment 2 is to expand TennCare coverage of children adopted from state custody to include those children who do not currently qualify for Medicaid on the basis of receiving federal or state adoption assistance. Coverage for this group of children would remove a potential barrier to adoption, as well as promote greater continuity of care for these children as they transition from foster care to permanent homes. As of the conclusion of DY 1, the notice and comment period was expected to conclude on January 10, 2022, with submission of the amendment to CMS to follow thereafter.

Enhancements to Maternal Health. On December 17, 2021, the State issued a public notice regarding certain enhancements to maternal health coverage under the Demonstration to take place in 2022. Specifically, the State will provide 12 months of postpartum coverage following the end of pregnancy; and pregnant and postpartum women age 21 and older will receive a comprehensive dental benefit under the Demonstration. These program enhancements are expected to lead to improved maternal health outcomes for individuals enrolled in TennCare. As of the end of DY 1, the public notice and comment period related to these changes was ongoing, with implementation of these changes expected to begin on April 1, 2022.

Policy or Administrative Difficulties in Operating the Demonstration

There were no significant administrative difficulties in operating the demonstration during DY 1. For much of the demonstration year, the State awaited CMS approval of Demonstration Amendment 1, which would allow the state to proceed with the planned integration of certain services for members with intellectual disabilities into the larger TennCare managed care program.

Key Challenges During Demonstration Year 1

Throughout DY 1, the State continued to address the threat to public health and safety posed by the novel coronavirus disease 2019 (or "COVID-19"). As the agency in Tennessee state government responsible for providing health insurance to more than 1.6 million individuals, the Division of TennCare has developed a multilayered response to the COVID-19 emergency.

Working in tandem with partners and stakeholders at the federal and state levels, TennCare designed and deployed a strategy consisting of such elements as—

- Coordinating with the provider community and TennCare's health plans to ensure access to care for TennCare members in need of testing or treatment for COVID-19;
- Assisting providers in offering covered services to TennCare members via telehealth when medically appropriate;
- Increasing care coordination services for members impacted by COVID-19 who are self-isolated, so that they can receive additional supports as needed;
- Pausing nearly all terminations of eligibility for TennCare and CoverKids (the State's separate CHIP program) members during the COVID-19 emergency;
- Working with TennCare's health plans to streamline or temporarily lift authorization requirements to ensure services are delivered promptly and claims paid quickly;
- Expediting access to home-based care for former nursing facility patients being discharged from hospitals and electing to transition home;
- Enhancing access to prescription drugs by allowing early refills of prescriptions and by allowing 90-day supplies to be prescribed for most medications;
- Obtaining multiple Section 1135 waivers from CMS that provide flexibilities to help ensure that TennCare members receive necessary services;
- Submitting emergency amendments to the TennCare Demonstration to make retainer payments to providers of HCBS in the Employment and Community First CHOICES program; to obtain additional flexibilities to support TennCare HCBS providers during the public health emergency; and to furnish Enabling Technologies to recipients of HCBS;
- Assisting providers of long-term services and supports in reducing the spread of COVID-19 among individuals who are residents of nursing facilities; and
- Implementing targeted, state-directed managed care payments to provide enhanced financial support for providers disproportionately affected by the COVID-19 emergency, including primary care providers, nursing facilities, dentists, and community mental health centers and other providers of behavioral health services.

Additional resources concerning the State's response to the COVID-19 pandemic are available on a dedicated page of the TennCare website.

Key Achievements During the Demonstration Year

During DY 1, implementation of a number of new TennCare initiatives began. Furthermore, the State achieved notable results in the area of long-term services and supports by enrolling more children in the Katie Beckett program and by making enhancements to HCBS programs. In addition, the State conducted a procurement for MCOs.

Chiropractic Services for Adults. During DY 1, the State began the process of adding chiropractic services to its package of covered benefits for adults. These efforts included amending MCO contracts and ensuring that each MCO had an adequate network in place to support member access, amending the State's administrative rules, and working with CMS to add chiropractors' services as a covered benefit in the Medicaid State Plan. The State implemented chiropractic

services for adults on January 1, 2022. The State will monitor member usage of this new benefit and seek to identify any positive health outcomes associated with the new benefit.

Katie Beckett/Medicaid Diversion Program. On November 23, 2020, the State launched a new Katie Beckett/Medicaid Diversion program as part of the TennCare Demonstration. The program provides services and supports for children under age 18 with disabilities and/or complex medical needs who are not eligible for traditional Medicaid because of their parents' income or assets.

The State's program consists of three parts:

- **Katie Beckett (Part A)** – Children with the most severe needs receive the full TennCare benefits package, as well as essential wraparound home and community based services. These individuals are subject to monthly premiums, which are determined on a sliding scale based on the member's household income.
- **Medicaid Diversion (Part B)** – Individuals in this group receive a specified package of essential wraparound services and supports, including premium assistance. These services are intended to prevent or delay the need for traditional Medicaid supports.
- **Continued Eligibility (Part C)** – Children in this group are enrolled in TennCare, have been determined no longer to meet the eligibility requirements for a Medicaid category, meet the criteria for enrollment in Katie Beckett (Part A), but do not have available slots in which to enroll. These individuals receive the full TennCare benefits package.

The new Katie Beckett/Medicaid Diversion program began accepting self-referral forms from interested families on November 23, 2020. As of the last day of DY 1, a total of 1,107 children were enrolled in the program, with 128 enrolled in Katie Beckett (Part A), 978 enrolled in Medicaid Diversion (Part B), and 1 enrolled in Continued Eligibility (Part C).

Enhancements to Home and Community Based Services. The American Rescue Plan Act of 2021 provides federal funding to enhance, expand, and strengthen Medicaid HCBS programs. In accordance with CMS guidance and after an extensive stakeholder input process, the State submitted a proposed HCBS Spending Plan and Narrative to CMS on July 12, 2021, outlining how additional federal resources would be used to strengthen the TennCare Demonstration's HCBS programs. The State initially received partial approval of its HCBS spending plan and narrative on August 2, 2021, and after some minor clarifications, received final approval from CMS on September 22, 2021. The major components of the State's plan to enhance and strengthen HCBS are outlined below:

- **Improving access to HCBS for persons needing supports and family caregivers.** Notably, the State intends to reduce by half the number of persons on the referral list for Employment and Community CHOICES by enrolling an additional 2,000 qualifying individuals into the program. In addition, based on significant input from stakeholders, for individuals who are already enrolled in HCBS programs, the State has increased, for a limited period of time, access to flexible family caregiver benefits in order to address the additional stresses from impacts of COVID-19, and ensure the sustainability of these

supports going forward. The State has also made targeted enhancements to its HCBS benefits package, beginning with Enabling Technology for persons enrolled in CHOICES.

- **Investing in the HCBS Workforce.** The State has also used additional federal resources to make targeted provider rate increases for services in CHOICES and in Employment and Community First CHOICES that have a direct care component. In addition, the State plans to implement a quality incentive pilot program to incentivize HCBS providers to offer value-based wage increases to their frontline HCBS workers who successfully complete a competency-based training program.
- **Investing in HCBS Provider Capacity.** The State has implemented a referral incentive program for specified types of HCBS to help providers recruit and retain qualified frontline staff.

Taken together, these initiatives represent a significant investment in access to HCBS for persons in Tennessee and in the quality of HCBS available in Tennessee. Following receipt of final CMS approval, the State began planning for implementation of each of these components. On August 23, 2021, the State submitted updated enrollment target ranges for ECF CHOICES for the remainder of the program year in anticipation of the additional enrollment planned. In addition, the State is working with CMS to secure any additional authority needed to implement the components of the HCBS spending plan described above (e.g., amending the demonstration to add Enabling Technology as a CHOICES benefit).

MCO Procurement. On June 11, 2021, TennCare issued a Request for Proposals (RFP) for three entities to furnish managed care services—including delivery and coordination of physical health services, behavioral health services, and long-term services and supports—to the TennCare population. The due date for proposals was September 1, 2021. On November 8, 2021, TennCare notified bidders that the highest scoring proposals had been submitted by Amerigroup, BlueCare, and UnitedHealthcare.

Phase 2 of Employment and Community First CHOICES. On July 1, 2021, the State implemented Phase 2 of the Employment and Community First CHOICES program. Most notably, Phase 2 of Employment and Community First CHOICES entails the implementation of the ECF CHOICES Working Disabled Group, a category of Demonstration Eligibility tailored to support working individuals. Implementation of Phase 2 of Employment and Community First CHOICES helps ensure that individuals with intellectual or developmental disabilities working to achieve their employment-related goals do not lose TennCare eligibility as an unintended consequence of increased earnings.

Issues or Complaints Identified by Beneficiaries

Eligibility Appeals. Table 2 presents a summary of eligibility appeal activity throughout DY 1. It should be noted that appeals (whether related to eligibility, medical services, or LTSS) may be resolved or taken to hearing in a quarter other than the one in which they are initially received by TennCare.

Table 2
Eligibility Appeals for Demonstration Year 1

	Jan – Mar 2021	Apr – Jun 2021	Jul – Sep 2021	Oct – Dec 2021
No. of appeals received	5,136	4,869	4,663	4,941
No. of appeals resolved or withdrawn	5,423	4,636	4,931	4,569
No. of appeals taken to hearing	1,579	1,271	1,257	843
No. of hearings resolved in favor of appellant	44	41	42	28

Medical Service Appeals. Table 3 below presents a summary of the medical service appeals handled throughout DY 1.

Table 3
Medical Service Appeals for Demonstration Year 1

	Jan – Mar 2021	Apr – Jun 2021	Jul – Sep 2021	Oct – Dec 2021
No. of appeals received	2,860	2,662	2,813	2,539
No. of appeals resolved	1,557	1,275	1,400	1,360
• Resolved at the MCC level	410	308	324	311
• Resolved at the TSU level	115	60	154	127
• Resolved at the LSU level	1,032	907	922	922
No. of appeals that did not involve a valid factual dispute	1,255	1,221	1,340	1,309
No. of directives issued	292	269	266	269
No. of appeals resolved by fair hearing	1,111	1,008	1,035	1,050
No. of appeals that were withdrawn by the enrollee at or prior to the hearing	324	282	299	334
Appeals that went to hearing and were decided in the State's favor	654	591	587	553
Appeals that went to hearing and were decided in the appellant's favor	54	34	36	35

By way of explanation:

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

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

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

LTSS Appeals. The following table provides information regarding certain appeals administered by TennCare's Long-Term Services and Supports Division during DY 1 (e.g., appeals of PreAdmission Evaluation denials, appeals of PreAdmission Screening and Resident Review determinations, etc.).

Table 4
Long-Term Services and Supports Appeals for Demonstration Year 1

	Jan – Mar 2021	Apr – Jun 2021	Jul – Sep 2021	Oct – Dec 2021
No. of appeals received	101	87	91	80
No. of appeals resolved or withdrawn	69	49	56	53
No. of appeals set for hearing	21	19	26	20
No. of hearings resolved in favor of appellant	0	0	0	0

Grievances. Table 5 presents information about grievances received and resolved by TennCare's managed care contractors (MCOs, DBM, and PBM) during the October-December 2021 quarter, as well as grievance totals for DY 1. It should be noted that grievances may be resolved in a quarter other than the one in which they are received.

Table 5
Most Common Grievance Categories for October – December 2021 and Totals for Demonstration Year 1

Grievance Category	Grievances Received Oct – Dec 2021	Grievances Resolved Oct – Dec 2021	Grievances Received DY 1	Grievances Resolved DY 1
Access and Availability	300	329		
Attitude and Service	242	207		
Billing and Financial Issues	132	144		
Quality of Care/Quality of Service	212	241		
Other	41	43		
Total	927	964	3,027	3,246

Each time an enrollee contacted the State or a managed care contractor to voice a complaint, the grievance was logged, and steps were taken to address the enrollee's concern. TennCare and the managed care contractors review issues, complaints, and grievances raised by enrollees to inform quality improvement efforts.

Audits, Investigations, or Lawsuits that Impact the Demonstration

During DY 1, the results of two audits of the Division of TennCare were released: a Performance Audit conducted by the Tennessee Comptroller of the Treasury for the period of July 1, 2019, through May 31, 2021, and an audit performed by the Office of Inspector General within the U.S. Department of Health and Human Services that covers State Fiscal Years 2009 – 2014. Details of these audits are as follows:

Performance Audit by the Tennessee Comptroller of the Treasury

In Tennessee, each agency of state government is authorized to operate for a set period of time, at the conclusion of which a Performance Audit (sometimes referred to as a "sunset audit") is conducted to determine whether the agency should be continued, restructured, or terminated. On September 14, 2021, the Tennessee Comptroller of the Treasury released a Performance Audit Report of selected programs and activities of the Division of TennCare. This sunset audit, which covers the period from July 1, 2019, through May 31, 2021, was designed to assist the Joint Government Operations Committee of the Tennessee General Assembly in determining whether the TennCare agency should continue in its current form past June 30, 2022, or whether it should be restructured or terminated. The audit ultimately identified no findings regarding TennCare's performance.

The summary report did include four observations regarding the TennCare program. These were:

1. Division management should continue their efforts to obtain reliable telehealth claims data to monitor and track the utilization of telehealth services.
2. Division management and the managed care organizations increased their Buprenorphine Enhanced Supportive Medication Assisted Recovery and Treatment (BESMART) provider network.[2]
3. Project Iris status, update.[3]
4. BlueCare's electronic visit verification system allowed personal care providers to override a system control, resulting in BlueCare paying unsupported claims.

In addition, the Performance Audit Report made note of three emerging issues:

1. Children who age out of the Katie Beckett program at their 18th birthday will lose services unless they qualify for services through adult programs.
2. While TennCare members' neonatal abstinence syndrome birth rates decreased in 2017, 2018, and 2019, division management expects an increase in neonatal abstinence syndrome births in 2020 due to the COVID-19 pandemic.
3. Once the public health emergency ends, Division of TennCare management will implement the established plan to renew members' eligibility.

All of the observations and emerging issues identified in the 2021 Performance Audit Report will inform TennCare's strategic planning. TennCare's 2021 Performance Audit Report is included as Attachment B to this report.

Federal Audit by the Office of Inspector General

On October 19, 2021, the Office of the Inspector General (OIG) in the U.S. Department of Health and Human Services released the results of an audit related to TennCare. The audit focused on certified public expenditures (CPEs) claimed by TennCare for uncompensated care provided by Tennessee hospitals and institutions during State fiscal years 2009 – 2014. OIG's summary report included the following five findings:

1. The State agency did not return federal overpayments of CPEs identified through reconciliation.
2. The State agency's calculated actual CPEs included unsupported costs for uninsured patients who received services from institutions for mental diseases (IMDs).
3. The State agency's calculated actual CPEs included IMD costs for TennCare enrollees aged 21 to 64.
4. The State agency's calculated actual CPEs included incorrectly calculated IMD inpatient routine costs.
5. The State agency did not have adequate internal controls in place.

As a result of these findings, OIG recommended that the State agency—

[2] BESMART is a program of buprenorphine-based medication assisted treatment (MAT) for individuals with opioid use disorder (OUD).

[3] Project Iris is an ongoing project to modernize the State's Medicaid Management Information System (MMIS).

1. Refund to the Federal Government $397,341,616 in overpayments representing the Federal share of CPEs that the State agency claimed in excess of the allowable amount;
2. Provide support for or refund to the Federal Government $370,119,499 for the net costs of caring for uninsured IMD patients for which the State agency did not provide detailed supporting documentation; and
3. Establish additional policies and procedures to ensure compliance with the STCs governing CPEs.

The State disagreed with virtually all of OIG's findings, noting that sufficient documentation to support CPEs claimed during the relevant years had been provided to OIG, and disputing OIG's interpretation of the relevant policies and authorities governing the claiming of CPEs.

The findings of OIG's audit were referred to CMS for consideration. The State is committed to communicating with CMS about the lack of validity of most of OIG's findings and recommendations, especially those suggesting that Tennessee did not comply with Federal requirements and that hundreds of millions of dollars should be refunded. OIG's Audit Report is included as Attachment C to this report.

During DY 1, the Division of TennCare was also involved in several lawsuits. Details of these suits are as follows:

A.M.C., et al. v. Smith Lawsuit. On March 19, 2020, the Tennessee Justice Center filed a federal lawsuit on behalf of a proposed class of plaintiffs against the Division of TennCare. The lawsuit alleges statutory and constitutional deficiencies with TennCare's eligibility redetermination process and the Tennessee Eligibility Determination System. Another allegation within the suit is that TennCare is violating the Americans with Disabilities Act by not providing reasonable accommodations, thereby preventing disabled individuals from participating in the TennCare program. Plaintiffs have two pending motions before the court: one for class certification and one for preliminary injunction, both of which TennCare opposed. The State filed a timely motion to dismiss the case, which is also pending with the Court. The parties are currently engaged in discovery.

Dowdy v. Smith Lawsuit. On March 12, 2021, TennCare member Shannon Dowdy filed suit in federal court against TennCare to obtain private duty nursing care on a 24-hours-a-day/7-days-a-week basis from his TennCare MCO. This level of services is not currently available to Mr. Dowdy under the TennCare program. The plaintiff had previously been receiving 24/7 nursing care through a combination of programs, with the majority of nursing hours furnished through a 1915(c) waiver program for individuals with intellectual disabilities, and the balance of hours provided by his MCO. Mr. Dowdy's complaint alleged that the services delivered through the 1915(c) waiver were insufficiently staffed, meaning that he was being denied necessary care. The plaintiff initially sought a preliminary injunction, but the parties reached an agreement for the provision of hours during the litigation that mooted the request for an injunction. The parties subsequently reached a resolution of the issues in the suit, and the case was dismissed on June 22, 2021.

Dyersburg Family Walk-In Clinic, Inc. v. Tennessee Department of Finance and Administration, et al. Lawsuit. On December 22, 2020, Dyersburg Family Walk-In Clinic, Inc., which does business under the registered assumed name Reelfoot Family Walk-In Clinic, filed a federal lawsuit against TennCare in the District Court for the Western District of Tennessee. Reelfoot operates three Rural Health Clinics that receive supplemental payments from TennCare. The lawsuit challenges TennCare requirements related to these supplemental payments and seeks injunctive and declaratory relief. In April 2021, TennCare successfully petitioned to have the case transferred to the District Court for the Middle District of Tennessee.

EMCF v. TennCare Lawsuit. In September 2018, Emergency Medical Care Facilities, P.C., filed a complaint for declaratory judgment and injunctive relief against the Division of TennCare in Davidson County Chancery Court. The suit relates to a $50 cap imposed by the agency on payment for emergency room physician services determined to be non-emergent. EMCF alleges that the State implemented this cap through its contractual relationship with its MCOs and not through the administrative rulemaking process. The parties filed cross-motions for summary judgment, and, on September 1, 2020, the Chancellor granted summary judgment to EMCF on their claim that the $50 cap was void. EMCF then voluntarily dismissed their remaining claims pertaining to the determination of payment for the services in question. The State filed an appeal, and, on October 7, 2021, the Court of Appeals ruled in the State's favor and reversed the trial court's ruling. The Court of Appeals found that the reimbursement limit fell within the internal management exception of a rule and was not subject to rulemaking requirements. EMCF has filed an application for permission to appeal to the Tennessee Supreme Court, and this application was still pending as of the end of DY 1.

Erlanger Health System v. TennCare Lawsuit. This declaratory order action was commenced against the State regarding the applicability and validity of two TennCare rules that set the reimbursement rates for emergency services provided to TennCare enrollees by non-contract hospitals. TennCare's Commissioner's Designee issued a declaratory order upholding the rules being challenged by Erlanger, and on November 12, 2021, Erlanger filed a Petition for Judicial Review of the declaratory order in Chancery Court.

M.A.C., et al. v. Smith Lawsuit. Five TennCare members filed a federal lawsuit against TennCare alleging that the Home and Community-Based Services they received through the State's 1915(c) waiver programs are not being fully staffed, resulting in a denial of necessary care and sufficient alternatives to institutionalization. On September 27, 2021, the Tennessee Attorney General's office acting on behalf of TennCare filed a timely motion to dismiss the suit.

McCutchen et al. v. Becerra Lawsuit. On May 20, 2021, the State of Tennessee filed a motion to intervene in the federal lawsuit challenging CMS' approval of the TennCare III Demonstration. This lawsuit was filed by the Tennessee Justice Center (TJC), acting on behalf of 14 individual plaintiffs, against CMS in the District Court for the District of Columbia. On August 5, 2021, the State's motion was granted. As of the end of the July-September 2021 quarter, the McCutchen

suit had been stayed pending the outcome of a federal comment period on the TennCare III Demonstration.

Unusual or Unanticipated Trends

Throughout DY 1, the State claimed the enhanced FMAP authorized under Section 6008 of the Families First Coronavirus Response Act (FFCRA). As a condition of receiving this federal funding, the State is generally maintaining eligibility for all persons currently enrolled in TennCare. TennCare enrollment has continued to increase steadily during the COVID-19 public health emergency while the FFCRA continuous coverage requirement remains in effect. During DY 1 alone, the number of individuals enrolled in TennCare increased by 5.2 percent from the first quarter of DY 1 to the last quarter.

Legislative Updates

The Tennessee General Assembly passed a number of pieces of legislation with implications for TennCare during DY 1. Among the more notable examples were the following:

- Authorization for implementation of the TennCare III Demonstration Waiver.
- Funding for maternal health enhancements, TennCare coverage for certain children adopted from State custody, and other service enhancements.
- One-year extensions of annual assessments on hospitals, nursing homes, and ground ambulance providers.
- Addition of chiropractic services to the list of healthcare services that may be covered by TennCare.
- Imposition of a four-year statute of limitations on TennCare estate recovery claims.
- Wage increases for workers in Tennessee's 1915(c) waivers for individuals with intellectual and developmental disabilities.
- Authorization for pharmacists to bill TennCare for administering COVID-19 vaccines to TennCare members.
- Permission for certain healthcare professionals licensed in other states to practice telehealth while providing healthcare services on a volunteer basis through a free clinic in Tennessee.

Details of the manner in which TennCare implements these pieces of legislation have been included in various Monitoring Reports (including this one) and will continue to be addressed in the future.

Public Forums

In compliance with the federal regulation at 42 CFR § 431.420(c) and STC 61 of the Demonstration, the State hosted its first public forum of the TennCare III Demonstration on July 6, 2021. The purpose of the forum was to provide members of the public an opportunity to comment on the progress of the TennCare Demonstration project, which has delivered Medicaid services to eligible Tennesseans under a managed care model since 1994.

The July 6 open meeting was not the only avenue through which feedback could be offered. Notice of the forum, which appeared on the TennCare website, included an email address and a physical address at which comments would be accepted. Ultimately, approximately 80 sets of comments were received, some of which were presented verbally at the July 6 meeting, and others of which were submitted by mail or email. Most of the comments expressed concern with either the potential impact of the TennCare III Demonstration on members' abilities to access health care, or the effect on vulnerable populations of integrating care for individuals with intellectual disabilities into managed care (the subject of proposed Demonstration Amendment 1). A more comprehensive summary of comments received is available in Attachment D to this Annual Monitoring Report.

Enrollment and Member Month Data

Information about TennCare enrollment by category throughout DY 1 is presented in Table 6.

Table 6
Enrollment Counts for Demonstration Year 1

Demonstration Populations	Jan – Mar 2021	Apr – Jun 2021	Jul – Sep 2021	Oct – Dec 2021
EG1 Disabled	134,288	134,350	135,471	135,128
EG9 H-Disabled	638	660	643	660
EG2 Over 65	296	190	222	251
EG10 H-Over 65	40	35	33	33
EG3 Children	814,080	825,106	834,726	843,369
EG4 Adults	451,565	467,207	482,179	496,980
EG5 Duals and EG11 H-Duals 65	156,660	159,629	160,924	161,263
EG6E Expan Adult	0	0	0	0
EG7E Expan Child	1,171	1,229	1,373	1,385
EG8, Med Exp Child	0	0	0	0
Med Exp Child, Title XXI Demonstration Population	9,670	10,190	11,198	11,468
EG12E Carryover	1,569	1,460	1,393	1,320
EG13 Katie Beckett	22	52	75	129
EG14E Medicaid Diversion	611	783	916	1,011
EG15 Continued Eligibility	N/A	2	4	1
TOTAL*	1,570,610	1,600,893	1,629,157	1,652,998

*** Unique member counts for reporting quarter, with at least one day of eligibility. To avoid duplication, the member counts are based on the last eligibility group (EG) of the quarter.**

The majority of TennCare's enrollment consists of Type 1 EG3 children and Type 1 EG4 adults, with 81 percent of TennCare enrollees appearing in one of these categories. The number of individuals enrolled in TennCare increased by 5.2 percent from the first quarter of DY 1 to the

last quarter. This rise in enrollment is largely attributable to the continuous coverage requirement contained in the Families First Coronavirus Response Act.

Table 7 below presents the member month reporting by eligibility group for each month in the final quarter of DY 1.

Table 7
Member Month Reporting for October – December 2021

Eligibility Group	October 2021	November 2021	December 2021	Sum for Quarter Ending 12/31/21
EG1 Disabled	136,199	135,226	134,383	405,808
EG2 Over 65	207	219	230	656
EG3 Children	835,004	837,837	840,863	2,513,704
EG4 Adults	484,827	489,913	494,853	1,469,593
EG5 Duals	151,274	151,500	151,693	454,467
EG6E Expan Adult	0	0	0	0
EG7E Expan Child	1,359	1,365	1,385	4,109
EG8 Med Exp Child	0	0	0	0
EG9 H-Disabled	628	640	652	1,920
EG10 H-Over 65	30	32	31	93
EG11 H-Duals	6,690	6,656	6,645	19,991
Med Exp Child, Title XXI Demo Pop	11,268	11,396	11,507	34,171
EG12E Carryover	1,336	1,313	1,283	3,932
EG13 Katie Beckett	97	123	130	350
EG14E Medicaid Diversion	957	994	1,017	2,968
EG15 Continued Eligibility	4	1	1	6
TOTAL	1,629,880	1,637,215	1,644,673	4,911,768

Information and Data about the CHOICES Program

CHOICES is TennCare's program of managed long-term services and supports for individuals who are elderly and/or have physical disabilities. Implemented in 2010, CHOICES offers nursing facility services (CHOICES 1) and home and community-based services (CHOICES 2 and 3) to eligible individuals via the State's managed care program.

As required by STC 33.d., the State offers the following table delineating CHOICES enrollment in each quarter of DY 1, as well as information about the number of available reserve slots. The operational procedures by which slots are reserved for members of CHOICES 2 are included as Attachment E to this Annual Monitoring Report.

Table 8
CHOICES Enrollment and Reserve Slots
for Demonstration Year 1

	Statewide Enrollment Targets and Reserve Capacity[4]	Enrollment and Reserve Slots Being Held as of the End of Each Quarter			
		Jan – Mar 2021	Apr – Jun 2021	Jul – Sep 2021	Oct – Dec 2021
CHOICES 1	Not applicable	14,002	14,236	14,325	14,392
CHOICES 2	11,000	10,168	10,172	10,003	9,856
CHOICES 3 (including Interim CHOICES 3)	To be determined	2,153	2,119	2,095	2,084
Total CHOICES	Not applicable	26,323	26,527	26,423	26,332
Reserve capacity	300	300	300	300	300

The CMS letter approving CHOICES implementation in Middle Tennessee dated February 26, 2010, and STC 53 require specific monitoring and reporting activities that include:

Data and trends of the designated CHOICES data elements: STC 53.d. requires the State to submit to CMS periodic statistical reports about the use of LTSS by TennCare enrollees. Eighteen separate reports of data pertaining to the CHOICES program have been submitted between August 2011 and June 2021.

Taken together, the reports depict a program evolving according to the characteristics of LTSS recipients, with institutional care available to individuals with the highest acuity of need, and Home and Community-Based Services (HCBS) available to individuals whose needs can be safely and effectively met at home or in other non-institutional settings. Point-in-time data revealed declining use of Nursing Facility (NF) services over time, with placement in institutional settings decreasing from 21,530 individuals on June 30, 2011, to 16,126 individuals on June 30, 2020. According to annual aggregate data contained in the reports, this downward trend was even more pronounced for new LTSS recipients, 81 percent of whom had been admitted to NFs in the year prior to implementation of the CHOICES program, as compared with 64 percent admitted to NFs in the tenth year of CHOICES. Furthermore, nursing facility expenditures in the year prior to CHOICES implementation accounted for more than 90 percent of total LTSS expenditures, whereas the percentage was approximately 79 percent ten years later.

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

By contrast, appropriate use of HCBS by TennCare enrollees grew significantly during these years. The aggregate number of members accessing HCBS increased from 6,226 in the twelve-month period preceding CHOICES implementation in Middle Tennessee to 15,159 after CHOICES had been in place for ten full fiscal years. This trend was mirrored in point-in-time data as well: on the day prior to CHOICES implementation, 4,861 individuals were using HCBS, but the number had grown to 12,206 by June 30, 2020. The percentage of LTSS expenditures devoted to HCBS grew as well, rising from 9.75 percent in the year prior to CHOICES, to 20.79 percent after the CHOICES program had been in place for ten years.

Selected elements of the aforementioned CHOICES data are summarized in Table 9.

Table 9
Changes in Use of HCBS by Persons Who Are Elderly or Disabled (E/D) Before and After CHOICES Implementation

Annual Aggregate Data			Point-in-Time Data		
No. of TennCare enrollees accessing HCBS (E/D), 3/1/09 – 2/28/10	No. of TennCare enrollees accessing HCBS (E/D), 7/1/19 – 6/30/20	Percent increase over a ten-year period	No. of TennCare enrollees accessing HCBS (E/D) on the day prior to CHOICES implementa-tion	No. of TennCare enrollees accessing HCBS (E/D) on 6/30/20	Percent increase from the day prior to CHOICES implementa-tion to 6/30/20
6,226	15,159	143%	4,861[5]	12,206	151%

Frequency and use of MCO-distributed transition allowances (CHOICES approval letter dated February 26, 2010): The allocation of CHOICES transition allowance funds by Grand Region during DY 1 is detailed in Table 10.

Table 10
CHOICES Transition Allowances for Demonstration Year 1

Grand Region	Jan – Mar 2021	Apr – Jun 2021	Jul – Sep 2021	Oct – Dec 2021
East	$9,259	$4,476	$5,207	$10,960
Middle	$10,228	$13,948	$10,758	$1,505
West	$3,677	$12,563	$6,500	$4,125
Statewide Total	$23,164	$30,987	$22,465	$16,590

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

Information and Data about the Employment and Community First CHOICES Program

Designed and implemented in partnership with people with intellectual and developmental disabilities, their families, advocates, providers, and other stakeholders, Employment and Community First CHOICES is the first managed LTSS program in the nation that is focused on promoting and supporting integrated, competitive employment and independent community living as the first and preferred option for people with intellectual and other types of developmental disabilities.

As required by STC 34.d., the State offers the following table delineating ECF CHOICES enrollment throughout DY 1, as well as information about enrollment targets and the number of available reserve slots. It should be noted that the number of filled reserve slots does not include slots in a "held" status that have been assigned to a person but for whom actual enrollment is pending an eligibility determination. The operational procedures by which slots are reserved for members of ECF CHOICES are included as Attachment F to this Annual Monitoring Report.

Table 11
ECF CHOICES Enrollment, Enrollment Targets, and Reserve Slots for Demonstration Year 1

	Statewide Enrollment Targets and Reserve Capacity[6]	Enrollment and Reserve Slots Filled as of the End of Each Quarter			
		Jan – Mar 2021	Apr – Jun 2021	Jul – Sep 2021	Oct – Dec 2021
ECF CHOICES 4	1,346.0	890	892	894	922
ECF CHOICES 5	2,930.0	1,555	1,580	1,591	1,642
ECF CHOICES 6	1,581.5	1,009	1,082	1,166	1,242
ECF CHOICES 7	35.0	30	30	30	23
ECF CHOICES 8	50.0	41	47	44	33
Total ECF CHOICES	5,942.5[7]	3,525	3,631	3,725	3,862

[6] Statewide enrollment targets and reserve capacity for DY 1 were adjusted to reflect new appropriation authority, effective July 1, 2021. A total of 300 reserve capacity slots were added to ECF CHOICES Groups 4, 5, 6, 7, and 8. The distribution of these slots reflects 20 additional slots in Group 4, 60 additional slots in Group 5, 200 additional slots in Group 6, and 10 slots each for Groups 7 and 8. Of the 20 slots allocated for Groups 7 and 8, a total of 5 were assigned to Group 7, and 1 was assigned to Group 8. Furthermore, because of the higher expected cost of benefits in Groups 7 and 8, it was possible to convert the remaining 14 slots from Groups 7 and 8 to a total of 21 slots for Group 6. In the fourth quarter, three DD Aging Caregiver reserve capacity slots were reallocated, with 2 moved from Group 4 to Group 6, and 1 moved from Group 5 to Group 6. Statewide enrollment targets and reserve capacity were adjusted to reflect CMS' conditional approval of ARP funding for additional ECF CHOICES slots effective September 22, 2021. A total of 2,000 reserve capacity slots were added to ECF CHOICES, with 400 additional slots in Group 4, 1,275 additional slots in Group 5, and 325 additional slots in Group 6.

[7] As provided in the revised enrollment target ranges submitted to CMS on August 23, 2021, while the combined total of all upper limits is 6,000, there would never be a scenario in which all benefit groups would be set at the

	Statewide Enrollment Targets and Reserve Capacity[6]	Enrollment and Reserve Slots Filled as of the End of Each Quarter			
		Jan – Mar 2021	Apr – Jun 2021	Jul – Sep 2021	Oct – Dec 2021
Reserve capacity	3,592.5	1,129	1,224	1,327	1,470
Waiver Transitions[8]	Not applicable	66	69	74	78

Data and trends of the designated ECF CHOICES data elements: STC 53.d. requires the State to provide CMS periodic statistical reports about the ECF CHOICES program. To date, the State has submitted baseline data for the year-long period preceding implementation of ECF CHOICES, as well as four years' worth of post-implementation data. In comparing the baseline data with the post-implementation data, several notable trends emerged:

- The number of individuals with intellectual disabilities receiving HCBS through the TennCare program grew from 8,295 in the year preceding implementation of ECF CHOICES to 8,588 after ECF CHOICES had been in place for four years.
- The number of individuals with developmental disabilities other than intellectual disabilities who received HCBS through the TennCare program grew from 0 to 1,718.
- Average LTSS expenditures for individuals with intellectual or developmental disabilities fell from $94,327 per person to $88,008 per person.
- The percentage of working age adults with intellectual or developmental disabilities who are enrolled in HCBS programs, employed in an integrated setting, and earning at or above the minimum wage grew from 14.32 percent to 22.54 percent.

As ECF CHOICES gains enrollment capacity, these trends toward individuals with intellectual and developmental disabilities living independently in the community are expected to accelerate.

Information and Data about the Katie Beckett and Medicaid Diversion Groups

The State's Katie Beckett and Medicaid Diversion groups provide services and supports for children under age 18 with disabilities and/or complex medical needs who are not eligible for traditional Medicaid because of their parents' income or assets. Although the State has long provided Katie Beckett program services to certain TennCare members via its three section 1915(c) HCBS waivers and the ECF CHOICES program, the availability of these services expanded

upper limit, since program funding would be insufficient to cover. These upper limits provide flexibility to move slots as required to meet the needs of program applicants.

[8] Waiver transitions are instances in which an individual enrolled in a 1915(c) HCBS waiver program is transferred into the ECF CHOICES program. Since these individuals have an independent funding source (i.e., the money that would have been spent on their care in the 1915(c) program), their enrollment in ECF CHOICES does not count against the enrollment target. Waiver transition numbers are cumulative since the program began. Group 6 enrollment includes some of these transitions that do not count against the enrollment target.

significantly with the implementation of the new Katie Beckett/Medicaid Diversion program on November 2, 2020.

The State offers services to eligible children through a traditional Katie Beckett program, in which members receive the full TennCare benefits package plus essential wraparound HCBS. In addition, the Demonstration includes an innovative Medicaid Diversion component, which furnishes a specified package of essential wraparound services and supports, including premium assistance. The Continued Eligibility element of the State's program ensures that children who would otherwise lose TennCare eligibility because slots in the Katie Beckett program are not available for them are able to remain eligible for the full TennCare benefits package.

As required by STC 35.c., the State offers the following table delineating Katie Beckett, Medicaid Diversion, and Continued Eligibility enrollment throughout DY 1, as well as information about enrollment targets and the number of available reserve slots. The operational procedures by which slots are reserved for members of the Katie Beckett and Medicaid Diversion groups are included as Attachment G to this Annual Monitoring Report.

Table 12
Katie Beckett, Medicaid Diversion, and Continued Eligibility Enrollment and Reserve Slots For Demonstration Year 1

	Statewide Enrollment Targets and Reserve Capacity	Enrollment and Reserve Slots Filled as of the End of Each Quarter			
		Jan – Mar 2021	Apr – Jun 2021	Jul – Sep 2021	Oct – Dec 2021
Katie Beckett	267[9]	21	49	69	128
Medicaid Diversion	2,700	576	770	923	978
Continued Eligibility	N/A	N/A	2	4	1
Reserve capacity	267	21	49	69	128

[9] At program implementation, 50 slots were available to children who met Tier 1 level of care eligibility (as defined in TennCare rules). The purpose of these Reserve Capacity slots was to ensure that children with the most significant medical needs and disabilities were enrolled into the Katie Beckett group (Part A) before the group was opened for enrollment to other children, subject to available funding. During the April-June 2021 quarter, an additional 50 slots were added for children who met Tier 2 level of care eligibility requirements (as described in TennCare rules). In the July-September 2021 quarter, an additional 147 slots for children who met Tier 2 requirements were added. During the October-December 2021 quarter, based on the total funding appropriated for the Katie Beckett group and projected utilization per child, an additional 13 slots were added for children who met Tier 2 requirements. All available slots for the Katie Beckett group are Reserve Capacity slots.

Data and trends of the designated Katie Beckett/Medicaid Diversion data elements: STC 53.d. requires the State to provide CMS periodic statistical reports about the Katie Beckett and Medicaid Diversion groups. The State anticipates submitting baseline data for these groups one year after full program implementation, with trend data to follow on an annual basis thereafter.

Steps Taken to Ensure Compliance with Regulations Governing HCBS Settings

The State's Transition Plan—delineating the State's process for assuring compliance with the HCBS settings rule—has been fully implemented. The State submitted its final Statewide Transition Plan Quarterly Status Report to CMS on April 11, 2019, affirming that all identified settings had achieved full compliance by March 17, 2019. The State continues to monitor ongoing compliance with the HCBS Settings Rule, as described in each Annual Report.

Beginning in March 2020, certain aspects of compliance with the HCBS Settings Rule have been affected by stay-at-home orders and social distancing expectations resulting from the COVID-19 public health emergency. On April 30, 2020, an amendment to the State's 1115 demonstration was submitted to CMS. One component of the amendment was a request to temporarily provide services in alternative settings, including settings that do not comply with the HCBS settings requirement at 42 CFR § 441.301(c)(4)(vi)(D) that individuals are able to have visitors of their choosing at any time. The purpose of the request was to minimize the spread of infection during the COVID-19 pandemic. This amendment was approved and incorporated into the STCs as Attachment K to the TennCare Demonstration on June 19, 2020. A request to extend the approved Attachment K was subsequently submitted as the public health emergency continued. The extension of Attachment K was approved by CMS for six months after the public emergency ends.

A more comprehensive description of the steps taken to ensure compliance with the regulations governing HCBS settings is included as Attachment H to this Annual Monitoring Report.

Health and Welfare of HCBS Recipients

The State's system for assuring the health and welfare of TennCare members receiving HCBS is outlined in Attachment I to this Annual Monitoring Report.

II. Performance Metrics

Progress Toward Goals and Targets in the Monitoring Protocol

STC 55 requires the State to submit to CMS a draft Monitoring Protocol no later than 150 days after the January 8 start date of the TennCare III approval period. The purpose of the Monitoring Protocol is to define the quantitative and qualitative elements the State will use in its Quarterly and Annual Monitoring Reports to chart progress toward fulfillment of the goals and targets of the TennCare III Demonstration. On June 7, 2021, the State submitted its draft Monitoring Protocol to CMS. As of the end of DY 1, CMS was reviewing the document.

Impact of the Demonstration in Providing Insurance Coverage

As noted in Section I of this report, the TennCare III Demonstration was furnishing health care coverage to 1,652,998 Tennesseans as of the end of DY 1. This total represents approximately 24 percent of the 6.9 million persons living in Tennessee.

Impact of the Demonstration in Ensuring Access to Care

Ensuring Access Through Contractual Means

TennCare's managed care contractors (MCCs) are contractually required to furnish available, accessible, and adequate numbers of contracted providers for the delivery of TennCare-covered services (including medical, behavioral, long-term services and supports, dental, and pharmacy). The State uses specialized software to monitor enrollee access to care and to ensure that access requirements contained in the MCCs' contracts are fulfilled. If a deficiency in an MCC's provider network were to be identified, the MCC would be notified and a Corrective Action Plan would be required to address the deficiency. Financial penalties would then be assessed by the State if the Corrective Action Plan were determined to be inadequate.

Measuring Access Through Provider Data Validation

In October 2021, TennCare's External Quality Review Organization (EQRO), Qsource, published the results of its provider data validation survey for the July-September 2021 quarter. The EQRO took a sample of provider data files from TennCare's MCCs[10] and reviewed each for accuracy in the following categories:

- Active contract status
- Provider address
- Provider specialty / behavioral health service code
- Provider panel status
- Services for children
- Services for adults (MCO only)
- Primary care services (MCO only)
- Prenatal care services (MCO only)
- Availability of routine care services
- Availability of urgent care services

The validity of such information is one measure of providers' availability and accessibility to TennCare enrollees. The EQRO's report demonstrated generally strong performance by the MCCs, especially in the categories of "active contract status" (93.7 percent accuracy), "provider specialty / behavioral health service code" (94.0 percent accuracy), "services for children" (95.2 percent accuracy), "primary care services" (95.9 percent accuracy), and "prenatal care services" (94.3 percent accuracy).

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

Progress in accuracy rates is currently being measured on a quarter-to-quarter basis. Qsource's report concluded that the MCCs "achieved high accuracy rates" for the third quarter of Calendar Year 2021.

Impact of the Demonstration in Improving Health Outcomes and Ensuring Quality of Care

HEDIS/CAHPS Report

The annual report of HEDIS/CAHPS data—titled "Comparative Analysis of Audited Results from TennCare MCOs for Measurement Year (MY) 2020"—was released in November 2021. The full name for HEDIS is "Healthcare Effectiveness Data Information Set," and the full name for CAHPS is "Consumer Assessment of Health Plans Surveys." This report, which is presented in Attachment K and posted on the TennCare website, provides data that enables the State to compare the performance of its MCOs against national norms and benchmarks and to compare performance among MCOs.

Improved statewide performance was noted for certain child health measures this year, with higher success rates achieved in all of the following categories:

- Immunizations for Adolescents – HPV
- Immunizations for Adolescents – Combination 2
- Appropriate Testing for Pharyngitis (3-17 years)
- Asthma Medical Ratio (both 5-11 years and 12-18 years)
- Appropriate Treatment for Upper Respiratory Infection (3 months-17 years)
- Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (3 months-17 years)
- Postpartum Care

Improvement was also evident in a variety of health categories applicable to adults, including Pharmacotherapy Management of COPD Exacerbation (both "Systemic Corticosteroid" and "Bronchodilator"); Asthma Medical Ratio ("19-50 years"); Persistence of Beta-Blocker Treatment After a Heart Attack; Statin Therapy for Patients with Cardiovascular Disease; Statin Therapy for Patients with Diabetes; Appropriate Treatment for Upper Respiratory Infection (18-64 years); Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (18-64 years); Use of Opioids at High Dosage; and Use of Opioids from Multiple Providers.

Categories related to women's health showed higher outcomes as well, with improved results in the areas of Statin Therapy for Patients with Cardiovascular Disease ("Females 40-75 Years") and Non-Recommended Cervical Cancer Screening in Adolescent Females.

HEDIS MY 2020 was the twelfth year of statewide reporting of behavioral health measures following the integration of medical and behavioral health services among TennCare's health plans. Results superior to those in the preceding measurement period were achieved in the behavioral health categories of Antidepressant Medication Management (both "Effective Acute Phase Treatment" and "Effective Continuation Phase Treatment"); Follow-Up Care for Children Prescribed ADHD Medication (both "Initiation Phase" and "Continuation and Maintenance

Phase"); Follow-Up After Hospitalization for Mental Illness (both "7-Day Follow-Up: 18-64 Years" and "30-Day Follow-Up: 18-64 Years"); Follow-Up After High-Intensity Care for Substance Use Disorder; Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence (five out of six sub-categories); and Adherence to Antipsychotic Medications for Individuals with Schizophrenia.

With regard to the CAHPS portion of the MY 2020 report, the performance of the MCOs was generally strong, and was comparable to the results achieved in the preceding measurement period. CAHPS data in the report was organized into three major areas: Adult Medicaid Survey Results, Child Medicaid Survey Results (General Population), and Child Medicaid Survey Results (Children with Chronic Conditions). Each of these three major categories contained several subcategories (e.g., "Getting Needed Care," "Getting Care Quickly," "How Well Doctors Communicate," etc.) in which the health plans were rated in terms of the national percentile achieved. The MY 2020 ratings of the MCOs generally fell into the top two national percentiles: "greater than 75th percentile" and "25th to 75th percentile".

Innovative Measures to Improve Health and Ensure Quality

Data documenting the effect of the TennCare Demonstration in improving health outcomes and ensuring quality of care will be included in future Quarterly and Annual Monitoring Reports based on the availability of data and in accordance with the Shared Savings Metric Set. In addition, the State has a variety of innovative programs designed to improve the health of TennCare members. Information about three of those programs—Patient Centered Medical Home, Health Starts Provider Partnerships, and BESMART—appears below.

Patient-Centered Medical Home Program. The Patient-Centered Medical Home (PCMH) program is a comprehensive care delivery model designed to improve the quality of primary care services for TennCare members, the capabilities and practice standards of primary care providers, and the overall value of health care delivered to the TennCare population.

Members attributed to a PCMH receive team-based care, care coordination services leading to improved quality and health outcomes, greater emphasis on primary and preventative care, and improved care coordination with behavioral health providers. Participating providers receive ongoing financial support to assist with practice transformation, technical assistance, opportunities to attend webinars and conferences throughout the year, quarterly reports with actionable data, and access to a web-based application (known as the Care Coordination Tool) that allows providers to identify and track closure of gaps in care linked to specific quality measures. To ensure that the principles of the PCMH model are actually incorporated into health care furnished to TennCare members, participating providers are required to maintain or achieve National Committee for Quality Assurance (NCQA) PCMH recognition for all of their practice sites.

The PCMH program began with the first group of participating provider organizations on January 1, 2017. As of December 2021, approximately 730,000 TennCare members are attributed to one of 79 PCMH-participating organizations, and 95.5 percent of these organizations' 454 sites are currently NCQA-PCMH-recognized. In addition, providers have recently been engaged with

coaching and numerous trainings. In October 2021, more than 50 PCMH providers participated in a delivery systems transformation conference to hear from subject matter experts on a diverse range of topics.

Health Starts. The State's Health Starts Provider Partnerships program launched on April 1, 2021. The goal of these partnerships is to improve quality of care for TennCare members by addressing social risk factors in the TennCare population. The partnership program currently involves 14 provider groups across Tennessee, including patient-centered medical homes, long-term services and supports providers, hospitals, and behavioral health providers. The State is working with each provider partner to screen members for social risk factors, refer them to community resources based on identified needs, and close the loop on referrals to verify that member needs are met. Thus far, the partnership program has impacted over 2,500 unique members and identified needs across various domains, including transportation, housing, utility assistance, and child care. While this effort remains in the early stages, the State has begun gathering data to inform future quality improvement initiatives related to addressing Tennesseans' social risk factors.

BESMART Program. The buprenorphine-enhanced supportive medication-assisted recovery and treatment (or "BESMART") program is a core component of the State's strategy to address the opioid epidemic in Tennessee. The BESMART program is a network of high-quality buprenorphine clinicians who provide a coordinated set of services to help TennCare members in their recovery journeys. Buprenorphine therapy is an evidence-based, FDA-approved treatment for opioid use disorder that combines medication and behavioral health supports. The BESMART program includes services such as a psychosocial assessment and development of a treatment plan, individual and group counseling, peer recovery services, care coordination, and opioid-agonist therapy.

The BESMART Program officially launched on January 1, 2019, and has continued to grow and serve more Tennesseans. As of March 2019, there were approximately 100 high-quality BESMART providers contracted with TennCare managed care organizations to treat 2,000 members. By December 2021, the number of BESMART providers had increased to 356, and the number of unique members served per month had grown to approximately 18,000. Additionally, buprenorphine covered by TennCare remains in the top five controlled substances by claims, meaning that TennCare pays for more buprenorphine to treat opioid use disorder than for short-acting opioids to treat pain.

The focus that TennCare has placed on combatting the opioid epidemic through treatment and other major prevention efforts has also shown tremendous success in reducing the number of newborns with neonatal abstinence syndrome (NAS), or signs and symptoms of opioid withdrawal as an infant due to opioid exposure during the pregnancy. In 2019, the NAS rate in the TennCare population was 20 NAS births per 1,000 live births, as compared with the 2016 rate, which was 28 NAS births per 1,000 live births. A decline in the NAS rate has been achieved for three consecutive years.

Beneficiary Survey

Every year since 1993, the Boyd Center for Business and Economic Research (BCBER) at the University of Tennessee in Knoxville has conducted a survey of Tennessee citizens—TennCare enrollees, individuals with private insurance, and uninsured individuals alike—to assess their opinions about health care. Respondents provide feedback on a range of topics, including demographics (age, household income, family size, etc.), perceptions of quality of care received, and behavior relevant to health care (the type of provider from whom an individual is most likely to seek initial care, the frequency with which care is sought, etc.).

On November 17, 2021, BCBER published a summary of the results of the most recent survey titled "The Impact of TennCare: A Survey of Recipients, 2021". Although the findings of a single survey must be viewed in context of long-term trends, several results from the report are noteworthy:

- Satisfaction with TennCare remained high. Ninety-two percent of respondents covered by TennCare expressed satisfaction with the quality of care they had received. This level of satisfaction tied for the fourth highest in the program's history, and 2021 was the thirteenth straight year in which survey respondents had reported satisfaction levels exceeding 90 percent.
- The uninsured rate in Tennessee remained the same for adults and declined slightly for children. The reported percentage of uninsured adults in 2021 was 9.9 percent, which was identical to the result from 2020. Furthermore, the reported percentage of uninsured children fell from 2.8 percent in 2020 to 2.5 percent in 2021. The overall uninsured rate reported in 2021 was 8.3 percent, which was identical to the 2020 reported uninsured rate.
- TennCare members were slightly more likely to use the emergency room for initial medical care. While heads of households with TennCare continued to seek initial medical care for themselves at hospitals six percent of the time, the likelihood of seeking such care for their children in hospitals rose from three percent in 2020 to four percent in 2021.

In summary, the report notes, "TennCare continues to receive positive feedback from its recipients, with 92 percent reporting satisfaction with the program. This positive feedback is a strong indication that TennCare is providing satisfactory medical care and meeting the expectations of those it serves." BCBER's summary report of the 2021 survey is included as Attachment J to this Annual Monitoring Report.

Quality Improvement Strategy

As required by federal law and the State's demonstration agreement with CMS, the Division of TennCare has developed a strategy for evaluating and improving the quality and accessibility of care offered to enrollees through the managed care network. TennCare submitted its annual update of the strategy—titled *2021 Update to the Quality Assessment and Performance Improvement Strategy*—to CMS on May 5, 2021.

In addition to laying out the measures of quality assurance already in place, the report outlines TennCare's goals and objectives relative to quality and access for the year to follow. Furthermore, a variety of best practices (such as the Population Health program; enhanced use of telehealth services in the context of the pandemic; and the successes of Tennessee Health Link, which is a care coordination service based on the Health Home model) and challenges (like lack of member engagement in various programs; coordination of benefits for members who are dually eligible for Medicare and Medicaid; and a workforce shortage in the arena of long-term services and supports) are detailed in the concluding section of the report, as is the positive potential of the Maternal Opioid Misuse (MOM) Model grant awarded to Tennessee by CMS. The 2021 update to TennCare's strategy is included as Attachment L of this report.

Progress on Shared Savings Metric Set

On March 8, 2021, the State submitted measures for the Shared Savings Metric Set to CMS. The State will report on its progress on these metrics in future Monitoring Reports, as the measures become available each year.

III. Budget Neutrality and Financial Reporting Requirements

Budget neutrality was successfully maintained by the State throughout DY 1. The State's budget neutrality workbook for the October-December 2021 quarter will be submitted to CMS under separate cover.

IV. Evaluation Activities and Interim Findings

STC 90 requires the State to submit to CMS a draft Evaluation Design for the approval period of the TennCare III Demonstration (January 8, 2021 – December 31, 2030). This draft Evaluation Design was submitted to CMS on July 7, 2021. As of the conclusion of DY 1, CMS was continuing to review the document.

The State's proposed Evaluation Design was developed in accordance with the STCs and relevant CMS guidance on evaluation of 1115 demonstration projects. The State's proposed Evaluation Design identifies five primary goals to be achieved by the TennCare III Demonstration:

1. Provide high-quality care to enrollees that will improve health outcomes.
2. Ensure enrollee access to health care, including safety net providers.
3. Ensure enrollees' satisfaction with services.
4. Provide enrollees with appropriate and cost-effective HCBS within acceptable budgetary parameters.
5. Manage expenditures at a stable and predictable level, and at a cost that does not exceed what would have been spent in a Medicaid fee-for-service program.

For each of these goals, the Evaluation Design outlines a set of corresponding hypotheses, research questions, and data sources to guide the State's evaluation of whether the goals of TennCare III are being achieved.

Once CMS has completed its review of the Evaluation Design, the State will finalize the document, and begin testing its hypotheses and answering its research questions. Summaries of these evaluation activities will be included in future Quarterly and Annual Monitoring Reports.

V. Supplemental Report

At CMS' request, the State has prepared a summary of events and data from the six-month period from July 1 through December 31, 2020. That summary is included as Attachment M of this report.

VI. State Contact

Aaron Butler
Director of Policy
Division of TennCare
310 Great Circle Road
Nashville, TN 37243
Phone: 615-507-6448
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Date Submitted to CMS: April 7, 2022

Attachment A:
Special Terms and Conditions Report

STC Activity Report – Demonstration Year 1

The State maintained compliance with all Special Terms and Conditions during Demonstration Year 1. Specific actions and deliverables are detailed below.

STCs #6 and #7: The State drafted two demonstration amendments during DY 1, one of which was submitted to CMS by the end of the reporting period. The State also made preparations to add allowable benefits not requiring submission of a demonstration amendment. Details of these proposed program changes are as follows:

- Amendment 1 would integrate services for members with intellectual disabilities into the TennCare managed care program; transition the care of children receiving Supplemental Security Income (SSI) benefits from the TennCare Select health plan to one of the other health plans that serves TennCare members; and assign to the TennCare Select health plan certain inmates of public institutions who receive inpatient services in a setting located outside the public institution. The State submitted Amendment 1 to CMS on March 31, 2021, and CMS was still reviewing the amendment as DY 1 concluded.
- Amendment 2 would extend TennCare coverage to children adopted from state custody who do not receive federal or state adoption assistance. The State posted a draft of Amendment 2 on its website on December 7, 2021, and, as of the end of DY 1, was accepting public feedback on the proposal.
- The State made preparations to introduce a set of maternal health enhancements into the TennCare program, effective April 1, 2022. These enhancements consist of an extension of full coverage for postpartum women from the current duration (60 days) to a full 12 months, and also a dental benefits package for pregnant and postpartum women age 21 and older. As provided in STC 6, these allowable benefits do not require submission of a demonstration amendment, but the State did initiate a public notice and comment period on December 17, 2021.

STC #12: Public notice concerning demonstration amendments was provided to Tennessee newspapers and posted on TennCare's website as follows:

- Amendment 1 – February 22, 2021
- Amendment 2 – December 7, 2021

STC #32.f: On March 8, 2021, the State submitted its Shared Savings Quality Measures Protocol to CMS.

STC #32.m: On June 30, 2021, the State submitted a Designated State Investment Programs (DSIP) claiming protocol to CMS.

STC #33.d.ii: On April 30, 2021, the State submitted to CMS an enrollment target range for CHOICES Group 2 for the program year beginning July 1, 2021. The range was 10,180 – 11,500.

STC #33.d.iv.(A): Each Quarterly Monitoring Report submitted during DY 1 provided data on enrollment in all three CHOICES groups, enrollment targets for CHOICES 2 and 3, and the number

of reserve capacity slots being held for CHOICES Group 2. The operational procedures for determining individuals for whom CHOICES Group 2 reserve capacity slots are to be held are included as Attachment E to this Annual Monitoring Report. The State originally submitted these procedures to CMS on February 2, 2010, and has subsequently included the procedures as an attachment to each Annual Report.

STC #34.d.ii: On April 30, 2021, the State submitted to CMS enrollment target ranges for all five ECF CHOICES benefit groups for the program year beginning July 1, 2021, as follows:

- Essential Family Supports (ECF CHOICES Group 4): 890 – 948
- Essential Supports for Employment and Independent Living (ECF CHOICES Group 5): 1,555 – 1,758
- Comprehensive Supports for Employment and Community Living (ECF CHOICES Group 6): 943 – 1,194
- Intensive Behavioral Family Supports (ECF CHOICES Group 7): 30 – 50
- Comprehensive Behavioral Supports for Employment and Community Living (ECF CHOICES Group 8): 41 – 50

On August 23, 2021, the State submitted to CMS updated enrollment target ranges for all five ECF CHOICES benefit groups, reflecting additional enrollment anticipated as a result of the State's plan to expand HCBS. The revised enrollment target ranges were as follows:

- Essential Family Supports (ECF CHOICES Group 4): 897 – 1,348
- Essential Supports for Employment and Independent Living (ECF CHOICES Group 5): 1,580 – 3,033
- Comprehensive Supports for Employment and Community Living (ECF CHOICES Group 6): 1,110 – 1,519
- Intensive Behavioral Family Supports (ECF CHOICES Group 7): 33 – 50
- Comprehensive Behavioral Supports for Employment and Community Living (ECF CHOICES Group 8): 45 – 50

STC #34.d.iv.(A): Each Quarterly Monitoring Report submitted during DY 1 provided enrollment totals, enrollment targets, and the number of reserve capacity slots being held for all five ECF CHOICES groups. The operational procedures for determining individuals for whom ECF CHOICES reserve capacity slots are to be held are included as Attachment F. The State originally submitted these procedures to CMS on October 28, 2016, and has subsequently included the procedures as an attachment to each Annual Report.

STC #43: The State requested approval by CMS of Statewide MCO Contract Amendment 14 and TennCare Select Contract Amendment 50 on June 29, 2021.

STC #50: Each Quarterly Monitoring Report has summarized actions taken by the State to comply with the HCBS Settings Rule. A comprehensive description of the steps taken to ensure compliance with the regulations governing HCBS settings is included as Attachment G to this Annual Monitoring Report.

STCs #51 and #52: The State submitted the document entitled *2021 Update to the Quality Assessment and Performance Improvement Strategy* to CMS on May 5, 2021.

STC #53.d: The State addressed data and trends of the designated CHOICES and ECF CHOICES data elements in each of the Quarterly Monitoring Reports and in this Annual Monitoring Report. Electronic copies of the CHOICES and ECF CHOICES point-in-time data and annual aggregate data were submitted to CMS on June 30, 2021. (The first submission of data for the Katie Beckett and Medicaid Diversion data elements is expected to occur in DY 2 and will be addressed in the corresponding Quarterly and Annual Monitoring Reports.)

STC #54: The State submitted to CMS a draft Implementation Plan for the TennCare III Demonstration on April 8, 2021. Following receipt of CMS feedback on the document on June 17, 2021, the State submitted a revised Implementation Plan on August 16, 2021.

STC #55: On June 7, 2021, the State submitted to CMS a draft Monitoring Protocol for the TennCare III Demonstration.

STC #56: The State submitted Quarterly Monitoring Reports to CMS on May 28, 2021; August 31, 2021; and December 6, 2021. (The State also submitted the concluding Quarterly Progress Report for the TennCare II Demonstration—covering the October-December 2020 quarter—to CMS on March 1, 2021.)

STC #60: The State participated in monthly monitoring calls with CMS on January 28, 2021; March 25, 2021; April 22, 2021; June 24, 2021; and August 26, 2021. All other monitoring calls were cancelled by joint agreement of CMS and the State.

STC #61: On June 4, 2021, the State notified the public of its intent to host a public forum in which comments on the progress of the TennCare Demonstration would be accepted. The State held the forum on July 6, 2021, and included a summary of comments received at the forum in the Quarterly Monitoring Report submitted to CMS on December 6, 2021.

STC #63.e: Member months were reported to CMS by Eligibility Group in each Quarterly Monitoring Report and in this Annual Monitoring Report.

STC #73: Quarterly budget neutrality status updates for the January – March 2021 and April – June 2021 quarters were submitted to CMS on October 7, 2021. The quarterly budget neutrality status update for the July – September 2021 quarter was submitted to CMS on December 1, 2021. The quarterly budget neutrality status update for the October – December 2021 quarter is being submitted to CMS concurrently with this Annual Monitoring Report.

STC #90: On July 7, 2021, the State submitted to CMS a draft Evaluation Design for the TennCare III Demonstration.

Attachment B:
Performance Audit Report of Division of TennCare by Tennessee Comptroller of the Treasury

TENNESSEE COMPTROLLER OF THE TREASURY

PERFORMANCE AUDIT REPORT

Division of TennCare

September 2021

Jason E. Mumpower
Comptroller of the Treasury

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to make government work better.

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TENNESSEE COMPTROLLER OF THE TREASURY

JASON E. MUMPOWER
Comptroller

September 14, 2021

The Honorable Randy McNally
Speaker of the Senate
The Honorable Cameron Sexton
Speaker of the House of Representatives
The Honorable Kerry Roberts, Chair
Senate Committee on Government Operations
The Honorable John D. Ragan, Chair
House Committee on Government Operations
and
Members of the General Assembly
State Capitol
Nashville, Tennessee 37243
and
Mr. Stephen M. Smith, Deputy Commissioner
Division of TennCare
310 Great Circle Road
Nashville, Tennessee 37243

Ladies and Gentlemen:

We have conducted a performance audit of selected programs and activities of the Division of TennCare for the period July 1, 2019, through May 31, 2021. This audit was conducted pursuant to the requirements of the Tennessee Governmental Entity Review Law, Section 4-29-111, *Tennessee Code Annotated*.

Although our audit did not disclose any findings, we disclosed in the Audit Conclusions section of this report certain observations and emerging issues that impact the division's mission.

This report is intended to aid the Joint Government Operations Committee in its review to determine whether the division should be continued, restructured, or terminated.

Sincerely,

Katherine J. Stickel

Katherine J. Stickel, CPA, CGFM, Director
Division of State Audit

KJS/jw
21/043

Division of State Audit

Division of TennCare

Performance Audit
September 2021

Our mission is to make government work better.

AUDIT HIGHLIGHTS

Division of TennCare's Mission
Improving lives through high-quality, cost-effective care.

Audit Scope:
July 1, 2019, through May 31, 2021

Scheduled Termination Date:
June 30, 2022

KEY CONCLUSIONS

FINDINGS

There are no current findings. The current audit disclosed that management deferred actions relating to the following prior audit findings due to the COVID-19 pandemic; therefore, we are deferring our follow-up work until the next performance audit.

2018 Performance Audit Report

- TennCare could not provide sufficient documentation to support actual cost savings, did not set clear vendor contract expectations, and did not fully document and implement a formal monitoring plan, which calls into question whether the episodes of care strategy is positively changing the way healthcare is provided in Tennessee.

Due to the pandemic, management waived risk-sharing payments for providers, which could have negatively impacted TennCare providers' revenues.

2020 Special Project – Division of TennCare's Redetermination Process and the Impact on Children's Enrollment

- The Division of TennCare denied two child members for CoverKids for having other insurance, even though the members' applications indicated they did not have other insurance.
- The Division of TennCare did not take final administrative action on 1 eligibility appeal within 90 days; as a result, 1 child member inappropriately lost TennCare coverage for over a year.

According to the requirements in the federal Families First Coronavirus Response Act, division management could not terminate members who were enrolled as of March 18, 2020 (the beginning of the public health emergency) until the federal government ends the public health emergency.[1]

The following observations and emerging issues are included in this report because of their effect on the operations of the Division of TennCare and the citizens of Tennessee.

OBSERVATIONS

Implementation of Telehealth Services During the Pandemic

- Division management should continue their efforts to obtain reliable telehealth claims data to monitor and track the utilization of telehealth services (see page 12).

Opioid Epidemic Improvement and Potential Pandemic-Related Opioid Setbacks

- Division management and the managed care organizations increased their Buprenorphine Enhanced Supportive Medication Assisted Recovery and Treatment (BESMART) provider network (see page 18).

TennCare System Modernization: Timeline and Budget

- Project Iris status update (see page 26).

Preventing Improper Payments for Personal Care Visits

- BlueCare's electronic visit verification system allowed personal care providers to override a system control, resulting in BlueCare paying unsupported claims (see page 32).

EMERGING ISSUES

Potential Impacts After Katie Beckett

- Children who age out of the Katie Beckett program at their 18th birthday will lose services unless they qualify for services through adult programs (see page 9).

Opioid Epidemic Improvement and Potential Pandemic-Related Opioid Setbacks

- While TennCare members' neonatal abstinence syndrome birth rates decreased in 2017, 2018, and 2019, division management expects an increase in neonatal abstinence syndrome births in 2020 due to the COVID-19 pandemic (see page 17).

Management's Preparation For Statewide Member Eligibility Renewals

- Once the public health emergency ends, Division of TennCare management will implement the established plan to renew members' eligibility (see page 21).

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[1] For information about the federal public health emergency, see page 19.

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INTRODUCTION

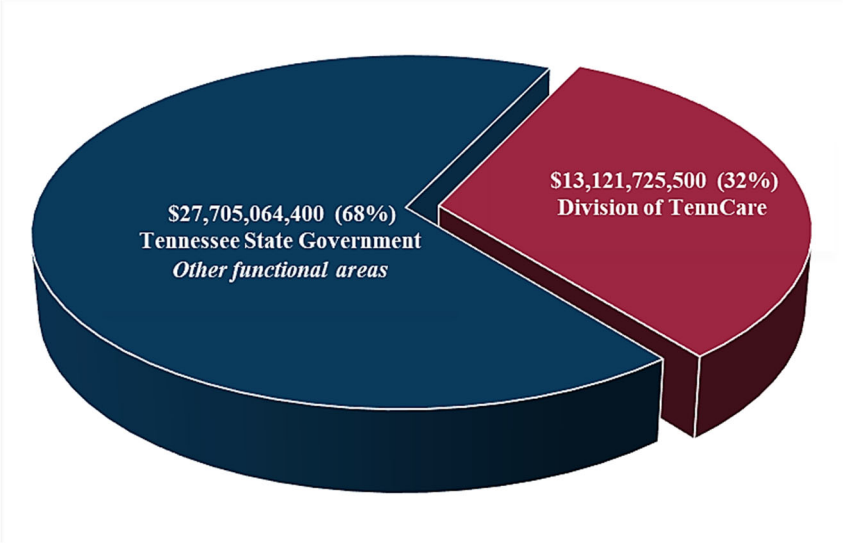
AUDIT AUTHORITY

This performance audit of the Division of TennCare was conducted pursuant to the Tennessee Governmental Entity Review Law, Title 4, Chapter 29, *Tennessee Code Annotated*. Under Section 4-29-243, the division is scheduled to terminate June 30, 2022. The Comptroller of the Treasury is authorized under Section 4-29-111 to conduct a limited program review audit of the agency and to report to the Joint Government Operations Committee of the General Assembly. This audit is intended to aid the committee in determining whether the division should be continued, restructured, or terminated.

BACKGROUND

Originally housed under the Tennessee Department of Health, effective October 19, 1999, Govenor Sundquist transferred the Division of TennCare to the Tennessee Department of Finance and Administration (F&A). Although the Division of TennCare is part of F&A's organization, the division operates as a separate entity. The Division of TennCare has an annual budget of approximately $13.1 billion, which, in fiscal year 2021, was 32% of the state's budget (see **Figure 1**). The division's primary responsibility is to operate the TennCare program, the state's Medicaid program, which provides health coverage to approximately 1.5 million Tennesseans.

Figure 1
Tennessee State Budget
Fiscal Year 2021



Source: Tennessee State Budget for fiscal year 2020–2021.

Authorized by Title XIX of the Social Security Act, President Lyndon Johnson signed Medicaid into law in 1965. All states, the District of Columbia, and U.S. territories have federally

regulated Medicaid programs, and each state administers the program differently according to their needs. The TennCare program is a Medicaid waiver, sometimes known as a demonstration project. According to Section 1115 and Section 2107 of the Social Security Act, the Secretary of Health and Human Services can approve experimental, pilot, or demonstration projects that promote the objectives of the Medicaid program. Under this authority, the Secretary may waive certain provisions of the Medicaid law to give states additional flexibility to design and improve their programs. TennCare's previous waiver, TennCare II, was set to expire on June 30, 2021. In accordance with state law, in 2019 TennCare management submitted an amendment to the TennCare II waiver to provide Medicaid services in Tennessee by means of a block grant. In January 2021, the Centers for Medicare and Medicaid Services (CMS) elected to approve TennCare's proposal as a new Section 1115 waiver, called TennCare III, rather than extend the TennCare II waiver. CMS approved TennCare III on January 8, 2021, and the Tennessee General Assembly voted to authorize the waiver the following week.

Led by the Deputy Commissioner,[2] the Division of TennCare is composed of different operational units to meet the mission of "improving lives through high-quality, cost-effective care" and to fulfill the vision of a healthier Tennessee. See **Appendix 2** and **Appendix 3** for the division's organizational description and chart.

The TennCare program, funded on both the federal and state level, provides health insurance coverage to certain groups of low-income individuals, such as pregnant women, children, caretaker relatives of dependent children and older adults, and adults with disabilities. The Division of TennCare is also responsible for administering the CoverKids program, Tennessee's Children's Health Insurance Program, another federally funded program that provides health coverage to eligible children who do not have access to other insurance, including Medicaid. As shown in **Appendix 2**, the division receives assistance from numerous state agencies to help administer TennCare.

Under the TennCare program model, the state operates Medicaid through a managed care system, a health care delivery system where entities manage healthcare costs, service utilization, and service quality through contracts with managed care organizations (MCOs). In order to manage and coordinate care and maintain a network of healthcare providers, including long-term care, for TennCare members, division management contracts with the following three MCOs and three third-party administrators:

<u>MCOs</u>

- Amerigroup
- BlueCare (part of BlueCross BlueShield of Tennessee)
- UnitedHealthcare Community Plan

[2] The Deputy Commissioner is also known as the Director of TennCare.

Third-Party Administrators

- TennCare Select (part of BlueCross BlueShield of Tennessee)
- OptumRx (pharmacy services)
- DentaQuest (dental services for TennCare children under age 21 and CoverKids children)

The division's MCOs are "at risk," which means the MCOs are responsible for paying all claims for services provided to TennCare members. The division pays the MCO a monthly fee, called a capitation payment, for members assigned to the MCO. Third-party administrators are non-risk or partial risk-bearing administrators of, or claims processors for, health plans, and division management carries the risk of financial loss for the claims the third-party administrators pay.

Single Audit

As part of the annual Single Audit of the State of Tennessee, the Comptroller of the Treasury's Division of State Audit performs a risk assessment and audits certain federal programs administered by state agencies in accordance with Title 2, *Code of Federal Regulations*, Section 200, Part 500, et seq. As part of each year's Single Audit, we review the division's systems of internal control over the TennCare program, and we also review the division's compliance with federal regulations. For the 2020 Single Audit, we audited the Medical Assistance and Children's Health Insurance programs. We present the division's federal expenditures in **Table 9** in **Appendix 4**.

In response to 2020 Single Audit findings and recommendations, division management must develop corrective action plans to submit to CMS, the federal agency that oversees the TennCare program. CMS is responsible for issuing final management decisions on the division's findings, including any directives to repay the federal grants. We present the number of division management's Single Audit findings for fiscal year 2020 in **Table 1**. For the complete list of Single Audit findings, see **Appendix 7**.

Table 1
Division of TennCare Findings Reported in the 2020 Single Audit of the State of Tennessee

FINDINGS	TOTAL KNOWN QUESTIONED COSTS
1 Repeat	**$111,402**
1 New	**$3,409**

Our office is required to determine whether TennCare has taken full corrective action, partial corrective action, or no action on Single Audit findings and recommendations, and we will include this determination in our work for the 2021 Single Audit.

AUDIT SCOPE

We have audited the Division of TennCare for the period July 1, 2019, through May 31, 2021. We focused on the effectiveness and efficiency of division management's processes to deliver services and to administer the program. Our audit scope included a review of internal controls and compliance with laws, regulations, policies, procedures, and provisions of contracts in the following areas:

- Potential Impacts After Katie Beckett,
- Implementation of Telehealth Services During the Pandemic,
- Opioid Epidemic Improvement and Potential Pandemic-Related Opioid Setbacks,
- Management's Preparation for Statewide Member Eligibility Renewals,
- Division's Monitoring of TEDS and interChange Data Transfer,
- Data Supporting TennCare Member Satisfaction,
- TennCare System Modernization: Timeline and Budget,
- Program Integrity,
- Preventing Improper Payments for Personal Care Visits,
- Removing Ineligible Members,
- Medical Necessity and Medical Appeals, and
- Management's Corrective Action of Other Prior Audit Findings.

Division management is responsible for establishing and maintaining effective internal control and for complying with applicable laws, regulations, policies, procedures, and provisions of contracts.

We provide further information on the scope of our assessment of internal control significant to our audit objectives in **Appendix 1**. In compliance with generally accepted government auditing standards, when internal control is significant within the context of our audit objectives, we include in the audit report (1) the scope of our work on internal control and (2) any deficiencies in internal control that are significant within the context of our audit objectives and based upon the audit work we performed. We provide the scope of our work on internal control in the detailed methodology of each audit section and in **Appendix 1**, and we identify any internal control deficiencies significant to our audit objectives in our audit conclusions, findings, and observations.

For our sample design, we used nonstatistical audit sampling, which was the most appropriate and cost-effective method for concluding on our audit objectives. Based on our professional judgment, review of authoritative sampling guidance, and careful consideration of underlying statistical concepts, we believe that nonstatistical sampling provides sufficient appropriate audit evidence to support the conclusions in our report. Although our sample results

provide reasonable bases for drawing conclusions, the errors identified in these samples cannot be used to make statistically valid projections to the original populations. We present more detailed information about our methodologies in the individual sections of this report.

We conducted our audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

PRIOR AUDIT FINDINGS

REPORT OF ACTIONS TAKEN ON PRIOR AUDIT FINDINGS

Section 8-4-109(c), *Tennessee Code Annotated*, requires that each state department, agency, or institution report to the Comptroller of the Treasury the action taken to implement the recommendations in the prior audit report. The Division of TennCare's prior performance audit report was dated December 2018 and contained six findings. The division filed its follow-up report with the Comptroller of the Treasury on June 7, 2019. We conducted a follow-up of the prior audit findings as part of the current audit. We also conducted a special project report, dated February 2020, which contained two findings. The division filed its follow-up report with the Comptroller of the Treasury on August 8, 2020.

RESOLVED AUDIT FINDINGS

The current audit disclosed that the division resolved the following audit findings from the 2018 performance audit report concerning

- developing formal policies to track provider registration processing times;
- recovering improper payments made on behalf of deceased, incarcerated, and duplicate members;
- establishing controls to prevent improper claims and to ensure that TennCare members receive critical long-term care services;
- detecting and terminating potentially ineligible providers; and
- implementing information systems controls.

DEFERRED MANAGEMENT ACTION

The current audit disclosed that management deferred actions relating to the following prior audit findings due to the COVID-19 pandemic; therefore, we are deferring our follow-up work until the next performance audit.

2018 Performance Audit Report

- TennCare could not provide sufficient documentation to support actual cost savings, did not set clear vendor contract expectations, and did not fully document and implement a formal monitoring plan, which calls into question whether the episodes of care strategy is positively changing the way healthcare is provided in Tennessee.

Due to the pandemic, management waived risk-sharing payments for providers, which could have negatively impacted TennCare providers' revenues.

2020 Special Project – Division of TennCare's Redetermination Process and the Impact on Children's Enrollment

- The Division of TennCare denied two child members for CoverKids for having other insurance, even though the members' applications indicated they did not have other insurance.
- The Division of TennCare did not take final administrative action on 1 eligibility appeal within 90 days; as a result, 1 child member inappropriately lost TennCare coverage for over a year.

According to the requirements in the federal Families First Coronavirus Response Act, division management could not terminate members who were enrolled as of March 18, 2020 (the beginning of the public health emergency) until the federal government ends the public health emergency.[3]

[3] For information about the federal public health emergency, see page 19.

Audit Conclusions

TennCare Service Delivery

POTENTIAL IMPACTS AFTER KATIE BECKETT

Federal Enactment and Tennessee's Implementation

The Katie Beckett program was enacted as a provision of the federal Tax Equity and Fiscal Responsibility Act of 1982 and is a Medicaid waiver[4] for home-based Medicaid services for children under 18.[5] To use Medicaid dollars for the Katie Beckett program, states must obtain approval from CMS to extend Medicaid coverage to certain children with disabilities who live at home. Specifically, the Katie Beckett program serves children with disabilities and complex medical needs. According to division management, the program provides children with support and other services, while letting the children live in their own home rather than a hospital, facility, or institution even if their parents' income exceeds the Medicaid income threshold.

Division of TennCare management and the Department of Intellectual and Developmental Disabilities (DIDD) designed and implemented the Katie Beckett program by gathering input from parents, advocates, medical professionals, and community services providers; quickly updating the eligibility determination system; and reaching out to the children and families interested in the Katie Beckett program. In spring 2019, the General Assembly appropriated $77 million for the Katie Beckett program ($27 million of which is state funded), which would serve an estimated 3,000 children. The division submitted the Katie Beckett program waiver request to CMS on September 20, 2019, and CMS approved it on November 2, 2020. Division management began accepting program applications on November 23, 2020. As of August 19, 2021, a total of 1,455 children have applied, and management has enrolled 892 children in the program.

Currently, the Division of TennCare and DIDD administer the state's Katie Beckett program.

Service and Benefit Plan Descriptions

Tennessee's Katie Beckett program consists of three service parts based on a child's needed level of care. Federal and state dollars fund the benefit plans deemed as Parts A, B, and C. For a description of the Katie Beckett eligibility process, see **Appendix 5**.

Part A

Children enrolled in Part A have the *most complex medical or behavioral needs, are at high risk of needing hospital care, or have other extraordinary daily living needs, but would rather receive care at home*. Children in Part A receive Medicaid benefits based on their medical and behavioral health needs, such as

[4] Katie Beckett is part of the Section 1115 waiver. See page 2 for a description of the waiver.

[5] According to *Understanding Medicaid Home and Community Services: A Primer (2010 Edition)*, published by the U.S. Department of Health and Human Services' Office of the Assistant Secretary for Planning and Evaluation, the program was named after Katie Beckett, a child who had been hospitalized since infancy after contracting a viral infection that affected her ability to breathe. The federal government created this program in order to reduce Medicaid costs.

- home health services;
- in-home nursing;
- medical equipment and supplies;
- occupational, physical, and speech therapies; and
- medical transportation.

Part A

- 60 slots filled as of August 19, 2021, and management has paused enrollment
- Children through age 18
- Children enrolled in Medicaid
- State and federal funding

In addition, the child is eligible for wraparound services, such as respite[6] or supportive home care which allow the child to remain at home, but the cost of at-home care cannot exceed the cost to care for the child in an institution. The child's doctor must certify that the child can safely receive care at home.

Part A had an estimate of 300 slots available. As of August 19, 2021, 60 slots were filled. Division management stated there are currently no slots open until they determine if more Part A slots can be allotted.

Part B

Part B is available to children *with complex medical needs and disabilities but do not qualify for care in a medical institution*. Part B also serves children that are waiting for a program slot in Part A. An eligibility caseworker assigns children to Part B on a first-come, first-served basis, and if no Part B slots are available when the child applies, the eligibility caseworker places them on a waiting list.

Part B

- Up to 2,700 slots available; 830 filled as of August 19, 2021
- Children through age 18
- DIDD-administered services
- Covers children not enrolled in Medicaid
- State and federal funding

The Division of TennCare's eligibility caseworker does not enroll Part B children in Medicaid; instead, DIDD administers a flexible benefit package for the children and their families that provides up to $10,000 per year toward their care needs. Parents may use part of the funding to pay for the child's private insurance or to pay for services the child's insurance does not cover. Parents can also use the funds to pay for the medical and behavioral support services that children enrolled in Part A receive.

Part C

If the household income of a child already enrolled in Medicaid disqualifies the child for continued Medicaid eligibility, the child qualifies to enroll in Part A, and there is no Part A spot available, division management will move the child to Part C. If the child remains eligible for Part A, a child may remain on Part C until they receive a Part A slot or reach their 18th birthday. Children enrolled in Part C have primary Medicaid physical and behavioral health benefits, but do

[6] According to the division's waiver, respite services are provided to an eligible person when their unpaid caregivers are absent or need relief from routine caregiving responsibilities.

not receive the additional wraparound services that children in Part A receive. **As of August 19, 2021, division management has enrolled two children in Part C**.

Audit Conclusions

1. **Audit Objective:** How many children has division management enrolled and served in the Katie Beckett program?

   Conclusion: As of August 19, 2021, the Katie Beckett program serves 892 children.

2. **Audit Objective:** Does the state have health service options for Katie Beckett children who reach their 18th birthday and age out of the program?

   Conclusion: Children who age out of the program at their 18th birthday will lose services unless they qualify for services through an adult program. See **Emerging Issue 1**.

Methodology to Achieve Objectives

To address our audit objectives, including gaining an understanding of the Katie Beckett program and obtaining an understanding of and assessing management's design and implementation of internal control significant to our audit objectives, we met with the Division of TennCare's Assistant Commissioner/Chief of Long-Term Services and Supports (LTSS) and Assistant Deputy Chief of LTSS. We obtained and reviewed federal and state documentation related to the program's requirements; documentation of the collaborations between the Division of TennCare and DIDD with parents, advocates, medical professionals, and community services providers surrounding the design of the program; and documentation of the outreach performed for the children and families who were interested in the program. We also obtained and reviewed information on enrollment numbers and any waiting lists that could impact the children enrolled in the program.

Emerging Issue 1 – Children who age out of the Katie Beckett program at their 18th birthday will lose services unless they qualify for services through adult programs

Children in the Katie Becket program, especially the children with the most complex medical or behavioral needs who are at risk for institutionalization, may continue to need medical and other wraparound services as adults. These services include home health services; in-home nursing; medical equipment and supplies; occupational, physical, and speech therapies; and medical transportation. Children enrolled in Part A may qualify for these services that allow them to remain at home; similarly, children enrolled in Part B may use the $10,000 reimbursement account to offset the cost of such services. At 18, these young adults will age out of the Katie Beckett program and may lose access to these services unless they qualify for some level of support services through other programs.

Because the Katie Beckett program is specifically for children and families who would not otherwise qualify for Medicaid, they will have to start the process to find other service options to meet their continuing needs. As of April 30, 2021, there are 63 children enrolled in the Katie Beckett program who will turn 18 years old within the next 3 years. See **Table 2**.

Table 2
Children 15 to 18 Years of Age Enrolled in Katie Beckett Program
As of April 30, 2021

Member Age	Part A	Part B	Total
15	1	21	**22**
16	3	25	**28**
17	0	11	**11**
18	0	2	**2**
Total	**4**	**59**	**63**

Source: Division management.

When children age out of the Katie Beckett program, these young adults may have limited options for continued, comparable care, including wraparound services. Due to limited funding and long waiting lists, it is unlikely these young adults would receive the same services they received through the Katie Beckett program.

According to the Assistant Commissioner/Chief of Long-Term Services and Supports, while enrollment into other service options, like Employment and Community First CHOICES, has been limited for the past several years, managements of the Division of TennCare and DIDD have a shared strategic goal to increase enrollment and reduce the waiting list in the Employment and Community First CHOICES program. The division and DIDD are hopeful that the plan to integrate all Medicaid programs and services for individuals with intellectual and developmental disabilities into a single, person-centered service delivery system, along with new funding opportunities, will allow them to identify resources to offer these important services to more individuals.

The division cannot currently disenroll children aging out of the Katie Beckett program because the state is operating under the public health emergency.[7] Division management should continue to collaborate with parents, advocates, medical professionals, community services providers, and other state agencies to assist families whose children age out of Katie Beckett and need continuing services into adulthood.

IMPLEMENTATION OF TELEHEALTH SERVICES DURING THE PANDEMIC

General Background

As one of its program goals, TennCare strives to "assure appropriate access to care" for members. To receive care, a TennCare member generally must see a provider that participates in his or her managed care organization (MCO) network. TennCare requires its MCOs to develop

[7] See page 19 for more information about the public health emergency.

networks with a sufficient number, specialty variety, and geographic distribution of providers to ensure patients have reasonable access to services based on travel distance and time. Telehealth services allow TennCare providers to administer certain services by voice or video call, such as

- behavioral health services,
- follow-up with a surgeon to check on progress after a surgery,
- review of symptoms with a primary care provider to determine if the member should be prescribed medication to treat an illness, and
- sending images of a rash to a dermatologist for review.

Telehealth services can expand access to care for TennCare members and remove barriers for those members that cannot attend in-office appointments.

For more information about how TennCare assisted its providers during the COVID-19 pandemic, see **Appendix 6** on page 54.

COVID-19 Pandemic Response

On March 12, 2020, Governor Lee declared a state of emergency to facilitate the treatment and containment of COVID-19. Beginning on March 13, 2020, and over the course of several months, Tennesseans were urged to stay at home. According to division management, during the COVID-19 pandemic, the program experienced an overall decrease in all medical services areas. Based on our evaluation of claims data provided by division management, well-child visits for the period of April 1, 2019, through December 31, 2020, declined, especially in April 2020. Management found that the pandemic had less of an impact on the frequency of services provided to CHOICES[8] members and disabled members who required ongoing care because these members received services in their homes or nursing homes.

Prior to the COVID-19 pandemic, MCOs could choose to cover telehealth in their policy, but division management did not require them to cover these services. During the 111th and 112th General Assemblies, legislators enacted two new laws[9] to increase the types of telehealth services that TennCare and the MCOs are now required to cover in their policies.

On March 17, 2020, Division of TennCare management and the MCOs issued guidance to providers to expand the use of telehealth options, and on April 7, 2020, division management issued guidance to providers that listed telehealth-related procedure codes to report telehealth services. Division management wanted to use these codes to measure members' utilization of telehealth services and to determine whether telehealth services helped close the service gap for members during the pandemic.

After June 30, 2021, MCOs are no longer required to cover audio-only telehealth for physical therapy services but may choose to cover additional telehealth services beyond the services they are legislatively required to cover.

[8] Tennessee's CHOICES program includes nursing facility services and home- and community-based services for adults 21 years of age and older with a physical disability and seniors (age 65 and older).

[9] Sections 56-7-1002, 56-7-1003, 56-7-1003(a)(6), 56-7-1011, 56-7-1012, and 63-1-155, *Tennessee Code Annotated,* were amended.

Audit Conclusions

Audit Objective: Did division management ensure telehealth services addressed members' healthcare needs during the COVID-19 pandemic?

Conclusion: Although division management implemented telehealth services and issued guidance to providers, division management did not have consistent data to track and monitor the utilization and effectiveness of telehealth services. See **Observation 1**.

Methodology to Achieve Objective

To address our audit objective, including gaining an understanding of telehealth services and obtaining an understanding of and assessing management's design and implementation of internal control significant to our audit objective, we interviewed division management and key personnel. In addition, we performed a walkthrough of the manual data validation process to obtain an understanding of how management ensured member claims data for telehealth services was reliable, as well as how management used the data to track and monitor member services.

To identify telehealth services trends, we obtained populations of members' telehealth data from April 1, 2019, to December 31, 2020, to evaluate the period before, during, and directly after the pandemic-related shutdowns.

Observation 1 – Division management should continue their efforts to obtain reliable telehealth claims data to monitor and track the utilization of telehealth services

Division of TennCare management explained they do not have reliable data to determine the utilization and effectiveness of telehealth services delivery during the pandemic. Although division management and MCOs issued guidance to providers on how to claim telehealth services, division management did not have a monitoring process to ensure MCOs followed the billing and procedure code guidance for telehealth services. The TennCare Chief Medical Officer noted that, as of March 30, 2021, some providers did not consistently use the correct procedure codes to report telehealth claims. For example, some providers submitted claims using the procedure codes for in-office visits, rather than for telehealth services. In order to obtain reliable and valid claims data that management can properly analyze, division management should continue to work with MCOs to educate providers on how to process telehealth claims with the correct procedure codes to ensure providers use the correct codes going forward.

OPIOID EPIDEMIC IMPROVEMENT AND POTENTIAL PANDEMIC-RELATED OPIOID SETBACKS

General Background

As part of TennCare's mission to improve lives, division management continues to analyze and respond to the ongoing opioid epidemic, developing strategies and taking actions in line with the state's coordinated effort to reduce opioid misuse and abuse.[10] According to the U.S. Department of Health and Human Services (HHS), in the late 1990s, many pharmaceutical companies reassured the medical community that patients would not become addicted to opioid pain relievers, and healthcare providers began to prescribe them at greater rates. HHS also stated that increased prescriptions of opioid medications led to widespread misuse of both prescription and non-prescription opioids before it became clear that these medications could indeed be highly addictive. According to the U.S. Centers for Disease Control and Prevention, from 1999 to 2019, more than 500,000 people in the United States died from overdoses related to opioids.[11] According to the Tennessee Department of Health, opioid overdose deaths in Tennessee rose from 1,186 in 2016 to 1,543 in 2019, an increase of 30%.

The Division's Strategy to Prevent Opioid Misuse and Abuse

From 2004 through 2021, the Division of TennCare has continued to develop an opioid strategy to prevent, treat, and support members faced with opioid misuse and abuse. The strategy has three key objectives:

1. **Primary prevention** – to prevent members from becoming newly dependent or addicted to opioids by
    - improving access to non-opioid and non-drug therapies for pain;
    - establishing strict opioid quantity limits for repeated and first-time users; and
    - increasing prior authorization requirements for all opioid refills.
2. **Secondary prevention** – to reduce the impact of opioid misuse by
    - reaching out to and providing education and treatment options for women of childbearing age who chronically use opioids;
    - removing barriers to allow women to access voluntary, long-acting reversible contraceptives, such as injectable contraceptives, intrauterine devices, or implants; and
    - educating providers on appropriate prescribing habits and tapering of chronic opioid use.
3. **Tertiary prevention** – to support active recovery for severe opioid dependence and addiction by

[10] The U.S. Food and Drug Administration (FDA) defines prescription drug misuse as a person who is not following medical instructions but is not taking the drug to get high. The FDA defines prescription drug abuse as a person using medication without a prescription, in a way other than as prescribed, or to get high.

[11] This statistic includes prescription opioids; heroin; and synthetic opioids, like fentanyl.

- increasing member access to evidence-based medication-assisted treatment, which includes buprenorphine products, methadone, and naltrexone;
- lowering TennCare's allowed maximum dosage for chronic opioid use; and
- increasing outreach to the highest risk members to refer for treatment.

During our audit, we focused on neonatal abstinence syndrome (NAS) birth rates and the related financial impact to TennCare. We also focused on division management's plan to increase providers in the Buprenorphine Enhanced Supportive Medication Assisted Recovery and Treatment (BESMART) network.

The average cost of care for a NAS infant in the first year of life is more than eight times higher than for infants born at a normal weight. See **Table 3**.

Neonatal Abstinence Syndrome

Division management considers infants exposed to opioids or other drugs in the mother's womb a part of the vulnerable population within TennCare's members. NAS is a collection of conditions infants may experience as a result of prenatal exposure to certain substances, such as prescription medications or illicit drugs. After the infant is born, the child experiences withdrawal due to no longer receiving the substances. NAS effects the infant's quality of life by causing central nervous system irritability, overactivity, and gastrointestinal tract dysfunction as well as significantly increasing the cost of care during the infant's first year of life. The most common substances causing NAS are opioids, which include both prescription opioids, like morphine, and illicit opioids, like heroin.

Infants with NAS often require longer stays in the hospital and, occasionally, pharmaceutical intervention. In calendar year 2018,[12] TennCare's average cost of care for a NAS infant in the first year of life was more than eight times higher than the average cost of care for normal-birth-weight infants and nearly equal to the average cost of care for low-birth-weight infants. These costs could continue for the infant's lifetime. See **Table 3**.

Table 3
Impact of Neonatal Abstinence Syndrome on Infant Health Care Expenditures
Calendar Year 2018

Children Born to TennCare Members	Number of Births	Total Actual Costs for Infants in First Year of Life	Average Cost in First Year of Life per Child	Average Length of Hospital Stay (Days)
All Live Births	46,423	$426,525,051	$9,188	4.1
Normal-Birth-Weight	41,308	$206,445,547	$4,998	2.4
Low-Birth-Weight	5,115	$220,079,504	$43,026	18.2
NAS Infants*	1,170	$50,084,236	$42,807	21.8

* The NAS infants' information is also included in the normal-birth-weight and low-birth-weight rows.
Source: Obtained online from TennCare Neonatal Abstinence Syndrome (NAS) Data.

[12] TennCare's most recent published information was for calendar year 2018.

TennCare's NAS Monitoring and Response

Division management addresses the risk of infants born with NAS through its secondary prevention objective, specifically by providing women of childbearing age with educational programs and access to contraceptives. To analyze and track the number of TennCare infants born with NAS, division management compiles data from paid claims, including pharmacy claims, as well as the Department of Health's Controlled Substance Management Database. Using these sources, division management can determine whether the cases of infants born with NAS are increasing or decreasing, as well as evaluate the financial impact on the TennCare program. Division management leverages the results of their ongoing monitoring to target educational and drug prevention programs, as well as provide access to voluntary, long-acting reversible contraceptives.

Increased Provider Network to Treat Substance Use Disorder

As part of their tertiary objective, division management has prioritized developing a comprehensive program to help members living with opioid use disorder to move toward recovery by providing them access to medication-assisted treatment (MAT). MAT uses evidence-based medications,[13] in combination with counseling and behavioral therapies, to provide a whole-patient approach to treat substance use disorders. Beginning in June 2018, division management created the Buprenorphine[14] Enhanced Supportive Medication Assisted Recovery and Treatment (BESMART)[15] program to help meet their priority of ensuring consistent access to addiction and recovery care. Each managed care organization (MCO) established a BESMART provider network to broaden access to quality treatment for opioid or substance use disorder.

Audit Conclusions

1. **Audit Objective:** Did division management monitor the number of infants born with NAS, as well as the financial impact on the TennCare program, to determine the effectiveness of ongoing education and prevention programs?

   Conclusion: Division management monitored the number of infants born with NAS and the cost to TennCare to determine the effectiveness of ongoing education and prevention programs. Although management identified a decrease in the number of infants born with NAS from 2016 to 2019, they expect an increase in 2020 and 2021 in the number of infants born with NAS due to the COVID-19 pandemic. See **Emerging Issue 2**.

[13] Evidence-based medications include buprenorphine, methadone, and naltrexone.

[14] According to the Substance Abuse and Mental Health Services Administration, buprenorphine is the first medication that physician offices can prescribe or dispense to treat opioid use disorder, significantly increasing access to treatment.

[15] The BESMART program includes provider networks where facilities provide optional approaches such as comprehensive maintenance treatment, medical maintenance treatment, detoxification, and medically supervised withdrawal.

2. **Audit Objective:** In an effort to achieve the objective of supporting active recovery for severe opioid dependence and addiction, did division management and the MCOs increase the BESMART provider network since 2017?

Conclusion: Division management and the MCOs increased the BESMART provider network. We illustrate the increase in providers from November 2017 to May 2021 in **Observation 2.**

Methodologies to Achieve Objectives

To address audit objective 1, including gaining an understanding of management's secondary prevention strategies and obtaining an understanding of and assessing management's design and implementation of internal control as it relates to the audit objective, we met with the division's Chief Medical Officer and the Director of Policy and Strategy and performed walkthroughs of management's process for tracking birth rates for infants diagnosed with neonatal abstinence syndrome (NAS).

To determine if management monitored the number of infants with NAS, we obtained TennCare's annual NAS report for 2018, which included TennCare data collected from 2008 to 2018, as well as TennCare's "Opioid Strategy Evaluation Overview" PowerPoint presentation dated February 2021, which included TennCare data collected from 2019. We also obtained and reviewed the Tennessee Department of Health's *Neonatal Abstinence Syndrome Surveillance Annual Report 2019* and *Neonatal Abstinence Syndrome Education Material for Medication-Assisted Treatment (MAT) Providers*, the Substance Abuse and Mental Health Services Administration's *Clinical Guidance for Treating Pregnant and Parenting Women With Opioid Use Disorder and Their Infants*, and Vanderbilt University Medical Center's *The Impact of the Tennessee Initiative for Perinatal Quality Care "Immediate Postpartum Long Acting Reversible Contraception" Project*.

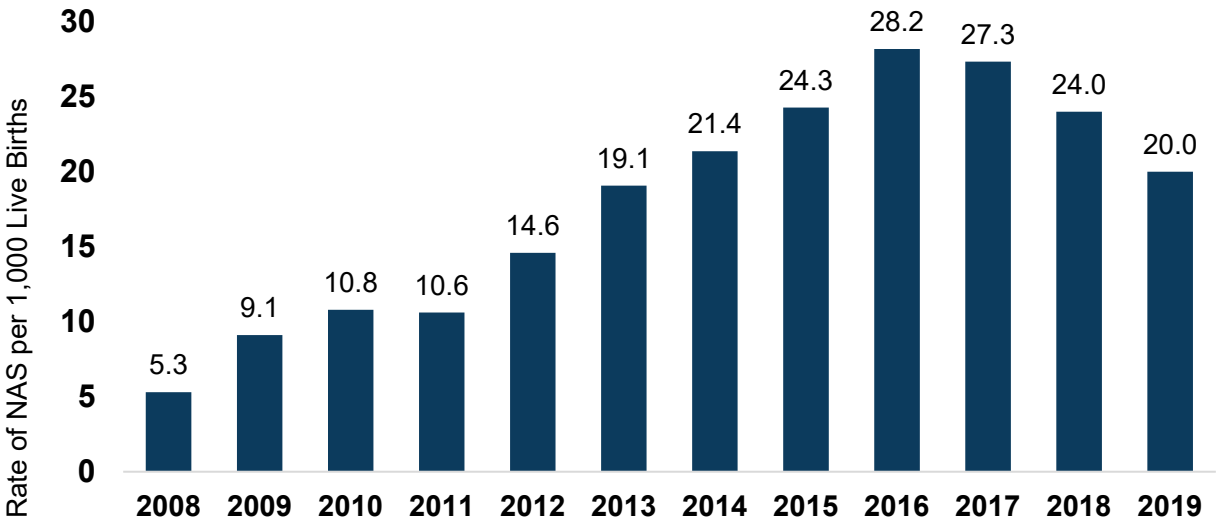
To address audit objective 2, including gaining an understanding of management's tertiary prevention strategies and obtaining an understanding of and assessing management's design and implementation of internal control as it relates to the audit objective, we interviewed the division's Chief Medical Officer and the Director of Policy and Strategy and performed walkthroughs of management's process to analyze the BESMART provider network.

To determine if management and the managed care organizations (MCOs) achieved the BESMART provider network priority to increase the number of providers, we obtained data on the 2018 buprenorphine provider network from the 2018 performance audit report of the Division of TennCare and data on the 2021 BESMART provider network from the three MCOs. We compared the 2018 and 2021 provider network information to determine if TennCare and the MCOs expanded the network options for its members. We also obtained and reviewed the Centers for Disease Control and Prevention's *Guideline for Prescribing Opioids for Chronic Pain – United States, 2016* and TennCare's "Buprenorphine Medication Assisted Treatment (MAT) Program" PowerPoint presentation dated May 16, 2018.

Emerging Issue 2 – While TennCare members' neonatal abstinence syndrome birth rates decreased in 2017, 2018, and 2019, division management expects an increase in neonatal abstinence syndrome births in 2020 due to the COVID-19 pandemic

From 2008 to 2016, management experienced a nearly five-fold rise in TennCare infants born with neonatal abstinence syndrome (NAS), but management saw a decrease in the number of infants diagnosed with NAS from calendar years 2016 through 2019. Division management collaborates with the Tennessee Department of Health to obtain vital statistics data, including information on birthrates, and management stated that 2020 data will not be available until fall 2021. See **Chart 1**.

Chart 1
TennCare Neonatal Abstinence Syndrome Births per 1,000 Live Births
Calendar Years 2008 to 2019



Source: Division of TennCare management.

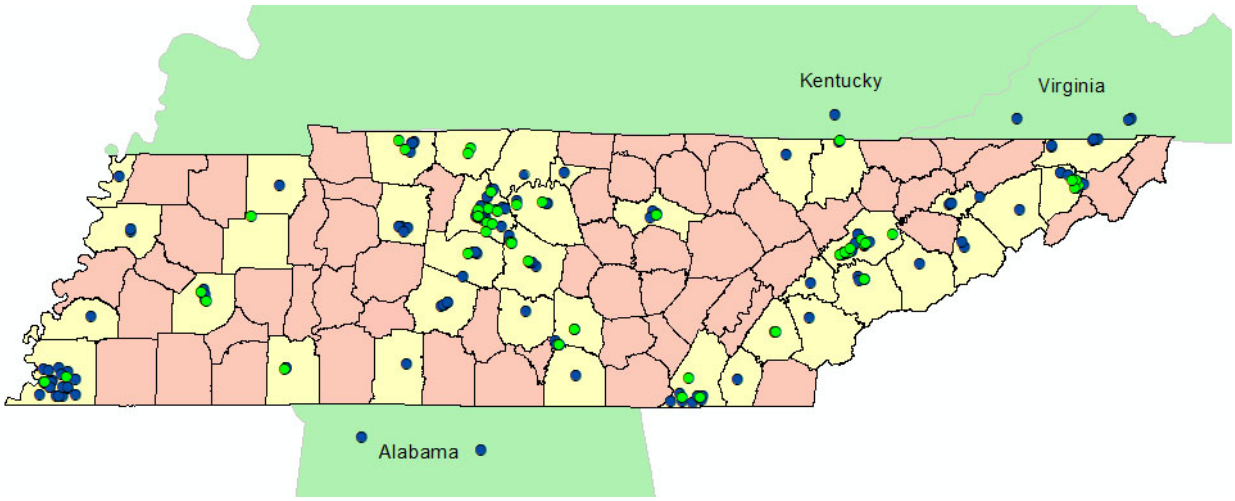
Based on our discussions with TennCare's Chief Medical Officer and the Director of Policy and Strategy, the COVID-19 pandemic may have an impact on substance use and opioid use, and trends in NAS will need to be closely monitored. TennCare's data does not reflect the current pandemic, and future numbers for infants diagnosed with NAS may not be as encouraging as they have been in the past. Due to the ongoing impact to children, families, and the healthcare system, division management should continue to monitor the number of infants born with NAS; analyze the financial impact to the TennCare program, including any effect the ongoing COVID-19 pandemic may have; and take appropriate actions to protect children and manage costs to the TennCare program.

In the next sunset audit, we will review TennCare's data on the number of infants diagnosed with NAS to determine if this number increased or not and evaluate the division's response as needed.

Observation 2 – Division management and the managed care organizations increased their Buprenorphine Enhanced Supportive Medication Assisted Recovery and Treatment (BESMART) provider network

In the 2018 TennCare performance report, TennCare data (as of November 2017) showed that the TennCare network included 180 licensed buprenorphine prescribers. As of May 5, 2021, there are 278 providers that are licensed buprenorphine prescribers. See **Figure 2**. We encourage division management to continue to monitor its BESMART provider network to ensure members have appropriate access to quality care to move toward recovery.

Figure 2
Comparison of TennCare's BESMART Provider Locations for 2018 and 2021



Legend

- New BESMART providers since prior audit
- Continuing BESMART providers since prior audit

Tennessee counties with active TennCare BESMART provider(s)

Bedford	Davidson	Hardin	Loudon	Putnam	Sullivan
Blount	Dickson	Hawkins	Madison	Robertson	Sumner
Bradley	Dyer	Henry	Maury	Rutherford	Tipton
Campbell	Franklin	Knox	McMinn	Scott	Trousdale
Carroll	Greene	Lake	Monroe	Sevier	Washington
Cocke	Hamblen	Lawrence	Montgomery	Shelby	Williamson
Coffee	Hamilton				Wilson

Other states with active TennCare BESMART provider(s)

Alabama Kentucky Virginia

Source: Obtained from the managed care organizations' BESMART provider network directory.

MANAGEMENT'S PREPARATION FOR STATEWIDE MEMBER ELIGIBILITY RENEWALS

To receive TennCare benefits, individuals must apply for TennCare coverage. In accordance with federal regulations, TennCare members must renew their eligibility in order to continue receiving benefits each year. The division uses the Tennessee Eligibility Determination System (TEDS) to process eligibility applications and renewals and to store member eligibility information. With the implementation of TEDS in April 2019, management had to convert pre-existing member data from legacy eligibility systems into TEDS to ensure the continuation of member benefits.

Application Process

Applicants apply for eligibility using TennCare Connect, the TEDS public-facing web portal, or they can apply using one of the following methods:

- by phone or a paper application;
- by phone or online through the Federally Facilitated Marketplace, which is operated by the U.S. Department of Health and Human Services where individuals can apply for health insurance;
- by visiting a Department of Human Services office for in-person assistance with applying online, by paper, or by phone; or
- online through the TennCare Access partner portal.[16]

In whatever format an applicant chooses to apply for TennCare, the applicant's demographic, income, and household information is entered into TEDS for automated processing, thereby removing the need for human intervention in many cases. Management calls this automated processing "no-touch" processing. This process applies a series of rules and checks to determine eligibility, such as verifying Social Security numbers with the Social Security Administration or household income with the Internal Revenue Service. As an example, TennCare provided metrics for April 14, 2021, when TEDS received a total of 249 applications through TennCare Connect. TEDS processed 207 of these applications via no-touch processes and made eligibility decisions for 115 of these applications. If TEDS cannot process an application automatically, the system creates a task for a caseworker to process the application manually.

Members in TEDS Conversion Status and the Federally Required Pause on Eligibility Renewals

While the majority of TennCare members were converted from the legacy systems to TEDS, division staff and Deloitte, the contractor responsible for managing TEDS, placed some members in "conversion status" in June 2019, meaning the information in their cases required additional manual verification or renewal before TEDS could determine the members' eligibility. According to management, placing these members in conversion status protects the members from

[16] TennCare partners with the Department of Health, certain hospitals, and certain long-term care providers to help individuals with the application process.

having their benefits terminated before caseworkers can work the members' cases. If TEDS terminated benefits, members would have to reapply.

During the 2020 Single Audit of Tennessee, we identified members on conversion status who were not eligible to receive TennCare benefits. We provide the details in the *2020 Single Audit Report.*

As of February 2021, TEDS had a total of 85,395 member cases in conversion status representing 3 different benefit programs. See **Table 4**. Of the 85,395 members, division management stated that 85,267 members may have to undergo the eligibility renewal process after CMS declares an end to the public health emergency. According to the Assistant Commissioner of Member Services, 128 members in conversion status are in eligibility categories that do not require eligibility renewals, such as members who receive Supplemental Security Income benefits, but caseworkers will have to update the members' cases with any current information.

Table 4
Members in TEDS Conversion Status Program
As of February 2021

Program Name	Number of Members
Medicaid	75,571
CoverKids	549
Medicare Savings Program	9,275
Total	**85,395**

Source: Division of TennCare management.

During the 2020 Single Audit, the Assistant Commissioner stated that management was working toward resolving the issues relating to the members in conversion status. However, pursuant to the federal Families First Coronavirus Response Act, division management is not permitted to terminate members who were enrolled when the federal COVID-19 public health emergency period began. As such, management paused Medicaid and CoverKids eligibility renewals, eligibility changes to lower categories, and member terminations on March 18, 2020. During this pause, management is only allowed to terminate Medicaid and CoverKids coverage for existing members due to the member's death, when a member voluntarily terminates coverage, or when a member becomes a resident in another state. Because of the length of the pause, most TennCare members' eligibility could have changed, but they are still in the program because of the federal pause.

TennCare is faced with the challenge of resolving member cases currently residing in "TEDS conversion status," as well as renewing most TennCare members' eligibility status once the public health emergency ends.

TennCare's Renewal Plan for Members Requiring Renewal

Based on CMS's August 2021 written guidance to state agencies, a date for when the public health emergency will end was not provided, but CMS provided division management with a timeline of having 12 months to complete all eligibility renewals once the public health emergency ends. According to management, CMS will give them a 60-day notice to begin renewals.

Meanwhile, management is working to identify, categorize, track, and prioritize member case metrics to prepare for the renewal process. Division management established priority levels based on member eligibility categories to facilitate the renewal process.

Audit Conclusions

Audit Objective: To ensure TennCare members had continued access to care, did division management have a reasonable plan to complete member case conversions to TEDS within a reasonable timeline?

Conclusion: Division management developed a reasonable plan and timeline to complete member case conversions to TEDS once the federal public health emergency ends. See **Emerging Issue 3**.

Methodology to Achieve Objective

To achieve our objective, we held multiple interviews with TennCare personnel, including the Chief Information Security Officer, the Assistant Commissioner, the Deputy Director of TennCare Member Services, and the Deputy Director of Behavioral Health Operations, to gain an understanding of TEDS and member cases in conversion status. We also interviewed the Deloitte contractors that assist TennCare with back-end processes within TEDS, including Deloitte's Consultant Manager.

To assess management's design and implementation of controls and processes as it relates to the audit objective, we interviewed TennCare personnel to obtain an understanding of relevant processes and inspected examples of the dashboards and reports TennCare uses to monitor member status in TEDS. Additionally, we obtained and inspected written explanations by the Director of Eligibility Services about TennCare's plans for resolving the member cases in conversion status. We obtained and reviewed the August 13, 2021, letter from the Centers for Medicare and Medicaid Services to states regarding updated guidance for planning the resumption of normal state operations once the public health emergency ends.

Emerging Issue 3 – Once the public health emergency ends, Division of TennCare management will implement the established plan to renew members' eligibility

Once the public health emergency period ends, TennCare must restart the eligibility renewal process for approximately 822,000[17] TennCare members. While awaiting further instruction from CMS, Member Services staff is working to resolve as many TEDS conversion-related tasks as possible for members who require renewals. Staff will also prioritize members who did not undergo renewal due to the pandemic.

It is imperative that members respond to TennCare's communication and complete the eligibility renewal process in order to keep their TennCare benefits.

[17] Division management stated that this number reflects total TennCare membership as of June 8, 2021. According to the Assistant Commissioner of Member Services, this number will grow as each month passes.

To prepare for the eligibility renewal process, division management also plans to conduct calling campaigns to inform members.

Because CMS has not given the Division of TennCare management a firm end date for the public health emergency, management cannot be certain that they have sufficient resources in place to fulfill CMS's future instructions. Given the division's current staffing, processes, and technology, the Assistant Commissioner of Member Services estimated that management would need approximately 12 months to work through all the member cases that require renewal.

The Assistant Commissioner of Member Services estimated that management would need approximately 12 months to work through all the member cases that require renewal.

DIVISION'S MONITORING OF THE TEDS AND INTERCHANGE DATA TRANSFER

Division management relies on TennCare's information systems to conduct critical business functions, including application processing, eligibility renewals, and payment processing. The Division of TennCare established a digital interface between the Tennessee Eligibility Determination System (TEDS), which serves as a program eligibility determination system, and interChange, the division's claims management system. This digital interface includes a daily transfer of member data from TEDS to interChange and a transfer of processed data from interChange back to TEDS. Division management utilizes a series of automated processes to verify newly transmitted member information from TEDS before the data is updated in interChange. This process ensures interChange reflects the most current member eligibility data to process accurate payments to managed care organizations and providers.

Interface Design, Operation, and Monitoring

Division staff coordinated with Deloitte, the contractor responsible for managing TEDS, for assistance with designing, monitoring, and operating the TEDS portion of the interface. Similarly, division staff rely on assistance from Gainwell Technologies, the contractor responsible for managing interChange, for operating and monitoring the interChange portion of the interface.

Both Deloitte and Gainwell staff use specialized software to manage and monitor the interface operations for TEDS and interChange, respectively, and division management and the contractors have designed various monitoring activities for the interface to ensure the accuracy of data and the ongoing effectiveness of the interface. When the automated processes find data discrepancies and errors, interChange generates an error response file and sends it back to Deloitte for reconciliation. TennCare staff collaborate with Deloitte contractors to review the error response file and take appropriate actions to correct the errors. Once Deloitte corrects the errors, they will include the corrected data in a future transfer. In the event that an automated process fails due to an issue with the data, Deloitte and Gainwell staff use specialized software to alert them about the failure. Interface operators also use digital dashboards to monitor the interface operation in real time and to investigate problems as they arise.

Audit Conclusions

Audit Objective: Did division management and the contractors ensure that systems accurately transferred data from TEDS to interChange and that interChange appropriately updated the member information?

Conclusion: Based on our review of the design and implementation of the interface and associated internal controls, division management and contractors worked together to ensure TEDS member data appropriately transfers to and updates in interChange.

Methodology to Achieve Objective

To address our audit objective, including obtaining an understanding of related internal control, we interviewed TennCare personnel, including the Chief Information Security Officer and the Director of Eligibility Services, to gain an understanding of the interface between TEDS and interChange. We also interviewed Deloitte and Gainwell contractor staff who help TennCare operate and monitor the TEDS and interChange interface. To assess management's design and implementation of internal control as it relates to the audit objective, we performed walkthroughs of the monitoring processes employed by the respective interface operators for TEDS and interChange. Likewise, we obtained and inspected policies, procedures, and interface design documents. Additionally, we observed copies of reports and dashboards that TennCare uses to monitor the interface and reconcile the data between TEDS and interChange.

DATA SUPPORTING TENNCARE MEMBER SATISFACTION

Division management uses an annual survey as a tool to measure whether the division is meeting the mission of improving lives through high-quality, cost-effective care and to disclose member satisfaction rates in public hearings and media releases. Because the Division of TennCare operates the TennCare program via a waiver approved by the Centers for Medicare and Medicaid Services (CMS), division management must conduct a survey of beneficiaries and include the results in the division's annual report to CMS. Since 1993, the division has contracted with the University of Tennessee's (UT) Boyd Center for Business and Economic Research[18] to conduct the annual survey of 5,000 Tennessee residents, both TennCare members and non-TennCare members.

Based on our review of the final survey reports for 2019 and 2020, the survey includes questions about respondent demographics, healthcare coverage, satisfaction with private insurance, and satisfaction with TennCare services for the head of household and their children. According to division management and the UT Survey Project Director, they have made few changes to the survey questions since 1993 to compare data over time; however, in 2020 division management and UT added new questions relating to the COVID-19 pandemic. The survey asked respondents questions about whether COVID-19 impacted the quality of their healthcare,

[18] The Boyd Center works with UT's Social Work Office of Research and Public Service (SWORPES) to administer the survey. SWORPES subcontracted with Wilkins Research Services.

appointment availability, and/or frequency of doctor visits. Division management approved the original and new questions. UT contacts Tennessee residents until they reach at least 5,000 households. The 2019 survey included 5,015 households, and the 2020 survey included 5,464.

During the audit, we focused our work on the 2019 and 2020 reports' findings about satisfaction with the quality of care received from TennCare, including a table that shows TennCare member satisfaction rates over time. The survey asks respondents "Overall, would you say you are not satisfied, somewhat satisfied or very satisfied with the quality of care received from TennCare?" The division's member satisfaction rate has exceeded 90% since 2009 (see **Figure 3**).

Figure 3
TennCare Member Satisfaction Rates From 2006 Through 2020

2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
87	90	89	92	94	95	93	95	93	95	92	95	95	94	94

Source: 2020 *Impact of TennCare – A Survey of Recipients* report.

According to management, they have implemented program changes and performed outreach to MCOs in response to survey results. For example, because members stated in the survey that they typically sought care in emergency rooms, management informed MCOs to remind members to use primary care physicians.

Audit Conclusions

Audit Objective: Is management's member survey tool based on a reasonable approach to assess members' satisfaction?

Conclusion: Based on our audit work, we found that division management's approach to surveying their members was reasonable.

Methodology to Achieve Objective

To address our audit objective and assess management's design and implementation of internal control as it relates to the objective, we interviewed division management and the University of Tennessee (UT) survey administrators to gain an understanding of relevant internal control. We also performed walkthrough procedures to document how both parties developed and administered the member satisfaction portion of the *Impact of TennCare – A Survey of Recipients* reports for 2019 and 2020 to Tennessee residents. We reviewed contracts, survey scripts, survey response data, and UT's averaged responses, and we used this information to recalculate the TennCare member satisfaction rates published in the 2019 and 2020 reports.

Administrative Functions

TennCare System Modernization: Timeline and Budget

Medicaid Modernization Project

In 2015, the Division of TennCare partnered with the federal Centers for Medicare and Medicaid Services (CMS) to launch the Medicaid Modernization Project and update its legacy systems. The modernization project focuses on two main areas, which include replacing

- the eligibility and enrollment systems; and
- interChange, the division's current Medicaid management information system (MMIS).

Division management initiated Project Iris in 2018 to facilitate the replacement of interChange, with expected completion in 2026, and in 2019 management implemented the Tennessee Eligibility Determination System (TEDS), its eligibility and enrollment system.

Project Iris – TennCare's interChange Replacement

As part of the federal/state collaborative project, CMS has outlined a system certification process by which CMS will evaluate TennCare's progress toward MMIS implementation. CMS's involvement includes a streamlined approach to ensure that all states eligible for federal matching dollars are implementing systems that meet the business needs of both the state and CMS. This federal/state process provides that CMS will fund 90% of the costs for the design, development, and implementation of the modernization project, with 75% committed to ongoing operation and maintenance costs. In February 2021, division management stated that they expected that interChange has approximately four remaining years of useful life, thus requiring management to complete the replacement by 2026.

To facilitate Project Iris's implementation process, division management contracted with KPMG, LLP,[19] to obtain technical advisory services, such as developing system goals and advising TennCare on best practices to align program processes and procedures. KPMG will also serve as project management through the modernization project's development and implementation phases. Management also contracted with NTT Data State Health Consulting, LLC, for business support services, such as documenting existing processes, supporting testing and certification, and recommending and implementing process improvements. Management's implementation will involve seven modules.

The estimated cost to complete Project Iris is $665 million through fiscal year 2026. As discussed at the Governor's budget hearing on November 10, 2020, management will complete the project in phases.

[19] TennCare's contract with KPMG, LLP, began in September 2015, when KPMG provided technical services for the TEDS project and assisted division management in assessing the original vendor's delays. KPMG will continue to provide technical advisory services throughout the completion of Project Iris.

Audit Conclusions

Audit Objective: Is division management on track with Project Iris in terms of estimated costs and timeline?

Conclusion: Management's first of seven modules went live in January 2020, and they have a contract in place to develop the second module. TennCare has invested $77 million into the project through August 2021, with an expected total budget of $665 million for completion. Given that management is in the early phases of the modernization process, we have no reason to conclude the project cannot be completed on time and within budget. We provide further information in **Observation 3**.

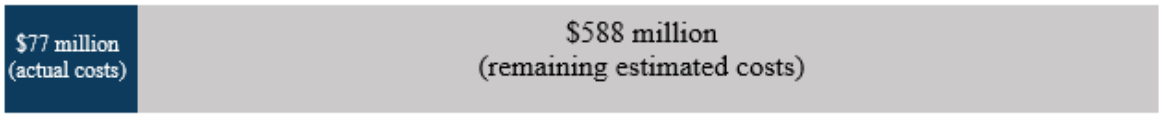
Methodology to Achieve Objective

To address our audit objective, including obtaining an understanding of Project Iris, its components, management's anticipated timeline, and associated costs, we interviewed the Chief Information Officer and the Chief Information Security Officer. We also met with division management to gain an understanding and assess management's design of internal control significant to our audit objective. We reviewed federal documentation related to Medicaid system development and implementation, as well as the division's budget documents related to Project Iris. We also reviewed division management's budget presentation to the Governor on November 10, 2020, and the budget presentation to the House Finance, Ways, and Means Committee on March 9, 2021.

Observation 3 – Project Iris status update

While the division estimates Project Iris will cost $665 million through fiscal year 2026, since fiscal year 2018, division management has invested nearly $77 million in the development and operation of Project Iris modules.

Project Iris Actual and Remaining Estimated Costs as of August 23, 2021



Source: The auditor prepared this chart with budget documents obtained from management.

Of the total $665 estimated federal/state costs, management estimated that $398 million ($358 million in federal funds and $40 million in state funds) will be dedicated to Project Iris's design, development, and implementation. The remaining $267 million ($200 million in federal funds and $67 million in state funds) will be dedicated to Project Iris's operations and maintenance.

We will continue to track management's efforts throughout the project's full implementation.

PROGRAM INTEGRITY

General Background

Fraud, waste, and abuse in Medicaid programs, including the TennCare program, costs the nation billions of dollars each year. According to the Government Accountability Office, in 2015 alone, improper payments totaled more than $29 billion. Title 42, *Code of Federal Regulations* (CFR), Section 455, Part 14, requires state Medicaid agencies, such as the Division of TennCare, to conduct a preliminary investigation for any complaint of Medicaid fraud or abuse it receives or any questionable practices it identifies. The division established the Office of Program Integrity (the office), which according to the division's website, is "responsible for the prevention, detection and investigation of alleged provider fraud, waste and/or abuse" to protect the financial and health care integrity of the Medicaid program.

According to the National Conference of State Legislatures, *well-designed program integrity initiatives* ensure that

- eligibility decisions are made correctly,
- prospective and enrolled providers meet federal and state participation requirements,
- delivered services are medically necessary and appropriate, and
- provider payments are made in the right amount and for appropriate services.

The office is responsible for investigating provider administrative fraud, such as fraudulent claims filed by providers. The office refers other types of investigations to responsible agencies, such as provider license issues to the Tennessee Department of Health or allegations involving the Tennessee Department of Intellectual and Developmental Disabilities' (DIDD) Medicaid providers to DIDD. The office works with managed care organizations (MCOs); OptumRx, the pharmacy benefits manager; DentaQuest, the dental benefits manager; law enforcement; and a variety of state and federal agencies, including

- the Tennessee Bureau of Investigation (TBI), which houses Tennessee's Medicaid Fraud Control Unit;[20]
- the Office of the Attorney General and Reporter (AG), which, unlike TennCare, has the authority to prosecute provider fraud cases; and
- the Department of Finance and Administration's Office of the Inspector General (OIG), which is the agency responsible for investigating TennCare member fraud.

Fraud Tips and the Office of Program Integrity's Investigative Process

Fraud Tips

The office receives tips from multiple sources, including the MCOs, OptumRx, DentaQuest, OIG, the AG's Office, the Department of Health, the TennCare Provider Fraud

[20] 42 CFR 455.15 states that if the division's preliminary investigation gives it a reason to believe that an incident of provider fraud or abuse has occurred, division management must refer the case to its Medicaid Fraud Control Unit (MFCU). Section 71-5-2508, *Tennessee Code Annotated*, establishes that TBI, acting as the MFCU, may investigate and refer Medicaid fraud violations to the Attorney General for prosecution.

Hotline, and news reports. From July 1, 2019, through February 28, 2021, the office received 1,234 tips from MCOs and 121 tips from non-MCO sources. Based on our analyses, we found that the office received an average of 68 tips per month.

Division of TennCare Provider Fraud Hotline

1-833-687-9611
ProgramIntegrity.TennCare@tn.gov

Investigations

If a tip warrants an investigation, office staff work with TennCare's Program Integrity Analytics group to pull provider claims data. The office's four investigators, who are Certified Professional Coders,[21] review medical records relating to the investigation. If investigators require additional expertise, they consult with a physician in TennCare's Medical Office.

Once the investigators complete their investigation, office management decides whether the office will refer the case to TBI and the AG. The TennCare Fraud Investigations Manager directs a bimonthly referral meeting with representatives from TBI and the AG, at which each investigator presents their individual cases. TBI and the AG then have two weeks to decide whether either or both will take up the case for prosecution or decline it. If they accept, the respective agencies assume responsibility for the investigation, up to and including prosecution and monetary settlements. Office investigators continue to assist TBI and AG during the course of the investigations.

From July 1, 2019, through February 28, 2021, the office opened 157 investigations. See **Table 5** for a breakdown of the status of these investigations as of March 25, 2021.

Table 5
Office of Program Integrity's Status of Investigations
July 1, 2019, Through February 28, 2021
As of March 25, 2021

Status	Number of Investigations
Closed the Investigation Without Referral*	73
Referred to TBI/AG	50
Open Investigations	34
Total	**157**

* The office closes cases when staff cannot substantiate a tip.
Source: Auditor created from data obtained from Division of TennCare management.

Results of Investigations

From July 1, 2019, through February 28, 2021, 15 TennCare providers agreed to $3,469,048 in settlements with the AG's Office. From July 1, 2019, through March 31, 2021, TennCare collected $2,904,844 in provider settlement payments and returned $8,689,776 to the state, for a total of $11,594,620 in recoveries.

[21] Certified Professional Coders are responsible for overseeing the medical coding in a medical setting, such as a doctor's office. They translate medical diagnoses, procedures, and other services into codes that are submitted on claims to payers, such as insurance companies, for reimbursement.

Audit Conclusions

Audit Objective: Did the Office of Program Integrity comply with federal requirements to conduct preliminary investigations of any complaint of Medicaid fraud or abuse it receives or any questionable practices it identifies?

Conclusion: The Office of Program Integrity complied with federal requirements governing Medicaid fraud investigations by reviewing tips, conducting investigations into Medicaid provider administrative fraud, or referring complaints to other agencies. Additionally, the office recovered settlements by collaborating with the Tennessee Bureau of Investigation and the Office of the Attorney General and Reporter.

Methodology to Achieve Objective

To obtain an understanding and assess management's design, implementation, and operating effectiveness of internal controls as it relates to audit objectives 1 and 2, we discussed and documented the investigation process with division management and reviewed tip summaries, referral documents, staff-prepared meeting agendas, and meeting minutes. We also tested the internal controls over the annual investigation referral process as part of the state's Single Audit.

We obtained the Office of Program Integrity's tip sources and investigation statuses and calculated the monthly average of tips, investigations, and referrals to determine if the office addressed provider fraud. We also analyzed the office's and the Program Integrity Analytics group's expenditures and provider fraud collections, as well as provider fraud settlements collected by TBI and AG.

Preventing Improper Payments for Personal Care Visits

General Background

Many TennCare members require personal care services to support their daily living activities, such as bathing, dressing, toileting, and meal preparation. Providing personal care services presents unique challenges to division management because the program serves a vulnerable population, such as individuals with intellectual and developmental disabilities and the elderly. Members of this vulnerable population may not be able to report improper or missing services, such as a personal care worker missing a scheduled appointment. Without supervision or documentation, the providers could inappropriately bill managed care organizations (MCOs) for services not rendered and could potentially jeopardize members' safety.

According to a December 2017 report by the U.S. Department of Health and Human Services' Office of Inspector General, during federal fiscal years 2012 through 2015, personal care services fraud cases were a "substantial and growing percentage of Medicaid Fraud Control Unit (MFCU) cases and outcomes." The report found that in federal fiscal year 2015, fraud cases involving personal care services providers made up 12% of all MFCU cases. To address the increase in fraud, the 21st Century Cures Act was enacted on December 13, 2016. This law required state Medicaid agencies to implement electronic visit verification (EVV) systems for personal care and home health services by January 1, 2020.

TennCare's and the Managed Care Organizations' Electronic Visit Verification System Process

TennCare's three MCOs, Amerigroup, UnitedHealthcare, and BlueCare, are responsible for using EVV systems to track personal care visits. The EVV systems track

- the type of service performed,
- the individual receiving the service,
- the date of the service,
- the service location,
- the worker providing the service, and
- the time the service begins and ends.

TennCare's MCOs may elect to use a vendor to oversee and manage their EVV system. Amerigroup and UnitedHealthcare both use CareBridge, while BlueCare uses Sandata.

When the MCOs' service providers go to the member's home to provide services, the worker uses a tablet, mobile application on a personal smart phone, or telephone to electronically check in when they arrive and check out when they leave. According to division management, if the worker cannot use an electronic method, they can use a paper time log that verifies the worker performed the service in the member's home; the MCOs call this method a manual confirmation. **Table 6** presents our results of workers' personal and attendant care visit check-in and check-out methods for each MCO.

Table 6
Methods Used to Record Personal and Attendant Visits
in the Electronic Visit Verification System
January 2020 Through December 2020

	 Tablet	 Mobile App	 Telephone	 Manual	 Varied
	Electronically Captures Date, Time, and Location		Electronically Captures Date and Time	No Electronic Data Capture	Electronic or Manual
Amerigroup	35%	25%	18%	16%	6%
BlueCare	21%*		54%	18%	7%
UnitedHealthcare	30%	16%	15%	32%	6%

* BlueCare's system classifies records created by tablet and mobile application into a single category. This is not a concern, however, because the tablet and mobile application methods both collect the same check-in and check-out data.

Source: Auditor created using the MCOs' EVV records.

Results of Prior Audit

In the Division of TennCare's 2018 performance audit report, we found that the division did not ensure the MCOs established controls to prevent improper claims and to ensure that TennCare members received critical long-term care services. Specifically, we found that two MCOs (Amerigroup and UnitedHealthcare) lacked controls to prevent workers from claiming to care for different members at the same time, called an overlapping visit. Additionally, we determined that providers created approximately 30% of personal care services records manually, rather than electronically. We determined that these control gaps increased the risk of improper payments and the risk to the safety and well-being of vulnerable TennCare members who rely on home care services to live. In response to the prior audit finding, management concurred with our assertions that the EVV systems failed to function as required but disagreed that this may have prevented TennCare members from receiving the necessary care.

Management's Current Process

Since the prior audit and management's implementation of the 21st Century Cures Act's EVV requirements, division management now requires MCOs to use unique identification numbers for personal care workers in the EVV system. Unique identification numbers help providers and management identify the care worker who completed the visit and identify overlapping visits. Additionally, MCOs are required to upload paper time logs for manual confirmations. Both the care worker and the visited member must sign the paper time logs, and the provider must upload the paper time logs into the EVV system to confirm the personal care visits before submitting the claim to the MCO for payment.

Audit Conclusions

Audit Objective: Did TennCare and MCO management effectively implement corrective action to resolve the prior audit finding related to inadequate controls for home-delivered services and provider billings, including manual worker check-ins?

Conclusion: Based on our work, although division management effectively implemented corrective action to address the prior audit finding, we found that BlueCare's EVV system controls allowed workers to submit claims for unsupported manual worker check-ins for payment. See **Observation 4**.

Methodology to Achieve Objective

To address our audit objective, we interviewed the Division of TennCare's Assistant Commissioner/Chief of Long-Term Services and Supports and the Assistant Deputy Chief of Policy, Programs, Contracts, and Compliance, as well as key personnel at each managed care organization (MCO) to gain an understanding of the personal care services provided through the MCOs' electronic verification system; to obtain an understanding of internal control significant to our audit objective; and to assess management's design, implementation, and operating effectiveness of internal control. We also reviewed federal and state laws, regulations, polices, and procedures pertaining to personal and attendant care services for TennCare members.

From the MCOs, we obtained populations of electronic visit verification records associated with current procedural terminology codes S5125 (attendant care services) and T1019 (personal care services) for Amerigroup and UnitedHealthcare for the period July 1, 2019, through December 31, 2020, and BlueCare for the period July 1, 2019, through March 15, 2021. The population consisted of 763,718 Amerigroup records; 1,452,924 UnitedHealthcare records; and 999,701 BlueCare records. We summarized the records by check-in and check-out type (see **Table 6** on page 30).

Our data analysis disclosed the following potentially overlapping visits: 950 in the Amerigroup data; 1,137 in the UnitedHealthcare data; and 1,245 in the BlueCare data. We selected a random, nonstatistical sample of 137 potentially overlapping visits (35 for Amerigroup, 30 for UnitedHealthcare, and 72 for BlueCare) from the MCOs for testwork. We reviewed interChange, TennCare's claims management system, to determine whether MCOs paid the providers' claims for services attributed to the overlapping times. We provided our sample to TennCare's Long-Term Services and Supports unit and each MCO to analyze the visits.

Our data analysis disclosed the following manual confirmations: 136,403 in the Amerigroup data; 183,139 in the UnitedHealthcare data; and 73,076 in the BlueCare data. We selected a random, nonstatistical sample of 60 manual confirmations, 20 from each MCO, for testwork. We examined paper time logs to determine whether MCOs paid manual confirmation claims without proper supporting documentation.

Observation 4 – BlueCare's electronic visit verification system allowed personal care providers to override a system control, resulting in BlueCare paying unsupported claims

Based on our testwork relating to BlueCare's manual visits, we found 4 claims, totaling $499, that BlueCare paid without a paper time log attached. Further review revealed that 111 of 400 provider employees (28%) were inappropriately given administrator status in the EVV system's settings, which allowed them to submit unsupported claims. The vendor identified the override issue in April 2020 and corrected it in December 2020 but did not inform division management of the override issue. We informed the Division of TennCare management of this override issue on May 25, 2021.

We found instances of employees with inappropriate administrator status, who submitted unsupported claims in the EVV system.

According to the MCO Statewide Contract, Section 2.9.6.13.3, the contractor must notify TennCare within five business days of the identification of any issue affecting the EVV system operation that impacts the contractor's performance of the contract, including how and when the contractor will resolve the issue.

Division management should ensure BlueCare management researches the effect of the override on paid claims to identify and recover any improper payments.

REMOVING INELIGIBLE MEMBERS

General Background

To provide cost-effective care and protect taxpayer dollars, division management must ensure only eligible members receive TennCare benefits. Federal regulations do not allow management to make payments on behalf of ineligible members, including deceased members, incarcerated members, or members who have multiple recipient identification numbers (duplicate members).[22] To safeguard public funds and comply with federal regulations, division management must have processes to identify ineligible members and terminate their benefits.

In general, TennCare makes two types of payments on behalf of its members:

1. *Monthly premiums to managed care organizations (MCOs)* – Otherwise known as capitation payments, monthly premium payments provide medical and behavioral health coverage for members. TennCare pays three MCOs monthly premiums regardless of whether a member uses services during that month.
2. *Fee-for-service claims submitted by providers* – Although TennCare serves the majority of members in managed care, some members receive medical care on a fee-for-service basis. In this model, members still belong to a managed care plan, but TennCare reimburses providers directly for services the MCOs do not provide.

Management also contracts with two benefits management companies to coordinate members' prescription coverage, as well as dental coverage for certain members.[23] TennCare reimburses the benefits management companies for pharmacy and dental services provided to members.

Results of Prior Audit

In the Division of TennCare's 2018 performance audit report, we found that the division did not recover improper premiums and fee-for-service payments made on behalf of deceased, incarcerated, and duplicate members between July 1, 2016, and December 31, 2017. In response to the prior audit finding, management agreed with the portion involving fee-for-service claims paid on behalf of deceased members. Management did not agree with our finding related to premium payments for deceased, incarcerated, or duplicate members.

[22] TennCare Policy 005.045 states that management will terminate eligibility once it verifies a member's date of death. According to Title 42, *Code of Federal Regulation*s (CFR), Part 431, Section 213(a), TennCare does not have to send advance notice of termination if a member dies. 42 CFR 435.1009(a) prohibits federal financial participation for "individuals who are inmates of public institutions." In some cases, TennCare issues duplicate recipient IDs for several reasons. For example, TennCare may receive multiple applications containing the same individuals, and the applications may contain differences in demographic data.

[23] TennCare members eligible for dental coverage include children and members of the Employment and Community First CHOICES program for individuals with intellectual and developmental disabilities.

Results From the U.S. Department of Health and Human Services, Office of Inspector General Report

In a 2019 report[24] released by the U.S. Department of Health and Human Services, Office of Inspector General (HHS-OIG), the federal auditors examined TennCare's Medicaid premium payments for the period January 2, 2015, through December 31, 2017. They identified 1,383 instances where more than 1 member ID could be matched to a single member and tested a sample of 100 of those instances. In their conclusion, HHS-OIG auditors estimated that the division made unallowable premium payments of at least $581,422, with the federal share totaling $378,137. As noted in the report, division management informed the federal auditors that management needed

> a significantly more complex matching algorithm than the one that it already had in place to identify [member] matches that existed in its system. Furthermore, [management] stated that, during the period of [HHS-OIG's] review, the process to recoup duplicate capitation payments after linking duplicate recipient records was limited to 9 months and did not include the recoupment of payments beyond that 9-month period.

HHS-OIG requested that division management refund the federal government $378,137. Division management refunded the federal grantor and agreed with the federal auditors' findings.

The Comptroller's Office and HHS-OIG conducted their audits prior to the division's implementation of the Tennessee Eligibility Determination System (TEDS) in April 2019.

Management's Current Processes

Since the prior audit, management established automated matching processes to identify potential ineligible members from receiving TennCare benefits, including members who were deceased, incarcerated, or assigned multiple member identification numbers. TEDS matches data against other data in TEDS or against external sources, including the Tennessee Department of Health; the Office of Vital Records' death records; and the Tennessee Department of Correction's incarceration data, for offenders assigned to a state correctional facility or housed in a local jail.

Furthermore, division management implemented automated look-back processes to capture new data relating to deceased, incarcerated, and duplicate members and recover any improper premium payments management did not identify using the automated matching processes. When the matches identify improper payments, management retroactively voids the payments and requests refunds from the MCOs or providers for these individuals.

Audit Conclusions

Audit Objective: Did division management effectively implement corrective action to resolve the prior audit finding related to ineligible members, such as members who have died, were incarcerated, or have duplicate recipient IDs?

[24] The report is titled "Tennessee Made Unallowable Capitation Payments for Beneficiaries Assigned Multiple Medicaid Identification Numbers."

Conclusion: Based on our work, we found that, although we identified minor issues with management's processes to identify ineligible members, management effectively implemented corrective actions to address the prior audit finding.

Methodology to Achieve Objective

To address our audit objective, including gaining an understanding of management's internal controls over the removal of deceased, incarcerated, and duplicate members from the TennCare program, and to assess management's design and implementation of internal controls, we interviewed the Assistant Commissioner of Member Services and the Medicaid Management Information System Director and their staff, and we reviewed federal regulations, division policies and procedures, and flowcharts describing automated processes performed in the Tennessee Eligibility Determination System. To assess the operating effectiveness of internal controls, we obtained and reviewed the following records.

Deceased Members

We obtained management's payment records consisting of premium payments and fee-for-service (institutional, physician, dental, and pharmacy) claims for the period July 1, 2019, to June 30, 2020. We matched TennCare's membership rolls and payment records to the Tennessee Department of Health's Office of Vital Records death data. When the match identified dates of death conflicts between TennCare's records and the Tennessee Department of Health's data, we obtained verification from the Tennessee Department of Health regarding dates of death and researched obituaries to establish the correct date.

Our match identified the following payments that management paid on behalf of members after their date of death:

- 13,995 premium payments, totaling $21,466,407;
- 751 fee-for-service physician claims, totaling $4,494;
- 7 fee-for-service institutional claims, totaling $884;
- 53 TennCare Select fee-for-service claims, totaling $5,737;
- 54 dental claims, totaling $71; and
- 4,215 pharmacy claims, totaling $194,873.

For our testwork, we tested all fee-for-service institutional, TennCare Select, and dental payments. Using the above populations, we also selected the following nonstatistical, random samples:

- 60 capitation payments, totaling $93,630;
- 53 fee-for-service physician claims, totaling $170; and
- 60 pharmacy claims, totaling $4,252.

When we identified errors relating to premium payments, we identified and reviewed all payments made on behalf of the deceased members during our audit period. We tested management's process to recover these payments.

Incarcerated Members

We matched TennCare's membership and payment records to the Tennessee Department of Correction's inmate incarceration data for the period July 1, 2019, through June 30, 2020. When incarceration dates conflicted, we contacted the Department of Correction's Detainer Administrator to validate the correct dates. Our match identified the following payments that management paid on behalf of members during incarceration:

- 1,337 premium payments, totaling $314,893;
- 19 fee-for-service physician claims, totaling $97;
- 358 fee-for-service institutional outpatient claims, totaling $2,245; and
- 822 fee-for-service institutional crossover claims, totaling $295,319.

Although we tested all fee-for-service claims paid on behalf of incarcerated members, we tested a nonstatistical, random sample of 61 premium payments, totaling $14,874, that management paid the MCOs on behalf of incarcerated members. We tested management's process to recover these payments.

Duplicate Members

We analyzed Social Security numbers in TennCare's membership file to find members with potentially multiple active member identification numbers. We matched those members to the payment records and located 1,722 payments, totaling $529,761, that division management paid to MCOs on behalf of those members during the period July 1, 2019, through June 30, 2020. We selected a random sample of 60 matched premium payments, totaling $46,057, and then reviewed the payments in the interChange system and consulted division management to determine whether TennCare identified and recovered the improper duplicate payments. When we identified errors, we pulled and reviewed all premium payments made on behalf of the deceased member during our audit period. We tested management's process to recover these payments.

MEDICAL NECESSITY AND MEDICAL APPEALS

General Background

In an effort to achieve cost-effective, high-quality care, the TennCare program identifies certain services that require prior authorization from the managed care organization (MCOs). MCOs determine whether the requested services, such as home health nurses, certain pharmacy prescriptions, and dental services, are medically necessary and meet the criteria established by the *Rules of the Tennessee Department of Finance and Administration:*

- it must be recommended by a licensed provider who is treating the member,
- it must be required in order to diagnose or treat or treat a member's medical condition,
- it must be safe and effective,
- it must not be experimental or investigational, and
- it must be the least costly alternative course of diagnosis or treatment that is adequate for the enrollee's medical condition.

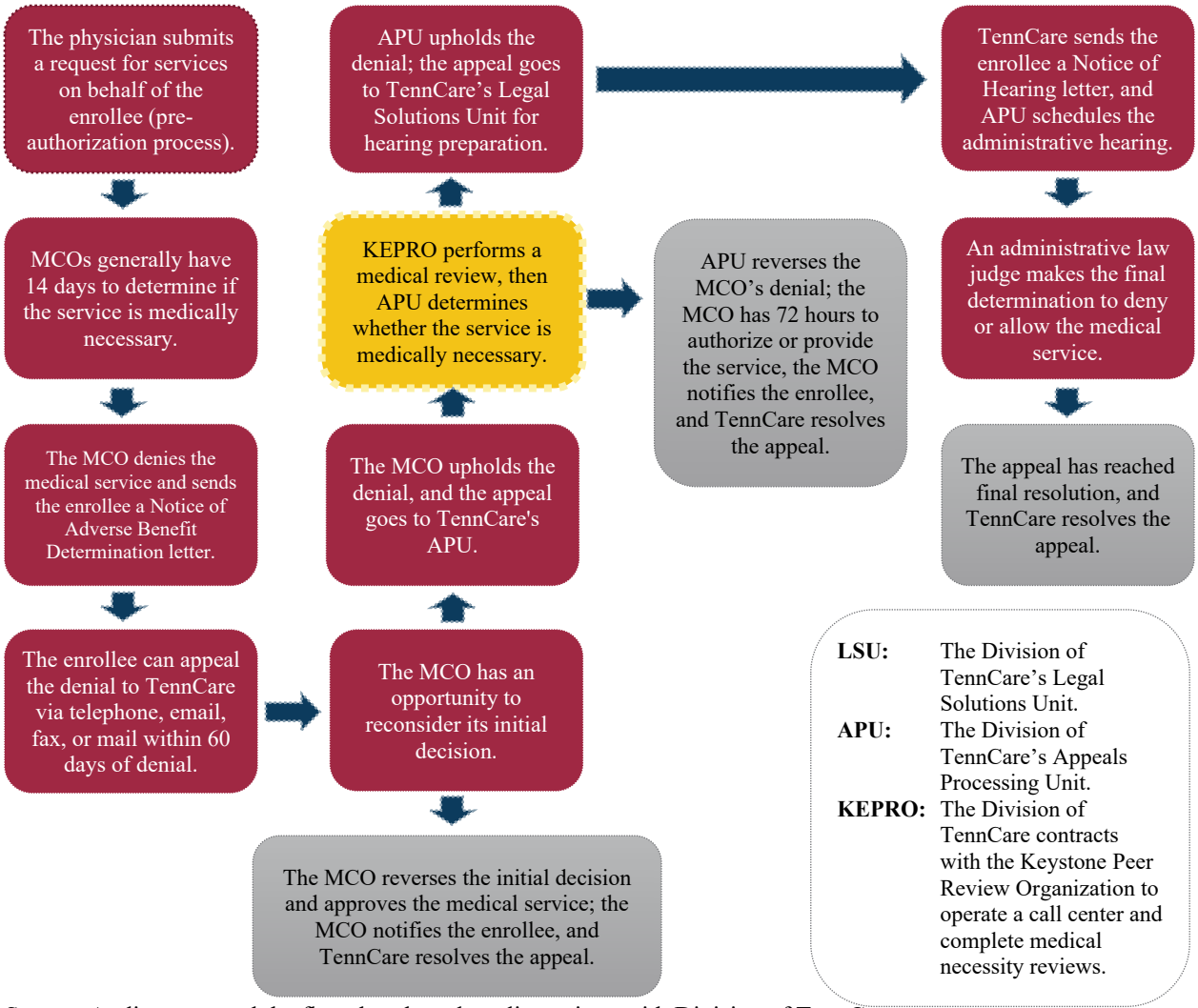
Some MCOs could abuse the prior authorization process in an effort to increase profits, denying costly services that are medically necessary but expensive to the MCO. Because the potential exists for an MCO to deny costly services that are medically necessary but expensive, Title 42, *Code of Federal Regulations,* Part 438, Section 400, requires each MCO to have a grievance and appeals system in place. Additionally, federal regulations require the state to hold a fair hearing for a member if the MCO denies their appeal. In an effort to protect TennCare members, to ensure MCOs provide medically necessary services, and to comply with federal regulations, the Division of TennCare has an established appeal process to review the MCOs' medical service denials.

Members file appeals through TennCare's Member Medical Appeals call center. The MCO reviews the denial and reconsiders its initial decision. If the MCO upholds the denial, the appeal goes to TennCare's Appeals Processing Unit (APU), and APU staff review a completed medical review[25] to decide whether to uphold or reverse the MCO's decision. As promulgated in the *Rules of the Department of Finance of Administration*, Chapter 1200-13-13-.11 and .12, TennCare must maintain documentation of its review and decision. See **Figure 4** for a breakdown of the standard medical appeal process.

We focused our review on TennCare staff's review of medical appeals (see the yellow box in **Figure 4**).

[25] TennCare contracts with the Keystone Peer Review Organization (KEPRO) to complete a medical review.

Figure 4
Standard Medical Appeal Process



Source: Auditors created the flowchart based on discussions with Division of TennCare management.

From February 21, 2020, to April 1, 2021, TennCare received 6,018 medical service appeal requests. See **Table 7** for a breakdown of appeal resolutions.

Table 7
Medical Appeals Statistics for the Period February 21, 2020, to April 1, 2021

	Totals	Percentages
Total Appeal Requests Received	**6,018**	**100%**
Denials Upheld by MCOs and Division	**4,047**	**67%**
Denials Overturned in Favor of Enrollee	**1,971**	**33%**
Overturned at MCO Reconsideration	*1,413*	*23%*
Overturned by TennCare	*403*	*7%*
Overturned by Administrative Hearing	*155*	*3%*

Source: Appeals data provided by division management.

During the appeals process, the MCO or TennCare may discover new information regarding the member's medical necessity. According to the Managed Care Director, this new information is generally the reason that MCOs and TennCare may overturn appeals.

Audit Conclusions

Audit Objective: Did division management ensure MCOs and division staff followed the established appeal process for MCOs' denials of medical services?

Conclusion: Based on our review, division management ensured MCOs and division staff followed the established appeal process.

Methodology to Achieve Objectives

To address our audit objective, including gaining an understanding of the medical appeals process and obtaining an understanding of and assessing management's design and implementation of internal control as it relates to audit objectives 1 and 2, we interviewed division management to obtain an understanding of relevant internal control and reviewed federal and state documentation related to the requirements of the medical appeals process.

To assess the operating effectiveness of internal controls, we obtained a list of all medical appeals made from February 21, 2020, to April 1, 2021, and compiled statistics on the number of appeals that were denied and the number of appeals that were overturned in favor of the enrollee. We tested a nonstatistical, random sample of 60 medical appeals that TennCare's Appeals Processing Unit reversed during the appeals process to determine whether staff had documented their justification for reversals.

Management's Corrective Action of Other Prior Audit Findings

General Background

During our work, we reviewed policies and supporting documentation to determine if management resolved the findings related to provider eligibility and information systems controls noted in the 2018 performance audit report. Below, we summarize the deficiencies noted in the 2018 performance audit report and our previous recommendations, describe management's corrective actions, and provide the results of our current audit work. Furthermore, during this audit, we identified a federal regulation requiring division management to report audit results to the Centers for Medicare and Medicaid Services (CMS).

Provider Eligibility

According to Title 42, *Code of Federal Regulations* (CFR), Part 455, Section 450,

> the State Medicaid agency must screen all initial applications, including applications for a new practice location, and any applications received in response to a re-enrollment or revalidation of enrollment request based on a categorical risk

level of "limited," "moderate," or "high." If a provider could fit within more than one risk level described in this section, the highest level of screening is applicable.

Division of TennCare management uses the Provider Database Management System (PDMS) to register and screen providers. When providers submit their registration applications, they include provider license information and all other required information mandated by TennCare's State Plan,[26] and TennCare's Provider Services staff review and approve the applications.

Prior Audit Results

During the 2018 performance audit, we reported that

- TennCare Provider Services management did not track registration processing times in PDMS or develop a formal policy to track and approve provider applications; and
- division management and the managed care organizations did not detect and terminate potentially ineligible providers with missing, expired, inactive, revoked, or unknown medical license numbers; deceased providers; or providers with invalid service addresses.

For provider registration processing, we recommended that management analyze application processing times in order to develop policies that address the registration process. We also recommended that these policies should include

- procedures for meeting performance goals for prompt processing, and
- procedures for regularly monitoring these processing times to ensure staff resolve registration errors and promptly approve registrations.

Furthermore, for provider eligibility, we recommended that management implement a policy to periodically identify and suspend providers with expired licenses, timely remove deceased providers from the active provider files, and update its provider enrollment process to verify service addresses.

Current Audit Results

In response to our prior audit findings, management implemented two policies as corrective actions to address the findings:

- the Electronic Registration of Providers policy, which requires staff to process clean applications within 30 days;[27] and

[26] A state plan is an agreement between the state and the federal government that describes how the state will administer a federal program. The plan ensures the state complies with federal rules and regulations and may claim federal matching dollars for program activities. For the TennCare program, management outlines member eligibility requirements, benefits provided, and provider activities, among other matters.

[27] In order for management to consider applications clean, provider applicants must ensure they submit accurate information, such as a correct National Provider Identifier, a unique provider number required in administrative and financial transactions adopted under the Health Insurance Portability and Accountability Act. Otherwise, PDMS will return an error and send an email to the appropriate parties for correction. Once PDMS determines all information is correct, the application is considered clean and ready for processing.

- the Provider Screening Requirements policy, which defines the risk areas promulgated in 42 CFR 455.450 and describes the division's screening procedures for providers based on their risk level.

To verify provider service addresses, in May 2019 management implemented an automated process to submit provider addresses to the managed care organizations for review to verify that the providers' service addresses are valid.

Information Systems Controls

Division management relies on information systems to support their critical business functions, including member and provider information management, as well as claims and premium payment processing. TennCare's Information Systems Division is responsible for systems development, operations, maintenance, and systems security. The Department of Finance and Administration's Strategic Technology Solutions establishes requirements and guidelines for state agencies' information systems, including system security controls.

Prior Audit Results

In the 2018 performance audit report, we noted that TennCare did not provide adequate controls in certain areas and recommended that management should promptly develop and implement internal controls in those areas to ensure compliance with applicable requirements and perform ongoing monitoring activities to identify and correct future deficiencies that may occur.

Current Audit Results

We focused our audit work on TennCare's information systems controls and operations of its interChange system, including management's measures to ensure the security, accuracy, and reliability of its hardware and software.

Federal Reporting Requirements of Audit Results

Additionally, 42 CFR 431.428 describes the division's annual reporting requirements to the Centers for Medicare and Medicaid Services (CMS). For one requirement, division management must submit "[the] existence or results of any audits, investigations or lawsuits that impact the demonstration"[28] in its annual CMS report.

Audit Conclusions

1. **Audit Objective:** Did division management effectively implement corrective action to resolve the prior audit findings related to (1) provider registration processing times and (2) detecting and terminating potentially ineligible providers and verifying provider service addresses?

[28] The TennCare waiver is also called a demonstration project. CMS approves demonstration projects to allow states the flexibility to design and improve Medicaid programs to better serve the program's members.

Conclusion: Based on our audit work, division management effectively implemented corrective action to resolve both prior audit findings.

2. **Audit Objective:** As noted in the prior audit finding, did division management follow state information systems security policies regarding information systems controls?

   Conclusion: We determined that management addressed the prior audit finding by following state information systems security policies regarding information systems controls.

3. **Audit Objective:** Did division management report the Office of the Comptroller's findings from the 2018 performance report to CMS in its annual report?

   Conclusion: Once division management became aware of the requirement to report audit findings to CMS, they submitted the 2018 performance audit findings via email to CMS on May 18, 2021.

Methodologies to Achieve Objectives

To address our objectives, including obtaining an understanding of internal control and assessing management's design and implementation of internal control, we interviewed Provider Services management to gain an understanding of the processes management used to track provider registrations and verify provider license status based on the provider's risk category, to identify deceased providers, and to verify provider service addresses. We obtained a copy of management's Electronic Registration of Providers and Provider Screening Requirements policies and the CMS Data Exchange System report. To determine if staff processed clean applications within 30 days, we obtained and reviewed Provider Database Management System (PDMS) reports. During our work on the fiscal year 2020 State of Tennessee Single Audit, we haphazardly selected two providers from each managed care organization and reviewed their profiles in PDMS to determine if the providers had valid service addresses.

Furthermore, we inquired with division leadership to determine if they reported the audit results of the 2018 performance audit to the Centers for Medicare and Medicaid Services and reviewed federal regulations regarding audit reporting requirements.

To obtain an understanding of relevant internal controls and assess management's design, implementation, and operating effectiveness of internal control as it relates to audit objectives 1 and 2, we interviewed management, performed walkthroughs, reviewed relevant policies and procedures, and performed testwork of management's control activities.

Appendices

TENNESSEE COMPTROLLER OF THE TREASURY

APPENDIX 1
Internal Control Significant to the Audit Objectives

The U.S. Government Accountability Office's *Standards for Internal Control in the Federal Government* (Green Book) sets internal control standards for federal entities and serves as best practice for non-federal government entities, including state and local government agencies. As stated in the Green Book overview,[29]

> Internal control is a process used by management to help an entity achieve its objectives . . . Internal control helps an entity run its operations effectively and efficiently; report reliable information about its operations; and comply with applicable laws and regulations.

The Green Book's standards are organized into five components of internal control: control environment, risk assessment, control activities, information and communication, and monitoring. In an effective system of internal control, these five components work together to help an entity achieve its objectives. Each of the five components of internal control contains principles, which are the requirements an entity should follow to establish an effective system of internal control. We illustrate the five components and their underlying principles below:

Control Environment	
Principle 1	Demonstrate Commitment to Integrity and Ethical Values
Principle 2	Exercise Oversight Responsibility
Principle 3	Establish Structure, Responsibility, and Authority
Principle 4	Demonstrate Commitment to Competence
Principle 5	Enforce Accountability
Risk Assessment	
Principle 6	Define Objectives and Risk Tolerances
Principle 7	Identify, Analyze, and Respond to Risks
Principle 8	Assess Fraud Risk
Principle 9	Identify, Analyze, and Respond to Change

Control Activities	
Principle 10	Design Control Activities
Principle 11	Design Activities for the Information System
Principle 12	Implement Control Activities
Information and Communication	
Principle 13	Use Quality Information
Principle 14	Communicate Internally
Principle 15	Communicate Externally
Monitoring	
Principle 16	Perform Monitoring Activities
Principle 17	Evaluate Issues and Remediate Deficiencies

In compliance with generally accepted government auditing standards, we must determine whether internal control is significant to our audit objectives. We base our determination of significance on whether an entity's internal control impacts our audit conclusion. In the following matrix, we list our audit objectives, indicate whether internal control was significant to our audit objectives, and identify which internal control components and underlying principles were significant to those objectives.

[29] For further information on the Green Book, please refer to https://www.gao.gov/greenbook/overview.

			Internal Control Components and Underlying Principles																
			Significant to the Audit Objectives																
			Control Environment					Risk Assessment				Control Activities			Information & Communication			Monitoring	
	Audit Objectives	Significance	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17
1	How many children has division management enrolled and served in the Katie Beckett Program?	Yes	–	–	–	–	–	Yes	Yes	–	Yes	–	–	–	–	–	–	–	–
2	Does the state have health service options for Katie Beckett children who reach their 18th birthday and age out of the program?	No	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–
3	Did division management ensure telehealth services addressed members' healthcare needs during the COVID-19 pandemic?	Yes	–	–	–	–	–	–	–	–	–	–	–	–	Yes	–	Yes	–	–
4	Did division management monitor the number of infants born with NAS, as well as the financial impact on the TennCare program, to determine the effectiveness of ongoing education and prevention programs?	Yes	–	–	–	–	–	–	Yes	–	–	–	–	–	Yes	–	Yes	–	–
5	In an effort to achieve the objective of supporting active recovery for severe opioid dependence and addiction, did division management and the MCOs increase the BESMART provider network since 2017?	Yes	–	–	–	–	–	–	Yes	–	–	–	–	–	–	–	–	–	–
6	To ensure TennCare members had continued access to care, did division management have a reasonable plan to complete member case conversions to TEDS within a reasonable timeline?	No	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–
7	Did division management and the contractors ensure that systems accurately transferred data from TEDS to interChange and that interChange appropriately updated the member information?	Yes	–	–	–	–	–	–	–	–	–	–	Yes	–	–	–	–	–	–
8	Is management's member survey tool based on a reasonable approach to assess members' satisfaction?	Yes	–	–	–	–	–	–	–	–	–	–	–	–	Yes	–	Yes	–	–

			Internal Control Components and Underlying Principles																
			Significant to the Audit Objectives																
			Control Environment					Risk Assessment				Control Activities			Information & Communication			Monitoring	
	Audit Objectives	Significance	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17
9	Is division management on track with Project Iris in terms of estimated costs and timeline?	Yes	–	–	–	–	–	Yes	Yes	–	Yes	Yes	–	Yes	–	–	–	–	–
10	Did the Office of Program Integrity comply with federal requirements to conduct preliminary investigations of any complaint of Medicaid fraud or abuse it receives or any questionable practices it identifies?	No	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–
11	Did TennCare and MCO management effectively implement corrective action to resolve the prior audit finding related to inadequate controls for home-delivered services and provider billings, including manual worker check-ins?	Yes	–	–	Yes	–	–	Yes	–	–	–	–	–	–	–	–	–	–	–
12	Did division management effectively implement corrective action to resolve the prior audit finding related to ineligible members, such as members who have died, were incarcerated, or have duplicate recipient IDs?	Yes	–	–	–	–	–	–	–	–	–	Yes	–	Yes	–	–	–	–	Yes
13	Did division management ensure MCOs and division staff followed the established appeal process for MCOs' denials of medical services?	Yes	–	–	–	–	–	–	–	–	–	Yes	–	Yes	–	–	–	–	–
14	Did division management effectively implement corrective action to resolve the prior audit findings related to (1) provider registration processing times and (2) detecting and terminating potentially ineligible providers and verifying provider service addresses?	Yes	–	–	–	–	–	–	Yes	–	–	–	–	Yes	–	–	–	Yes	Yes
15	As noted in the prior audit finding, did division management follow state information systems security policies regarding information systems controls?	Yes	–	–	–	–	–	–	–	–	–	–	Yes	–	–	–	–	–	–
16	Did division management report the Office of the Comptroller's findings from the 2018 performance report to CMS in its annual report?	No	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–

APPENDIX 2
Division of TennCare Operations

Deputy Commissioner/Director's Direct Reports

The Long-Term Services and Supports Unit offers long-term services and supports to individuals enrolled in TennCare. Long-term services and supports are medical and/or personal care and supportive services needed by individuals who have lost some capacity to perform activities that are essential to daily living. These activities include not only bathing, dressing, eating, and toileting but also completing housework, preparing meals, taking medications, shopping, and managing money. The unit also works with the Department of Intellectual and Developmental Disabilities to administer the Employment and Community First CHOICES (ECF CHOICES) program, which is a program for people of all ages who have an intellectual or developmental disability.

The Medical Office provides medical direction for the TennCare program and oversees the medical, pharmacy, and dental services delivered through a network of managed care organizations (MCOs) and benefits managers. The office is involved in developing medical policy and monitoring access to care, service quality, and health outcomes. The office also serves as the focal point for provider education. This office also has the TennCare Member Medical Appeals Unit that processes medical, pharmacy, and dental appeals.

The Legislative Affairs Office monitors legislation affecting TennCare by reviewing filed legislation and coordinating activities of staff involved in the review and analysis of the legislation.

The Office of General Counsel provides TennCare's legal counsel. This includes legal oversight of the development, implementation, and monitoring of TennCare's contracts for its MCOs, contractors, grantees, subcontractors, and vendors. The office works with other staff to ensure compliance with federal and state laws, regulations, court rulings, and consent decrees. The office also assists in drafting TennCare rules and policies and is involved in legal proceedings involving TennCare.

Chief Operating Officer's Direct Reports

TennCare's organizational chart is on page 50.

The Fiscal Division includes the accounting and budget personnel, purchasing, and health care informatics functions. It is also responsible for monitoring, reviewing, and signing off on all contracts. A small team of employees from the Department of Finance and Administration is responsible for processing and approving select invoices, refunds, deposits, interunit journals, expense reports, travel authorizations, and reallocation journals, and for distributing mail collected from the mail room.

The Information Systems Division is responsible for the Medicaid management information system (known as interChange), which includes member eligibility and enrollment, claims processing, data analysis, data reporting, and other related system functions. This division also handles all of TennCare's hardware, software, and system security needs through a

combination of TennCare and Department of Finance and Administration, Strategic Technology Solutions employees, and independent contractors.

Member Services leads TennCare's application process, eligibility redeterminations and terminations, and all other efforts involving TennCare's members. Member Services also processes TennCare member eligibility appeals.

Managed Care Operations is responsible for managing and overseeing TennCare's MCOs. The office negotiates the contracts with the MCOs, monitors contract compliance, and refines MCO performance measures.

The Commissioner's Designee Unit presides over contested case proceedings pursuant to the Uniform Administrative Procedures Act (UAPA) and authors final orders or other dispositive orders that accurately articulate the agency's position on matters including, but not limited to, Medicaid eligibility, long-term services and supports benefits, provider suspensions or terminations, involuntary transfers of residents from Medicaid-certified nursing homes, and declaratory order proceedings consistent with the requirements of the UAPA.

Deputy Director's Direct Reports

The Strategic Planning and Innovation Group takes on new TennCare initiatives by serving in a leadership role with special projects, taking these new initiatives and special projects to various TennCare divisions, and helping these divisions develop long-term strategies to successfully execute them.

The Policy Unit prepares program proposals for the federal Centers for Medicare and Medicaid Services (CMS) for Medicaid waiver agreements, files appropriate rules to support TennCare's programs, files Medicaid State Plan amendments, conducts research and writes policy statements to interpret programs, and submits reports required by the waiver agreements to CMS.

The Audit and Investigations Unit works with TennCare's staff to evaluate internal controls to ensure that assets are safeguarded, information is accurate and reliable, internal policies and procedures as well as external laws and regulations are followed, resources are used efficiently, operations and programs are carried out as designed, and prior audit findings are resolved.

In the Communications Office, the Public Affairs Office coordinates TennCare's communications with the General Assembly, other state agencies, healthcare associations, advocates, members, and the news media.

Within Administration and Talent Management, the Administrative Services Office coordinate employee relations by ensuring all employees are treated fairly and consistently. This area also includes a Human Resources division, a Facilities Management division, and a Contract and Asset Management division.

Assistance From Other State Agencies

The Department of Commerce and Insurance's TennCare Oversight Division protects the public health and the integrity of the TennCare program by overseeing, examining, and monitoring managed care organizations (MCOs) participating in the program. The division ensures that the MCOs under contract with the state comply with statutory and contractual requirements relating to their financial responsibility, stability, and integrity.

The Department of Children's Services provides case management for children in state custody and processes eligibility for children in foster care and children receiving adoption assistance payments.

The Department of Health (TDH) provides a broad array of services for TennCare members. TDH supports care coordination and referrals to health departments and primary care doctors for well-child visits through TDH's Community Health and Access Navigation in Tennessee program. As part of the Oral Health Services agreement, TDH provides oral health screening and treatments in health departments and community settings like schools. TDH also provides general Medicaid eligibility and support services for all members who access care through health departments. It also screens and processes presumptive eligibility for pregnant women and individuals undergoing treatment for breast and cervical cancer. Tennessee's Fetal Infant Mortality Review Board and broader TDH/TennCare strategic partnerships supporting women's health and improving infant mortality is supported through an agreement between TDH and TennCare. TDH's division of Health Care Facilities serves as the State Survey Agency for Nursing Facilities and other Medicaid facilities to meet federal requirements. TDH also provides an immunization data feed to TennCare.

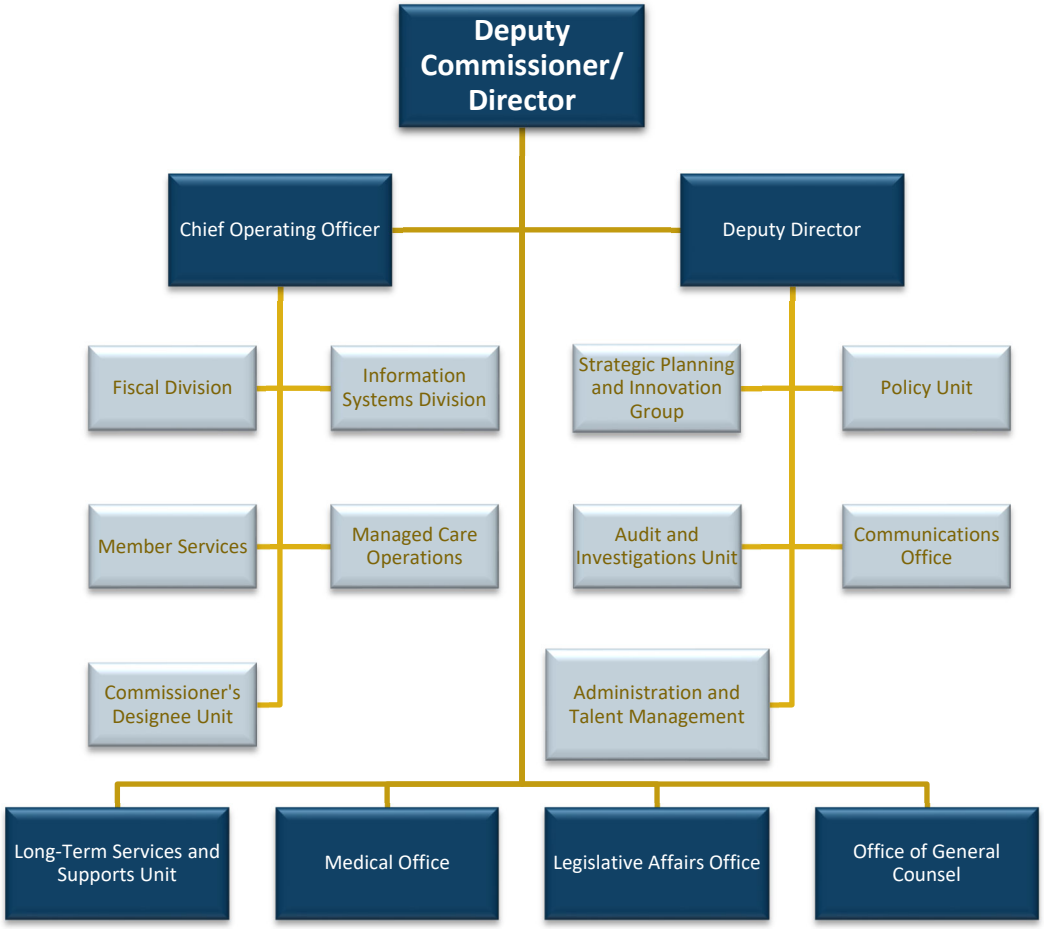
The Secretary of State reviews contested medical appeals decisions. The Department of Education partners with TennCare on CoverKids outreach in an annual back-to-school campaign. The Department of General Services provides centralized facilities management, contracting, and printing of some member notices. The Department of Correction provides data on incarcerated individuals. The Department of Human Resources provides centralized support to agencies to administer employee compensation, payroll, benefits management, and a centralized job posting database.

Department of Human Services (DHS) county offices provide in-person eligibility assistance if needed. TennCare has an agreement with DHS for Vocational Rehabilitation (VR) services for ECF CHOICES and Katie Beckett members. It is a no-cost agreement, but it prescribes the roles and responsibilities of both VR and TennCare. The Comptroller of the Treasury calculates payments to Federally Qualified Health Centers, Rural Health Clinics, and Intermediate Care Facilities for Individuals with Intellectual Disabilities for TennCare. The Comptroller's Office also performs audits of various TennCare providers.

The Department of Intellectual and Developmental Disabilities (DIDD) serves TennCare members with intellectual and developmental disabilities (I/DD) who receive services through a 1915(c) waiver. TennCare also contracts with DIDD to perform intake and certain quality-related functions for ECF CHOICES. In the future, DIDD will perform contracted administrative and

oversight functions across Medicaid I/DD programs and authorities, including with MCOs. DIDD also manages Katie Beckett Part B and intake functions for Katie Beckett Part A. TennCare contracts with the Department of Mental Health and Substance Abuse Services and DIDD to serve as the state mental health and intellectual disabilities authorities, respectively, in the federally required Pre-Admission Screen and Resident Review process.

APPENDIX 3
Division of TennCare Organizational Chart
February 2021



Source: Division of TennCare management.

APPENDIX 4
Division Financial Information

Table 8
Fiscal Year 2020 Budget and Actual Expenditures and Revenues

Division of TennCare		FY 19–20 Recommended Budget*	FY 19–20 Actual Expenditures and Revenues†
Expenditures	Payroll	$ 98,964,800	$ 92,463,700
	Operational	12,170,515,100	12,319,124,400
	Total	$12,269,479,900	$12,411,588,100
Revenues	State	$ 3,910,904,300	$ 3,599,493,400
	Federal	7,609,891,800	7,974,489,200
	Other	748,677,800	837,607,500
	Total	$12,269,479,900	$12,411,588,100

* Source: Tennessee State Budget, Fiscal Year 2019–2020.
† Source: Tennessee State Budget, Fiscal Year 2021–2022 (Actual Expenditures and Revenues).

Table 9
Division of TennCare's Fiscal Year 2020 Federal Expenditures

Federal Program	Federal Funds Expended
Medical Assistance Program (MAP)	$7,668,242,162
MAP COVID Relief Funds	$ 332,006,967
Children's Health Insurance Program (CHIP)	$ 113,768,220
CHIP COVID Relief Funds	$ 2,875,284
Total	**$8,116,892,633**

Source: Single Audit reports for fiscal year 2020.

APPENDIX 5
Katie Beckett Program Eligibility

TennCare Member Services does not automatically review all TennCare child applicants for Katie Beckett eligibility. Therefore, when a parent submits a TennCare application for their child in TennCare Connect, the Division of TennCare's public-facing portal for the Tennessee Eligibility Determination System (TEDS), they must indicate on the application if they are also applying for the Katie Beckett program. Once the parent submits the application, TEDS will send a notification to the Division of TennCare and Department of Intellectual and Developmental Disabilities (DIDD) staff and will hold a Part B slot until the determination process is complete.

To enroll in the Katie Beckett program, a child must be both medically and financially eligible. DIDD makes the medical eligibility determination for Part B, while the Division of TennCare's eligibility caseworker determines the financial eligibility. Although these two agencies begin their reviews at the same time, the Division of TennCare's eligibility caseworker cannot approve a child financially until the child is determined medically eligible. DIDD staff determine Part B medical eligibility through a medical review called a pre-admission evaluation (PAE). The PAE helps management determine the level of care the child needs by thoroughly documenting the child's medical, behavioral, and functional needs. The Division of TennCare currently contracts with a third party to conduct the institutional level of care assessment. While a child's application is pending a financial and/or medical eligibility determination, the Division of TennCare holds open a Part B slot for that child.

Medical Eligibility

Once DIDD staff receive notification of a new Katie Beckett application, they contact the applicant to schedule the PAE assessment. Once they complete the assessment and collect all necessary documents, DIDD staff make a level of care determination as to Part B. If DIDD staff approve the Part B level of care, TennCare Member Services can complete the financial process and enroll the applicant in Part B unless the applicant triggered or requested Part A. If DIDD staff think the child qualifies for Part A or the child's parent requests a Part A review, TEDS will continue to hold the Part B slot while DIDD staff send a referral to Ascend, with whom Division of TennCare management has contracted to complete the assessments for Part A.

Once Ascend receives the application, they contact the applicant and schedule a time to complete an additional medical assessment. After they complete their assessment and collect all necessary documents, an Ascend physician determines whether or not the child is eligible for Part A benefits. If they find the applicant eligible, TennCare holds a Part A slot for the applicant, based on priority, until the Division of TennCare staff determine the applicant's financial eligibility. The Division of TennCare Long-Term Services and Supports reviews and makes final determinations.

Financial Eligibility

When the parent submits the child's application through TennCare Connect, TEDS processes the provided information and determines whether the application requires the Division of TennCare staff to manually verify the applicant's financial information. Under normal

circumstances, if TEDS requires manual verification, such as bank statements to verify income, the eligibility caseworker requests additional information from the applicant and updates the case based on the response. DIDD staff or an Ascend physician processes the child's medical eligibility first; once complete, TEDS will prompt the eligibility caseworker to process the child's case to determine financial eligibility. The eligibility caseworker reviews the member's case for household income and family size to ensure that the child does not qualify for Medicaid through another eligibility category. For a child deemed eligible for Part A, TEDS will build a budget using the household's income and resources to determine if the parent must pay a premium. If the parents must pay a premium, the Division of TennCare eligibility caseworker will not enroll the child until they have made the payment.

APPENDIX 6
Division of TennCare Management's Response to the COVID-19 Pandemic

During the COVID-19 pandemic, Division of TennCare management took several steps to reduce a potential negative impact on providers and members, thereby allowing management to continue to meet its mission of providing high-quality, cost-effective care to its members.

Additional Payments to Providers to Offset Lost Revenue

Primary Care

Management secured state and federal funding totaling approximately $15.8 million to provide direct payments to TennCare primary care providers for services performed in January 2020 and February 2020. Management provided these payments to help providers offset the reductions in Medicaid revenue due to canceled or postponed services during the pandemic. See **Table 10** for each MCO's COVID-19 targeted payment distribution.

Table 10
COVID-19 Targeted MCO Payment Distribution for Primary Care Providers

Managed Care Organization	Total Distribution
Amerigroup	$ 3,507,973
BlueCare	7,265,988
UnitedHealthcare	5,014,702
Total	**$15,788,633**

Source: Division of TennCare management.

Nursing Facilities and Home- and Community-Based Services Providers

In addition to primary care providers, division management provided payment assistance to nursing facilities and home- and community-based services (HCBS) providers to offset revenue losses and pay additional funds to frontline workers. According to division management, management paid an additional $120 million to nursing facilities during calendar year 2020. The division offered temporary retainer payments[30] to

- Adult Day Care[31] providers in the CHOICES[32] program; and

[30] Retainer payments are payments made to allow certain home- and community-based providers to bill and receive payment for individuals enrolled in Medicaid even if the services cannot be provided during a public health emergency.

[31] Adult Day Care programs provide daytime programs for adults who need supervision when their caregivers are not available.

[32] TennCare's CHOICES program includes nursing facility services and home- and community-based services for adults 21 years of age and older with a physical disability and seniors (age 65 and older).

- Job Coaching,[33] Supported Employment for Small Groups, Integrated Employment Path, and Community Integration Support Services providers in the Employment and Community First CHOICES[34] program.

For the listed services, if the providers planned to serve TennCare members for the period March 13, 2020, through May 12, 2021, but did not provide the actual or an alternative service to the members due to the public health emergency, the providers could file claims to their MCOs to obtain retainer payments. Division management set the retainer payment at 75% of the rate the provider would have received for the actual delivery of services, but the provider had to agree to pay their staff at the current wage or salary levels.

Division management paid a temporary rate increase to home- and community-based services residential and personal care providers in the CHOICES program, ECF CHOICES program, and the Section 1915(c) home- and community-based waivers operated by DIDD if the providers agreed, by June 1, 2020, to the following:

- The providers will restore wage and salary levels for currently employed staff to the amount staff would have been paid prior to March 13, 2020.
- If the provider laid off or furloughed staff, the provider must offer a return to work, with the employees earning at least the amount of wages they were paid prior to the public health emergency.
- The providers must commit to providing services during and after the public health emergency.

We found that, with the federal assistance it received and the flexibilities it authorized for the providers, TennCare was able to continue providing services to members without disruptions in services.

Furthermore, management stated that HCBS providers received a significantly higher add-on payment if their workers served a member who was confirmed COVID-19 positive at home.

TennCare's Provider Network – Pre- and Post-COVID-19 Pandemic Comparison

From March 2020 to February 2021, the MCOs' networks of primary care and long-term care providers saw both increases and decreases in provider locations in West, Middle, and East Tennessee. However, we were unable to determine whether these fluctuations were due to standard network changes or the COVID-19 pandemic. Additionally, we acknowledge that simple physical location counts are not the only way to look at network adequacy because they do not reflect how many patients the providers treat at each location.

[33] Job coaching for Employment and Community First CHOICES members includes identifying, through job analysis, and providing services and supports that assist the individual in maintaining individualized employment.

[34] Employment and Community First CHOICES uses Medicaid managed care to provide home- and community-based long-term services and supports for individuals with intellectual or developmental disabilities.

APPENDIX 7
Fiscal Year 2020 Single Audit Findings

The 2020 Single Audit disclosed the following two findings:

- As noted in the prior audit, TennCare management did not promptly address TennCare's Medicaid eligibility process deficiencies, resulting in $111,402 in federal and state questioned costs (see page 54 of the *Single Audit Report*); and
- Management should promptly address TennCare's CoverKids eligibility process deficiencies (see page 66 of the *Single Audit Report*).

As a result of our audit findings, we recommended that management develop an adequate plan to work the conversion cases and eliminate the backlog, provide further training to eligibility caseworkers, ensure the TEDS contractor's system fixes operate as design, and update the division's annual risk assessment. Management concurred with both findings.

Attachment C:
Audit Report of Tennessee Medicaid by Office of Inspector General

DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF INSPECTOR GENERAL

OFFICE OF AUDIT SERVICES, REGION IV
61 FORSYTH STREET, SW, SUITE 3T41
ATLANTA, GA 30303

October 19, 2021

Report Number: A-04-19-04070

Mr. Stephen Smith
Director
Division of TennCare
310 Great Circle Rd.
Nashville, TN 37243

Dear Mr. Smith:

Enclosed is the Department of Health and Human Services (HHS), Office of Inspector General (OIG), final report *Tennessee Medicaid Claimed Hundreds of Millions of Federal Funds for Certified Public Expenditures That Were Not in Compliance With Federal Requirements*. We will forward a copy of this report to the HHS action official noted on the following page for review and any action deemed necessary. The HHS action official will make final determination as to actions taken on all matters reported.

Section 8M of the Inspector General Act, 5 U.S.C. App., requires that OIG post its publicly available reports on the OIG website. Accordingly, this report will be posted at https://oig.hhs.gov.

If you have any questions or comments about this report, please do not hesitate to call me, or contact Mark Wimple, Assistant Regional Inspector General for Audit Services, at (678) 642-2962 or Mark.Wimple@oig.hhs.gov. Please refer to report number A-04-19-04070 in all correspondence.

Sincerely,

LORI PILCHER Digitally signed by LORI PILCHER Date: 2021.10.18 08:55:00 -04'00'

Lori S. Pilcher
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Enclosure

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Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

TENNESSEE MEDICAID CLAIMED HUNDREDS OF MILLIONS OF FEDERAL FUNDS FOR CERTIFIED PUBLIC EXPENDITURES THAT WERE NOT IN COMPLIANCE WITH FEDERAL REQUIREMENTS

Inquiries about this report may be addressed to the Office of Public Affairs at Public.Affairs@oig.hhs.gov.

Christi A. Grimm
Principal
Deputy Inspector General

October 2021
A-04-19-04070

Office of Inspector General

https://oig.hhs.gov

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OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

The designation of financial or management practices as questionable, a recommendation for the disallowance of costs incurred or claimed, and any other conclusions and recommendations in this report represent the findings and opinions of OAS. Authorized officials of the HHS operating divisions will make final determination on these matters.

Report in Brief
Date: October 2021
Report No. A-04-19-04070

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL

Tennessee Medicaid Claimed Hundreds of Millions of Federal Funds for Certified Public Expenditures That Were Not in Compliance With Federal Requirements

Why OIG Did This Audit

Under a Medicaid waiver, Tennessee was allowed to claim as certified public expenditures (CPEs) the uncompensated cost of care (UCC) at public hospitals for Medicaid enrollees and uninsured patients. For State fiscal years (SFYs) 2009–14, Tennessee claimed a total of $2 billion in CPEs.

For SFYs 2010–13, Tennessee each year claimed the same amount of $373.8 million, indicating that it may not have calculated specific estimates of the CPEs for each of those years, as required. Additionally, a recent audit found that another State had improperly paid $686 million in Medicaid supplemental pool payments.

Our objective was to determine whether Tennessee complied with Federal requirements for claiming CPEs for public hospital unreimbursed costs.

How OIG Did This Audit

Our audit covered the $2 billion in CPEs that Tennessee claimed for SFYs 2009–14 (audit period), which were the most recent SFYs for which supporting calculations of actual CPEs were available. We compared the CPEs that Tennessee claimed to its summaries of actual CPEs for each SFY and reviewed the UCC calculations and supporting documentation for five hospitals that received disproportionate share hospital payments and five institutions for mental diseases (IMDs).

What OIG Found

Tennessee did not comply with Federal requirements for claiming CPEs for public hospital unreimbursed costs. Of the $2 billion in CPEs that Tennessee claimed during our audit period, $909.4 million was allowable and supported. However, the remaining $1.1 billion ($767.5 million Federal share) exceeded the amount allowed. This amount included $482.1 million ($337.5 million Federal share) of excess CPEs that Tennessee claimed but did not return after calculating actual CPEs.

In addition, the actual CPEs that Tennessee calculated included another $609.4 million ($430 million Federal share) that exceeded the allowable amount. It was composed of $522.3 million ($370.1 million Federal share) of unsupported net costs of caring for IMD uninsured patients, $53.6 million ($37.9 million Federal share) of unallowable net costs of caring for TennCare IMD patients between the ages of 21 and 64, and $33.5 million ($22 million Federal share) of overstated costs because of incorrect calculations.

What OIG Recommends and Tennessee Comments

We recommend that Tennessee: (1) refund $397.4 million in overpayments to the Federal Government for CPEs that it claimed in excess of the allowable amount; (2) provide support for or refund to the Federal Government $370.1 million for the net costs of caring for uninsured IMD patients for which it did not provide detailed supporting documentation; and (3) establish additional policies and procedures to ensure compliance with Federal requirements. The detailed recommendations are listed in the body of the report.

In written comments on our draft report, Tennessee disagreed with our first recommendation, objecting to the years covered by our audit and to our interpretation of Federal requirements governing costs related to IMD patients between the ages of 21 and 64. Tennessee disagreed with our second recommendation, stating that, in addition to its disagreement regarding Federal requirements, it provided sufficient data to support uninsured IMD costs. Tennessee generally agreed with our third recommendation to establish additional policies and procedures except that it did not agree that it should establish policies to identify and exclude costs for IMD patients between the ages of 21 and 64. After considering Tennessee's comments, we maintain that our findings and recommendations are valid for the reasons detailed in the report.

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INTRODUCTION

WHY WE DID THIS AUDIT

In 2002, the Centers for Medicare & Medicaid services (CMS) approved Tennessee's Research and Demonstration Waiver for Medicaid reform, TennCare II (waiver). The waiver allowed Tennessee's State Medicaid agency (State agency) to claim the uncompensated cost of care (UCC) experienced by public hospitals caring for Medicaid beneficiaries (TennCare enrollees) and uninsured patients as certified public expenditures (CPEs).[1] In this report, we refer to TennCare enrollees and uninsured patients collectively as "low-income patients."

For State fiscal years[2] (SFYs) 2009–14, the State agency claimed about $2 billion in CPEs for low-income patients treated at 28 hospitals. For SFYs 2009 and 2014, it claimed about $386 million and $120 million, respectively. However, for SFYs 2010–13, the State agency each year claimed the same amount of $373.8 million,[3] indicating that it may not have calculated estimates of the CPEs for each of those years, as required.

Additionally, a recent audit found that another State had improperly paid $686 million ($412 million Federal share) in Medicaid supplemental pool payments[4] that were not in accordance with its waiver and applicable Federal regulations.[5]

OBJECTIVE

Our objective was to determine whether the State agency complied with Federal requirements for claiming CPEs for public hospital unreimbursed costs.

[1] Public funds may be considered part of the State's share and eligible for Federal financial participation (FFP) if they are certified by the contributing public agency (in this case, public hospitals) as representing expenditures eligible for FFP (42 CFR § 433.51).

[2] Tennessee's State fiscal year is July 1 through June 30.

[3] The actual amount claimed each year was $373,799,863 for SFYs 2010, 2011, and 2013 and $373,799,861 for SFY 2012.

[4] The State made the supplemental payments as part of its Low Income Pool program, which it established to compensate providers for the cost of care given to low-income patients.

[5] Department of Health and Human Services, Office of Inspector General report number A-04-17-04058, "Florida Medicaid Paid Hundreds of Millions in Unallowable Payments to Jackson Memorial Hospital Under Its Low Income Pool Program." Available online at https://oig.hhs.gov/oas/reports/region4/41704058.asp.

BACKGROUND

Medicaid Program

The Medicaid program provides medical assistance to low-income individuals and individuals with disabilities. The Federal and State Governments jointly fund and administer the Medicaid program. At the Federal level, CMS administers the program. Each State administers its Medicaid program in accordance with a CMS-approved State plan. A State plan establishes which services the Medicaid program will cover. Although a State has considerable flexibility in designing and operating its Medicaid program, it must comply with applicable Federal requirements.

The Federal Government pays its share of a State's medical assistance costs based on the Federal medical assistance percentage, which varies depending on a State's relative per capita income. In Tennessee, the State agency administers the Medicaid program.

Medicaid Demonstration Projects

The State agency operates the waiver, which CMS approved in 2002 under section 1115 of the Social Security Act (the Act).[6] Section 1115 of the Act gives CMS authority to approve experimental, pilot, or demonstration projects that it considers likely to assist in promoting the objectives of the Medicaid program. The purpose of these projects, which give States additional flexibility to design and improve their programs, is to demonstrate and evaluate State-specific policy approaches to better serve Medicaid populations.

Special Terms and Conditions

To implement a State demonstration project, States must comply with the special terms and conditions (STCs) of the agreement between CMS and the State.[7] STCs specify the nature, character, and extent of Federal involvement in the waiver and a State's obligations to CMS during the life of the waiver.

Authorization of Certified Public Expenditures

The waiver's STCs included a provision for the Unreimbursed Public Hospital Costs Pool for CPEs under which the State agency was allowed to claim CPEs for actual unreimbursed costs incurred by Government-operated hospitals for the provision of inpatient and outpatient

[6] This waiver is a continuation of the original waiver, TennCare, which began in January 1994.

[7] Three versions of the STCs were in effect during our audit period: One was effective July 1, 2008, through June 30, 2010 (STC-a); a second was effective July 1, 2010, through June 30, 2013 (STC-b); and a third was effective July 1, 2013, through June 30, 2014 (STC-c).

TennCare services provided to low-income patients.[8] To claim CPEs, the State agency was required to document actual costs that exceeded the amounts paid by various sources for providing the TennCare services (STC-a, paragraph 54(h), STC-b, paragraph 57(h), and STC-c, paragraph 55(h)).

Certified Public Expenditure Methodology and Protocol

The STCs include the methodology for calculating CPEs.[9] A State agency contractor calculated UCC for public hospitals during the audit period. Federal law requires that States make disproportionate share hospital (DSH) payments[10] to a qualifying hospital that serves a large number of Medicaid and uninsured individuals.[11] The contractor calculated UCC for DSHs using the DSH survey form. The contractor calculated UCC for non-DSHs using an identical methodology but did not use the DSH survey forms.[12] To calculate UCC, the contractor used Medicare cost reports[13] as well as low-income patient days, ancillary charges, and payments that it obtained from the hospitals' UCC surveys and Tennessee's Medicaid paid claims listing.[14] Although the UCC calculations include the costs of caring for patients with various payor sources, to calculate CPEs the State agency removes from these calculations the costs net of payments for all patients except TennCare enrollees and the uninsured. The UCC surveys included a certification from a representative of each hospital stating that the data used in the calculation of UCC were "true and accurate to the best of our ability and supported by the financial and other records of the hospital."

[8] The Unreimbursed Public Hospital Costs Pool for CPEs was included in a group of cost pools that had a combined annual limit of $540 million for the period July 1, 2008, through June 30, 2016.

[9] The methodology is included in Attachment F of both STC-b and STC-c and was approved retroactively to July 1, 2008.

[10] DSH payments are designed to pay hospitals for the UCC incurred for treating Medicaid and uninsured patients.

[11] The Act §§ 1902(a)(13)(A)(iv) and 1923.

[12] Both the DSH survey form and the identical calculation for non-DSHs that the State agency's contractor prepares are calculations of a hospital's costs net of payments (i.e., UCC) for TennCare enrollees, uninsured patients, patients eligible for Medicaid and Medicare (i.e., dual eligible patients), patients eligible for Medicaid and other insurance, and out-of-State Medicaid patients.

[13] The Medicare cost report is a form that all hospitals must submit to CMS to determine program payments and support Federal program management.

[14] Hospitals prepared UCC surveys that provided patient data summary totals for uninsured patients, dual eligible patients, Medicaid eligible patients with other insurance coverage, and out-of-State Medicaid patients.

Calculation of Hospital Uncompensated Care

The STCs describe the steps hospitals should perform to calculate the costs of caring for low-income patients in this way:

- determine the total hospital costs per day by inpatient routine cost center and the total cost-to-charge ratio by ancillary cost center;[15]

- multiply each inpatient routine cost center's low-income patient days[16] by the costs per day for the cost center; and

- multiply each ancillary cost center's inpatient and outpatient low-income charges by the cost-to-charge ratio for the cost center (STCs, Attachment F,[17] section I).

Hospitals should reduce the calculated low-income costs (i.e., costs of caring for low-income patients) by payments received on the related low-income accounts to arrive at UCC.

Interim Reconciliation

Each year, the State claims estimates of CPEs on the CMS-64s and receives Federal financial participation (FFP).[18] However, hospitals are not required to file Medicare cost reports until 5 months after a fiscal year ends. Once hospitals file their Medicare cost reports for the payment year, the State agency must reconcile the estimated CPEs previously claimed to the UCC calculated using the Medicare cost reports for that year (i.e., the actual CPEs). In this report, we refer to the UCC calculated by the State agency for this interim reconciliation as the "actual CPEs."

[15] Costs, days, and ancillary charges are included in the Medicare cost-report worksheets B part I, S-3, and C part I, respectively (STCs, Attachment F). The data on these cost-report worksheets are broken down into cost centers based on the hospital services to which they relate. Examples of inpatient routine service cost centers are the adults and pediatrics unit, intensive care unit, and coronary care unit. Examples of ancillary cost centers are operating room, recovery room, and radiology. Worksheet C of the Medicare cost report includes the ratio of total costs to total charges for each ancillary cost center (i.e., cost-to-charge ratio).

[16] Low-income patient days refers to the total of days of service for all low-income patients during which those patients were inpatients at a hospital.

[17] Only STCs b and c have an Attachment F; however, both documents note that CMS approved the cost calculation protocol from Attachment F for use beginning July 1, 2008, which was the beginning date for our audit period.

[18] The CMS-64 "Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program" is a summary of expenditures derived from source documents such as invoices, cost reports, and eligibility records that Medicaid State agencies use to report program costs to CMS for FFP.

If the State agency determines that the payments to a hospital together with the claimed CPEs exceeded the actual cost of caring for low-income patients—i.e., the hospital was overpaid—then the State agency must credit the excess to the Federal Government. But if the State agency determines that a hospital was underpaid, then the State agency should claim the difference as additional CPEs. According to the STCs, the State agency is required to revise its FFP claim "to reconcile actual CPEs with the CPE estimates" within 12 months of the end of a SFY (STC-a, paragraph 54(h), STC-b, paragraph 57(h), and STC-c, paragraph 55(h)).

Reconciliation to the Finalized Medicare Cost Report

The STCs require that the State agency repeat the reconciliation process after a Medicare administrative contractor (MAC)[19] finalizes Medicare cost reports.[20] Again, the State agency should credit to the Federal Government any overstatements of CPEs (STCs, Attachment F, section IV).

Uncompensated Cost of Care for the Audit Period

For the audit period, the State claimed estimates of CPEs on the CMS-64s of $2 billion. For each year in the audit period, the State agency prepared interim reconciliation files in which it summarized by hospital the cost of care for low-income patients for all public hospitals for which it claimed CPEs and then compared the costs to payments received for those patients to arrive at the net UCC (actual CPEs). According to these interim reconciliation files, the total cost of caring for low-income patients for all public hospitals was $4.1 billion[21] and the total payments received for these patients was $2.6 billion[22] for net actual CPEs of $1.5 billion for the audit period, as determined by the State agency.[23] UCC calculations that the State agency's contractor prepared for individual public hospitals are the primary source documents for the summary interim reconciliation files.

[19] A MAC is a private health care insurer that contracts with CMS as the primary operational contact between the Medicare program and enrolled health care providers for a multistate region. A MAC performs many activities including enrolling providers in the Medicare program, processing and paying Medicare claims, and auditing Medicare cost reports.

[20] In Appendix A, we noted that in recalculating the low-income costs portion of actual CPEs we used data from finalized Medicare cost reports when available. However, there were only minor changes to low-income costs attributable to using the finalized Medicare cost report versions.

[21] The total cost was $4,069,267,405.

[22] The total paid was $2,550,410,335.

[23] The total net actual CPEs was $1,518,857,070.

HOW WE CONDUCTED THIS AUDIT

Our audit covered the $2 billion[24] in CPEs that the State agency claimed for SFYs 2009–14 (audit period).[25] For each SFY in the audit period, we compared the CPEs that the State agency claimed on the CMS-64s with the actual CPEs according to the State agency's summary interim reconciliation files.[26] We then reviewed the UCC calculations for the five DSHs with the highest costs of caring for low-income patients and for all five State-owned institutions for mental diseases (IMDs). We performed recalculations of UCC using Medicare cost reports and summary totals for low-income patient data (patient days and ancillary charges). We traced summary low-income patient data to the supporting details for 1 year for the five DSHs and for all years for the IMDs.[27]

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

We conducted our audit from May 2019 to April 2021. See Appendix A for the details of our scope and methodology and Appendix B for applicable Federal requirements.

FINDINGS

The State agency did not comply with Federal requirements for claiming CPEs for public hospital unreimbursed costs. Of the $2 billion in CPEs that the State agency claimed during our audit

[24] The total amount of CPEs claimed was $2,000,994,010.

[25] SFY 2009 was the earliest SFY for which State officials indicated that they had not adjusted the CPE estimates to correct overpayments. SFY 2014 was the most recent year for which the State agency had completed its calculations of actual CPEs when we began our audit in 2019.

[26] On March 2, 2020, the State agency provided revised interim reconciliation files for SFY 2010 through SFY 2012 that reflected an increase in the actual CPEs of about $329.5 million over the previous versions. These revisions included: (1) a $291 million increase to include hospitals that the State agency had previously erroneously excluded ($259.5 million for IMDs and $31.5 million for other hospitals); (2) a $32.7 million increase to reflect a reduction in DSH payments because of redistribution; and (3) other changes resulting in a net increase of $5.8 million. We audited the revised versions of the interim reconciliation files for those years.

[27] We traced to patient-level detail for only 1 year for DSHs because DSHs had significantly more low-income patient data. Additionally, for IMDs we needed the patient-level detail for each year to identify low-income patient data related to patients between the ages of 21 and 64.

period, $909.4 million[28] was allowable and supported. However, the remaining $1.1 billion[29] ($767.5 million[30] Federal share) that the State agency claimed exceeded the amount allowed by Federal requirements.

The $2 billion that the State agency claimed in CPEs was $482.1 million[31] ($337.5 million[32] Federal share) higher than the actual CPEs of $1.5 billion[33] that the State agency calculated. However, the State agency never refunded the overpayment of $337.5 million to the Federal Government as required by the waiver. In addition, the actual CPEs of $1.5 billion that the State agency calculated included unallowable costs of $609.4 million[34] as follows:

- $522,301,135 ($370,119,499 Federal share) of net costs for caring for uninsured IMD patients for which the State agency had no detailed supporting documentation;

- $53,629,631 ($37,873,870 Federal share) of net costs for caring for TennCare IMD patients between the ages of 21 and 64 for whom Federal funding was not allowable and costs were expressly prohibited by the waiver; and

- $33,477,410 ($21,985,082 Federal share) in costs that were overstated because the State agency incorrectly calculated inpatient routine costs for IMDs.

(See Appendix C for a summary of these findings by year and in total.)

The State agency did not adjust CPE estimates to actual CPEs because it did not have policies and procedures in place to ensure that it did so. The State agency claimed costs for uninsured IMD patients for which it had no patient-level detailed support because it neither had policies and procedures nor actual practices in place for collecting patient-level detail data for uninsured IMD patients. The State agency claimed the costs of caring for TennCare enrollees who were IMD patients between the ages of 21 and 64 because it believed that the costs for those patients were allowable and thus had no policies and procedures to identify and exclude those costs. Finally, the State agency also overstated actual CPEs that it calculated for IMDs

[28] The allowable amount claimed was $909,448,894.

[29] The remaining amount claimed was $1,091,545,116.

[30] The Federal share was $767,461,115.

[31] The total amount was $482,136,940.

[32] The total Federal share was $337,482,664.

[33] The total actual CPEs calculated by the State agency were $1,518,857,070.

[34] The total of unallowable costs was $609,408,176.

because it did not have a review process in place that would identify errors in the calculations that its contractor made.

As a result, over a 6-year period the State agency received overpayments of $397.4 million[35] from the Federal Government and may have received additional overpayments of $370.1 million[36] for unsupported costs.

THE STATE AGENCY DID NOT RETURN FEDERAL OVERPAYMENTS OF CERTIFIED PUBLIC EXPENDITURES IDENTIFIED THROUGH RECONCILIATION

Within 12 months of the end of each SFY, the waiver requires the State agency to reconcile "actual CPEs" with "CPE estimates" and revise its FFP claim for CPEs on its CMS-64s. The State agency must calculate actual CPEs using the protocol in Attachment F of the STCs.[37] If the State agency identifies that a hospital received an overpayment, the State agency should credit the Federal Government, and if it identifies that a hospital has been underpaid, the State agency can claim additional reimbursement for the underpayment. Upon finalization of the hospitals' Medicare cost reports, the State agency must perform a final reconciliation based on the finalized Medicare cost reports.[38]

The State agency calculated the actual CPEs and determined that for the audit period the estimated CPEs claimed on the CMS-64s exceeded actual CPEs in the aggregate (i.e., hospitals had been overpaid). However, it did not adjust its estimated claims for CPEs to reflect this overpayment, as required, or return the Federal share of overpayments. The State agency originally claimed estimated CPEs totaling $2 billion. The State agency calculated actual CPEs of only approximately $1.5 billion—a difference of about $482.1 million. Because it did not adjust the estimated CPEs claimed to the actual CPEs that it calculated, the State agency received an overpayment of $337.5 million from the Federal Government.

THE STATE AGENCY'S CALCULATED ACTUAL CERTIFIED PUBLIC EXPENDITURES INCLUDED UNSUPPORTED COSTS FOR UNINSURED PATIENTS WHO RECEIVED SERVICES FROM INSTITUTIONS FOR MENTAL DISEASES

When defining CPEs, the STCs only allow the actual costs incurred by Government-operated hospitals for the provision of inpatient and outpatient TennCare services for TennCare enrollees and uninsured patients. In addition, the STCs require that the State be able to document that

[35] The total overpayment was $397,341,616. We rounded this amount up to $397.4 million so that the rounded overpayments ($397.4 million and $370.1 million) correctly total $767.5 million.

[36] The total additional overpayment was $370,119,499.

[37] STC-a, paragraph 54(h), STC-b, paragraph 57(h), and STC-c, paragraph 55(h).

[38] STCs, Attachment F, sections III and IV.

the hospitals had actual unreimbursed costs for providing those services, which exceeded the amounts paid to the hospital (STC-a, paragraph 54(h), STC-b, paragraph 57(h), and STC-c, paragraph 55(h)). When calculating uninsured costs, the State may use data for services furnished to uninsured patients during the payment year to the extent that the data can be verified to be complete and accurate (STCs, Attachment F, section I). The STCs also require the State to calculate costs by multiplying inpatient routine costs per day and ancillary cost-to-charge ratios, as derived from the Medicare cost report, by low-income patient days and ancillary charges, respectively (STCs, Attachment F, section I).

Furthermore, the Act does not allow FFP for IMD costs for patients between the ages of 21 and 64 (the Act, sections 1905(a)(14),(16), and (30)(B)). In addition, the STCs expressly prohibit claiming FFP for expenditures for TennCare enrollees who are IMD patients between the ages of 21 and 64 (STCs a and c, paragraph 31, and STC-b, paragraph 33), and the costs of such services for uninsured patients are not eligible as CPE.[39]

During the audit period, the State agency included in its calculation of actual CPEs the costs for five State-owned IMDs. The actual CPEs calculated by the State agency included $522.3 million ($370.1 million Federal share) in net costs (i.e., costs net of payments) for caring for uninsured IMD patients for which the State agency provided no supporting patient-level detail. If supporting patient-level detail for the costs showed that the State agency's claim did not comply with Federal requirements (e.g., some costs related to patients between the ages of 21 and 64, some costs included amounts for insured patients, some payments were not netted against costs, or some overstated patient days and ancillary charges were used in calculating costs), then the State agency may have received an overpayment of $370.1 million from the Federal Government.

For SFYs 2012–14, the State agency calculated actual CPEs for the IMDs using the STC-prescribed methodology. However, the State agency did not provide patient-level details to support the uninsured patient days that it used in its calculations.

For SFYs 2009–11, in addition to not having patient-level details, the State agency did not calculate the IMD net uninsured costs using the methodology prescribed in the STCs, Attachment F, section I. (See "Hospital Cost Portion of Calculations" in the background section of this report.) Instead, for those 3 years the State agency derived a cost-to-charge ratio from

[39] The STCs allow Government-operated hospitals to certify as public expenditures eligible for FFP the actual unreimbursed costs incurred for the provision of TennCare-covered services for TennCare enrollees and uninsured patients. Because services provided to IMD patients who are between the ages of 21 and 64 are not TennCare-covered services, costs incurred for providing such services to TennCare enrollees and uninsured patients are not eligible as CPE.

the Joint Annual Reports (JARs)[40] for the IMDs and multiplied that ratio by the charity charges from the JARs to determine the net uninsured costs.

Without supporting patient-level details, we were unable to verify the summary totals of uninsured patient days and payments used in the UCC calculations. Additionally, we were unable to determine whether the patients being served were between the ages of 21 and 64—an age range for which Federal funding is not available. Moreover, 85.4 percent of the IMD costs for TennCare enrollees was for services to patients who were between the ages of 21 and 64. (See the next section of this report.) Therefore, it is likely that a large portion of the uninsured costs was also for patients in this age range.

THE STATE AGENCY'S CALCULATED ACTUAL CERTIFIED PUBLIC EXPENDITURES INCLUDED INSTITUTIONS FOR MENTAL DISEASES COSTS FOR TENNCARE ENROLLEES AGED 21 TO 64

The Act does not allow FFP for IMD costs for patients between the ages of 21 and 64 (the Act, sections 1905(a)(14),(16), and (30)(B)). In addition, the STCs expressly prohibit claiming FFP for expenditures for TennCare enrollees who are IMD patients between the ages of 21 and 64 (STCs a and c, paragraph 31, and STC-b, paragraph 33).

The actual CPEs calculated by the State agency inappropriately included $53.6 million ($37.9 million Federal share) in CPEs for net IMD costs of caring for TennCare enrollees between the ages of 21 and 64,[41] representing about 85.4 percent of the total net costs of caring for TennCare enrollees for its 5 State-owned IMDs for the audit period. Because the State agency inappropriately included IMD costs related to TennCare enrollees between the ages of 21 and 64 in its calculation of actual CPEs, it received an overpayment of $37.9 million from the Federal Government.

THE STATE AGENCY'S CALCULATED ACTUAL CERTIFIED PUBLIC EXPENDITURES INCLUDED INCORRECTLY CALCULATED INSTITUTIONS FOR MENTAL DISEASES INPATIENT ROUTINE COSTS

The CPE protocol in Attachment F of the STCs provides for inpatient routine costs to be calculated by multiplying patient days from various low-income categories by costs per day for

[40] The JAR is a report that the Tennessee Department of Health requires all licensed hospitals in the State to complete. It contains various financial data including charges, expenses, bad debts, assets, liabilities, and charity care that a hospital provides.

[41] Although the State agency did not have patient-level detail supporting documentation for the IMD patients that were uninsured, it did have detail for TennCare enrollees.

the applicable inpatient routine cost center, as derived from the Medicare cost report (STCs, Attachment F, section I).

The State agency included in its calculation of actual CPEs a total of $33.5 million ($22 million Federal share) in overstated costs that resulted from errors in its formulas and the incorrect allocation of patient days for four out of its five State-owned IMDs.

Errors Resulting in Incorrect Costs Per Day

The State agency's contractor that prepared the cost calculations for the IMDs made errors in its calculations of the inpatient routine costs for SFY 2014 resulting in an overstatement of costs totaling approximately $18 million[42] ($11.8 million[43] Federal share). The contractor allocated patient days to the various inpatient routine cost centers. However, instead of multiplying the patient days that it assigned to each inpatient routine cost center by the costs per day for that specific cost center, the contractor multiplied all of the patient days by the costs per day of the adults and pediatrics cost center. As a result of this error in its calculation of actual CPEs, the State agency received an overpayment of $11.8 million from the Federal Government.

Allocation of Patient Days Did Not Match Supporting Documentation

In addition to the errors for SFY 2014, the allocation of patient days to various inpatient routine cost centers for four of the five State-owned IMD facilities for the other years in the audit period did not match what the allocation should have been according to either the detail of patient data for the TennCare enrollees or the summary of patient data for the uninsured. Consequently, the State agency in some cases multiplied patient days by the wrong costs per day, causing the calculated actual CPE amounts to be overstated by $15.5 million[44] ($10.2 million[45] Federal share). As a result of the improper allocation of patient days in its calculation of actual CPEs, the State agency received an overpayment from the Federal Government of $10.2 million.

[42] The total overstatement was $18,021,465.

[43] The total Federal share was $11,804,060.

[44] The total overstatement was $15,455,945.

[45] The total Federal share was $10,181,022.

THE STATE AGENCY DID NOT HAVE ADEQUATE INTERNAL CONTROLS IN PLACE

The State agency did not comply with Federal requirements for claiming CPEs for public hospital unreimbursed costs because it did not have adequate internal controls[46] in place. Specifically, the State agency did not have policies and procedures for:

- adjusting its CPE estimates to the actual CPEs that it calculated,
- collecting supporting patient-level detail for the data for uninsured IMD patients used in calculating actual CPEs, or
- identifying and excluding the costs of caring for IMD patients between the ages of 21 and 64.

The State agency did not have policies and procedures for collecting supporting patient-level detail for uninsured IMD patients or for identifying and excluding the costs of caring for IMD patients between the ages of 21 and 64 because it erroneously believed that the costs of caring for both uninsured patients and TennCare enrollees in IMDs were allowable as charity regardless of the ages of the patients.[47]

Additionally, the State agency did not monitor its contractor but instead relied solely on the contractor to perform the calculations of actual CPEs, and the State had no review process in place to identify errors the contractor might have made.

Because of these deficiencies in its internal controls, during a 6-year period the State agency received overpayments of $397.4 million from the Federal Government and may have received additional overpayments of $370.1 million for unsupported costs.

[46] Control activities are the actions management establishes through policies and procedures to achieve objectives and respond to risks in the internal control system (GAO-14-704G Federal Internal Control Standards).

[47] Additionally, State agency officials said that they elected not to burden non-DSHs with collecting supporting patient-level detail for uninsured patients because those hospitals did not receive DSH payments (all five IMDs were non-DSHs during the audit period).

RECOMMENDATIONS

We recommend that the Tennessee State Medicaid Agency:

- refund to the Federal Government $397,341,616 in overpayments representing the Federal share of CPEs that the State agency claimed in excess of the allowable amount;

- provide support for or refund to the Federal Government $370,119,499 for the net costs of caring for uninsured IMD patients for which the State agency did not provide detailed supporting documentation; and

- establish additional policies and procedures to ensure compliance with the STCs including policies and procedures for:

    - adjusting the CPE estimates to actual costs on the CMS-64s upon determining that hospitals have been overpaid or underpaid,

    - collecting and maintaining patient-level detail data for the uninsured population for the IMDs,

    - ensuring that the State agency identifies and excludes from its actual CPE calculations the net costs of caring for IMD patients between the ages of 21 and 64, and

    - reviewing the actual CPE calculations of its contractor.

STATE AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, the State agency did not concur with our first two recommendations and partially concurred with our third recommendation. The State agency's comments are summarized below.

After reviewing the State agency's comments, we maintain that our recommendations are valid for the reasons detailed below.

The State agency's comments are included in their entirety as Appendix D.

RECOMMENDATION TO REFUND $397.4 MILLION IN OVERPAYMENTS

State Agency Comments

The State agency disagreed with our recommendation to refund $397.4 million in overpayments for two reasons.

First, the State agency said that it was unreasonable for us to audit a period that reached back more than a decade and concluded more than 7 years ago. The State agency contended that this made it difficult for it to address the allegations of overclaiming. It stated that much of the information we requested was no longer available, per standard data retention policies. The State agency also stated that employee turnover in the intervening years made it difficult to provide the information that we had requested. The State agency added that we had "inexplicably and seemingly arbitrarily failed to include 2015—a year in which the State undercollected—when the State provided that data to the auditors."

Second, the State agency specifically disagreed with $37.9 million of the refund recommendation that related to the costs of caring for IMD patients who were TennCare enrollees between the ages of 21 and 64. The foundation of the State agency's argument is its statement that "in determining allowable costs, the Disproportionate Share Hospital (DSH) Payments Rule is followed when defining unreimbursed costs." The State agency cited various criteria that demonstrated that, for purposes of determining uncompensated care for Medicaid DSH calculations, States may include the costs of caring for IMD patients between the ages of 21 and 64.

Furthermore, the State agency contended that we misapplied the language of the STCs regarding IMD patients between the ages of 21 and 64. The State agency said that in 1994 TennCare's waiver authorized the payment of Medicaid claims for IMD patients between the ages of 21 and 64 but that this authority was eventually phased out. It said that the STC language prohibiting these costs was included to make it clear that TennCare was no longer allowed to pay these claims but that the STC language does not prohibit the State agency from claiming the costs as uncompensated care. It said that the STC language we cited was intended neither to govern uncompensated care policy nor to result in Tennessee surrendering its right to classify these costs as uncompensated care. Finally, the State agency said that if CMS had intended the STCs to prohibit the claiming of the costs in question it would have said so in the section addressing supplemental pool payments rather than the sections containing provisions related to IMDs, which the State agency thought we had taken out of context.

Office of Inspector General Response

We disagree with the State agency's contention that our audit period was unreasonable. When the audit started on May 13, 2019, SFY 2014 was the most recent year for which the State agency had completed its calculations of actual CPEs. Our audit period excluded SFY 2015

because the state had not yet completed its calculations for that year. The State agency did not provide us with its SFY 2015 actual CPE calculations until January 2020, more than 8 months after the audit started.

The State agency asserted that our audit period was unreasonable because the information we requested for this time was no longer available. However, our audit found that the State agency had the necessary documentation to calculate and had calculated the actual CPEs for SFYs 2009–14. Most of the report findings are not based on missing or incomplete documentation. The only finding in this report that is based on missing or incomplete documentation is related to patient-level detail for uninsured IMD patients, which the State agency said it has never required of the IMDs and is discussed in our response to State agency comments on our second recommendation.

The State agency provided an additional argument for $37.9 million of the $397.4 million overpayment.[48] The State agency offered no additional argument concerning why it should not refund the $337.5 million by which the CPEs claimed on the CMS-64s exceeded actual CPEs. Furthermore, the State agency agreed that its contractor made miscalculations regarding IMD inpatient routine costs that resulted in a $22 million overpayment, although it stated that it had already corrected the errors.

Neither the STCs nor any of the Medicaid DSH regulations cited by the State agency support the point that allowable costs for CPEs may be determined by following the Medicaid DSH rule. These criteria are not relevant to TennCare's CPE costs. Furthermore, it does not follow that because these costs may have been allowable in the Medicaid DSH calculations they are allowable for the claiming of CPEs. The State agency agreed to different rules for the allowable costs for CPEs in the STCs.

Additionally, the State agency argued that the STC sections with IMD provisions prohibit the State from claiming FFP for Medicaid claims payments for IMD services provided to patients between the ages of 21 and 64 but do not prohibit claiming those costs as uncompensated care. The relevant STC sections say only that "[e]xpenditures for services rendered to TennCare . . . enrollees between the ages of 21 and 64 who are patients in IMDs are not eligible for FFP." CPEs that the State agency claimed are expenditures. Thus, by including in its CPEs the costs of caring for IMD patients who are TennCare enrollees between the ages of 21 and 64, the State agency claimed expenditures in violation of those STC sections.

Finally, in regard to the State agency's assertion that the section of the STCs governing supplemental pools (STC-a, paragraph 54(h), STC-b, paragraph 57(h), and STC-c, paragraph 55(h) for public hospital CPEs) would have addressed the costs in question had CMS intended for them to be unallowable, we would point out that the section states that the State agency

[48] The $397.4 million overpayment consists of three different amounts that we identified in Appendix C: (1) $337.5 million – Overpayments of CPEs Not Returned, (2) $37.9 million – IMD Costs for Medicaid Patients Aged 21 to 64, and (3) $22 million – Incorrectly Calculated IMD Inpatient Routine Costs.

may claim only unreimbursed costs for providing TennCare covered hospital inpatient and outpatient services for TennCare enrollees and the uninsured. As previously explained, the earlier sections of the STCs clearly stated that expenditures for IMD services provided to TennCare enrollees between the ages of 21 and 64 are not eligible for FFP, and those services are not listed as TennCare benefits under the waiver. Accordingly, those costs are not TennCare-covered services, and the State agency may not include those costs in its CPE calculations.

We maintain that the State agency should refund the entire $397.4 million overpayment.

RECOMMENDATION TO PROVIDE SUPPORT FOR OR REFUND $370.1 MILLION IN INSTITUTIONS FOR MENTAL DISEASES COSTS FOR UNINSURED PATIENTS

State Agency Comments

The State agency disagreed with our recommendation that it provide support for or refund to the Federal Government $370.1 million for the net costs of caring for uninsured IMD patients. The State agency said that, in addition to its disagreement with our interpretation of Federal requirements, it had provided sufficient data to support the claims. Furthermore, the State agency said that the recommendation to disallow the entire cost of uninsured IMD patients over the dispute regarding supporting documentation is extreme and inappropriate. The State agency contended that the summary supporting documentation that it provided to support the costs of caring for uninsured IMD patients was sufficient. The State agency claimed that for many years it required each hospital to submit revenue-code-level details (as opposed to patient-level details) along with an attestation from the hospital that the data were accurate representations of incurred costs. The State agency argued that the documentation produced to support this requirement was consistent with what the waiver required and that it provided us with auditable documentation. The State agency also noted that it provided patient-level details for the IMD costs related to TennCare enrollees.

Also, the State agency argued that the Medicaid Financial Accountability Rule (MFAR) that CMS proposed in late 2019 included a new requirement that each State have claim data for uninsured costs in its Medicaid Management Information System (MMIS).[49] The State agency concluded that because CMS withdrew the proposed MFAR rule, having patient-level details to claim FFP is not a requirement. The State agency contended that to require such details the Federal Government should go through the appropriate rulemaking process.

Finally, the State agency contended that we had taken "the unreasonable position that the IMDs had absolutely no uninsured-related uncompensated care costs for the 6-year period covered by the audit."

[49] The MMIS is a mechanized claims processing and information retrieval system that a State Medicaid program must have to be eligible for Federal funding.

Office of Inspector General Response

We maintain that the State agency should either provide patient-level details supporting the $370.1 million that it claimed for the costs of caring for uninsured IMD patients or refund that amount. We disagree with the State agency's contention that revenue code-level details constituted auditable documentation to support its claim for the cost of caring for uninsured IMD patients. The STCs allow the claiming of FFP only for actual unreimbursed costs of providing TennCare-covered services, which do not include services rendered to IMD patients between the ages of 21 and 64. Therefore, to properly audit the costs of caring for uninsured IMD patients that the State agency included in its CPEs, patient-level details are required to verify the summary totals of uninsured patient days and payments used in the UCC calculations and to identify the ages of uninsured patients. The State agency correctly noted that it provided patient-level details for TennCare enrollees; however, those details do not help us evaluate the IMD costs for uninsured patients.

CMS's withdrawal of its 2019 proposed MFAR rule, including its requirement regarding Medicaid MMIS data, is not relevant to our request for patient-level details to support IMD costs for uninsured patients. The State agency provided patient-level details for both TennCare enrollees and uninsured patients for the DSHs that we tested, as well as patient-level details for TennCare enrollees for the IMDs. We asked only that the State agency similarly provide us with auditable patient-level details to support uninsured IMD costs. Without supporting patient-level details to enable us to verify the summary totals of uninsured patient days and payments used in the UCC calculations and to determine the patients' ages, we cannot evaluate whether the claim for the cost of caring for uninsured IMD patients is compliant with the STCs.

Finally, the State agency was incorrect in claiming that we assumed that the IMDs had absolutely no uninsured-related uncompensated care costs for the 6-year period covered by the audit. Rather, we made a reasonable request that the State agency either provide auditable patient-level details to support the costs as it did for the TennCare enrollee IMD patients or refund the costs that it claimed. As we noted in this report, 85.4 percent of the IMD costs for TennCare enrollees was for patients who were between the ages of 21 and 64.

We maintain that the State agency should provide support for or refund $370.1 million that it claimed for the costs of caring for uninsured IMD patients.

RECOMMENDATION TO ESTABLISH ADDITIONAL POLICIES AND PROCEDURES TO ENSURE COMPLIANCE WITH THE SPECIAL TERMS AND CONDITIONS

State Agency Comments

The State agency said that it would implement further written procedures for adjusting the CPE estimates to actual costs on the CMS-64s and written policies regarding how the Federal share of any CPE claim in excess of allowable amounts should be returned. In response to our

recommendation to establish additional policies and procedures for reviewing the actual CPE calculations of its contractor, the State agency said that it had corrected the issue of its contractor incorrectly calculating inpatient routine costs several years earlier. Furthermore, the State agency indicated that it is now requesting that IMDs submit patient-level details for their uninsured patients. However, it said that it did not concur with our recommendation that the State stop claiming CPEs for IMD patients between the ages of 21 and 64 because it believed our interpretation of the applicable law and CMS guidance was incorrect.

Office of Inspector General Response

We maintain that, in accordance with the STCs, the State should identify and exclude from its CPE claim the costs of caring for IMD patients between the ages of 21 and 64.

Although the State agency may have corrected the specific error that we identified in this report, we maintain that the State agency should establish policies and procedures for reviewing all of its contractor's CPE calculations, not just those related to the error we identified in this report.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered CPEs that the State agency claimed for SFYs 2009–14 (audit period).[50] For this period, the State agency claimed CPEs totaling $2 billion.

We conducted our audit from May 2019 to April 2021. In planning and performing our audit, we limited our review of the State agency's internal controls to those controls related to verifying that the CPEs it claimed complied with Federal requirements.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable laws and regulations;
- reviewed the waiver's STCs, which contained the governing guidance for the CPE program;
- reviewed the CMS-64s for the quarters ended September 30, 2008, through June 30, 2021,[51] to identify CPEs that TennCare claimed for the audit period;
- identified from the CMS DSH audit files the UCC for all Tennessee public DSHs for all SFYs in the audit period;
- reviewed for each SFY in the audit period the State agency's interim reconciliation files that contained summary calculations of actual CPEs for all Tennessee public hospitals;
- reconciled the actual CPEs from the State agency's interim reconciliation files with the CMS DSH audit files for all Tennessee public DSHs for all SFYs in the audit period and summarized the results;
- calculated the difference between the CPEs claimed by TennCare for the audit period and the actual CPEs as reflected in TennCare's interim reconciliation files; and

[50] SFY 2009 was the first SFY for which State officials indicated that they had not adjusted the CPE estimates to correct overpayments. SFY 2014 was the most recent year for which the State agency had completed its calculations of actual CPEs when we began our audit.

[51] Because States can make adjustments on CMS-64s that apply to prior periods, we looked at all of TennCare's CMS-64s after our audit period.

- selected for testing 10 providers that accounted for 80 percent of the total cost of caring for low-income patients included in the State's interim reconciliation files, including the 5 publicly owned DSHs with the highest cost of caring for low-income patients and all 5 State-owned IMDs;

For the five DSHs selected for testing and for all SFYs in our audit period, we:

- reconciled the DSH survey file UCC calculations to the CMS DSH audit file and summarized the results;

- recalculated the total hospital costs per day for inpatient routine cost centers and cost-to-charge ratios for ancillary cost centers used in the CPE calculations, using finalized cost reports where available;[52]

- recalculated the low-income costs by multiplying our calculation of inpatient routine costs per day and ancillary cost-to-charge ratios times low-income patient days and ancillary charges, respectively; and

- compared the low-income costs that we calculated to the low-income costs used by the State agency in calculating actual CPEs.

For the five DSHs selected for testing and one SFY in our audit period, we tied to the patient-level detail totals for TennCare enrollees and uninsured patients, without material variance, the summary low-income patient days, ancillary charges, and payments that were used in the CPE calculations.

For the five State-owned IMDs selected for testing and all SFYs in our audit period, we:

- recalculated the total hospital costs per day for inpatient routine cost centers, using the finalized Medicare cost reports when available;

- reviewed and adjusted as necessary the State agency's allocation of low-income patient days to the various inpatient routine cost centers;

- recalculated the low-income costs by multiplying our calculation of inpatient routine costs per day for each inpatient routine cost center times that cost center's low-income patient days;

[52] We tested a total of 58 cost-report years (9 facilities including 5 DSHs and 4 IMDs for 6 cost-report years each plus 1 IMD for only 4 cost-report years because it closed in SFY 2012). Of the 58 cost-report years tested, we were able to use the finalized Medicare cost reports for 43 cost-report years, or about 74 percent. For those cost-report years for which we had access to the finalized Medicare cost reports, there were only immaterial changes to low-income costs (i.e., costs of caring for low-income patients) attributable to the different cost-report versions.

- compared the TennCare enrollee patient days and payment summary figures used in the CPE calculations with the patient-level detail for TennCare enrollees, identifying any differences;

- identified the patient data for TennCare enrollees between the ages of 21 and 64 and determined the effect of that data on the State agency's actual CPE calculations; and

- identified the net uncompensated costs (i.e., costs net of payments) for uninsured patients included in the actual CPEs calculated by the State agency because the State agency could not provide patient-level detail.

Also, we discussed the results of our audit with State agency officials.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

APPENDIX B: FEDERAL REQUIREMENTS

SOCIAL SECURITY ACT

Social Security Act § 1905(a)

According to section 1905(a), IMD costs for patients under the age of 21 and for patients 65 years of age and older are allowable medical assistance costs for Medicaid. Section 1905(a)(14) states that medical assistance costs incurred in an IMD are allowable for patients 65 years of age or over. Section 1905(a)(16) says that, as of January 1, 1973, inpatient psychiatric hospital services for individuals under the age of 21 are allowable medical assistance costs. Section 1905(a)(30)(B)[53] says that, except as provided in section 1905(a)(16) (i.e., that IMD costs are allowed for persons under the age of 21), IMD costs for persons under the age of 65 are not allowable.

Social Security Act § 1905(h)(1)(A)

Section 1905(h)(1)(A) of the Act further clarifies that the services for individuals under age 21 must be provided "in an institution (or distinct part thereof) which is a psychiatric hospital as defined in section 1861(f) or in another inpatient setting that the Secretary has specified in regulations."

Social Security Act § 1905(i)

Section 1905(i) of the Act defines an IMD as "a hospital, nursing facility, or other institution of more than 16 beds, that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services."

CMS SPECIAL TERMS AND CONDITIONS FOR THE WAIVER

STC-a and STC-c, Paragraph 31, and STC-b, Paragraph 33

"Expenditures for services rendered to TennCare . . . enrollees between the ages of 21 and 64 who are patients in IMDs are not eligible for FFP."

[53] During our audit period, the applicable requirement was at section 1905(a)(29)(B) of the Act. Public Law No. 115-271, § 1006(b) (Oct. 24, 2018) redesignated paragraph (29) as paragraph (30).

STC-a, Paragraph 54(h), STC-b, Paragraph 57(h), STC-c, Paragraph 55(h)

> Actual costs incurred by government operated hospitals for the provision of inpatient and outpatient TennCare services for TennCare enrollees and uninsured patients are eligible as CPE. The State must be able to document that the applicable hospitals had actual unreimbursed costs for providing those TennCare covered hospital inpatient and outpatient services, which exceeded the amounts paid to the hospital . . . .

Within 12 months of the end of each fiscal year, the State agency is required to revise its FFP claim for CPEs to reconcile on an interim basis actual CPEs with the estimated CPEs that it claimed on the CMS-64s. (This is referred to as the interim reconciliation in Attachment F.)

Attachment F

If during the interim reconciliation process the State agency identifies that a hospital received an overpayment, the State agency should credit the Federal Government. If the State agency identifies that a hospital has been underpaid, the State agency can claim additional reimbursement for the underpayment. Upon finalization of hospitals' Medicare cost reports, the State agency must perform a final reconciliation based on the finalized Medicare cost reports.

"Actual uninsured data for services furnished during the payment year are used to the extent such data can be verified to be complete and accurate."

Inpatient routine costs for each category of low-income patients should be calculated by determining the overall hospital costs per day for each inpatient routine cost center and multiplying it by the low-income patient days for the cost center.

All TennCare supplemental pool payments must be offset against costs in calculating CPEs.

APPENDIX C: UNALLOWABLE COSTS CLAIMED AS CERTIFIED PUBLIC EXPENDITURES

Types of Unallowable Costs	2009	2010	2011	2012	2013	2014	Total
Overpayments of CPEs Not Returned	$118,745,690	$40,664,851	$111,586,490	$122,509,599	$160,992,212	($72,361,902)	**$482,136,940**
Unsupported IMD Uninsured Costs	107,736,490	125,289,170	110,482,137	81,588,413	48,361,257	48,843,668	**522,301,135**
IMD Costs for Medicaid Patients Aged 21 to 64	15,201,172	10,435,749	10,130,121	1,274,404	8,173,255	8,414,930	**53,629,631**
Incorrectly Calculated IMD Inpatient Routine Costs	(631,483)	(59,305)	(161,580)	(947,238)	17,255,551	18,021,465	**33,477,410**
Total Unallowable Costs Claimed by the State Agency	**$241,051,869**	**$176,330,465**	**$232,037,168**	**$204,425,178**	**$234,782,275**	**$2,918,161**	**$1,091,545,116**

Types of Unallowable Costs (Federal Share)	2009	2010	2011	2012	2013	2014	Total
FMAP RATES	71.11%	75.09%	73.67%	66.23%	66.19%	65.50%	
Overpayments of CPEs Not Returned	$84,440,060	$30,533,203	$82,208,557	$81,141,170	$106,556,720	($47,397,046)	**$337,482,664**
Unsupported IMD Uninsured Costs	76,611,418	94,073,373	81,394,952	54,038,046	32,009,107	31,992,603	**370,119,499**
IMD Costs for Medicaid Patients Aged 21 to 64	10,809,553	7,835,682	7,463,113	844,070	5,409,673	5,511,779	**37,873,870**
Incorrectly Calculated IMD Inpatient Routine Costs	(449,048)	(44,529)	(119,040)	(627,379)	11,421,018	11,804,060	**21,985,082**
Total Unallowable Costs Claimed by the State Agency	**$171,411,983**	**$132,397,729**	**$170,947,582**	**$135,395,907**	**$155,396,518**	**$1,911,396**	**$767,461,115**

APPENDIX D: STATE AGENCY COMMENTS

STATE OF TENNESSEE
DIVISION OF TENNCARE
310 Great Circle Road
NASHVILLE, TENNESSEE 37243

BILL LEE
GOVERNOR

STEPHEN SMITH
DIRECTOR

July 9, 2021

Lori S. Pilcher
Regional Inspector General for Audit Services
Department of Health and Human Services Office of Inspector General
Office of Audit Services, Region IV
61 Forsyth Street, SW, Suite 3T41
Atlanta, GA 30303

Dear Ms. Pilcher:

The State of Tennessee's Medicaid program, TennCare, does not concur with the federal Department of Health and Human Services Office of Inspector General's (OIG's) recommendations related to its audit of the State's claiming for certified public expenditures (CPE) for public hospital unreimbursed costs. Furthermore, the State strongly objects to the approach taken in this audit. The audited years (2009 to 2014) are based on findings that date back more than a decade and place the State of Tennessee in an untenable and unreasonable position of having to 1) piece together communications and understandings, both verbal and written, formal and informal, among state and federal officials no longer employed or associated with the respective agencies; and/or 2) locate and provide individual claiming data that is not required by generally accepted auditing standards and for which hospital providers had no reason to anticipate the federal government's future demand.

Furthermore, the recommendations are based on faulty reasoning, as described below, and would have a detrimental impact on the more than 1.5 million Tennesseans who rely on Medicaid for benefits and services, as every dollar of the funds in question was utilized to serve Tennessee Medicaid members as part of the operation and delivery of the TennCare program.

OIG Recommendation #1:

Tennessee refund $397.4 million in overpayments to the Federal Government for CPEs that it claimed in excess of the allowable amount.

State Response:

The State does not concur with this recommendation. The recommendation is inappropriate and unreasonable, and OIG's interpretation of federal requirements governing costs related to patients aged 21 to 64 in Institutions for mental disease (IMDs) is flawed.

This audit, released in 2021, began as an examination of the State's entire supplemental pool program and was ultimately narrowed to CPE for public hospital unreimbursed costs in state fiscal years 2009-2014. The result is an audit that reaches back more than a decade into the past, to two prior state executive administrations, and beyond any reasonable audit standard. This approach of releasing audit findings 12 years after the activity in question takes place shines a light on a flawed structure for federal audits that places states, their citizens, and taxpayers at a serious disadvantage and risk.

The fact this audit dates back 12 years and concludes with a year 7 years in the past presented extreme difficulty to the State in addressing allegations of overclaiming. Much of the relevant information is no longer available per standard data retention policies. And none of the relevant employees from Tennessee or CMS involved in the activities under review remain employed at the respective agencies. While the State has provided all materials that have been preserved and are able to be located, there are, of course, many other pieces of documentation and communication that have been lost to time, including communications and documents from CMS regarding the State's claiming methodology. We believe some of this documentation could have been relevant to mitigating if not outright refuting the concerns presented by OIG had the audit been conducted within a reasonable time period. If OIG had audited a more reasonable time period, the result of this audit would have looked very different. In addition, OIG inexplicably and seemingly arbitrarily failed to include 2015 – a year in which the State undercollected - when the State provided that data to the auditors.

It's also important to note that OIG's approach of examining years as far back into the past as it has highlights a major flaw in the system that should be examined. How far is too far? Is there any point in time that OIG would position as too far? For example, at one point during the audit examination, OIG auditors requested information from 2003 – nearly 20 years ago. No standard of reasonableness could result in an expectation that a state be able to provide any meaningful or relevant documentation from nearly 20 years ago.

With the preceding comments establishing the extreme difficulty in which the State had to operate to counter OIG allegations and findings, the State did work diligently to locate documentation and piece together communications from more than a decade ago among individuals who are no longer with TennCare or CMS. This documentation, at a minimum, revealed uncertainty around the applicable CPE protocol during the audit period. For example, documentation shows that, in accordance with the demonstration terms and conditions then in effect, the State submitted a CPE protocol for CMS review and approval on June 26, 2008. On August 20, 2008, CMS responded committing to an "expedient" review of the protocol; however, based on best available records, it appears CMS failed to do so. This, along with the fact CMS promulgated a CPE rule on May 24, 2007, that was later vacated by a federal court [Alameda Cty. Med. Ctr. v. Leavitt, 559 F. Supp. 2d 1 (D.D.C. 2008)], contributed to an environment of uncertainty and, at the very least, calls into question an audit recommendation seeking the repayment of hundreds of millions of dollars.

In addition, the State strongly objects to the portion of the recommendation related to IMDs. The OIG identifies a $37,873,870 overpayment because it believes the State cannot claim CPE on any persons aged 21-64 that receive services in IMDs. *(Note: In Recommendation #2, OIG also asserts the portion of these dollars related to services for this age group are also unallowable.)* The OIG's interpretation of this issue represents a fundamental misunderstanding of basic federal policy. In summary, federal policy clearly allows unreimbursed costs for Medicaid enrollees aged 21-64 at IMDs to be treated as uncompensated care costs and factored into hospital supplemental pools. Tennessee's approach has been consistent with this federal guidance.

In determining allowable costs, the Disproportionate Share Hospital (DSH) Payments Rule is followed when defining unreimbursed costs. Under the DSH rule, states may make DSH payments to IMDs, which are defined by the Social Security Act (the Act) as hospitals, nursing facilities, or other institutions of more than 16 beds that primarily serve individuals with mental diseases (§ 1905(i) of the Act). Because IMDs cannot receive Medicaid payment for individuals age 21–64 (§ 1905(a)(B) of the Act), IMD services provided to Medicaid enrollees in this age range are classified as unpaid costs of care for the uninsured, a type of uncompensated care that is eligible for DSH funding, and thus allowed for FFP claiming.

42 CFR Parts 447 and 455 Medicaid Program; Disproportionate Share Hospital Payments; Final Rule, Page 77929, #15 states:

> *For Medicaid eligible individuals under age 21 or over age 65, uncompensated care costs for those eligible individuals would be reported as uncompensated costs for the Medicaid population. For the costs of services provided to those patients between the ages of 22 and 64 who are otherwise eligible for Medicaid, the treatment for the hospital-specific limit may vary based on State practices. Many States remove these individuals from eligibility rolls for administrative convenience (and must reinstate them if they are discharged from the IMD); if so, the costs should be reported as uncompensated care for the uninsured. States that do not remove the individuals from the Medicaid eligibility rolls should report the costs as uncompensated care for the Medicaid population.*

CMS Additional Information on the DSH Reporting and Audit Requirements, Question 28 states:

> *For the costs of services provided to those patients between the ages of 22 and 64 who are otherwise eligible for Medicaid, the treatment of the service costs in the hospital-specific limit may vary based on State practice. Many States remove these individuals from eligibility rolls for administrative convenience (and must reinstate them if they are discharged from the IMD); if so, the costs should be reported as uncompensated care for the uninsured. States that do not remove the individuals from the Medicaid eligibility rolls should report the costs as uncompensated care for the Medicaid population. Therefore, the costs of services provided in an IMD to an individual who is 22-64 and who is otherwise Medicaid eligible, can be included either as uninsured uncompensated or Medicaid uncompensated in the UCC, depending on the eligibility status (as determined by the State) of the individual while in the IMD.*

Also, a MACPAC report to Congress issued in March 2016 titled "Overview of Medicaid Policy on Disproportionate Share Hospital Payments," page 6, Box 1-2 states, "Because IMDs cannot receive Medicaid payment for individuals age 21–64 (§ 1905(a)(B) of the Act), IMD services provided to Medicaid enrollees in this age range are classified as unpaid costs of care for the uninsured, a type of uncompensated care that is eligible for DSH funding."

While Tennessee is not allowed to claim FFP for claims payments for Medicaid enrollees aged 21-64 at IMDs, the clear intent of this federal language is that those costs then become allowable uncompensated care. Tennessee has consistently held to this position and provided sufficient documentation to OIG to support it. OIG's response has been to cite STCs a and c, paragraph 31, and STC-b, paragraph 33 from TennCare's Section 1115 waiver agreement with CMS to claim that the State cannot claim FFP for these costs on CPEs. OIG is misapplying this language outside of its intended scope. The intent of these STCs was to prevent TennCare from claiming FFP for managed care claims payments to IMDs for enrollees aged 21-64. For additional context, when the original TennCare demonstration was established in 1994, Tennessee had authority in its 1115 waiver to pay Medicaid claims for IMD services for enrollees aged 21-64. This authority was temporary and eventually phased out. The STCs that OIG references were added into the TennCare waiver to make it clear that, while TennCare had

once been allowed to pay these Medicaid claims, it was no longer allowed to do so. This STC was intended to codify a change in TennCare covered benefits. It was not intended to govern uncompensated care policy. Nor was the intent of this language to result in Tennessee surrendering its right to classify these costs as uncompensated care, a right that CMS has expressly granted to every single state as demonstrated in the above guidance. OIG's assertion represents a fundamental lack of understanding about the interplay between the STCs and supplemental pools. If CMS had actually intended these STCs to also prohibit Tennessee from experiencing the same benefit that every other state experiences, it would certainly have stated so in the lengthy and detailed STC that governs hospital supplemental pool payments, STC 57. Instead, the language OIG is relying on for this novel interpretation is at STCs 31 and 33, 36 pages away from and out of the context of the language governing supplemental pools.

A smaller part of this alleged overpayment is related to miscalculations on IMD inpatient routine costs. This amount is $21,985,082 over the course of the audit period. The State recognizes that this was indeed a miscalculation, though as OIG recognizes, for four out of the six years in the audit period, this miscalculation actually resulted in the State claiming less federal CPE than it was entitled to. Furthermore, this calculation issue was already corrected many years ago, and OIG is only now identifying and enforcing it in 2021.

OIG Recommendation #2:

Tennessee provide support or refund to the Federal Government $370.1 million for the net costs of caring for uninsured IMD patients for which it did not provide detailed supporting documentation.

State Response:

The State does not concur with this recommendation. The State provided completely sufficient data to support the claims and therefore this recommendation and any refund is unwarranted. Furthermore, the recommendation to disallow the entire cost of uninsured IMD patients over the dispute regarding supporting documentation is particularly extreme and inappropriate. No rational basis exists to suggest IMDs had zero costs associated with caring for uninsured during the relevant time period.

Tennessee's approved CPE protocol allows the State to claim CPE on Medicaid shortfall and also on charity care for uninsured patients. In order to claim the CPE that is authorized by the 1115 demonstration for uninsured uncompensated care, Tennessee for many years had the hospitals submit detailed revenue code level data, along with an attestation from the hospitals that the data was an accurate representation of incurred costs. This standard is both consistent with the requirements of the 1115 demonstration and also provided OIG with auditable information. Furthermore, the State provided all patient-level detailed data requested by OIG for all Medicaid enrollees, which is the patient population for which Medicaid program maintains individual-level data. For the uninsured, the State also provided detailed revenue code level data and attestations for the uninsured patient data when requested by OIG.

Instead of accepting the provided data, OIG took the extreme approach of determining, without any support from CMS or the terms of the demonstration, that granular patient-level data regarding individuals outside the Medicaid program from more than a decade ago was the *only* acceptable source of documentation, even though that data is not specifically required by either CMS or the 1115 demonstration.

It is critical to note that when CMS proposed the Medicaid Financial Accountability Rule (MFAR) in late 2019, CMS included a new requirement that in order for states to claim FFP on uninsured costs, they must possess all related claims in their MMIS systems [see MFAR – proposed 42 CFR § 447.206(c)(1)]. CMS received many comments from multiple states objecting to this new requirement. At the end of 2020, CMS withdrew the MFAR. The clear conclusion is that having access to patient-level detailed data in order to claim FFP is not currently and has never been a requirement. If the federal government wishes it to be a requirement, then it should go through the appropriate rulemaking process to establish it as a requirement. It is inappropriate to enforce a standard from a proposed rule that CMS has withdrawn. The federal government has no legal basis to arbitrarily hold Tennessee to this unpromulgated rule.

Furthermore, by completely disallowing all IMD costs because of a lack of patient-level data, OIG is essentially taking the unreasonable position that the IMDs had absolutely no uninsured-related uncompensated care costs for the six-year period covered by the audit. Such a position is not based in reality or logic. The IMDs did have uninsured-related uncompensated care costs during this period (as they do in any given year), the State is allowed to claim those costs as CPE per the terms of Tennessee's demonstration, and the attested revenue code-level detailed data represents the most accurate picture of what occurred in 2009-2014. Again, Tennessee has provided all of this data to OIG for review and examination, and yet OIG is still disallowing the entire amount, resulting in a potential $370 million overpayment determination. It is unreasonable to suggest the State pay back hundreds of millions of dollars from as far back as 12 years ago based on an allegation that the costs do not exist when it is abundantly clear these costs did exist and are supported by revenue code-level data. For OIG to recommend a position that it knows does not accurately reflect the reality of what occurred is simply inappropriate.

OIG Recommendation #3:

Tennessee establish additional policies and procedures to ensure compliance with Federal requirements.

State Response:

The State concurs in part and does not concur in part. While the State will implement written internal policies regarding how the federal share of any CPE claim in excess of allowable amounts will be returned, the State disagrees with some of the OIG's interpretation of requirements around IMD claiming.

OIG has recommended that the state Medicaid agency establish internal procedures for reconciling CPEs. While the State already has the CPE protocol in place, the State will write and implement further procedures.

OIG has also recommended that the State review its contractor's CPE calculations related to the inpatient routine costs. As mentioned earlier in the comments, this issue was corrected several years ago.

OIG has also recommended that the State collect patient-level detail data related to the uninsured population at IMDs. The State maintains that, for patient-level detailed data to be required, this should be specified in the state's demonstration or in a statute or rule. Nevertheless, the State has already begun requesting that IMDs submit patient-level detail data for their uninsured patients.

OIG has also recommended that the State claim no CPE for IMD patients aged 21-64. As discussed above, the State does not concur and believes OIG's interpretation of this issue is incorrect under applicable law and CMS guidance.

Conclusion:

The State reiterates its strong non-concurrence with the recommendations of this audit. An audit process that dates back 12 years is fundamentally flawed and places the State in the impossible position of having to refute findings without key documents or historical knowledge of key agreements – both formal and informal - from individuals responsible for decisions and actions from both the state agency and the federal government.

Furthermore, despite the unreasonable timeframe, for more than half of the total dollars reflected in the OIG recommendations – those related to IMDs – the State has provided completely acceptable and auditable documentation and provided federal guidance and rules to confirm Tennessee rightly claimed expenses for uncompensated care. If OIG applied this clear federal guidance and the language of the demonstration as intended by CMS, the total findings would immediately be reduced by more than half.

The State looks forward to future discussions with CMS and is confident in its ability to counter OIG's findings and recommendations.

Sincerely,

Stephen Smith

Stephen Smith

Director

Attachment D:
Summary of Comments Received During the Public Forum on the Progress of the TennCare III Demonstration

From June 4, 2021, through July 9, 2021, the State held a public comment period on the progress of the TennCare III Demonstration. Feedback could be submitted throughout the public comment period via mail or email, or comments could be presented verbally during an in-person public forum held on July 6, 2021. The State received approximately 80 sets of comments from individuals and organizations during the public comment period. These comments are organized into three main topics and summarized below.

Services for Individuals with Intellectual Disabilities

A number of commenters expressed concern about the State's proposal to integrate services for members with intellectual disabilities into the larger TennCare managed care program (the subject of proposed Demonstration Amendment 1). In particular, several commenters expressed concern that benefits for individuals with intellectual disabilities would be reduced under managed care, or that members would no longer be able to obtain care from their preferred providers. Some commenters expressed the view that the planned transition to managed care is financially motivated and speculated that it could result in less access to HCBS.

The State thanks the commenters for the many thoughtful comments it received in response to its planned integration of services for individuals with intellectual disabilities into managed care, both during prior public comment periods and during this public forum. The State believes strongly that integrating services for individuals with intellectual disabilities into the managed care program will result in better alignment and coordination of care for these members. The demonstrated success of the CHOICES and Employment and Community First CHOICES MLTSS programs are a clear indication of the promise of this integrated approach to care delivery.

As with all TennCare populations and as required under federal regulations, MCOs will be required to contract with a network of qualified providers that is sufficient to provide care to their members and will be required to provide all medically necessary care in accordance with the member's plan of care. The State is committed to rigorous monitoring and oversight of its contracted MCOs in order to ensure that members have adequate access to and receive medically necessary services. As noted in response to prior public comment periods, the State does not intend to utilize a capitation (or risk)-based payment for these services at this time. Using flexibility provided under federal regulations, MCOs will be reimbursed for the services they provide, such that there is no incentive to reduce or deny services. The State will continue to evaluate the payment approach going forward, and should a risk-based payment approach be adopted in the future, will establish actuarially sound rates, with sufficient checks and balances to ensure that individuals continue to receive the services they need to live successfully in the community and achieve their individualized goals.

One commenter opposed the transition of HCBS to managed care because it would bolster reliance on consumer direction (viewed as akin to a stressful job). Other commenters expressed concern that the State's emphasis on competitive, integrated employment for persons with disabilities was inappropriate for beneficiaries enrolled in 1915(c) waivers, or that the MCOs would be incentivized to

focus resources on individuals most likely to achieve desired employment outcomes. Some commenters expressed concern that employment would be mandatory for all individuals enrolled in 1915(c) waivers. Another commenter noted that the State's emphasis on employment for individuals with ID would increase their income, thereby placing their eligibility for TennCare at risk.

Mandatory employment is not a feature of the State's proposal to transition services for individuals with intellectual disabilities into managed care. The State believes strongly in the value of competitive, integrated employment for all persons, and in providing meaningful opportunities for individuals with disabilities to identify and work toward their own education, employment, and/or community living goals. The State notes that it is concurrently seeking CMS approval of a Medicaid State Plan Amendment to disregard a significant amount of earned income for members enrolled in 1915(c) HCBS waivers, thus helping to ensure that members who are successful in achieving their employment-related goals are not at risk of losing their Medicaid eligibility. No members will be required to participate in consumer direction.

Some commenters expressed concern about the timing of the State's proposal to integrate services for individuals with intellectual disabilities into managed care. Some commenters perceived the timing to be accelerated (or "rushed"). Others suggested that integrating services for individuals with intellectual disabilities should not be implemented during a pandemic. Several commenters viewed the transition as especially problematic in light of staffing shortages in providers' offices caused by the pandemic.

The State respectfully disagrees with commenters suggesting that the planned implementation of managed care for HCBS has been rushed. The State's Medicaid agency and Department of Intellectual and Developmental Disabilities have worked diligently to plan the transition for many months, including extensive readiness review activities with the MCOs and with multiple opportunities for stakeholder input and engagement throughout the planning process. The State also believes the transition to managed care can be implemented safely and effectively under current conditions and does not believe it is in the best interests of the State or its Medicaid beneficiaries to postpone the implementation of managed care indefinitely due to the COVID-19 pandemic. The State acknowledges that there is currently a national need for qualified direct support professionals (DSPs) and other healthcare professionals, both prior to and during the COVID-19 public health emergency. Under the State's proposed managed care integration, MCOs will be required to contract with a network of providers that is sufficient to provide medically necessary services to all members in accordance with the member's plan of care. This includes continuity of existing services and providers for an initial period following implementation. The State is committed to continuing its work with healthcare providers, individuals with disabilities and their families, the advocacy community, and other stakeholders to identify strategies to strengthen the HCBS workforce.

Several commenters criticized the State's public notice process regarding proposed Demonstration Amendment 1 (entailing the integration of services for members with intellectual disabilities into the larger TennCare managed care program). These individuals suggested that many individuals affected by the proposal were unaware of it, and that the details of the proposal offered by the State were limited.

The State disagrees with these comments. The State notes that it held two public comment periods on the changes proposed in Amendment 1, from November 9 through December 11, 2020, and from February 22 through March 5, 2021. Both of these public comment periods entailed notices on the State's website, notices in major newspapers across the state, and public hearings. In addition, members of the public had opportunities to comment on corresponding amendments to the State's 1915(c) waivers. The State disagrees with commenters suggesting that its public notice processes were insufficient. The State has received numerous public comments on its proposal to integrate services for individuals with intellectual disabilities into managed care, and the State thanks the many individuals and organizations who have taken time to provide input.

Impact of the TennCare III Demonstration

A number of commenters expressed concern about the impact that the TennCare III Demonstration could have on members' ability to access health care. Several commenters, for example, suggested that the "shared savings" component of TennCare III incentivizes the State to limit spending on medical care, either by reducing benefits, or by not increasing reimbursement rates for TennCare providers, or even by disenrolling people from TennCare. Several commenters speculated that TennCare III will lead to negative outcomes for vulnerable populations, generally in the form of reduced access to care or benefit reductions. One commenter urged the State to introduce assurances in the TennCare III Demonstration that provider reimbursement rates would not be reduced in the future.

The State appreciates the many thoughtful comments it received about the accessibility and quality of care available under the TennCare Demonstration. The State, like these commenters, is committed to ensuring that TennCare provides high-quality care to members that improves health outcomes. The State, however, respectfully disagrees that the TennCare III Demonstration will lead to reductions in access to coverage or benefits. While the impact of TennCare III (like all Medicaid demonstration projects) must be evaluated over time, no such reductions have occurred since the approval of TennCare III. Likewise, the State emphatically disagrees that implementation of TennCare III in January of this year has led to harm for vulnerable populations or any Medicaid beneficiary in Tennessee. The State believes strongly that the TennCare III Demonstration establishes a framework in which additional resources can be invested into the TennCare program to enhance coverage, benefits, quality of care, and health outcomes. As a 100 percent managed care program, the State generally does not establish reimbursement rates for services provided under the demonstration; however, the State disagrees that there is anything inherent to the TennCare Demonstration that either incentivizes provider rate reductions or makes such reductions more likely.

Some commenters anticipated TennCare III's aggregate cap would not keep pace with the needs of the TennCare population (especially the aging segment of that population known as "baby boomers"), and that program reductions would inevitably result. One commenter characterized TennCare III's financing model as capped funding that could not be adjusted if there were an economic downturn, a natural disaster, or any other crisis requiring greater Medicaid expenditures. Other commenters observed that the financing model contained in the TennCare III Demonstration had been opposed by some

stakeholders prior to implementation, and concluded—as a result—that it should never have been implemented. Some commenters opined that the lower budget neutrality cap implemented for TennCare III ensures that shared savings obtained by the State will be meager and, therefore, inadequate to achieve meaningful investments in health. One of these commenters encouraged the State to seek a less restrictive budget neutrality cap from the new presidential administration.

The State appreciates the comments it received on the financing and budget neutrality aspects of the TennCare III Demonstration. Under the demonstration's STCs, the State's budget neutrality expenditure limit is adjusted for inflation and for population growth, with provisions that allow for additional adjustments due to unforeseen circumstances outside of the State's control, such as a public health crisis or major economic event. The State is confident that the budget neutrality framework for the TennCare III Demonstration is reasonable and that it adequately accounts for factors such as increases in TennCare enrollment and medical inflation. The State believes that the budget neutrality framework is an effective basis for the TennCare III Demonstration and does not intend to seek any adjustments at this time.

Multiple commenters suggested that, rather than continue implementation of TennCare III, the State focus on the needs of individuals with intellectual and developmental disabilities by eliminating waiting lists for HCBS services. Other commenters expressed concern the TennCare III Demonstration was not being used to expand TennCare eligibility to additional populations, such as individuals whose income is too high for them to qualify for Medicaid but too low to qualify for subsidized coverage on the health insurance exchange.

The State thanks these commenters for their comments and shares their concern for enhancing coverage. While these commenters expressed a belief that implementation of TennCare III stands in opposition to expanding coverage, this is not the case. Since the implementation of TennCare III in January 2021, the State has begun implementing plans to add 2,000 new slots to Employment and Community First CHOICES (the State's MLTSS program for individuals with intellectual or developmental disabilities), halving the program's referral list. (While the initial funding for these new program slots comes in part from funds appropriated under the American Rescue Plan Act, those funds are time-limited. Individuals' ongoing enrollment in Employment and Community First CHOICES will be predicated on the programmatic flexibilities and structures available under TennCare III.) In addition, the State is proceeding with plans to expand coverage of adopted children under the demonstration. It is anticipated that these are first of a number of potential expansions in coverage possible under TennCare III.

Some commenters expressed doubt that shared savings achieved by the State under the demonstration would be reinvested in the TennCare program, suggesting that there were inadequate rules and a lack of transparency about how the money in question would be spent.

Whether TennCare III ultimately leads to enhancements in Medicaid coverage and benefits is a key question in determining whether or not TennCare III is an effective framework for organizing a state's Medicaid program. The State believes strongly that TennCare III provides an effective framework for such enhancements and has committed publicly multiple times that shared savings achieved under the

TennCare III Demonstration will be used for the benefit of the TennCare program. As noted in this public forum, the State has already planned a number of near-term enhancements to coverage and benefits under TennCare III. These include (1) extending Medicaid postpartum coverage, (2) establishing a dental benefit for pregnant and postpartum women, (3) establishing a chiropractic benefit for adults, and (4) enhancing Medicaid coverage of adopted children in Tennessee, with longer-term goals to include eliminating all waiting lists for Medicaid HCBS programs. The State believes these are the first of what will be many opportunities to enhance coverage and benefits under the TennCare III Demonstration. In terms of transparency, the State notes that changes to Medicaid coverage and benefits continue to be subject to federal public notice requirements (as specified in the demonstration's STCs), the administrative rulemaking process, and the state budget process, in addition to other regular opportunities for public input (such as this public forum). Stakeholder input and transparency continues to be an important priority for TennCare.

A number of commenters objected to the pharmacy flexibilities granted to the State by the TennCare III Demonstration, with particular emphasis on the flexibility to operate a closed drug formulary. Concerns tended to focus on the possibility that TennCare members would be denied life-saving medications on the grounds that less expensive, less effective medications in the same drug classes would be available. Other commenters questioned the authority granted to the State to operate a closed formulary while simultaneously receiving rebates from drug manufacturers.

Both prior to and following the approval of TennCare III, both the State and CMS have given significant consideration to the concerns of some stakeholders regarding TennCare's pharmacy flexibilities. In requesting this flexibility, the State has always affirmed that maintaining the highest standard of patient care and ensuring access to medically necessary medications remain the State's paramount concern even with the potential introduction of a closed formulary. In approving this flexibility, CMS has established firm "guardrails" and protections around the use of this flexibility to ensure that Medicaid beneficiaries continue to access needed medications. These include, but are not limited to: (1) limiting the application of the closed formulary to adults age 21 and older; (2) requiring the State's formulary to meet the standards for Essential Health Benefit plans, which will align the State's coverage with requirements for plans in the individual insurance market and the standards that are applicable to Medicaid Alternative Benefit Plans under Section 1937 of the Social Security Act; and (3) requiring the State's formulary to comply with statutory requirements for coverage of mental health medications, agents used in medication-assisted treatment, and other protected class drugs. Most notably, under the TennCare III Demonstration, the State must maintain an exception process for beneficiaries to request and gain access to clinically appropriate drugs not on the State's formulary, thus ensuring that beneficiaries are able to access all necessary and appropriate drugs, regardless of the drug's formulary status. These protections ensure that beneficiaries will continue to have access to needed medications.

Some commenters expressed opposition to the flexibility granted to the State by the TennCare III Demonstration to temporarily suspend the Medicaid eligibility of a TennCare member convicted of Medicaid fraud. These commenters believed that the policy does not further the purposes of the

Medicaid Act and that other legal remedies are already available to punish individuals found guilty of Medicaid fraud.

The State respectfully disagrees with these commenters. The State does not believe it is unreasonable that some meaningful accountability should be in place for individuals who abuse Medicaid benefits. Under the terms of the demonstration, any suspension for fraud is limited to no more than 12 months, and individuals subject to this policy will receive all relevant protections, including advance notice of their suspension and their right to appeal any suspension implemented under this policy. This policy will enhance the integrity of the Medicaid program, helping to ensure the appropriate use of public resources dedicated to assisting needy individuals and families, while also providing robust beneficiary protections. This policy is also broadly consistent with existing policy under Section 1128 of the Social Security Act to exclude individuals convicted of fraud from the Medicaid program.

A number of commenters objected to the ongoing waiver of retroactive eligibility contained in the TennCare III Demonstration. Although the waiver no longer applies to pregnant or postpartum women or to children (effective June 30, 2021), commenters opposed the existence of the waiver altogether. These commenters indicated that retroactive eligibility is a means for individuals diagnosed with a serious health problem to obtain medical care without incurring substantial debt, either prior to applying for TennCare coverage, or after having temporarily lost TennCare coverage. They also cited the benefits of retroactive eligibility for providers, who would be compensated for services that would otherwise likely go unpaid.

The State thanks these commenters for their comments. The State's longstanding policy of beginning coverage on the day of an individual's application is reasonable and necessary for the State to meaningfully manage the care of its members (a key goal of the TennCare Demonstration). In fact, contrary to the State's and CMS' goal of promoting coverage and preventative care, retroactive eligibility incentivizes individuals to delay applying for coverage until they experience a serious health care event. In the decades that the State's policy has been in place, the State has adopted a number of strategies to help ensure that individuals applying for coverage can access care quickly, which include: (1) the use of presumptive eligibility for a number of populations, and (2) partnerships with nursing facilities, hospitals, and other medical institutions to facilitate the timely submission of applications when needed. The efficiencies realized as a direct result of the retroactive eligibility waiver have contributed to expansions of coverage and benefits under the TennCare Demonstration.

A few commenters expressed concern that the new demonstration project could result in TennCare's managed care program being released from federal regulations governing managed care arrangements in Medicaid. This possibility was viewed as a threat to the actuarial soundness of the State's managed care program. Other commenters objected to the managed care system altogether, characterizing TennCare MCOs as motivated primarily by financial gain and describing difficulties for members in obtaining services.

These commenters are incorrect. Nothing in the TennCare III Demonstration purports to waive the regulations governing Medicaid managed care programs.[1] Under the TennCare Demonstration, Tennessee continues to be subject to these regulations. The State disagrees with commenters objecting to the use of Medicaid managed care in general. Under the TennCare Demonstration, Tennessee has long demonstrated that the use of managed care promotes the delivery of care that is both high-quality and cost-effective.

Several commenters objected to the ten-year approval period of the TennCare III Demonstration. An approval period of three or five years was generally viewed as preferable by these commenters, since it would require the State not only to solicit feedback from the public more often, but also to change course on policies that had proven ineffective or counterproductive.

The State respectfully disagrees with these commenters. The policies envisioned and authorized under TennCare III—including (1) monitoring state expenditures relative to the State's budget neutrality model, (2) determining the amount (if any) of shared savings/DSIP funding the State may be eligible to access based on its performance in the prior year, (3) investing those savings to improve Medicaid coverage and benefits under the demonstration, and (4) evaluating the impact of those investments and making adjustments and refinements—are inherently policies that will take time to fully implement and evaluate. The 10-year approval of TennCare III thus creates a framework that allows (and in fact incentivizes) the State to implement long-term strategies for reforming the service delivery system and improving health outcomes in a way that is simply not possible when a state's demonstration authority is limited to as little as three years. By their nature, healthcare interventions are complex and take time to plan, implement, and demonstrate results. The 10-year approval of TennCare III acknowledges this reality, while still providing a meaningful framework for monitoring and oversight.

The State notes that the TennCare III Demonstration provides a robust framework for transparency and oversight, including multiple mechanisms to ensure ongoing transparency, communication, and opportunities for stakeholder input. These include the following:

- At least annually, the State will host a forum at which members of the public have an opportunity to comment or otherwise provide input on the progress of the demonstration (STC 61);
- Any changes to the demonstration must go through a prescribed public notice and input process prior to implementation; notably, this includes even program changes not otherwise subject to the demonstration amendment process (STCs 6, 7, and 12);
- The State will submit regular monitoring reports to CMS (available publicly online) and participate in monitoring calls with CMS at least monthly (STCs 56 and 60); and
- The State will produce interim evaluation reports throughout the life of the demonstration to ensure the demonstration is on track to achieve its intended goals; each evaluation report must be made publicly available on the State's website (STCs 94 and 95).

[1] The TennCare III Demonstration continues a longstanding waiver of 42 CFR § 438.52 to allow the State to contract with one pharmacy benefits manager and one dental benefits manager.

The State welcomes public input on all aspects of its Medicaid program and the TennCare Demonstration and is committed to working closely with CMS and other stakeholders over the life of the demonstration to provide opportunities for public input and to ensure that the demonstration adequately meets the needs of Medicaid beneficiaries in Tennessee.

One commenter supported a number of facets of the TennCare III Demonstration approved by CMS, including—

- **Greater administrative flexibility, since states are most capable of assessing the needs of their Medicaid populations;**
- **Requirements that flexibilities not be used to limit coverage or services;**
- **Guarantees that shared savings will be reinvested in the TennCare program; and**
- **Opportunities for public input on proposed program changes.**

The State thanks the commenter for these comments.

The Public Forum

Some commenters criticized the State's public notice and transparency process for the July 6 public forum on the progress of the TennCare Demonstration. Commenters recommended variously that the date, time, and location of future forums be publicized differently on the State's website; that the State provide online streaming options to facilitate remote participation in future forums; that the State hold more frequent public forums on the progress of the TennCare Demonstration; that the State develop an email distribution list to notify interested persons about future forums and other TennCare-related matters; and that the State provide more granular information at future forums to help members of the public better understand what kind of progress is actually being achieved by TennCare III.

The State will take these recommendations into consideration in planning future forums on the progress of the TennCare Demonstration.

Attachment E:
Operational Procedures Regarding Reserve Slots in CHOICES Group 2

Operational Procedures for
CHOICES Group 2 Reserve Capacity

Pursuant to STC #33.d.iv. A, ("**Reserve Capacity**") of the Special Terms and Conditions set forth in the current TennCare Section 1115 Demonstration Waiver, the State will reserve a specified number of slots in CHOICES Group 2 for:

- Individuals being discharged from a Nursing Facility (NF); and
- Individuals being discharged from an acute care setting who are in imminent risk of being placed in a NF setting absent the provision of Home and Community Based Services (HCBS).

Once all other available (i.e., unreserved) slots have been filled, individuals who meet specified criteria (including new applicants seeking to establish Medicaid eligibility in an institutional category as well as current SSI-eligible individuals seeking enrollment into CHOICES Group 2) may be enrolled into Reserve Capacity slots in accordance with the following procedures:

- The Area Agency on Aging and Disability (AAAD) or the Managed Care Organization (MCO), as applicable, must complete and submit a Reserve Capacity Enrollment Justification form to the TennCare Division of Long-Term Services and Supports (LTSS), along with supporting documentation.

- The Reserve Capacity Enrollment Justification form will require confirmation of the NF or hospital, as applicable, from which the person is being discharged, and in the case of a hospital discharge, a written explanation of the applicant's circumstances that warrant the immediate provision of NF services unless HCBS are immediately available. This explanation will include such factors as:
    - The reason for the acute care stay
    - The current medical status of the individual
    - Specific types of assistance needed by the individual upon discharge (medical as well as functional)
    - A description of the applicant's natural support system as it relates to discharge needs

- The TennCare Division of LTSS will review the form and supporting documentation in order to determine whether the person meets specified criteria for enrollment into a Reserve Capacity slot.

- If documentation is sufficient to demonstrate that the individual meets specified criteria for a Reserve Capacity slot, TennCare will notify the submitting entity and proceed with the enrollment process, including determination of categorical/financial eligibility (for new Medicaid applicants) and application of federal post-eligibility provisions.

- If documentation is not sufficient to demonstrate that the individual meets specified criteria for a Reserve Capacity slot, TennCare will notify the submitting entity and place the person on a waiting list for Group 2 until other (i.e., unreserved) capacity is available. TennCare will provide notice of the determination to the applicant, which will include the right to request a fair hearing regarding any valid factual dispute pertaining to the State's decision.

Attachment F:
Operational Procedures Regarding Reserve Slots in ECF CHOICES

Operational Procedures for
Employment and Community First CHOICES
Reserve Capacity

Revised* effective upon CMS final approval of Tennessee's Initial HCBS Spending Plan and Narrative pursuant to Section 9817 of the *American Rescue Plan (ARP) Act

Pursuant to STC #34.d.iv.A ("**Reserve Capacity**") of the Special Terms and Conditions set forth in the TennCare III Section 1115 demonstration waiver, the State reserves a specified number of slots in Employment and Community First (ECF) CHOICES for:

- Individuals with an intellectual disability who have an aging caregiver, as defined in State law;
- Individuals in emergent circumstances as defined in TennCare rule;
- Individuals with multiple complex health conditions as defined in TennCare rule;
- Individuals with significant medical or behavioral needs who require services available in ECFCHOICES to sustain current family living arrangements; and
- Individuals requiring planned transition to community living due to the caregiver's poor anddeclining health.

These groups were identified in partnership with stakeholders including:

- The Arc of Tennessee;
- The Tennessee Council on Developmental Disabilities;
- The Tennessee Disability Coalition;
- Disability Rights Tennessee (Protection and Advocacy); and
- The Statewide Independent Living Council of Tennessee.

For DY 2016 of the TennCare II Demonstration, the State reserved 350 slots within the ECF CHOICES Groups 4, 5, 6 Enrollment Targets. Due to limited availability of new state appropriations for DY 2017, DY 2018, and DY 2019 of the TennCare II Demonstration, and to further develop the capacity of community providers to deliver home and community-based services and supports, all increases in the Enrollment Targets for ECF CHOICES Groups 4, 5, and 6 during DY 17, DY 18, and DY 19 were Reserve Capacity slots (a total of 1,250 Reserve Capacity slots across the three approved ECF CHOICES Groups). In addition, all slots in ECF Groups 7 and 8 are considered to be Reserve Capacity slots (including the 50 slots added during DY 19—a total of up to 1,300 Reserve Capacity slots across all ECF CHOICES groups).

An additional 300 Reserve Capacity slots were added effective July 1, 2021, for a total of up to 1,600 Reserve Capacity slots across all ECF CHOICES groups.[1]

[1] As of July 1, 2021, 70 Group 7 and 8 slots are funded. To meet the needs of program applicants with severe co-occurring behavior support needs, funding for Group 6 slots has been moved to cover 15 additional slots in Group 8. However, because the expected cost of benefits in Group 8 is higher, it has required 1.5 Group 6 slots to cover 1 slot in Group 8. The result is 7.5 fewer total program slots being available, and 7.5 fewer Reserve Capacity slots (1,592.5). If additional slots are moved to fund increased capacity in Group 7 (up to the upper enrollment target limit of 50), total available Reserve Capacity slots could decrease further.

Reserve capacity groups established at the program's outset include:

Individuals with an intellectual disability who have an aging caregiver, as defined in State law

Pursuant to State law (TCA § 33-5-112), individuals who have an intellectual disability and have aging caregivers (currently defined by Tennessee statute as caregivers age 75 or older) will be eligible forenrollment into ECF CHOICES, subject to Medicaid and program eligibility criteria.

Individuals in emergent circumstances as defined in TennCare rule

An emergent situation will be defined as one that meets one or more of the criteria below and for which enrollment into ECF CHOICES is the most appropriate course, as determined through an interagency committee review process, including both TennCare and the Department of Intellectual and Developmental Disabilities (DIDD). The review will include consideration of other options, including the relative costs of such options. Discharge from another service system (DCS, DMHSAS, etc.) shall not be deemed an emergent situation unless other emergent criteria are met and unless diligent and timely efforts to plan and prepare for discharge and to facilitate transition to community living without long-term services and supports available in ECF CHOICES have been made, and it is determined through the interagency committee review process that enrollment in ECF CHOICES is the most appropriate way to provide needed supports.

Emergent criteria shall be as follows:

- The person's primary caregiver is recently deceased and there is no other caregiver available to provide needed long-term supports.
- The person's primary caregiver is permanently incapacitated and there is no other caregiver available to provide needed long-term supports.
- Services/supports in ECF CHOICES are urgently needed because of the recent loss of the person's living arrangement, including (as applicable), caregiver supports provided in that living arrangement that will not be available to the person going forward.
- There is clear evidence of serious abuse, neglect, or exploitation in the current living arrangement; the person must move from the living arrangement to prevent further abuse, neglect or exploitation; and there is no alternative living arrangement available.
- Enrollment into ECF CHOICES is necessary in order to facilitate transition out of a long-term care institution, i.e., a NF or a private or public ICF/IID into a more integrated community-based setting.
- The person is being discharged from an acute care setting and is at imminent risk of being placedin a NF setting absent the provision of HCBS or has applied for admission to a NF and been determined via the PASRR process to be inappropriate for NF placement. TennCare may require confirmation of the NF or hospital discharge and, in the case of hospital discharge, written explanation of the applicant's circumstances that warrant the immediate provision of NF servicesunless HCBS are immediately available.
- An adult's transition upon aging out of state custody, discharge from an inpatient psychiatric hospital (including regional mental health institute), or release from incarceration is *contingent* on the availability of services and supports in ECF because other appropriate services/supports are not available, and the services available in ECF (including covered physical and behavioral health services) will be sufficient to safely meet the person's needs in the community.
- The person is an adult age 21 or older enrolled in ECF CHOICES Group 4 (Essential Family Supports), ECF CHOICES Group 5 (Essential Supports for Employment and Independent Living),

or the Section 1915(c) Self-Determination Waiver and has recently experienced a significant change in needs or circumstances. TennCare has determined via a Safety Determination that the person can no longer be safely served within the array of benefits available in ECF CHOICES Group 4 (Essential Family Supports) or 5 (Essential Supports for Employment and Independent Living) or the Self-Determination Waiver, as applicable, and the person meets NF level of care, and must be transitioned to ECF CHOICES Group 6 in order to sustain community living in the most integrated setting.

- The health, safety, or welfare of the person or others is in immediate and ongoing risk of serious harm or danger; other interventions including Behavioral Health Crisis Prevention, Intervention and Stabilization services, where applicable, have been tried but were not successful in minimizing the risk of serious harm to the person or others without additional services available in ECF CHOICES; and the situation cannot be resolved absent the provision of such services available in ECF CHOICES.

Individuals with multiple complex health conditions as defined in TennCare rule
Reserve capacity will be established for a limited number of individuals who have multiple complex chronic or acquired health conditions that present significant barriers or challenges to employment and community integration, and who are in urgent need of supports in order to maintain the current living arrangement and delay or prevent the need for more expensive services, and for which enrollment into ECF CHOICES is the most appropriate way to provide needed supports, as determined through an interagency committee review process, including both TennCare and DIDD. The review will include consideration of other options, including the relative costs of such options.

Additional reserve capacity groups identified in partnership with stakeholders since the program's implementation include:

Individuals with significant medical or behavioral needs who require such supports to sustain current family living arrangements
Reserve capacity will be established for a limited number of individuals living at home with family who have significant medical or behavioral support needs that family caregivers are struggling to meet, and the sustainability of the current living arrangement is at significant risk. Services available through ECF CHOICES would help to support and sustain the current living arrangement and the continuation of natural caregiving supports, delaying the need for more expensive services.

Individuals requiring planned transition to community living due to the caregiver's poor and declining health
Reserve capacity will be established for a limited number of adults age 21 and older living at home with family whose primary caregiver is in poor and declining health, placing the long-term sustainability of the current living arrangement at significant risk. Planned transition to community living in the most independent and integrated setting appropriate is needed in order to avoid a potential crisis situation in the near future.

Individuals with a developmental disability who have an aging caregiver, as defined in State law
Pursuant to State law (TCA § 33-5-112), individuals who have a developmental disability and have aging caregivers (currently defined by Tennessee statute as caregivers age 80 or older) will be eligible for enrollment into Employment and Community First CHOICES, subject to Medicaid and program eligibility criteria.

Reserve capacity groups related to ECF CHOICES Groups 7 and 8

All slots in Groups 7 and 8 shall be reserve capacity slots. Enrollment into these slots shall proceed in accordance with eligibility and enrollment criteria set forth in STC 34 *(Operations of Employment and Community First (ECF) CHOICES)* of the approved 1115 demonstration or in state rule.

Reserve capacity slots may be held in the appropriate ECF CHOICES Group (4, 5, or 6) for individuals readyfor transition from Group 7 or 8, as applicable.

Reserve capacity slots funded through Tennessee's Initial HCBS Spending Plan and Narrative pursuant to Section 9817 of the *ARP*

The 2,000 slots funded through the ARP FMAP funds are initially targeted to serve those individuals who are actively seeking services, have been waiting to receive services the longest, and who do not meet employment-related prioritization criteria—based on information gathered during the referral or any subsequent intake or review process. If all 2,000 slots cannot be filled or as they are vacated, such slots may be repurposed as appropriate to ensure enrollment in the most appropriate benefit package.

<u>Operational Procedures</u>:

Unlike reserve capacity slots established for CHOICES Group 2 participants, reserve capacity slots in ECF CHOICES will be used as persons meeting specified criteria are identified and determined eligible to enroll.

Reserve capacity slots may be set aside for certain groups as defined herein, e.g., individuals with an intellectual or developmental disability who have an aging caregiver, as defined and required under Statelaw, children aging out of state custody, individuals transitioning out of Group 7 or 8, etc.

Except for individuals with an intellectual or developmental disability who have an aging caregiver, as defined in State law, individuals transitioning into Groups 4, 5, or 6 from Group 7 or 8, and those individuals who meet the criteria defined for enrollment into slots funded by the ARP Enhanced HCBS FMAP, review and selection of persons who meet criteria for reserve capacity slots in any ECF CHOICES Group will be determined by an interagency review committee, including both TennCare and DIDD. Except as provided above, a potential applicant for ECF CHOICES may apply for enrollment into a reserve capacity slot only if determined through the interagency committee review process that applicable reserve capacity criteria are met, and that enrollment into ECF CHOICES is the most appropriate way to provide needed supports. Such review shall include consideration of other options, including the relative costs of such options.

TennCare will require confirmation that an Applicant meets applicable reserve capacity criteria. Except for individuals with an intellectual or developmental disability who have an aging caregiver, as defined in State law, and individuals transitioning into Groups 4, 5, or 6 from Group 7 or 8, documentation shall be provided via a form developed by TennCare, along with medical evidence that is submitted by the MCO or DIDD, as applicable, to the interagency review committee.

Except as provided above, only Applicants determined by the interagency review committee to meet specified reserve capacity criteria (including new Applicants seeking to establish eligibility in the ECF

CHOICES 217-Like Group or the Interim ECF CHOICES At-Risk Group as well as current SSI-eligible individuals seeking enrollment into ECF CHOICES) may be enrolled into reserve capacity slots.

Once all reserve capacity slots set aside for a particular purpose have been filled, persons who meet such criteria shall not proceed with the enrollment process except as provided in STC paragraph 34.d.iv.B or C, but shall remain on the Referral List for ECF CHOICES, unless they qualify to enroll in an open priority group.

Except as provided in STC paragraph 34.d.iv.B or C, if a Potential Applicant does not meet criteria for a reserve capacity slot, the Potential Applicant shall not proceed with the enrollment process, but shall remain on the referral list for ECF CHOICES.

For purposes of transparency, reserve capacity criteria, including the operational procedures pertaining thereto, are set forth in TennCare Rule 1200-13-01 through the rulemaking process, recognizing that therulemaking processes may lag the initial availability of these slots to enroll additional individuals as appropriate.

Attachment G:
Operational Procedures Regarding Reserve Slots in Katie Beckett and Medicaid Diversion Groups

Operational Procedures for
Katie Beckett and Medicaid Diversion Groups'
Reserve Capacity

Pursuant to STC #35.c.ii.A. ("**Reserve Capacity**") of the Special Terms and Conditions set forth in the current TennCare III Section III5 Demonstration Waiver, the State may reserve slots in Katie Beckett (Part A) and Medicaid Diversion (Part B) groups for:

- Children with the highest level of need;
- Children awaiting discharge from an institution; and,
- Children who are at imminent risk of being placed in an institutional setting absent the provision of home and community-based services.

Pursuant to State law, Katie Beckett Part A targets and prioritizes enrollment of children with the most significant disabilities or complex medical needs who meet institutional level of care (LOC). There are 2 institutional LOC tiers for Part A, Tier 1 and Tier 2.

- Tier 1 is for children with the most complex needs and disabilities. There are 2 types of Tier 1 Institutional LOC.
    - Tier 1 – Medical Institutional LOC
    - Tier 1 – Behavioral Institutional LOC
- Tier 2 is for children who also meet institutional level of care, but their needs are not as significant as children who meet Tier 1 criteria. There are 3 standards for Tier 2 Institutional LOC and the child must meet only one of these standards to meet Tier 2:
    - Medical
    - Behavioral
    - Functional

Currently, all available slots in Katie Beckett (Part A) are reserve capacity. Children are enrolled into available Katie Beckett Part A program slots in accordance with prioritization criteria set forth in State rule. Once all Katie Beckett (Part A) slots have been filled, children who qualify for enrollment into Katie Beckett (Part A) shall not proceed with the enrollment process into Part A, but shall remain on the waiting list for Katie Beckett (Part A) until there is a Part A slot available.[1]

The first 50 reserve capacity slots are set aside specifically for children who meet the Tier 1 LOC prioritization criteria. The purpose is to ensure that children with the most significant medical needs and disabilities can be enrolled into Katie Beckett (Part A). If a child determined to meet medical eligibility for Katie Beckett (Part A) does not meet the criteria for one of these 50 reserve capacity slots and no other Part A reserve capacity slots are available, the child may not proceed with the enrollment process, but shall remain on the waiting list for Katie Beckett (Part A) unless there is a slot available for which the child meets reserve capacity criteria.

[1] The child may qualify to enroll in Part B until a Part A slot is available. If the child meets criteria for the Continued Eligibility Group, the child may be enrolled in the Continued Eligibility group until a Part A slot is available.

Enrollment into Medicaid Diversion (Part B) shall proceed on a first come, first serve basis. There are no reserve capacity slots in Medicaid Diversion (Part B).

For purposes of transparency, reserve capacity criteria, including the operational procedures pertaining thereto, are set forth in TennCare Rule 1200-13-01 through the rulemaking process.

Attachment H:
Compliance Measures for HCBS Regulations

COMPLIANCE WITH HCBS REGULATIONS

Regulation	Topic	Actions
42 CFR 440.180(a)	Description and requirements for HCBS	1. Attachments E, H, and L of the approved TennCare Demonstration and the State Rules for TennCare Long-Term Care Programs (1200-13-01) define the HCBS benefits that are available through the CHOICES, Employment and Community First CHOICES, and Katie Beckett programs and delineate when services may be provided to a CHOICES, Employment and Community First CHOICES, or Katie Beckett member. Where appropriate, service definitions identify "services not included" as specified in 42 CFR 440.180(c)(3). TennCare Rules are available for review at https://publications.tnsosfiles.com/rules/1200/1200-13/1200-13-01.20210518.pdf 2. The Contractor Risk Agreement between the Division of TennCare and each Managed Care Organization delineates HCBS available to CHOICES, Employment and Community First CHOICES, and Katie Beckett[1] enrollees, the scope of such services, and contractor requirements for the authorization and initiation of such services. The Contractor Risk Agreement also sets forth reporting requirements by which TennCare monitors the Managed Care Organizations' compliance and penalties as needed to remediate non-compliance. A sample contract is available for review at https://www.tn.gov/content/dam/tn/tenncare/documents/MCOStatewideContract.pdf. 3. Provider Agreements between the Managed Care Organizations and network providers delineate the type and scope of services that each provider may deliver and requirements for qualified staff.

[1] Kate Beckett (Part A) enrollees are assigned to only one of the three MCOs: BlueCare. While all three MCOs may serve children in the Continued Eligibility Group, an HCBS wraparound benefit is not provided.

Regulation	Topic	Actions
42 CFR 441.301(c); (1) (2) (3) (4) (5) (6)	Contents of request for a waiver: (1) Person-centered planning process (2) Person-centered service plan (3) Review of the person-centered service plan (4) Home and community-based settings (5) Settings that are not home and community-based (6) Home and community-based settings: compliance and transition	1. The Contractor Risk Agreement between the Division of TennCare and each Managed Care Organization delineates requirements for the person-centered planning process. A sample contract is available for review at the link provided above. 2. The Contractor Risk Agreement between the Division of TennCare and each Managed Care Organization delineates requirements for the person-centered support plan. MCOs use a person-centered support plan template prescribed by TennCare. The Contractor Risk Agreement also sets forth reporting requirements by which TennCare monitors the Managed Care Organizations' compliance and penalties as needed to remediate non-compliance. 3. The Division of TennCare conducts routine audits of enrollee records to ensure compliance with the person-centered planning requirements. Penalties as needed to remediate non-compliance are delineated in the Contractor Risk Agreement. Additional quality monitoring and improvement strategies for person-centered planning are set forth in the integrated Quality Improvement Strategy, a copy of which is Attachment L to this report. 4. [Applicable to (4)-(6) of the Regulation] Tennessee's required Statewide Transition Plan (STP) received final approval from CMS on April 13, 2016. The STP delineates the State's process for assuring compliance with the HCBS settings rule, including the method for assuring Medicaid-reimbursed HCBS are provided in compliant settings; the process for determining settings that are not home and community-based in nature; and the transition process, which encompasses transition to compliance, as well as transition of individuals from a non-compliant setting to a compliant setting of their choice, when applicable. The plan was updated as of July 31, 2018, to reflect completion of the heightened scrutiny review process, including

Regulation	Topic	Actions
		public comments regarding the posting of settings for which evidence has been submitted to CMS. By the original March 17, 2019 compliance date, all outstanding site-specific transition plans were fully implemented, bringing ALL of the sites identified in Tennessee's heightened scrutiny evidence package into compliance. The State's progress in implementing the STP and achieving full compliance is detailed in the document entitled *Statewide Transition Plan Quarterly Status Report*, April 2019, and which was previously submitted to CMS. All documents mentioned, are available here: https://www.tn.gov/tenncare/long-term-services-supports/transition-plan-documents-for-new-federal-home-and-community-based-services-rules.html In addition to achieving initial compliance with the HCBS settings rule, TennCare and contracted entities ensure that all provider settings maintain compliance with the HCBS Settings Rule on an ongoing basis. As outlined in the Statewide Transition Plan, TennCare amended its Contractor Risk Agreement (CRA) with the MCOs to include HCBS Settings Rule language effective January 1, 2015. Additional amendments became effective July 1, 2015, including the process for ensuring compliance with the HCBS Settings Rule prior to credentialing and re-credentialing providers. Prior to executing a provider agreement with any HCBS provider seeking Medicaid reimbursement, the MCOs are required under the CRA to verify that the provider is compliant with the HCBS Settings Rule using checklists approved by TennCare. The CRA has been amended to extend this credentialing and re-credentialing compliance review requirement to Employment and Community First CHOICES providers as well as Katie Beckett providers.

Regulation	Topic	Actions
		On July 1, 2016, the CRA was amended to require the MCOs to create settings compliance committees to conduct reviews of person-centered support plans and behavior support plans, as applicable, that include restrictive interventions, as well as all proposed or emergency right restrictions and restraints not contained in a person-centered support plan or behavior support plan. The committees must review any information from the provider's human rights committee, as applicable, identify and address potential compliance concerns, make recommendations regarding less restrictive interventions or referrals for appropriate services, and ensure informed consent for any restrictions. Settings compliance committees must also periodically review data regarding the use of interventions to determine ongoing effectiveness and whether such restrictions should be discontinued, review and make recommendations to the prescribing professional regarding potential instances of inappropriate utilization of psychotropic medications, review and make recommendations regarding complaints received pertaining to restrictive interventions or settings compliance concerns, and ensure that any proposed restriction, including restrictions in provider-owned or controlled residential settings, is the least restrictive viable alternative and is not excessive. TennCare also requires the MCOs to provide quarterly updates to TennCare on committee recommendations and actions. To monitor compliance at the individual level, a Care or Support Coordinator, as applicable to the particular program, conducts an Individual Experience Assessment (IEA) Survey, a tool developed by TennCare using the HCBS Settings Rule Exploratory Questions from CMS. The survey is intended to measure each individual's

Regulation	Topic	Actions
		level of awareness of and access to rights provided in the HCBS Settings Rule, freedom to make informed decisions, community integration, privacy requirements, and other member experience expectations. IEAs are completed upon initial service initiation, as part of the member's annual Person-Centered Support Plan (PCSP) review, within 30 days of a change in the mental or physical status of a member that impacts modifications/restrictions in place and anytime a change in residence or provider occurs for a person receiving residential services. This data is entered into an electronic system that TennCare uses to aggregate and analyze data by MCO and by provider. Currently, the MCOs are required to review IEA survey responses for all Medicaid recipients receiving HCBS and investigate each "No" response that indicates a potential rights restriction and ensure timely remediation of any potential compliance concern. This data is reported in the CHOICES HCBS Settings Report and the ECF CHOICES HCBS Settings Report from each MCO and DIDD on a quarterly basis. The report requires the MCOs to investigate these responses to determine if the restriction indicated has gone through the HCBS Settings Rule modifications procedure, and the restriction is appropriately included in the member's Person-Centered Support Plan. If the restriction has not gone through the modification process and is not supported in the person-centered support plan, the MCOs remediate the individual concerns by working with the provider and the person supported and his or her representative, if applicable. In addition, as part of ongoing monitoring of compliance with the HCBS Settings Rule, the MCOs are required to identify trends relating to member concerns with particular providers or provider settings and report those issues to TennCare along with steps for remediation to address those

Regulation	Topic	Actions
		concerns. TennCare's review and analysis of this data informs targeted technical assistance as well as overall ongoing systems transformation efforts.
42 CFR 441.302; (a) (c) (d) (g) (j)	State assurances: (a) Health and Welfare (c) Evaluation of need (d) Alternatives (g) Institutionalization absent waiver (j) Day treatment or partial hospitalization	1. The State Rules for TennCare Long-Term Care Programs (1200-13-01) define the standards for HCBS providers. These Rules are available for review at https://publications.tnsosfiles.com/rules/1200/1200-13/1200-13-01.20210518.pdf 2. The Contractor Risk Agreement between the Division of TennCare and each Managed Care Organization includes— a. Reportable Event Reporting and Monitoring requirements; b. Mandatory elements for all provider agreements; c. Credentialing requirements to ensure a network of qualified providers; d. Requirements pertaining to initial and annual Level of Care assessments; e. Mandatory elements of a CHOICES, Employment and Community First CHOICES, or Katie Beckett assessment and person-centered support plan, including risk assessment/planning, as applicable; and f. Maximum timelines for the assessment, development of the person-centered support plan, and service initiation for potential and new CHOICES, Employment and Community First CHOICES, or Katie Beckett members. 3. Provider Agreements between the Managed Care Organizations and network providers include critical incident reporting requirements. 4. Provider Agreements between DIDD and Katie Beckett Part B providers include critical incident reporting requirements. 5. Cost neutrality calculations ensure that an individual's needs can be met safely and effectively at a cost that is less than or equal to

Regulation	Topic	Actions
		care provided in a NF. If the individual's needs cannot safely and effectively be met with HCBS at a cost that is less than or equal to the same Level of Care in a NF, the individual is eligible for—and may elect to receive services in—a NF. 6. Level of Care is confirmed for each CHOICES, Employment and Community First CHOICES, and Katie Beckett member through standard PAE processes, requirements for supporting medical documentation, and annual recertification to assure no changes in the Level of Care. 7. Freedom of Choice education appears in materials used by the single point of entry, and in the Freedom of Choice election form (applicable for CHOICES), member handbook, and TennCare website. 8. Please refer to the integrated Quality Improvement Strategy in Attachment L of this report for a list of measures used to verify the State Assurances.
42 CFR 441.303; (a) (c) (d) (e)	Supporting documentation required: (a) Description of safeguards (c) Description of agency plan for evaluation (d) Description of plan to inform enrollees (e) Description of post-eligibility treatment of income	1. Level of Care eligibility for CHOICES, Employment and Community First CHOICES, and Katie Beckett (Part A) is determined through the completion and review of a PAE (PreAdmission Evaluation or Level of Care application). TennCare determines Level of Care for all LTSS programs, except Medicaid Diversion (Part B), which is determined by DIDD. On an annual basis, each PAE in use by a Medicaid participant must be reviewed by the Managed Care Organization or DIDD, as applicable, to verify that the individual still meets Level of Care. 2. Please refer to the integrated Quality Improvement Strategy in Attachment L of this report for a list of measures used to verify the State Assurances. These data are reported to CMS annually. 3. The State Rules for the Department of Health, Division of Healthcare Facilities delineate specific licensure requirements for nursing

Regulation	Topic	Actions
		facilities, assisted care living facilities, and Adult Care Homes-Level 2. https://publications.tnsosfiles.com/rules/1200/1200-08/1200-08.htm The State Rules for the Department of Intellectual and Developmental disabilities delineate specific licensure requirements for Community Living Supports, as defined in the three-page document following this table. 4. Post-eligibility treatment of income is delineated in State Rules for TennCare Technical and Financial Eligibility (1200-13-20). These Rules are available for review at https://publications.tnsosfiles.com/rules/1200/1200-13/1200-13-20.20210518.pdf
42 CFR 441.310	Limits on Federal financial participation	1. The Contractor Risk Agreement between the Division of TennCare and the Managed Care Organizations allows the Managed Care Organizations to contract only with licensed facilities that are eligible to participate in Medicaid. 2. Managed Care Organizations may not provide reimbursement for Room and Board, as is delineated in State Rules for TennCare Long-Term Care Programs (1200-13-01-.02). 3. CHOICES and Katie Beckett services do not include prevocational, educational, or supported employment services. Where appropriate, Employment and Community First CHOICES service definitions specify that services may not be provided under the Employment and Community First CHOICES program if such benefits would be available either under special education and related services as defined in section 602 of the Education of the Handicapped Act (20 U.S.C. 1401) or under vocational rehabilitation services available to the individual through a program funded under section 110 of the Rehabilitation Act of 1973 (29 U.S.C. 730).

Licensure and Quality Oversight of Community Living Supports and Community Living Supports-Family Model Providers

Providers of Community Living Supports (CLS) and Community Living Supports-Family Model (CLS-FM) in CHOICES and Employment and Community First CHOICES are licensed by the Department of Intellectual and Developmental Disabilities (DIDD) pursuant to statutory requirements set forth in Tennessee Code Annotated, Title 33, and in Chapter 0465-02 of the Rules of the Department of Intellectual and Developmental Disabilities, including:

0465-02-11 MINIMUM PROGRAM REQUIREMENTS FOR INTELLECTUAL AND DEVELOPMENTAL DISABILITIES RESIDENTIAL HABILITATION FACILITIES/SERVICES

0465-02-13 MINIMUM PROGRAM REQUIREMENTS FOR INTELLECTUAL AND DEVELOPMENTAL DISABILITIES PLACEMENT SERVICES

0465-02-15 MINIMUM PROGRAM REQUIREMENTS FOR INTELLECTUAL DISABILITIES SEMI-INDEPENDENT LIVING SERVICES and **0465-02-16** MINIMUM PROGRAM REQUIREMENTS FOR DEVELOPMENTAL DISABILITIES SEMI-INDEPENDENT LIVING SERVICES

0465-02-18 MINIMUM PROGRAM REQUIREMENTS FOR INTELLECTUAL AND DEVELOPMENTAL DISABILITIES SUPPORTED LIVING SERVICES

The specific type of licensure depends on the level of support need/reimbursement for individuals living in the home, as well as certain factors that are explicit in the statutory and regulatory requirements. For example:

- *The CLS1 and CLS2 provider is licensed by the Department of Intellectual and Developmental Disabilities (DIDD) for Intellectual Disabilities or Developmental Disabilities Semi-Independent Living Services in accordance with licensure regulations.*

  This is the licensure type for Semi-Independent Living services currently provided under the State's Section 1915(c) waiver authority for individuals with intellectual and developmental disabilities. CLS 1 and CLS 2 benefits are comparable to the Semi-Independent Living benefit currently provided under the State's Section 1915(c) waiver authority to individuals with intellectual and developmental disabilities.

- *The CLS3 provider is licensed for Intellectual and Developmental Disabilities Supported Living Services or Residential Habilitation Facilities/Services by the Department of Intellectual and Developmental Disabilities (DIDD) in accordance with licensure requirements.*

This is the licensure type for Supported Living and Residential Habilitation services, including Medical Residential services, currently provided under the State's Section 1915(c) waiver authority for individuals with intellectual and developmental disabilities.

The levels of support for Community Living Supports-Family Model are the same, but all are delivered in an adult foster home setting where the person lives in the home of a family who is the paid caregiver.

- *The CLS-FM provider is licensed by the Department of Intellectual and Developmental Disabilities (DIDD) as Intellectual and Developmental Disabilities Placement Services.*

This is the licensure type for providers of Family Model Residential Services currently provided under the State's Section 1915(c) waiver authority for individuals with intellectual and developmental disabilities.

Licensure standards establish the minimum standards that facilities must meet in order to be licensed. These include background checks for all staff.

Additional program and quality requirements are set forth in TennCare rules, MCO contracts, and provider agreements.

In addition to annual licensure surveys, TennCare contracts with the Department of Intellectual and Developmental Disabilities (DIDD), the operating agency for the state's three Section 1915(c) waivers for individuals with intellectual disabilities, to conduct quality monitoring surveys of providers of CLS and CLS-FM services. TennCare has built on a well-developed quality strategy to establish performance measures and processes for discovery, remediation, and ongoing data analysis and quality improvement regarding CLS services. In addition to providing data specific to the quality of these services offered in the CHOICES and Employment and Community First CHOICES programs, this ensures that TennCare has a comprehensive perspective of quality performance and strategies for quality improvement across the LTSS system as a whole.

In addition to annual licensure surveys and annual quality monitoring surveys, MCO Care or Support Coordinators are required to conduct periodic onsite visits of each person receiving CLS or CLS-FM services, including specific monitoring specified by TennCare, to ensure that services are being provided appropriately and that the members' needs are met.

TennCare contracts with Area Agencies on Agency and Disability to ensure the availability of Ombudsman services for individuals receiving CLS and CLS-FM services. This includes periodic in-person assessment of the quality of services being received, as well as the member's satisfaction with the services and with quality of life, using a standardized assessment tool.

Finally, TennCare participates in *National Core Indicators – Aging and Disability™ (NCI-AD)* survey to assess quality of life, community integration, and person-centered services for the

members in the CHOICES program. TennCare also participates in the *National Core Indicators*™ In-Person Survey (NCI-IPS) to assess quality of life, community integration, and person-centered services for Employment and Community First CHOICES members. Both survey processes use a standardized assessment tool to monitor quality of services and quality outcomes for seniors and adults with physical disabilities and individuals with I/DD receiving HCBS, including those in CLS and CLS-FM settings.

Attachment I:
Health and Welfare of HCBS Participants

Tennessee has designed and implemented an effective critical incident (called "reportable event") management system that engages partners at all levels of the system in assuring HCBS participants' health and welfare.

In CHOICES, Employment and Community First CHOICES, and the Katie Beckett Program, MCOs are contractually required to identify, report, and ensure timely investigation and remediation of critical incidents, and to track, trend, review, and analyze reportable events to identify and address potential and actual quality of care and/or health and safety issues. Each MCO is responsible for remediation of individual critical incident findings with review/validation by TennCare. MCOs regularly review the number and types of events and findings from investigations, identify trends and patterns, identify opportunities for improvement, and develop and implement strategies to assure health and welfare, reduce the occurrence of reportable events, improve the quality of HCBS programs, and improve quality of life for those receiving services.

MCOs are required to submit reportable event data to the State for purposes of monitoring, and to facilitate tracking and trending of data across LTSS programs and populations for purposes of broader systemic remediation and improvement as needed. The State system assures HCBS participants' health and welfare via ongoing review/analysis of reportable event data, including remediation; systemic remediation as needed; annual member record review regarding instances of abuse, neglect, and exploitation; and semi-annual audit record review of Critical Incident Management Systems.

Effective September 1, 2021, TennCare and DIDD launched One Aligned Reportable Event Management System. Taking into account recommendations from the joint report issued by the U.S. Department of Health and Human Services Office of Inspector General, the Administration for Community Living, and the Office for Civil Rights, the new One Aligned REM Protocol sets forth newly aligned expectations regarding REM processes for people receiving services in all TennCare HCBS programs including CHOICES and Employment and Community First CHOICES (as well as 1915(c) waivers, which currently sit outside the managed care program, but will be integrated upon CMS approval of Amendment 1 to the TennCare III Demonstration).

All Reportable Events, including critical incident data, in the One Aligned System are tracked and trended by DIDD, MCOs, and providers, with oversight from TennCare. Together, these entities evaluate the trended data to identify opportunities for systemic remediation and improvement in order to achieve desired Reportable Event Management outcomes—address and prevent instances of abuse, neglect, exploitation, and unexplained death.

Systems:

- Data describing investigations is entered on an ongoing basis into the DIDD Incident and Investigation (I&I) Database. Monthly reports are generated by DIDD and submitted to TennCare. They include data describing substantiated investigations concluded during the month and investigations for which an extension beyond thirty (30) days was granted, including the type of allegation, the reason for the extension, and the date the investigation was completed.

- MCOs are required to maintain LTSS Distinction as part of their NCQA Accreditation process. One of the core areas is case management, which requires the implementation and ongoing maintenance of a critical incident management system to promptly report, track, and follow up on incidents such as abuse, neglect, and exploitation. Each MCO's system is reviewed as part of the NCQA Accreditation process.

Reports:

- 1115 Critical Incident and Reportable Event Quarterly Reports track all critical incidents by incident type, setting, and the provider/staff accused of being responsible. The report includes a narrative describing the MCO's analysis of critical incidents for the reporting period, including trends and patterns; opportunities for improvement; and strategies implemented by the MCO to reduce the occurrence of incidents and improve quality.
- Emergency Department Utilization Quarterly Report of 1115 members evaluates members who have Emergency Department visits. The report allows TennCare to follow up with the MCOs to investigate members who have frequent ED visits.
- HCBS Settings Committee Reports are completed quarterly for the 1115 waiver programs by the MCOs. These reports include the total number of proposed or emergency rights restrictions or restraints reviewed during the quarter that are not part of a plan of care or PCSP or BSP, total number of periodic data reviews regarding interventions, the total number of reviews of psychotropic medications conducted during the quarter, the total number of complaints regarding restrictive interventions or settings compliance concerns received and reviewed during the quarter, and a summary of the outcomes of such reviews, including actions pertaining to individual members or providers or to broader systemic improvements.
- Quarterly HCBS Settings Reports are submitted for the 1115 waiver program. These reports aggregate the HCBS Settings data collected and identify trends relating to member concerns with particular providers or provider settings, including steps for remediation to address these concerns.

Audits:

- 1115 Existing Member Record Reviews (MRR) are conducted annually. These record reviews include performance measures related to education of members on the identification and reporting of suspected abuse.
- The CHOICES Critical Incident and ECF CHOICES Reportable Event Audit reviews incidents/events for proper reporting within timeframes as outlined in the CRA.

Specific performance measures related to Critical Incidents in Year 1 of the TennCare III Demonstration (CY 2021) are provided below. Note that **the first set of data represents reporting processes in place *prior to* implementation of the new One Aligned REM System on September 1, 2021.** Note, in addition, that as with any significant transition, there have been challenges and delays in design and rollout of a new reporting and tracking system, as well as provider training and adoption. Not all providers began utilizing the new system on September

1, 2021, such that some incidents were reported via the previous processes for the last 4 months of the year.

Finally, it is important to understand that **the One Aligned REM System is intended to better stratify reportable events by those that rise to the level of critical incidents, versus those which are reported for other care coordination and quality assurance purposes.** There are three (3) categories of Reportable Events: Tier 1, Tier 2, and Additional Reportable Events and Interventions. The type of Reportable Event dictates the reporting requirements and process that must be followed. Additional reportable events and interventions are <u>not</u> related to abuse, neglect, or exploitation, are <u>not</u> "critical incidents," and thus do not require investigation, but are nonetheless important aspects of assuring health and welfare, and reporting is required for purposes of care coordination and quality assurance/improvement. This more targeted stratification of event types on the front end has resulted in lower numbers of critical incidents (i.e., Tiers 1 and 2 reportable events) reflected in reporting post-implementation, but more accurately reflects incidents which are indeed "critical." This also increases the accuracy of substantiation rates, as substantiations are compared only against events that meet the definition of "critical incidents."

Health and Welfare Measure: number and percentage of CHOICES members with critical incidents per quarter

CHOICES G2 and G3 Critical Incidents	January 1, 2021-March 31, 2021	April 1, 2021-June 30, 2021	July 1, 2021-September 30, 2021	October 1, 2021-December 31, 2021
Number of critical incidents	332	380	255[1]	63[1]
Number of CHOICES G2 and G3 members[2]	12,321	12,291	12,098	11,940
Percentage	2.69%	3.09%	2.11%	0.53%

Health and Welfare Measure: number and percentage of ECF CHOICES members with critical incidents per quarter

ECF CHOICES (Groups 4-8) Critical Incidents	January 1, 2021-March 31, 2021	April 1, 2021-June 30, 2021	July 1, 2021-September 30, 2021	October 1, 2021-December 31, 2021
Number of critical incidents	112	109	100	N/A[3]
Number of ECF CHOICES Groups 4-8 members[4]	3525	3631	3725	N/A[2]
Percentage	3.18%	3.00%	2.68%	N/A[2]

Reportable Event Management Alignment-September 1, 2021

For the new REM process, reporting has started; however, modifications are still being made to the reporting requirements. In the new system, as of September 1, 2021, providers submit all allegations of reportable events to DIDD and the appropriate MCO for review. The system is a

[1] The decline in numbers is attributed to implementation of the new One Aligned REM System on September 1, 2021, as many (but not all) providers began utilizing the new system.

[2] Enrollment numbers from CHOICES Monthly Report as of the last month of the quarter.

[3] REM Processes for ECF CHOICES were fully aligned to new reporting September 1, 2021, and no reports were received for this quarter.

[4] Enrollment numbers from ECF CHOICES Monthly Report as of the last month of the quarter.

multi-tiered system in which all incidents are reviewed by three separate entities (the provider agency, DIDD, and the MCO for MLTSS programs) to ensure that potential acts of abuse, neglect, or exploitation are categorized, investigated, and remediated appropriately. The DIDD Investigations unit will triage all reports of abuse, neglect, exploitation, serious injuries, and unexpected deaths. MCOs also access the reports and provide any additional information to ensure the appropriate response. In this model, provider agencies are responsible for conducting Tier 2 investigations in which there are no injuries to a person supported while DIDD is responsible for all Tier 1 investigations. The State reserves the right to conduct any investigation, and the provider has the right to request an exception and request that the State investigate a Tier 2 event. All investigation reports go to DIDD and the MCOs for review. DIDD and the MCOs review investigations simultaneously, and together DIDD and the MCO implement the Action Plans to address the investigation conclusion and any additional findings during the course of the investigation.

Reportable Events and data are tracked and trended by DIDD, MCOs, and providers. MCOs and DIDD, in collaboration with TennCare and providers, evaluate the trended data to achieve desired Reportable Event Management outcomes—address and prevent instances of abuse, neglect, exploitation, and unexplained death.

Although the sixth month of implementation for ECF CHOICES and 1915(c) waiver programs is being finished, the third month of implementation for the CHOICES programs is being completed, and the State is still in the early stages of determining the most timely and appropriate methods of data collection, collaboration, and reporting. For that reason, the information below is being provided with the caveat that additional details may be provided to supplement this response.

Data reported in the One Aligned REM System below reflects only Tier 1 and Tier 2 reportable events—i.e., critical incidents. Previous reporting included other types of reportable events that did not rise to the level of critical incidents, which accounts for the reduction in numbers.

Health and Welfare Measure: number and percentage of CHOICES members with critical incidents per month[5]

CHOICES G2 and G3 Critical Incidents	**September 2021**	**October 2021**	**November 2021**	**December 2021**
Number of Tier 1 and Tier 2 Reportable Events (i.e., Critical Incidents)	21	24	15	19

[5] Shown by month due to change in reporting mid-quarter. Future reporting will be quarterly.

Number of CHOICES G2 and G3 members[6]	12,098	12,053	11,991	11,940
Percentage	0.17%	0.20%	0.13%	0.16%

Health and Welfare Measure: number and percentage of ECF CHOICES members with critical incidents per month[7]

ECF CHOICES (Groups 4-8) Critical Incidents	**September 2021**	**October 2021**	**November 2021**	**December 2021**
Number of Tier 1 and Tier 2 Reportable Events (i.e., Critical Incidents)	37	24	21	28
Number of ECF CHOICES Groups 4-8 members[8]	3725	3746	3786	3863
Percentage	1.00%	0.64%	0.55%	0.72%

Potential additional measures for which data is still being gathered:

1. Number and percentage of CHOICES members with substantiated investigations resulting from total investigations per quarter
    a. Metric: Number of CHOICES substantiated investigations/total number of investigations per quarter
2. Number and percentage of ECF CHOICES members with substantiated investigations resulting from total investigations per quarter
    a. Metric: Number of ECF CHOICES substantiated investigations/total number of investigations per quarter
3. Number and percentage of Katie Beckett members with substantiated investigations resulting from total investigations per quarter
    a. Metric: Number of CHOICES substantiated investigations/total number of investigations per quarter

[6] Enrollment numbers from CHOICES Monthly Report.
[7] Shown by month due to change in reporting mid-quarter. Future reporting will be quarterly.
[8] Enrollment numbers from ECF CHOICES Monthly Enrollment Report.

4. Number and percentage of Plans of Correction related to CHOICES substantiated investigations, required to be submitted by CHOICES providers, which are accepted by DIDD and/or the MCO after review
    a. Metric: Number of Plans of Correction related to substantiated investigations, required to be submitted by CHOICES providers, which are accepted by DIDD and/or MCO after review/total substantiated investigations
5. Number and percentage of Plans of Correction related to ECF CHOICES substantiated investigations, required to be submitted by ECF CHOICES providers, which are accepted by DIDD and/or the MCO after review
    a. Metric: Number of Plans of Correction related to substantiated investigations, required to be submitted by ECF CHOICES providers, which are accepted by DIDD and/or MCO after review/total substantiated investigations
6. Number and percentage of Plans of Correction related to Katie Beckett substantiated investigations, required to be submitted by Katie Beckett providers, which are accepted by DIDD and/or the MCO after review
    a. Metric: Number of Plans of Correction related to substantiated investigations, required to be submitted by Katie Beckett providers, which are accepted by DIDD and/or MCO after review/total substantiated investigations

Attachment J:
The Impact of TennCare: A Survey of Recipients, 2021

THE IMPACT OF TENNCARE

A Survey of Recipients, 2021

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The Impact of TennCare: A Survey of Recipients, 2021

Method

The Boyd Center for Business and Economic Research at the University of Tennessee, under contract with the Department of Finance and Administration of the State of Tennessee, conducted a survey of Tennessee residents to ascertain their insurance status and use of medical facilities and their level of satisfaction with the TennCare program. A target sample size of 5,000 households allows us to obtain accurate estimates for subpopulations. The Boyd Center prepared the survey instrument in cooperation with personnel from the Division of TennCare.

The University of Tennessee Social Work Office of Research and Public Service (SWORPS) and Wilkins Research Services conducted the survey by randomly selecting potential respondents from a land line and cell phone set of numbers and contacting those families between May and July 2021. TennCare provided SWORPS with 10,000 (de-identified) phone numbers to help reach TennCare households. We partnered with Wilkins Research Services again this year because social distancing and other University of Tennessee COVID-19 restrictions prevented SWORPS from conducting the survey in a timely manner. We also enhanced the telephone lists by using a larger web panel compared to the web panel used in previous years.[1] We added a few questions related to COVID-19, which are discussed in a separate section at the end of the report.

Up to five calls were made to each residence, at staggered times, to minimize non-response bias. The design chosen was a "Household Sample," and the interview was conducted with the head of the household. When Spanish-speaking households without an available English speaker were reached, a person fluent in Spanish would call the household at a later time to conduct the survey. Approximately 23.3 percent of those who answered their land line phone or cell phone were willing to participate in the survey.[2] The large sample size allowed for the weighting of responses by income and age to provide unbiased estimates for the entire population. For all statewide estimates, a correction factor was used to adjust for the degree to which the sample over- or under-represented Tennesseans grouped by household income and head of household age.[3] (Table 1)

[1] Beginning in 2017, SWORPS supplemented random dialing with a web panel of respondents. Prior to the survey, these web respondents provided some basic information such as age and income and were contacted to balance the distribution of responses across age and income combinations.

[2] This is a significant decrease from the 2020 telephone response rate, supporting the need for using the web panel to achieve the appropriate age and income distributions. In the land line phone sample, there were 2,728 completed surveys, 8,872 refusals, and 133 who did not qualify. In the cell phone sample, there were 826 completed surveys, 3,599 refusals, and 48 who did not qualify. There were 1,880 surveys completed by web panel participants. An individual will not qualify to participate if he/she is not a head of household or a Tennessee resident.

[3] Starting with the 2016 report, the 5-year American Community Survey (ACS) conducted by the U.S. Census is used to adjust the sample by household income and head of household age. The ACS is a nationwide survey designed to provide reliable and timely estimates of the demographic, social, economic and housing characteristics of the U.S. population and for parts of the U.S., such as states.

This is a follow-up to previous surveys of around 5,000 Tennessee households conducted annually since 1993, the last year of Medicaid before Tennessee adopted TennCare. Throughout this report, we make comparisons to findings from earlier surveys.

TABLE 1: Head of Household Age and Household Income

Age-Householders	Proportion in 2021 Survey (Percent)	Proportion in ACS* (Percent)	Deviation (Percent)
Under 25	8.1	4.2	-3.9
25-44	38.2	31.9	-6.3
45-64	37.1	38.0	0.9
65+	16.6	25.9	9.3

Household Income Level	Proportion in 2020 Survey (Percent)	Proportion in ACS* (Percent)	Deviation (Percent)
Less than $10,000	11.7	6.9	-4.8
$10,000 to $14,999	9.0	5.2	-3.8
$15,000 to $19,999	8.0	5.3	-2.7
$20,000 to $29,999	12.8	10.4	-2.4
$30,000 to $39,999	10.8	10.2	-0.6
$40,000 to $49,999	8.9	9.1	0.2
$50,000 to $59,999	8.0	8.2	0.2
$60,000 to $99,999	16.6	22.4	5.8
$100,000 to $149,999	8.5	12.8	4.3
$150,000 and over	5.7	9.5	3.8

*Census Bureau, 2015-2019 American Community Survey 5-year Estimates.

Estimates for Insurance Status

Estimates for the number of Tennesseans who are uninsured are presented below (Table 2 and Figure 1). These statewide estimates are extrapolated from the weighted sample. The overall rate of uninsured Tennesseans and the uninsured rate for adults did not change from 2020 to 2021. Specifically, the estimated population of uninsured represents approximately 8.3 percent of the 6,829,174 Tennessee residents, and 9.9 percent of adults.[4] The uninsured rate for children in 2021 is 2.5 percent, a decrease from 2.8 percent in 2020, and the estimated number of uninsured children in 2021 is 37,354 (Table 2a).

TABLE 2: Statewide Estimates of Uninsured Populations (2001–2021)

	2001	2002	2003	2004	2005	2006	2007
State Total	353,736	348,753	371,724	387,975	482,353	649,479	608,234
Percent	6.2	6.1	6.4	6.6	8.1	10.7	10

	2008	2009	2010	2011	2012	2013	2014
State Total	566,633	616,967	618,445	604,222	577,813	611,368	472,008
Percent	9.3	10	9.9	9.5	9.2	9.6	7.2

	2015	2016	2017	2018	2019	2020	2021
State Total	370,115	368,792	408,083	451,627	468,096	566,523	564,452
Percent	5.7	5.6	6.1	6.7	6.9	8.3	8.3

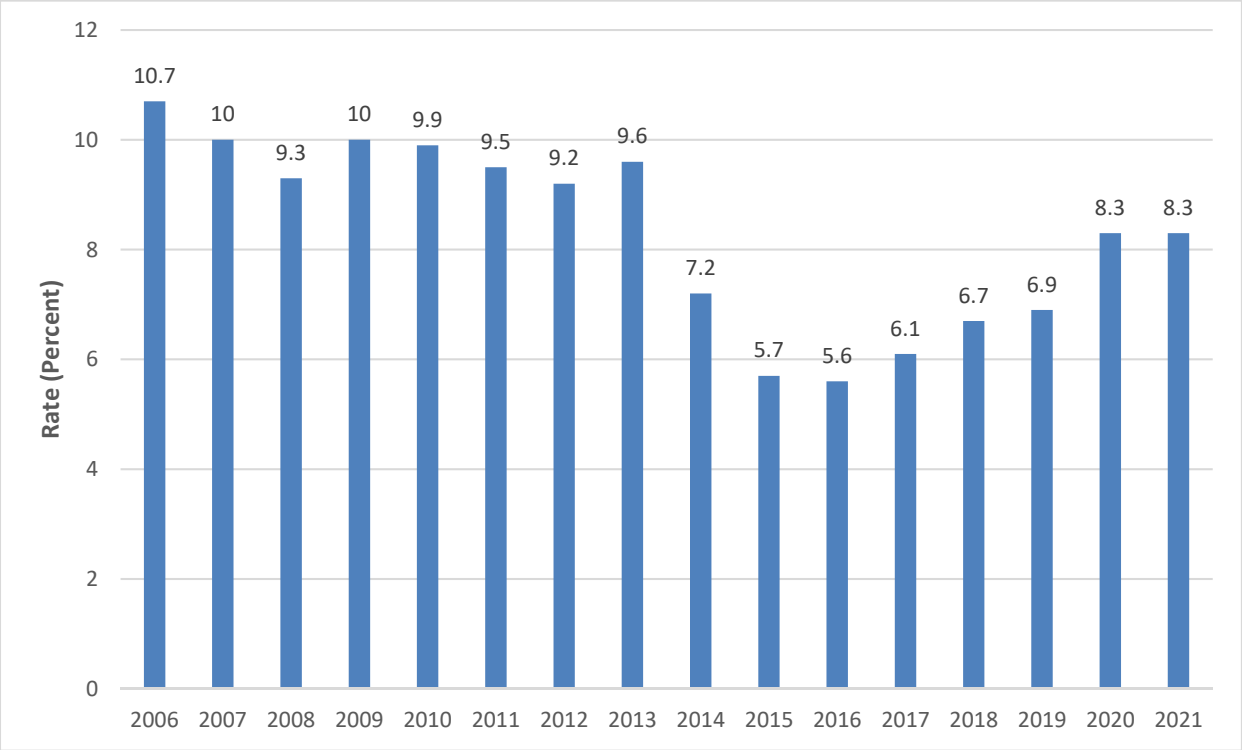
TABLE 2a: Uninsured Tennesseans by Age (2008–2021)

	2008	2009	2010	2011	2012	2013	2014
Under 18 Total	72,258	54,759	57,912	35,743	40,700	55,319	36,104
Under 18 Percent	4.9	3.7	3.9	2.4	2.7	3.7	2.4
18+ Total	494,375	562,208	560,532	568,479	537,113	556,049	435,904
18+ Percent	10.6	11.9	12	12	11.2	11.4	8.7

	2015	2016	2017	2018	2019	2020	2021
Under 18 Total	22,157	27,344	22,238	34,458	42,749	42,090	37,354
Under 18 Percent	1.5	1.8	1.5	2.3	2.8	2.8	2.5
18+ Total	347,958	341,449	385,800	417,170	425,347	524,433	527,098
18+ Percent	6.9	6.7	7.5	8.0	8.1	9.9	9.9

[4] Population estimates are found using United States Census Bureau Population Estimates. In prior years (1993 to 2008), population figures were gathered from the "Interim State Population Projections," also prepared by the United States Census Bureau.

FIGURE 1: Statewide Rate of Uninsured Populations (2006-2021)



Reasons for Failure to Obtain Medical Insurance

Affordability remains the top-cited reason for failing to obtain health insurance, with 80 percent of uninsured respondents citing “cannot afford” as a major reason and 6 percent citing affordability as a minor reason (Table 3). We report the distribution of responses who cited affordability as a reason by major income bracket in Table 4. The share of households in the $20,000-$39,999 bracket had the largest change declining from 84 percent in 2020 to 79 percent in 2021. Approximately 78 percent of households in the higher-income and lower income brackets cited affordability as a reason for failing to obtain health insurance in 2021.

TABLE 3: Reasons for Not Having Insurance (2001–2021) (Percent)

Reason	Cannot Afford			Did Not Get to It			Do Not Need		
Year	Major Reason	Minor Reason	Not a Reason	Major Reason	Minor Reason	Not a Reason	Major Reason	Minor Reason	Not a Reason
2001	78	9	13	11	20	69	12	16	72
2002	74	10	17	11	16	74	8	14	78
2003	82	8	10	10	20	70	8	15	77
2004	82	7	11	8	19	73	8	16	76
2005	82	7	10	9	16	75	8	15	77
2006	87	4	9	12	14	74	12	14	74
2007	89	6	4	9	11	79	5	13	82
2008	93	4	4	7	11	82	5	8	87
2009	92	3	4	3	15	81	5	10	85
2010	91	5	4	5	13	82	6	15	80
2011	88	5	7	11	12	77	8	12	79
2012	88	5	7	9	13	78	7	13	80
2013	83	6	11	9	17	74	5	16	79
2014	86	6	8	11	15	75	12	14	74
2015	83	7	10	9	13	77	9	10	80
2016	80	5	16	16	10	73	17	13	70
2017	78	9	13	11	15	74	13	13	74
2018	82	8	10	8	14	78	10	12	78
2019	81	8	11	11	15	74	13	12	75
2020	81	10	9	9	22	69	10	23	67
2021	80	6	14	12	22	66	11	18	71

TABLE 4: "Cannot Afford" Major Reasons for No Insurance: By Income (2016–2021) (Percent) [5]

Household Income	2016	2017	2018	2019	2020	2021
Less than $20,000	86	80	81	80	76	78
$20,000 - $39,999	69	75	80	81	84	79
$40,000 and above	79	42	77	68	79	78

[5] Results in Table 4 omit respondents who did not report household income.

Evaluations of Medical Care and Insurance Coverage

Tennessee residents' perceptions about the quality of care received remain consistent with their perceptions for more than a decade. Overall, in 2021, 79 percent of all heads of households and 73 percent of TennCare heads of households rated the quality of care as "good" or "excellent" (Table 5), nearly unchanged from 2020 responses.

TABLE 5: Quality of Medical Care Received by Heads of Households (2011–2021) (Percent)

All Heads of Households	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
Excellent	31	30	32	31	32	33	33	32	33	33	34
Good	46	46	46	47	46	45	45	45	47	46	45
Fair	15	17	16	16	17	17	17	17	15	16	15
Poor	7	7	6	6	5	5	5	6	5	5	6
Heads of Households w/ TennCare	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**
Excellent	30	24	24	25	28	31	27	26	30	30	30
Good	41	45	44	45	42	43	46	45	46	44	43
Fair	19	22	24	22	24	23	22	24	19	20	20
Poor	10	9	8	8	6	3	5	5	5	6	7

In 2021 all heads of households and heads of households with TennCare children reported similar levels of satisfaction with the quality of healthcare received by covered children. In 2021, 88 percent and 85 percent, respectively, reported quality of care received as "excellent" or "good." These responses are consistent with long-term trends, indicating respondents remain satisfied with the quality of care received by their children. See Table 6.

TABLE 6: Quality of Medical Care Received by Children of Heads of Households (2011–2021) (Percent)

All Heads of Households	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
Excellent	44	42	43	41	45	46	43	44	45	45	44
Good	45	45	43	48	44	42	45	45	44	44	44
Fair	9	10	10	9	8	10	10	9	8	9	10
Poor	2	3	4	2	3	2	2	2	3	3	2
Heads of Households w/ TennCare[6]	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**
Excellent	48	38	35	38	41	43	39	43	45	41	44
Good	39	42	45	49	46	44	48	45	42	43	41
Fair	11	14	14	10	9	12	10	10	10	13	12
Poor	2	6	6	3	4	1	3	2	3	3	3

Satisfaction with Quality of Care Received from TennCare

TennCare recipients continue to show high levels of satisfaction with the TennCare program as a whole (Table 7), and satisfaction with the quality of care their children receive. Specifically, 92 percent of respondents indicated they are "very satisfied" or "somewhat satisfied" with the TennCare program. Satisfaction rates have exceeded 90 percent for over a dozen consecutive years.[7] In addition, 96 percent are "very satisfied" or "somewhat satisfied" with the quality of care for their children.[8]

TABLE 7: Percent Indicating Satisfaction with TennCare (2007–2021) (Percent)

2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
90	89	92	94	95	93	95	93	95	92	95	95	94	94	92

Behavior Relevant to Medical Care

Each respondent was asked a series of questions regarding his or her behavior when initially seeking medical care (Table 8). Reported behavior for 2021 is very consistent with recent surveys. Ninety-four percent of all heads of households sought care first at a doctor's office or clinic while 93 percent of TennCare heads of household did the same. In 2021, 6 percent of TennCare households and 4 percent of

[6] This subgroup includes all households in which at least one child is enrolled in TennCare, even if the head of the household is not enrolled.

[7] A three-point scale was used, and respondents could indicate "very satisfied," "somewhat satisfied," or "not satisfied." We ask a related question about satisfaction with TennCare coverage, and 91 percent report that they are "satisfied."

[8] 2021 is the first year we separately report satisfaction with the quality of care for children.

TennCare households with children initially sought care at a hospital (Tables 8 and 9). The 2021 results are qualitatively similar to the amounts reported in 2020.

TABLE 8: Head of Household: Medical Facilities Used When Medical Care Initially Sought (2011-2021) (Percent)

All Heads of Households	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
Doctor's Office	83	82	81	81	81	80	80	79	78	78	77
Clinic	12	13	13	14	15	16	15	16	17	16	17
Hospital	4	4	4	3	3	3	3	3	3	4	4
Other	2	1	2	2	1	1	2	2	2	2	2
Heads of Households w/ TennCare	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**
Doctor's Office	80	75	80	72	76	78	79	76	76	79	76
Clinic	11	14	14	18	18	18	12	16	17	14	17
Hospital	8	10	6	8	6	3	7	7	6	6	6
Other	2	1	<1	2	0	1	2	1	1	1	1

TABLE 9: Children: Medical Facilities Used When Medical Care Initially Sought (2011-2021) (Percent)

All Heads of Households	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
Doctor's Office	88	88	86	87	86	85	84	85	81	83	81
Clinic	9	10	12	12	12	13	13	13	15	14	15
Hospital	2	2	1	1	1	1	2	1	3	2	3
Other	<1	<1	1	<1	<1	<1	<1	<1	1	1	1
Heads of Households w/ TennCare[9]	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**
Doctor's Office	84	86	84	84	83	86	85	85	78	83	82
Clinic	7	11	12	14	14	12	11	12	15	13	14
Hospital	9	3	3	1	3	2	4	2	6	3	4
Other	0	0	<1	1	0	<1	0	<1	<1	1	<1

TennCare recipients continue to report seeing physicians on a more frequent basis than the average Tennessee household (Table 10). The proportion of all heads of households that reported seeing a doctor at least weekly or monthly rose from 14 percent to 15 percent in 2021. This figure rose more sharply from 26 percent to 31 percent for TennCare heads of households. Similar trends are observed among children, with 9 percent of all households taking their children to visit a doctor at least monthly (unchanged from 2020) versus 19 percent of TennCare households with children (up from 13 percent in

[9] This subgroup includes all households in which at least one child is enrolled in TennCare, even if the head of the household is not enrolled.

2020). See Table 11. During 2020, many doctors' offices restricted non-emergency in-person office visits because of COVID-19. The 2021 results are similar to results pre-COVID 19 and indicate that doctor's offices and patient behavior returned to some level of normalcy during the survey period (i.e., May-July) when Covid-19 levels were relatively low.

TABLE 10: Frequency of Visits to Doctor for Head of Household (2011–2021) (Percent)

All Heads of Households	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
Weekly	2	1	2	2	2	2	2	2	2	2	3
Monthly	11	11	11	11	11	12	12	11	13	12	12
Every Few Months	44	46	46	47	46	44	46	47	47	45	45
Yearly	25	25	24	25	25	26	26	25	23	25	24
Rarely	17	17	17	15	16	16	14	15	15	16	16
Heads of Households w/ TennCare	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**
Weekly	6	4	5	6	3	5	5	5	5	4	6
Monthly	26	31	34	31	26	31	28	26	28	22	25
Every Few Months	46	43	43	45	49	42	42	45	43	48	42
Yearly	10	8	8	11	9	10	14	12	12	15	14
Rarely	11	14	10	8	13	12	11	12	12	11	13

TABLE 11: Frequency of Visits to Doctor for Children (2011–2021) (Percent)

All Heads of Households	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
Weekly	1	1	1	1	1	1	1	1	1	1	1
Monthly	10	8	9	9	7	8	7	7	10	8	8
Every Few Months	50	50	52	47	47	44	48	51	50	48	44
Yearly	31	35	30	35	36	38	36	35	32	36	40
Rarely	8	6	8	8	8	9	8	6	7	7	7
Heads of Households w/ TennCare[10]	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**
Weekly	1	0	1	2	1	3	3	2	2	2	4
Monthly	15	15	19	17	13	12	14	12	18	11	15
Every Few Months	55	58	53	53	51	53	48	57	52	51	46
Yearly	25	22	25	25	28	29	31	24	24	30	29
Rarely	10	4	5	2	2	5	3	5	4	6	6

[10] This subgroup includes all households in which at least one child is enrolled in TennCare, even if the head of the household is not enrolled.

Appointments

The reported time required to obtain an appointment increased overall compared to 2020. The share of respondents who obtained an appointment within one day increased from 34 percent to 35 percent. However, 66 percent of TennCare recipients were able to make a doctor's appointment within a week, down from 71 percent in 2020. Eighteen percent reported waiting more than three weeks, an increase from 14 percent in 2020 (Table 12). TennCare patients reported waiting on average 37 minutes after arriving for their appointments, the shortest time in history of the data. The average travel time to a physician's office was 23 minutes (Table 13).

TABLE 12: Time between Attempt to Make Appointment and First Availability of Appointment: TennCare Heads of Household (2011–2021) (Percent)

When you last made an appointment to see a primary care physician for an illness, in the past 12 months, how soon was the first appointment available?	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
Same day	21	20	18	18	24	19	21	23	21	14	15
Next day	19	21	25	21	18	22	21	24	21	20	20
1 week	30	25	23	29	26	28	29	28	30	37	31
2 weeks	10	14	10	8	8	9	9	10	13	11	11
3 weeks	4	2	4	6	3	4	5	4	4	4	5
Over 3 weeks	16	18	20	19	21	18	15	11	11	14	18

TABLE 13: Wait at Appointments: TennCare Heads of Household (2011–2021) (Minutes)

	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
Number of minutes wait past scheduled appointment time?	58	58	51	53	63	52	42	50	45	42	37
Number of minutes to travel to physician's office?	23	22	22	22	27	24	22	23	26	23	23

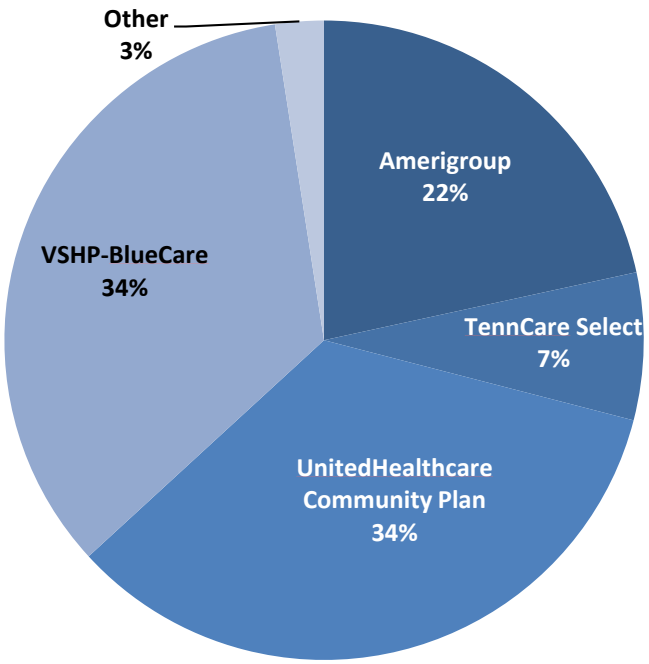
TennCare Plans

In 2021, 90 percent of TennCare survey household members report being signed up with one of three plans: 34 percent in Volunteer State Health Plan (VSHP), 34 percent in UnitedHealthcare, and 22 percent in Amerigroup. About 7 percent report being enrolled in TennCare Select. Although there are no other active TennCare plans, 3 percent indicate they are represented by some plan other than these four listed. Enrollments this year are generally consistent with prior surveys.

TABLE 14: Reported TennCare Plan (2016–2021) (Percent)

What company manages your TennCare plan?	2016	2017	2018	2019	2020	2021
Amerigroup	19	21	22	21	24	22
TennCare Select	3	9	6	8	7	7
UnitedHealthcare Community Plan (formerly AmeriChoice)	30	31	33	33	32	34
VSHP – BlueCare	44	36	36	36	34	34
Other	4	3	3	2	3	3

FIGURE 2: Reported TennCare Plan (2021)



Seven percent of respondents indicated that they had changed plans within the preceding 12 months. Of that total, 54 percent requested the change. The most commonly cited reason for changing plans was "limited choice of doctors and hospitals."

Seventy-four percent of TennCare heads of households report receiving a list of rights and responsibilities this year. Sixty-two percent of households report receiving an enrollment card, up from 59 percent in 2020. Sixty-six percent report receiving information about filing an appeal, which is an increase from the 64 percent who reported receiving this information in the prior year. (Table 15)

Mail is still the most popular mode of communication for TennCare households, though some changes are occurring. Approximately 62 percent report that mail is still the preferred method for receiving information, which is down from 73 percent three years ago. Approximately 17 percent report that they prefer to receive communication electronically by email or through online resources. (Table 16)

TABLE 15: Households Receiving TennCare Information from Plans (2011–2021) (Percent)

Please indicate whether or not you or anyone in your household has received each of the following regarding TennCare	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**
An enrollment card	61	62	69	63	69	67	71	67	69	59	62
Information on filing grievances	29										
Information on filing appeals[11]		73	76	70	82	76	76	74	70	64	66
A list of rights and responsibilities	68	80	82	78	85	81	82	79	75	72	74
Name of MCO to whom assigned	76	79	76	76	84	81	81	75	76	71	72

[11]Before 2012, survey respondents were asked whether they had received "information on filing grievances." The term "appeals" is much more widely used in the TennCare program than the term "grievances." Therefore, the question was changed in 2012 to ask whether respondents had received "information on filing appeals."

TABLE 16: Best Way to Get Information about TennCare (2011–2021) (Percent)

	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
Mail	78	80	74	75	78	78	72	73	64	64	62
Doctor	5	6	9	5	4	5	6	3	6	5	7
Phone	5	4	6	6	8	4	5	4	4	6	6
Handbook	6	5	4	4	3	2	4	4	4	2	2
Drug Store	<1	<1	<1	<1	<1	<1	<1	<1	<1	1	1
Friends	2	<1	<1	<1	<1	<1	<1	<1	1	2	3
TV	<1	<1	<1	<1	<1	<1	<1	<1	1	1	<1
Paper	0	<1	<1	<1	0	<1	<1	<1	<1	<1	<1
Email						5	6	7	10	12	13
Website						4	4	6	7	5	4
Other	4	4	4	6	8	<1	<1	1	2	2	1

In the past 12 months, 13 percent of TennCare families used a non-emergency care provider that did not participate in their plan, with 56 percent of those reporting using non-participating providers only one to two times (Figure 3). Of the 13 percent of TennCare households using non-participating providers, the most common type of care sought was from a general medical care/family doctor followed by dental care and by eye care (Table 17 and Figure 4). Approximately 5 percent of all TennCare households sought care from a non-TennCare provider because the service was not covered under TennCare. Further, 2 percent of TennCare households sought care from a non-TennCare provider because there was not a TennCare provider in the area, and 2 percent because they were dissatisfied with the quality of service from the TennCare provider. Over half of the respondents (59 percent) reported that TennCare helped them find a provider that participated in the TennCare plan.

FIGURE 3: Number of Times Sought Non-Emergency Care at a Non-Participating Provider in Past 12 Months (Percent)

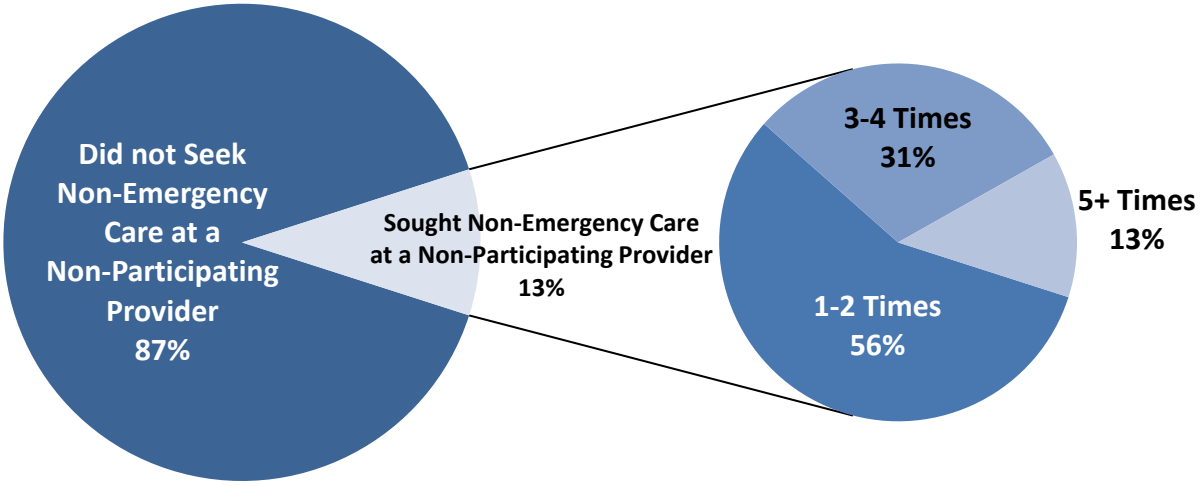


TABLE 17: Type of Non-Emergency Care Sought from a Non-TennCare Provider (2021) (Percent)

	2021
General Medical Care Specialist	50
Dental Care	41
Eye Care	29
Non-Surgical Specialist	25
Surgical Specialist	17
Not Sure	5

Respondents could choose more than one type of non-emergency care.

FIGURE 4: Type of Non-Emergency Care Sought from a Non-TennCare Provider (2021)

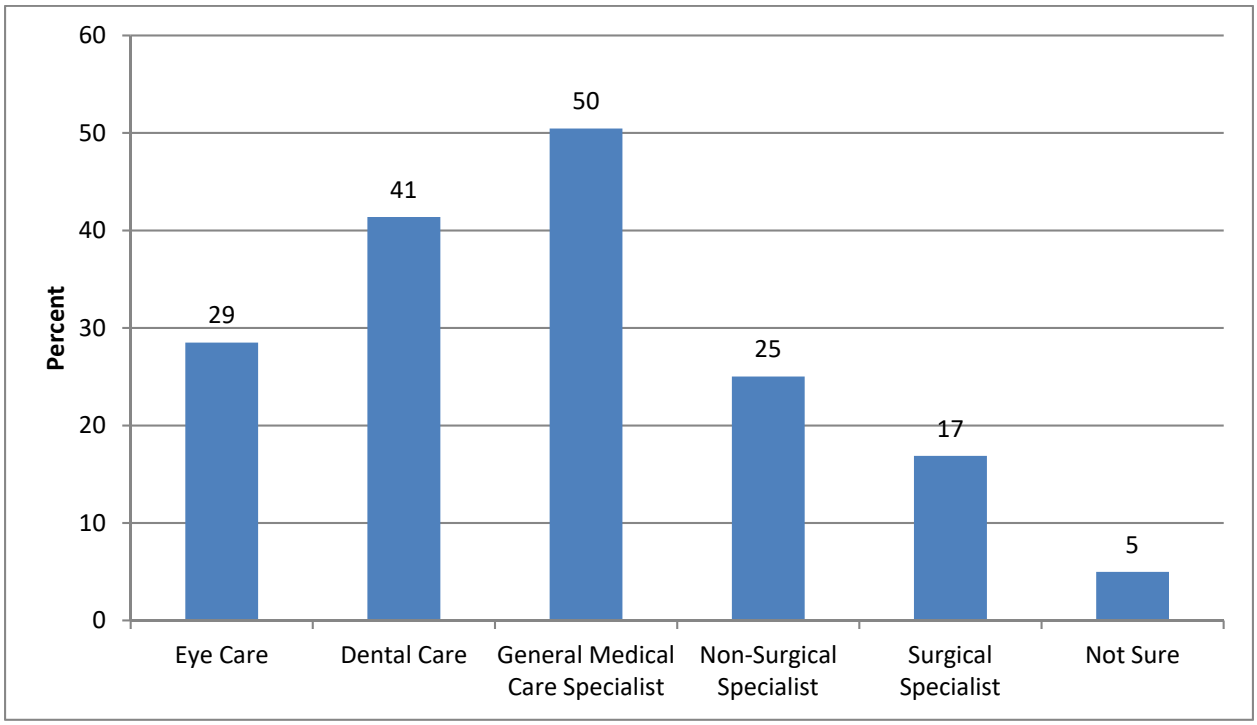


TABLE 18: Reasons Sought Non-Emergency Care from a Non-TennCare Provider (2021) (Percent of TennCare Recipients)

	2021
Dissatisfaction with quality of service from TennCare provider	2
Service was not covered by TennCare	5
No TennCare provider in the area	2
Could not get timely appointment with TennCare provider	1
When I made the appointment or received care, I mistakenly thought the provider participated in my TennCare health care plan	2
Not Sure	1

COVID-19 Considerations

The 2020 and 2021 surveys included questions relating to COVID-19. Slightly more than one in five respondents (about 21 percent) said that COVID-19 had impacted the quality of their healthcare, with nearly 72 percent of this group stating that the quality was worse during COVID-19. In addition, approximately 13 percent state that they were unable to make an appointment to see a physician in the past 12 months due to the physician's office being closed for non-emergency visits. Similarly, 4 percent of heads of households reported that they were unable to make an appointment for their child to see a physician in the past 12 months due to the physician's office being closed for non-emergency visits (Table 19).

Respondents report an increase in the use of telehealth and behavioral health services during the pandemic, with approximately 31 percent of respondents reporting using telehealth services more frequently, and nearly 9 percent report using behavioral health services more frequently due to COVID-19. Nearly two-thirds (61 percent) of the TennCare respondents report receiving communications from TennCare or from their TennCare health plan about available services and testing for COVID-19.

Table 19: COVID-19 Impacts

Overall quality of medical care has been impacted by COVID-19	20.8%
Quality is better	*28.2%*
Quality is worse	*71.8%*
Unable to see a physician because office was closed for non-emergency visits due to COVID-19	12.6%
Unable to make an appointment for their child to see a physician due to COVID-19	3.8%

Conclusion

The proportion of uninsured children decreased from 2.8 percent in 2020 to 2.5 percent in 2021, while the proportion of uninsured adults remained unchanged at 9.9 percent in 2021. Approximately 100,000 more Tennesseans are uninsured since the pandemic began; the 2021 uninsured rate remains the highest since 2013.

Affordability continues to be the major reason cited for not having insurance, cited by approximately 80 percent of respondents across all income categories. TennCare heads of households and their children tend to first seek medical care at a doctor's office or clinic (versus a hospital). TennCare recipients continue to report seeing doctors on a more frequent basis than the average Tennessee household.

Overall, TennCare continues to receive positive feedback from its recipients, with 92 percent reporting satisfaction with the program. This positive feedback is a strong indication that TennCare is providing satisfactory medical care and meeting the expectations of those it serves.

Attachment K:
Measurement Year 2020 HEDIS/CAHPS Report – Comparative Analysis of Audited Results from TennCare Managed Care Organizations

November 2021

2021 Annual

HEDIS/CAHPS Report

Comparative Analysis of Audited Results from TennCare MCOs for Measurement Year (MY) 2020

Following the MY2020 National Benchmark Release

TN Division of TennCare

Qsource

Table of Contents

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List of Figures

Acknowledgements, Acronyms, and Initialisms[1]

AAB ..... Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis

AAP ..... Adults' Access to Preventive/ Ambulatory Health Services

ABX ..... Antibiotic Utilization

ACIP ..... Advisory Committee on Immunization Practices

ADD ..... Follow-Up Care for Children Prescribed ADHD Medication

ADHD ..... Attention-Deficit/Hyperactivity Disorder

AG ..... Amerigroup Community Care, Inc., referred to as Amerigroup

AGE, AGM, AGW ..... AG referenced by operational region: East (E), Middle (M), or West (W)

AHRQ ..... Agency for Healthcare Research and Quality

AIS-E ..... Adult Immunization Status—ECDS

AMB ..... Ambulatory Care

AMM ..... Antidepressant Medication Management

AMR ..... Asthma Medication Ratio

AOD ..... Alcohol or Other Drug

APM ..... Metabolic Monitoring for Children and Adolescents on Antipsychotics

APP ..... Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics

ASF-E ..... Unhealthy Alcohol Use Screening and Follow-Up—ECDS

AWC ..... Adolescent Well-Care Visits

BC ..... BlueCare Tennessee℠ and BlueCare®, independent licensees of the BlueCross BlueShield Association

BCE, BCM, BCW ..... BC referenced by operational region: East, Middle, or West

BCS ..... Breast Cancer Screening

BMI ..... Body Mass Index

BP ..... Blood Pressure

BR ..... Biased Rate

CAHPS® ..... refers to the Consumer Assessment of Healthcare Providers and Systems, a registered trademark of AHRQ

CAP ..... Children and Adolescents' Access to Primary Care Practitioners

CBP ..... Controlling High Blood Pressure

CCC ..... Children With Chronic Conditions

CCS ..... Cervical Cancer Screening

CDC ..... Comprehensive Diabetes Care

CHIP ..... Children's Health Insurance Plan

CHL ..... Chlamydia Screening in Women

CIS ..... Childhood Immunization Status

CKBC ..... CoverKids BlueCare

COL ..... Colorectal Cancer Screening

CPA ..... CAHPS Health Plan Survey 5.0H Adult Version

CPC ..... CAHPS Health Plan Survey 5.0H Child Version

CRE ..... Cardiac Rehabilitation

[1] *Other company and product names may be trademarks of the respective companies with which they are associated. The mention of such companies and product names is with due recognition and without intent to misappropriate such names or marks.*

COPD ..... Chronic Obstructive Pulmonary Disease

COU ..... Risk of Continued Opioid Use

CVD ..... Cardiovascular Disease

CWP ..... Appropriate Testing for Pharyngitis

DMS-E ..... Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults—ECDS

DRR-E ..... Depression Remission or Response for Adolescents and Adults—ECDS

DSF-E ..... Depression Screening and Follow-Up for Adolescents and Adults—ECDS

DTaP ..... Diphtheria, Tetanus, and Acellular Pertussis Vaccination

ECDS ..... Electronic Clinical Data Systems

ED ..... Emergency Department

ENP/ENPA ..... Enrollment by Product Line/ENP Total

Flu ..... Influenza

FSP ..... Frequency of Selected Procedure

FUH ..... Follow-Up After Hospitalization for Mental Illness

FUM ..... Follow-Up After ED Visit for Mental Illness

FUA ..... Follow-Up After ED Visit for Alcohol and Other Drug Abuse or Dependence

FUI ..... Follow-Up After High-Intensity Care for Substance Use Disorder

FVA ..... Flu Vaccinations for Adults Ages 18 to 64

HbA1c ..... Hemoglobin A1c

HDO ..... Use of Opioids at High Dosage

HEDIS® ..... a registered trademark of NCQA that refers to the Healthcare Effectiveness Data and Information Set

HepA ..... Hepatitis A Vaccine

HepB ..... Hepatitis B Vaccine

HiB ..... *Haemophilus influenzae* Type B Vaccine

HPV ..... Human Papillomavirus Vaccine

HrHPV ..... High-Risk Human Papillomavirus

IAD ..... Identification of Alcohol and Other Drug Services

IHS ..... Index Hospital Stays

IET ..... Initiation and Engagement of AOD Abuse or Dependence Treatment

IMA ..... Immunizations for Adolescents

IP; IPU ..... Inpatient; IP Utilization – General Hospital/Acute Care

IPV ..... Inactivated Polio Vaccine

KED ..... Kidney Health Evaluation for Patients With Diabetes

LBP ..... Use of Imaging Studies for Low Back Pain

LDL-C ..... Low-Density Lipoprotein Cholesterol

LoS ..... Length of Stay

LSC ..... Lead Screening in Children

LTSS ..... Long-Term Services and Supports

LTSS-CAU ..... Comprehensive Assessment and Update

LTSS-CPU ..... Comprehensive Care Plan and Update

LTSS-RAC ..... Reassessment/Care Plan Update After Inpatient Discharge

LTSS-SCP ..... Shared Care Plan with Primary Care Practitioner

MCO ..... Managed Care Organization

MMA ..... Medication Management for People With Asthma

MMR ..... Measles, Mumps, and Rubella Vaccine

MPT ..... Mental Health Utilization

MSC ..... Medical Assistance With Smoking and Tobacco Use Cessation

MY ..... Measurement Year

NA ..... Not Applicable

NB ..... No Benefit

NCQA ..... National Committee for Quality Assurance

NCQA HEDIS Compliance Audit™ ..... trademark of NCQA

NCS ..... Non-Recommended Cervical Cancer Screening in Adolescent Females

NR ..... Not Reported

NQ ..... Not Required

OB-GYN ..... Obstetrician-Gynecologist

OUD ..... Opioid Use Disorder

PBH ..... Persistence of Beta-Blocker Treatment After a Heart Attack

PCE ..... Pharmacotherapy Management of COPD Exacerbation

PCP ..... Primary Care Practitioner

PCR ..... Plan All-Cause Readmissions

PCV ..... Pneumococcal Conjugate Vaccination

PDS-E ..... Postpartum Depression Screening and Follow-Up—ECDS

PMPY ..... Per Member Per Year

PND-E ..... Prenatal Depression Screening and Follow-Up—ECDS

POD ..... Pharmacotherapy for Opioid Use Disorder

PPC ..... Prenatal and Postpartum Care

PRS-E ..... Prenatal Immunization Status—ECDS

Qsource® ..... a registered trademark

Quality Compass® ..... a registered trademark of NCQA, the comprehensive national database of health plans' HEDIS and CAHPS results

R ..... Reportable

RV ..... Rotavirus Vaccination

SAA ..... Adherence to Antipsychotic Medications for Individuals With Schizophrenia

SMC ..... Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia

SMD ..... Diabetes Monitoring for People With Diabetes and Schizophrenia

SPC ..... Statin Therapy for Patients With Cardiovascular Disease

SPD ..... Statin Therapy for Patients With Diabetes

SPR ..... Use of Spirometry Testing in the Assessment and Diagnosis of COPD

SSD ..... Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications

TennCare ..... Tennessee Division of TennCare

Td; Tdap ..... Tetanus and Diphtheria Toxoids Vaccine; Td and Acellular Pertussis Vaccine

TCS ..... TennCare*Select*, operating statewide and administered by BlueCare Tennessee

UHC ..... UnitedHealthcare Community Plan, Inc., abbreviated as UnitedHealthcare

UHCE, UHCM, UHCW ..... UHC referenced by operational region: East, Middle, or West

UN ..... Unaudited

UOP ..... Use of Opioids From Multiple Providers

URI ..... Upper Respiratory Infection, and the measure: Appropriate Treatment for URI

VZV ..... Chicken Pox/Varicella Zoster Vaccination

W15 ..... Well-Child Visits in the First 15 Months of Life

W30 ..... Well-Child Visits in the First 30 Months of Life

W34 ..... Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life

WCC ..... Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents

WCV ..... Child and Adolescent Well-Care Visits

Executive Summary

Medicaid managed care organizations (MCOs) are required to report a full Healthcare Effectiveness Data and Information Set (HEDIS) as a part of the accreditation mandates in Tennessee. The HEDIS requirement is an integral part of the accreditation process of the National Committee for Quality Assurance (NCQA). In 2006, Tennessee became the first state in the nation requiring all MCOs to become accredited by NCQA, an independent, not-for-profit organization that assesses and scores MCO performance on important dimensions of care and service in a broad range of health issues.

More than 90% of health plans in America use the HEDIS tool because its standardized measures of MCO performance allow comparisons to national averages and benchmarks as well as between a state's MCOs, and over time. The Consumer Assessment of Healthcare Providers and Systems (CAHPS) set of standardized surveys is included in HEDIS to measure members' satisfaction with their care. This *2021 Annual HEDIS/CAHPS Report* summarizes the results for the MCOs contracting with the Division of TennCare (TennCare), the Medicaid program in Tennessee.

NCQA adopted a new naming convention to reduce confusion about the HEDIS measurement year (MY) and reporting year. Going forward, all HEDIS publication titles will refer to the HEDIS measurement year as "HEDIS Measurement Year [year]," abbreviated as "HEDIS MY[year]." This report, which previously would have referred to the most recent data as HEDIS 2021, uses the new nomenclature of HEDIS MY2020 to refer to data collected during calendar year 2020 and reported in calendar year 2021. To ensure consistency in the technical specifications and for easier reference to publications issued by NCQA, Qsource has retained NCQA's prior nomenclature to refer to previous years. For example, HEDIS 2020 remains as-is in this report and refers to data collected in MY2019.

For HEDIS 2020, NCQA allowed Medicaid plans to report their audited HEDIS 2019 hybrid rate rather than their HEDIS 2020 hybrid rate to reduce chart retrieval during the COVID-19 pandemic. For HEDIS MY2020, the regular process was followed and plans reported HEDIS MY2020 rates. For an overview of the performance of TennCare's MCOs, the Statewide Performance section provides a calculated weighted average of the scores of all those reporting. MCO-specific measures are presented in the Individual Plan Performance section. Weighted average performances of Tennessee's MCOs since 2017 on certain measures are presented in the HEDIS Trending section. The HEDIS and CAHPS results for Tennessee's Children's Health Insurance Plan (CHIP), CoverKids, are reported separately in a similar format in CHIP HEDIS/CAHPS Results.

Appendix A contains a comprehensive table of plan-specific results for HEDIS MY2020 Utilization Measures. The tables in Appendix B reveal populations reported by MCOs in member months by age

and sex for HEDIS MY2020. Appendix C includes plan-specific results for Measures Collected Using Electronic Clinical Data Systems (ECDS) and Long-Term Services and Supports (LTSS) measures. Appendix D presents the reporting options for each measure, whether administrative, hybrid, or both, as well as a table that presents the measurement years MCOs used for HEDIS 2020 hybrid measures. Appendix E offers additional utilization and risk-adjusted utilization measures and descriptive health plan information for the CHIP, including population in member months.

Background

HEDIS Measures—Domains of Care

HEDIS is an important tool designed to ensure the public has the information needed to reliably compare the performance of managed healthcare plans. Standardized methodologies incorporating statistically valid samples of members ensure the integrity of measure reporting and help purchasers make more reliable, relevant comparisons between health plans. HEDIS measures are subject to a NCQA HEDIS Compliance Audit that must be conducted by an NCQA-certified HEDIS Compliance Auditor under the auspices of an NCQA-licensed organization. This ensures the integrity of the HEDIS collection and calculation process at each MCO through an overall information systems capabilities assessment, followed by an evaluation of the ability to comply with HEDIS specifications.

HEDIS MY2020 assesses care across health systems, access to and satisfaction with healthcare services, and specific utilization through a total of 92 measures (Commercial, Medicare and Medicaid) across six domains of care:

- Effectiveness of Care
- Access/Availability of Care
- Utilization and Risk-Adjusted Utilization
- Experience of Care (CAHPS Survey Results)
- Health Plan Descriptive Information
- Measures Collected Using Electronic Clinical Data Systems (ECDS)

The following brief descriptions of selected HEDIS measures were extracted from NCQA's *HEDIS Measurement Year 2020 and Measurement Year 2021 Volume 2: Technical Specifications*, which includes additional information related to each measure. The measures presented in this report reflect data submitted from the following domains of care: Effectiveness of Care, Access/Availability of Care, Experience of Care, Utilization and Risk-Adjusted Utilization, Health Plan Descriptive Information, and ECDS. Additional LTSS measures are also included. Per NCQA, the following measures were retired for HEDIS MY2020: Adult BMI Assessment (ABA); Medication Management for People with Asthma (MMA); and Children and Adolescents' Access to Primary Care Practitioners (CAP).

Effectiveness of Care Measures

The measures in the Effectiveness of Care domain assess the quality of clinical care delivered within an MCO. They address how well the MCO delivers widely accepted preventive services and recommended screening for common diseases.

The domain also includes some measures for overuse and patient safety and addresses four major aspects of clinical care:

1. How well the MCO delivers preventive services and keeps members healthy
2. Whether members are offered the most up-to-date treatments for acute episodes of illness and get better

3. How well the MCO delivers care and assistance with coping to members with chronic diseases
4. Whether members can get appropriate tests

Effectiveness of Care measures are grouped into more specific clinical categories, which may change slightly year to year:

- Prevention and Screening
- Respiratory Conditions
- Cardiovascular Conditions
- Diabetes
- Behavioral Health
- Overuse/Appropriateness
- Measures collected through the CAHPS Health Plan Survey

Note: Only clinical categories with Medicaid measures are noted here.

Only certain measures from these categories are presented in this report, which does not include the additional category in this domain specific to Medicare. For some measures, eligible members cannot have more than one gap in continuous enrollment of up to 45 days during the measurement year (MY) and members in hospice (General Guideline 20) are excluded.

Prevention and Screening

Immunization measures follow guidelines for immunizations from the Centers for Disease Control and Prevention and the Advisory Committee on Immunization Practices (ACIP). HEDIS implements changes (e.g., new recommendations) after three years, to account for the measures' look-back period and to allow the industry time to adapt to new guidelines.

Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)

WCC measures the percentage of members 3 to 17 years of age who had an outpatient visit with a primary care practitioner (PCP) or obstetrician-gynecologist (OB-GYN) and who had evidence of three indicators: BMI percentile documentation, and counseling for nutrition and physical activity during the MY.

Note: Because BMI norms for youth vary with age and gender, this measure evaluates whether BMI percentile is assessed rather than an absolute BMI value.

For WCC, a total rate and two age stratifications are reported for each indicator:

- 3–11 years
- 12–17 years

Childhood Immunization Status (CIS)

CIS assesses the percentage of children who became two years of age during the MY and who had four diphtheria, tetanus, and acellular pertussis vaccines (DTaP); three inactivated polio vaccines (IPV); one measles, mumps, and rubella vaccine (MMR); three *Haemophilus influenzae* type B vaccines (HiB); three hepatitis B (HepB) vaccines; one chicken pox/varicella zoster vaccine (VZV); four pneumococcal conjugate vaccines (PCV); one hepatitis A (HepA) vaccine; two or three rotavirus vaccines (RV); and two influenza vaccines (Flu) by their second birthday.

The measure calculates a rate for each vaccine and nine separate combination rates numbered 2 to 10, as shown in Table CIS.

Table CIS. Combination Vaccinations for Childhood Immunization Status (CIS)

#	DTaP	IPV	MMR	HiB	HepB	VZV	PCV	HepA	RV	Flu
2	✓	✓	✓	✓	✓	✓				
3	✓	✓	✓	✓	✓	✓	✓			
4	✓	✓	✓	✓	✓	✓	✓	✓		
5	✓	✓	✓	✓	✓	✓	✓		✓	
6	✓	✓	✓	✓	✓	✓	✓			✓
7	✓	✓	✓	✓	✓	✓	✓	✓	✓	
8	✓	✓	✓	✓	✓	✓	✓	✓		✓
9	✓	✓	✓	✓	✓	✓	✓		✓	✓
10	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

Note: CIS follows the Centers for Disease Control and Prevention and ACIP guidelines for immunizations.

Immunizations for Adolescents (IMA)

IMA measures the percentage of adolescents 13 years of age who had one dose of meningococcal vaccine, one dose of tetanus, diphtheria toxoids, and acellular pertussis (Tdap) vaccine, and have completed the human papillomavirus (HPV) vaccine series by their 13th birthday. The measure calculates a rate for each vaccine and two combination rates: meningococcal and Tdap/Td; and meningococcal, Tdap/Td and HPV.

Lead Screening in Children (LSC)

LSC assesses the percentage of children who were 2 years of age during the MY and had one or more capillary or venous lead blood tests for lead poisoning on or before the second birthday. Both the date the test was performed and the result/finding must be documented in the medical record.

Breast Cancer Screening (BCS)

BCS measures the percentage of female members 50 to 74 years of age during the MY who had a mammogram to screen for breast cancer on or between October 1 two years prior to the MY, and through December 31 of the MY.

Cervical Cancer Screening (CCS)

CCS measures the percentage of women 21 to 64 years of age during the MY who were screened for cervical cancer using either of the following criteria:

- Women age 21–64 who had cervical cytology performed within the last three years
- Women age 30–64 who had cervical high-risk human papillomavirus (hrHPV) testing performed within the last five years
- Women age 30–64 who had cervical cytology/hrHPV co-testing performed within the last five years

Chlamydia Screening in Women (CHL)

CHL assesses the percentage of women 16 to 24 years of age who were identified as sexually active and who had at least one test for chlamydia during the MY. This measure calculates a total rate as well as two age stratifications:

- Women age 16–20
- Women age 21–24

Respiratory Conditions

Appropriate Testing for Pharyngitis (CWP)

CWP measures the percentage of episodes for members ages 3 years and older where the member was diagnosed with

pharyngitis, dispensed an antibiotic, and received a group A streptococcus (strep) test for the episode that occurred during the intake period between July 1 of the year prior to the MY and June 30 of the MY. A higher rate represents better performance (i.e., appropriate testing).

Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)

SPR reports the percentage of members 40 years of age and older with a new diagnosis during the intake period or newly active chronic obstructive pulmonary disease (COPD) who received appropriate spirometry testing to confirm the diagnosis. The first COPD diagnosis must have occurred during the intake period between July 1 of the year prior to the MY and June 30 of the MY.

Pharmacotherapy Management of COPD Exacerbation (PCE)

PCE assesses the percentage of COPD exacerbations for members 40 years of age and older who had an acute inpatient (IP) discharge or emergency department (ED) visit on or between January 1 and November 30 of the MY and who were dispensed appropriate medications. Two rates are reported:

- Dispensed a systemic corticosteroid (or evidence of an active prescription) within 14 days of the event
- Dispensed a bronchodilator (or evidence of an active prescription) within 30 days of the event

Note: The eligible population for this measure is based on acute IP discharges and ED visits, not on members. It is possible for the denominator to include multiple events for the same individual.

Asthma Medication Ratio (AMR)

AMR assesses the percentage of members 5 to 64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the MY. This measure calculates a total rate as well as four age stratifications:

- 5–11 years
- 12–18 years
- 19–50 years
- 51–64 years

Cardiovascular Conditions

Controlling High Blood Pressure (CBP)

CBP reports the percentage of members 18 to 85 years of age who had a diagnosis of hypertension and whose blood pressure (BP) was adequately controlled (<140/90 mm Hg) during the MY.

Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)

PBH measures the percentage of members 18 years of age and older during the MY who were hospitalized and discharged from July 1 of the year prior to the MY to June 30 of the MY with a diagnosis of acute myocardial infarction and who received persistent beta-blocker treatment for six months (at least 135 days of treatment within 180-day interval) after discharge.

Statin Therapy for Patients With Cardiovascular Disease (SPC)

SPC reports the percentage of members identified as having clinical atherosclerotic cardiovascular disease (ASCVD) and who met the following criteria:

- *Received Statin Therapy*—Members who were dispensed at least one high- or moderate-intensity statin medication during the MY
- *Statin Adherence 80%*—Members who remained on a high- or moderate-intensity statin medication for at least 80% of the treatment period

For SPC, a total rate and two stratifications of gender and age (as of December 31 of the MY) are reported:

- Males 21–75 years
- Females 40–75 years

Cardiac Rehabilitation (CRE)

CRE measures the percentage of members 18 years and older who attended cardiac rehabilitation following a qualifying cardiac event, including myocardial infarction, percutaneous coronary intervention, coronary artery bypass grafting, heart and heart/lung transplantation or heart valve repair/replacement. Four rates are reported:

- *Initiation*—The percentage of members who attended 2 or more sessions of cardiac rehabilitation within 30 days after a qualifying event.
- *Engagement 1*—The percentage of members who attended 12 or more sessions of cardiac rehabilitation within 90 days after a qualifying event.
- *Engagement 2*—The percentage of members who attended 24 or more sessions of cardiac rehabilitation within 180 days after a qualifying event.
- *Achievement*—The percentage of members who attended 36 or more sessions of cardiac rehabilitation within 180 days after a qualifying event.

The measure is reported as a total rate as well as two age stratifications:

- 18–64 years
- 65 years and older

Note: Rates for adults ≥65 years are Medicare provisions excluded in this report along with the total rate, which includes this age group.

Diabetes

Comprehensive Diabetes Care (CDC)

The CDC composite of six rates measures an MCO's performance on clinical management in aspects of diabetic care through the percentage of a single sample of diabetic members (type 1 and type 2) 18 to 75 years of age who met the criteria by having the following during the MY:

- Hemoglobin A1c (HbA1c) blood test
- Poorly controlled diabetes (HbA1c >9.0%)
  Note: a lower rate indicates better performance (i.e., low rates of poor control indicate better care)
- Controlled diabetes (most recent HbA1c <8.0%)
- Eye exam (retinal)
- Medical attention for nephropathy*
- Controlled blood pressure (<140/90 mm Hg)

** Medicare product line only*

Kidney Health Evaluation for Patients With Diabetes (KED)

KED reports the percentage 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. The measure is reported as a total rate as well as three age stratifications:

- 18–64 years
- 65–74 years
- 75–85 years

Note: Rates for adults ≥65 years are Medicare provisions excluded in this report along with the total rate, which includes this age group.

Statin Therapy for Patients With Diabetes (SPD)

SPD reports the percentage of members 40 to 75 years of age with diabetes during the MY who do not have ASCVD and met the following criteria reported as two rates:

- *Received Statin Therapy*—Members who were dispensed at least one statin medication of any intensity during the MY
- *Statin Adherence 80%*—Members who remained on a statin medication of any intensity for at least 80% of the treatment period

Behavioral Health

Antidepressant Medication Management (AMM)

AMM measures the percentage of members 18 years of age and older who were treated with antidepressant medication, had a diagnosis of major depression and who remained on an antidepressant medication treatment. Two rates are reported:

- *Effective Acute Phase Treatment*—The percentage who remained on an antidepressant medication for at least 84 days (12 weeks)
- *Effective Continuation Phase Treatment*—The percentage who remained on an antidepressant medication for at least 180 days (6 months)

Follow-Up Care for Children Prescribed ADHD Medication (ADD)

ADD assesses the percentage of children newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who had at least three follow-up care visits within a 10-month period, one of these visits must have been within 30 days of the earliest ambulatory prescription dispensed for ADHD medication, at which time the member must have been 6 to 12 years of age. Two rates are reported:

- *Initiation Phase*—The percentage who had one follow-up visit with a practitioner with prescribing authority during the 30-day Initiation Phase
- *Continuation and Maintenance Phase*—The percentage who remained on the medication for at least 210 days and who, in addition to the Initiation Phase follow-up, had at least two follow-up visits with a practitioner within 270 days (nine months) of the end of the Initiation Phase

Follow-Up After Hospitalization for Mental Illness (FUH)

FUH examines continuity of care for mental illness through the percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health provider. Two rates are reported as the percentage of discharges for which the member received follow-up within the following:

- 7 days after discharge
- 30 days after discharge

This measure is reported as a total rate as well as three age stratifications:

- 6–17 years
- 18–64 years
- 65 years and older

Note: Rates for adults ≥65 years are Medicare provisions excluded in this report along with the total rate, which includes this age group.

Follow-Up After Emergency Department Visit for Mental Illness (FUM)

FUM is the percentage of ED visits for members 6 years of age and older with a principal diagnosis of mental illness or intentional self-harm, who had a follow-up visit for mental illness. Two rates are reported as the percentage of ED visits for which the member received follow-up within the following:

- 7 days of ED visit
- 30 days of ED visit

This measure is reported as a total rate as well as three age stratifications:

- 6–17 years
- 18–64 years
- 65 years and older

Note: Rates for adults ≥65 years are Medicare provisions excluded in this report along with the total rate, which includes this age group.

Follow-Up After High-Intensity Care for Substance Use Disorder (FUI)

FUI is the percentage of acute inpatient hospitalizations, residential treatment, or detoxification visits for a diagnosis of substance use disorder among members 13 years of age and older that result in a follow-up visit or service for substance use disorder. Two rates are reported as the percentage of high-intensity care visits or discharges in which the member received follow-up within the following:

- 7 days after visit or discharge
- 30 days after visit or discharge

This measure is reported as a total rate as well as three age stratifications:

- 13–17 years
- 18–64 years
- 65 years and older

Note: Rates for adults ≥65 years are Medicare provisions excluded in this report along with the total rate, which includes this age group.

Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)

FUA is the percentage of ED visits for members 13 years of age and older with a principal diagnosis of alcohol or other drug (AOD) abuse or dependence, who had a follow-up visit for

AOD. Two rates are reported as the percentage of ED visits for which the member received follow-up within the following:

- 7 days of ED visit
- 30 days of ED visit

For FUA, a total rate and two age stratifications are reported:

- 13–17 years
- 18 years and older

Pharmacotherapy for Opioid Use Disorder (POD)

POD is the percentage of new opioid use disorder (OUD) pharmacotherapy events with OUD pharmacotherapy for 180 or more days for members ages 16 years and older with a diagnosis of OUD. The measure is reported as a total rate as well as two age stratifications:

- 16–64 years
- 65 years and older

Note: Rates for adults ≥65 years are Medicare provisions excluded in this report along with the total rate, which includes this age group.

Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)

SSD measures the percentage of members 18 to 64 years of age with schizophrenia, schizoaffective disorder, or bipolar disorder who were dispensed an antipsychotic medication and had a diabetes screening test during the MY.

Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD)

SMD is the percentage of members 18 to 64 years of age with schizophrenia or schizoaffective disorder, and diabetes who had both a low-density lipoprotein cholesterol (LDL-C) test and an HbA1c test during the MY.

Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (SMC)

SMC reports the percentage of members 18 to 64 years of age with schizophrenia or schizoaffective disorder, and cardiovascular disease (CVD) who had an LDL-C test during the MY.

Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)

SAA assesses the percentage of members with schizophrenia or schizoaffective disorder who were 18 years and older during the MY who were dispensed and remained on an antipsychotic medication for at least 80% of their treatment period.

Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)

APM measures the percentage of children and adolescents 1 to 17 years of age who had two or more antipsychotic prescriptions and had metabolic testing. Three rates are reported as the percentage of children and adolescents on antipsychotics who received the following:

- Blood glucose testing
- Cholesterol testing
- Blood glucose *and* cholesterol testing

The measure calculates a total rate as well as two age stratifications:

- 1–11 years
- 12–17 years

Overuse/Appropriateness

Non-Recommended Cervical Cancer Screening in Adolescent Females (NCS)

NCS records the percentage of adolescent females 16 to 20 years of age who were screened unnecessarily for cervical cancer.

Note: A lower rate indicates better performance.

Appropriate Treatment for Upper Respiratory Infection (URI)

URI measures 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 prescription. This measure is reported as an inverted rate [1 - (numerator/ eligible population)], with a higher rate indicating appropriate treatment with URI (i.e., the proportion of episodes that did not result in an antibiotic dispensing event).

The measure calculates a total rate as well as three age stratifications:

- 3 months–17 years
- 18–64 years
- 65 years and older

Note: Rates for adults ≥65 years are Medicare provisions excluded in this report along with the total rate, which includes this age group.

Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB)

AAB reports the percentage of episodes for members 3 months and older with a diagnosis of acute bronchitis/bronchiolitis that did not result in an antibiotic prescription. This measure is reported as an inverted rate [1 - (numerator/eligible population)], with a higher rate indicating appropriate treatment of acute bronchitis/bronchiolitis (i.e., the proportion of episodes that did not result in an antibiotic dispensing event).

The measure calculates a total rate as well as three age stratifications:

- 3 months–17 years
- 18–64 years
- 65 years and older

Note: Rates for adults ≥65 years are Medicare provisions excluded in this report along with the total rate, which includes this age group.

Use of Imaging Studies for Low Back Pain (LBP)

LBP assesses the percentage of members with a primary diagnosis of low back pain who did not have an imaging study (plain X-ray, MRI, CT scan) within 28 days of the diagnosis. This measure is reported as an inverted rate [1 - (numerator/ eligible population)], with a higher rate indicating an appropriate treatment of low back pain (i.e., the proportion for whom imaging studies did not occur).

Use of Opioids at High Dosage (HDO)

The proportion of members 18 years and older who received prescription opioids for ≥15 days during the MY at a high dosage (average morphine milligram equivalent dose [MME] ≥90 mg).

Note: A lower rate indicates better performance.

Use of Opioids from Multiple Providers (UOP)

For members 18 and older, the proportion receiving prescription opioids for ≥ 15 days from four or more different prescribers and/or pharmacies during the MY. Three rates are reported:

- Multiple Prescribers
- Multiple Pharmacies
- Multiple Prescribers and Multiple Pharmacies

Note: A lower rate indicates better performance for all three rates.

Risk of Continued Opioid Use (COU)

COU is the percentage of members 18 years of age and older who had a new episode of opioid use that puts them at risk of continued opioid use. Two rates are reported by length of opioid use:

- ≥ 15 days/30-day period
- ≥ 31 days/62-day period

Note: For this measure, a lower rate indicates better performance.

Measures Collected Through CAHPS Health Plan Survey

Flu Vaccinations for Adults Ages 18 to 64 (FVA)

FVA reports the percentage of members 18 to 64 years of age who received a flu vaccination between July 1 of the MY and the date when the CAHPS Health Plan Survey 5.0H Adult Version (CPA) was completed.

Medical Assistance With Smoking and Tobacco Use Cessation (MSC)

This measure's collection methodology arrives at a rolling average that represents the percentage of members 18 years of age and older who were current smokers or tobacco users seen during the MY. MSC assesses the following facets of providing medical assistance with smoking and tobacco use cessation:

- *Advising Smokers and Tobacco Users to Quit*—Those who received advice to quit
- *Discussing Cessation Medications*—Those for whom cessation medications were recommended or discussed
- *Discussing Cessation Strategies*—Those for whom cessation methods or strategies were provided or discussed

Percentage of Current Smokers and Tobacco Users is not a HEDIS performance measure, but provides additional information to support analysis of other MSC data. The MCOs started reporting these data in 2015 in CAHPS results; subsequently, the rates have been added to this report.

Access/Availability of Care Measures

The measures in the Access/Availability of Care domain evaluate how members access important and basic services of their MCO. Included are measures of overall access, how many members are actually using basic MCO services, and the use and availability of specific services.

Adults' Access to Preventive/Ambulatory Health Services (AAP)

This measures the percentage of members 20 years and older who had an ambulatory or preventive care visit during the MY to assess whether adult members have access to/receive such services. MCOs report a total rate and three age stratifications:

- 20–44 years
- 45–64 years
- 65 years and older

Note: Rates for adults ≥65 years are Medicare provisions excluded in this report along with the total rate, which includes this age group.

Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET)

IET assesses the percentage of adolescent and adult members aged 13 years and older who had a new episode of AOD abuse or dependence and received the following:

- *Initiation of AOD Treatment*—Initial treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth, or medication treatment within 14 days of the diagnosis.
- *Engagement of AOD Treatment*—Initial treatment as well as ongoing treatment (i.e., at least one engagement medication treatment event or at least two engagement visits) within 34 days of the initiation visit.

MCOs report a total rate and two age stratifications for each:

- 13–17 years
- ≥ 18 years

Prenatal and Postpartum Care (PPC)

PPC measures the percentage of live birth deliveries on or between October 8 of the year prior to the MY and October 7 of the MY. For these women, the composite assesses the percentage of deliveries where members received the following:

- *Timeliness of Prenatal Care*—A prenatal care visit in the first trimester on or before the MCO enrollment start date *or* within 42 days of enrollment.
- *Postpartum Care*—A postpartum visit on or between 7 and 84 days after delivery.

Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)

APP measures the percentage of children and adolescents 1 to 17 years of age who had a new prescription for an antipsychotic medication and had documentation of psychosocial care as first-line treatment. MCOs report a total rate and two age stratifications:

- 1–11 years
- 12–17 years

Utilization and Risk-Adjusted Utilization

This domain consists of utilization measures designed to capture the frequency of certain services provided for MCOs' internal evaluation only; NCQA does not view higher or lower service counts as indicating better or worse performance.

Utilization includes two kinds of measures:

- Measures that express rates of service in per 1,000 member years/months (defined/reported in Appendix A)
- Measures as percentages of members receiving specified services (similar to Effectiveness of Care Domain, defined in this section with data in the Results tables)

Well-Child Visits in the First 30 Months of Life (W30)

W30 reports the percentage of members who had a particular number of well-child visits with a PCP during the last 15 months. This measure uses the same structure and calculation guidelines as those in the Effectiveness of Care domain. Two rates are reported:

- *First 15 Months*—Children who turned 15 months old during the measurement year: six or more well-child visits.
- *Age 15 Months–30 Months*—Children who turned 30 months old during the measurement year: two or more well-child visits.

Note: For HEDIS MY2020, W30 replaces the former measure Well-Child Visits in the First 15 Months of Life (W15).

Child and Adolescent Well-Care Visits (WCV)

WCV reports the percentage of members 3–21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year. This measure uses the same structure and calculation guidelines as those in the Effectiveness of Care domain. A total rate as well as three age stratifications are reported:

- 3–11 years
- 12–17 years
- 18-21 years

Note: For HEDIS MY2020, WCV replaces the former measures Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34) and Adolescent Well-Care Visits (AWC).

Risk-Adjusted Utilization measures are for commercial or Medicare lines, except for the following measure:

Plan All-Cause Readmissions (PCR)

For members 18 years of age and older, PCR reports the number of acute inpatient and observation stays during the MY that were followed by an unplanned acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission. Data are reported in the following categories:

- Count of Index Hospital Stays (IHS) (denominator)
- Count of Observed 30-Day Readmissions (numerator)
- Count of Expected 30-Day Readmissions

Experience of Care

For a plan's results in this domain to be considered reliable, the Medicaid MCO must follow one of the standard CAHPS protocols or an enhanced protocol approved by NCQA. Details regarding this calculation methodology and the questions used in each composite are included in *HEDIS Measurement Year 2020 Volume 3: Specifications for Survey Measures.*

CAHPS Health Plan Survey 5.0H Adult Version (CPA) and 5.0H Child Version (CPC)

The CPA and CPC are tools for measuring consumer healthcare satisfaction with the quality of care and customer service provided by their MCOs. These survey tools include four composites asked of members (CPA) or parents of child members (CPC):

- Getting Needed Care
- Getting Care Quickly
- Customer Service
- How Well Doctors Communicate

Each composite category represents an overall aspect of plan quality and how well the MCO meets members' expectations.

There are four global rating questions that use a 0–10 scale to assess overall experience:

- Rating of All Healthcare
- Rating of Personal Doctor
- Rating of Specialist Seen Most Often
- Rating of Health Plan

A single question reflects experience of care in the Coordination of Care area.

For these scaled responses, a zero represents the 'worst possible' and 10 represents the 'best possible' healthcare received in the last six months. Summary rates represent the percentage of members who responded with a 9 or 10. Additional questions use the same calculations. For any given CPA and CPC question used in a composite, the percentage of respondents answering in a certain way is calculated for each MCO. Summary rates represent the percentage of members who responded in the most positive way, as defined by NCQA. The following descriptions provide a brief explanation of the five composite categories.

Getting Needed Care

The Getting Needed Care Composite measures the ease with which members were able to access care, tests, or treatments needed in the last 6 months. The summary rate represents the percentage of members who responded 'Always' or 'Usually' to specified questions.

Getting Care Quickly

The Getting Care Quickly Composite measures the ease with which members were able to access care quickly, including getting appointments as soon as needed, in the last 6 months. The summary rate represents the percentage of members who responded 'Always' or 'Usually' to specified questions.

How Well Doctors Communicate

The How Well Doctors Communicate Composite evaluates provider-patient communications for the last 6 months by asking members how often their personal doctor listens carefully, explains things in a way to easily understand, shows respect for what they have to say and spends enough time with them. The summary rate represents the percentage of members who responded 'Always' or 'Usually' to specified questions.

Customer Service

The Customer Service Composite measures how often members were able to get information and help from an MCO and how well they were treated by the MCO's customer service in the last 6 months. The summary rate represents the percentage of members who responded 'Always' or 'Usually' to specified questions.

Children With Chronic Conditions (CCC)

The CAHPS Consortium decided in 2002 to integrate a new set of items in the 3.0H version of the CAHPS Health Plan Survey child questionnaires (now 5.0H) to better address the needs of children with chronic conditions, commonly referred to as children with special healthcare needs. CCC is designed for children with a chronic physical, developmental, behavioral, or emotional condition and who require health and related services of a type or amount beyond that generally required by children. Three composites summarize parents' satisfaction with basic components of care essential for successful treatment, management and support of children with chronic conditions:

- Access to Specialized Services
- Family Centered Care: Personal Doctor Who Knows Child
- Coordination of Care for CCC

Summary rates are reported for each composite and are reported individually for two concepts:

- Access to Prescription Medicines
- Family Centered Care: Getting Needed Information

As of 2020, NCQA no longer produces general population results for the CCC population, and no longer produces CCC results for the general population.

Health Plan Descriptive Information Measures

These measures help describe an MCO's structure, staffing and enrollment—factors that contribute to its ability to provide effective healthcare to Medicaid members.

Enrollment by Product Line (ENP)

ENP reports the total number of members enrolled in the product line, stratified by age and gender (for the MCOs, reported as ENPA [ENP Total] Medicaid). These results are included in Appendix B as population in member months by MCO and Tennessee Grand Region served.

Measures Reported Using Electronic Clinical Data Systems (ECDS)

This domain requires automated and accessible data by the healthcare team at the point of care, data shared between clinicians and health plans to promote quality improvement across the care continuum. To qualify for HEDIS ECDS reporting, the data must use standard layouts, meet the measure specification requirements and the information must be accessible by the care team responsible for the member's healthcare needs.

NCQA does not require these measures to be reported. **BC**, **TCS**, and **UHC** reported results, which are presented in Appendix C. For HPA results, see Appendix E.

Breast Cancer Screening (BCS-E)

BCS-E measures the percentage of women 50–74 years of age who had a mammogram to screen for breast cancer during the MY.

Follow-Up Care for Children Prescribed ADHD Medication (ADD-E)

ADD-E measures the percentage of children newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who had at least three follow-up care visits within a 10-month period, one of which was within 30 days of when the first ADHD medication was dispensed. Two rates are reported.

- *Initiation Phase*—The percentage of members 6–12 years of age as of the Index Prescription Start Date (IPSD) with

an ambulatory prescription dispensed for ADHD medication, who had one follow-up visit with a practitioner with prescribing authority during the 30-day Initiation Phase.

- *Continuation and Maintenance (C&M) Phase*—The percentage of members 6–12 years of age as of the IPSD with an ambulatory prescription dispensed for ADHD medication, who remained on the medication for at least 210 days and who, in addition to the visit in the Initiation Phase, had at least two follow-up visits with a practitioner within 270 days after the Initiation Phase ended.

Depression Screening and Follow-Up for Adolescents and Adults (DSF-E)

DSF-E measures the percentage 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. Two rates are reported:

- *Depression Screening*—The percentage of members who were screened for clinical depression using a standardized instrument.
- *Follow-Up on Positive Screen*—The percentage of members who received follow-up care within 30 days of a positive depression screen finding.

Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults (DMS-E)

DMS-E measures the percentage of members 12 years of age and older with a diagnosis of major depression or dysthymia, who had an outpatient encounter with a PHQ-9 score present in their record in the same assessment period as the encounter. Four rates are reported:

- *Assessment Period 1*—January 1–April 30
- *Assessment Period 2*—May 1–August 31
- *Assessment Period 3*—September 1–December 31
- *Total*

Depression Remission or Response for Adolescents and Adults (DRR-E)

DRR-E measures the percentage of members 12 years of age and older with a diagnosis of depression and an elevated PHQ-9 score, who had evidence of response or remission within 4–8 months of the elevated score. Three rates are reported:

- *Follow-Up PHQ-9*—The percentage of members who have a follow-up PHQ-9 score documented within 4–8 months after the initial elevated PHQ-9 score.
- *Depression Remission*—The percentage of members who achieved remission within 4–8 months after the initial elevated PHQ-9 score.
- *Depression Response*—The percentage of members who showed response within 4–8 months after the initial elevated PHQ-9 score.

Unhealthy Alcohol Use Screening and Follow-Up (ASF-E)

ASF-E measures the percentage of members 18 years of age and older who were screened for unhealthy alcohol use using a standardized instrument and, if screened positive, received appropriate follow-up care. Two rates are reported:

- *Unhealthy Alcohol Use Screening*—The percentage of members who had a systematic screening for unhealthy alcohol use.
- *Alcohol Counseling or Other Follow-Up Care*—The percentage of members receiving brief counseling or other follow-up care within 2 months of screening positive for unhealthy alcohol use.

Adult Immunization Status (AIS-E)

AIS-E measures the percentage of members 19 years of age and older who are up to date on recommended routine vaccines for influenza, tetanus and diphtheria (Td) or tetanus, diphtheria, and acellular pertussis (Tdap), and zoster. MCOs reported three rates:

- Influenza
- Td or Tdap
- Zoster

Prenatal Immunization Status (PRS-E)

PRS-E reports the percentage of deliveries in the MY in which women had received influenza and Tdap vaccinations. Three rates are reported:

- Influenza
- Tdap
- Combination—influenza *and* Tdap

Prenatal Depression Screening and Follow-Up (PND-E)

PND-E assesses the percentage of deliveries in which members were screened for clinical depression while pregnant and, if screened positive, received follow-up care. Two rates are reported:

- *Depression Screening*: The percentage of deliveries in which members were screened for clinical depression during pregnancy using a standardized instrument.
- *Follow-Up on Positive Screen*: The percentage of deliveries in which members received follow-up care within 30 days of screening positive for depression.

Postpartum Depression Screening and Follow-Up (PDS-E)

PDS-E measures the percentage of deliveries in which members were screened for clinical depression during the postpartum period, and if screened positive, received follow-up care. Two rates are reported.

- *Depression Screening*: The percentage of deliveries in which members were screened for clinical depression using a standardized instrument during the postpartum period.
- *Follow-Up on Positive Screen*: The percentage of deliveries in which members received follow-up care within 30 days of screening positive for depression.

Long-Term Services and Supports (LTSS) Measures

Starting in 2020, TennCare required MCOs to submit statewide LTSS measure results, which are presented in this report in Appendix C. HEDIS LTSS measures are currently not required by NCQA to be audited.

Comprehensive Assessment and Update (LTSS-CAU)

LTSS-CAU measures the percentage of LTSS organization members 18 years of age and older who have documentation of a comprehensive LTSS assessment in a specified timeframe that includes documentation of core elements. Two rates are reported:

- *Assessment of Core Elements*—Members who had a comprehensive LTSS assessment with 9 core elements documented within 90 days of enrollment (for new members) or during the MY (for established members).
- *Assessment of Supplemental Elements*—Members who had a comprehensive LTSS assessment with 9 core elements and at least 12 supplemental elements documented within 90 days of enrollment (for new members) or during the MY (for established members).

Comprehensive Care Plan and Update (LTSS-CPU)

LTSS-CPU measures the percentage of LTSS organization members 18 years of age and older who have documentation of a comprehensive LTSS care plan in a specified time frame that includes core elements. Two rates are reported:

- *Care Plan With Core Elements Documented*—Members who had a comprehensive LTSS care plan with 9 core elements documented within 120 days of enrollment (for new members) or during the MY (for established members).
- *Care Plan With Supplemental Elements Documented*—Members who had a comprehensive LTSS care plan with 9 core elements and at least 4 supplemental elements documented within 120 days of enrollment (for new members) or during the MY (for established members).

Reassessment/Care Plan Update After Inpatient Discharge (LTSS-RAC)

LTSS-RAC measures the percentage of discharges from inpatient facilities for LTSS organization members 18 years of age and older for whom a reassessment and care plan update occurred within 30 days of discharge. Two rates are reported:

- *Reassessment After Inpatient Discharge*—The percentage of discharges from inpatient facilities resulting in an LTSS reassessment within 30 days of discharge.
- *Reassessment and Care Plan Update After Inpatient Discharge*—The percentage of discharges from inpatient facilities resulting in a LTSS reassessment and care plan update within 30 days of discharge.

Shared Care Plan With Primary Care Practitioner (LTSS-SCP)

LTSS-SCP measures the percentage of LTSS organization members ages 18 years and older with a care plan that was transmitted to their primary care practitioner (PCP) or other documented medical care practitioner identified by the member within 30 days of its development.

Medicaid Results

Statewide Performance

In conjunction with NCQA accreditation, TennCare MCOs are required to submit a full set of audited HEDIS measures to NCQA and TennCare each year. For HEDIS MY2020, this included the statewide MCO TennCare*Select* (**TCS**), and three statewide MCOs operating in each respective Grand Region (East, Middle and West): Amerigroup Community Care, Inc., as Amerigroup (**AG**—**AGE**, **AGM**, and **AGW**); BlueCare Tennessee (**BC**—**BCE**, **BCM**, and **BCW**); and UnitedHealthcare Community Plan, Inc., abbreviated as UnitedHealthcare (**UHC**—**UHCE**, **UHCM**, and **UHCW**).

Note: This report, which previously would have referred to the most recent data as HEDIS 2021, uses NCQA's new naming convention of HEDIS MY2020 to refer to data collected during calendar year 2020 and reported in calendar year 2021. To ensure consistency in the technical specifications and for easier reference to publications issued by NCQA, Qsource has retained NCQA's prior nomenclature to refer to previous years. For example, HEDIS 2020 remains as-is in this report and refers to data collected in MY2019.

Tables 1.a, 1.b, 2, and 3 summarize the weighted average TennCare score for each of the HEDIS 2020 and HEDIS MY2020 measures. Weighted state rates are determined by applying the size of the eligible population within each plan to overall results. Using this methodology, plan-specific findings contribute to the TennCare statewide estimate, proportionate to eligible population size.

In Tables 1.a, 1.b, 2, and 3, the column titled "Change from HEDIS 2020 to HEDIS MY2020" indicates whether there was an improvement (⬆), a decline (⬇), or no change (⬌) in statewide performance from HEDIS 2020 to HEDIS MY2020 when measure data are available for both years. Cells are shaded gray for those measures that were not calculated or for which data were not reported.

Each year, some measures' technical specifications change. Based on whether the changes are significant or minor, the measures may need to be trended with caution or may not be able to be trended. This version of the *2021 Annual HEDIS/CAHPS Report* was prepared following the release of the NCQA National Benchmarks for MY2020, although certain protected data were not included so that the report may be shared publicly.

Table 1.a. HEDIS MY2020 Weighted State Rates: Effectiveness of Care Measures			
Measure	**Weighted State Rate**		**Change from HEDIS 2020 to HEDIS MY2020**
	HEDIS 2020	**HEDIS MY2020**	
Prevention and Screening			
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)*:			
BMI Percentile: 3–11 Years	81.53%	80.87%	↓
12–17 Years	78.67%	77.88%	↓
Total	**80.51%**	**79.82%**	↓
Counseling for Nutrition: 3–11 Years	72.43%	71.85%	↓
12–17 Years	67.63%	67.15%	↓
Total	**70.68%**	**70.20%**	↓
Counseling for Physical Activity: 3–11 Years	66.18%	65.79%	↓
12–17 Years	67.89%	65.37%	↓
Total	**66.74%**	**65.65%**	↓
Childhood Immunization Status (CIS):			
DTaP/DT	76.70%	72.44%	↓
IPV	91.37%	88.15%	↓
MMR	88.90%	85.67%	↓
HiB	88.30%	84.56%	↓
HepB	91.62%	89.78%	↓
VZV	88.86%	85.05%	↓
PCV	78.90%	74.61%	↓
HepA	88.07%	84.82%	↓
RV	74.48%	71.20%	↓
Influenza	44.68%	43.98%	↓
Combination 2	74.51%	70.52%	↓
Combination 3	72.02%	67.88%	↓
Combination 4	71.63%	67.44%	↓
Combination 5	63.16%	58.96%	↓
Combination 6	39.43%	38.63%	↓

Table 1.a. HEDIS MY2020 Weighted State Rates: Effectiveness of Care Measures			
Measure	**Weighted State Rate**		**Change from HEDIS 2020 to HEDIS MY2020**
	HEDIS 2020	**HEDIS MY2020**	
Combination 7	62.88%	58.66%	↓
Combination 8	39.30%	38.45%	↓
Combination 9	35.74%	34.71%	↓
Combination 10	35.66%	34.64%	↓
Immunizations for Adolescents (IMA):			
Meningococcal	78.68%	76.51%	↓
Tdap/Td	87.90%	84.69%	↓
HPV	33.71%	33.95%	↑
Combination 1	78.02%	75.55%	↓
Combination 2	32.49%	32.74%	↑
Lead Screening in Children (LSC)	76.17%	72.54%	↓
Breast Cancer Screening (BCS)*	54.83%	51.98%	↓
Cervical Cancer Screening (CCS)*	64.06%	59.65%	↓
Chlamydia Screening in Women (CHL):			
16–20 Years	52.75%	48.78%	↓
21–24 Years	61.69%	55.72%	↓
Total	**56.17%**	**51.60%**	↓
Respiratory Conditions			
Appropriate Testing for Pharyngitis (CWP)*			
3–17 Years	88.08%	88.72%	↑
18–64 Years	74.22%	76.44%	↑
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)	28.83%	26.32%	↓
Pharmacotherapy Management of COPD Exacerbation (PCE):			
Systemic Corticosteroid	59.73%	67.75%	↑
Bronchodilator	76.33%	79.90%	↑
Asthma Medical Ratio (AMR):			
5–11 Years	81.15%	82.18%	↑

Table 1.a. HEDIS MY2020 Weighted State Rates: Effectiveness of Care Measures			
Measure	**Weighted State Rate**		**Change from HEDIS 2020 to HEDIS MY2020**
	HEDIS 2020	**HEDIS MY2020**	
12–18 Years	73.01%	74.71%	↑
19–50 Years	50.82%	52.86%	↑
51–64 Years	51.89%	50.82%	↓
Total	**69.24%**	**69.41%**	↑
Cardiovascular Conditions			
Controlling High Blood Pressure (CBP)**		62.67%	
Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)	78.07%	82.83%	↑
Statin Therapy for Patients with Cardiovascular Disease (SPC)*:			
Received Statin Therapy: Males 21–75 Years	78.16%	79.04%	↑
Females 40–75 Years	74.76%	76.60%	↑
Total	**76.48%**	**77.81%**	↑
Statin Adherence 80%: Males 21–75 Years	59.53%	69.74%	↑
Females 40–75 Years	57.45%	68.15%	↑
Total	**58.52%**	**68.95%**	↑
Cardiac Rehabilitation (CRE)*:** 18–64 Years			
Initiation		2.07%	
Engagement 1		1.47%	
Engagement 2		1.02%	
Achievement		0.46%	
Diabetes			
Comprehensive Diabetes Care (CDC):			
HbA1c Testing*	86.57%	86.05%	↓
HbA1c Control (<8.0%)*	52.57%	50.53%	↓
Retinal Eye Exam Performed*	51.28%	47.39%	↓
Blood Pressure Control (<140/90 mm Hg)**		63.02%	
Kidney Health Evaluation for Patients With Diabetes (KED)*:** 18–64 Years		26.70%	

Table 1.a. HEDIS MY2020 Weighted State Rates: Effectiveness of Care Measures			
Measure	**Weighted State Rate**		**Change from HEDIS 2020 to HEDIS MY2020**
	HEDIS 2020	**HEDIS MY2020**	
Statin Therapy for Patients with Diabetes (SPD)*:			
Received Statin Therapy	60.80%	63.48%	↑
Statin Adherence 80%	54.19%	66.04%	↑
Behavioral Health			
Antidepressant Medication Management (AMM):			
Effective Acute Phase Treatment	49.53%	49.91%	↑
Effective Continuation Phase Treatment	33.10%	34.70%	↑
Follow-Up Care for Children Prescribed ADHD Medication (ADD)*:			
Initiation Phase	46.13%	48.39%	↑
Continuation and Maintenance Phase	59.32%	62.33%	↑
Follow-Up After Hospitalization for Mental Illness (FUH)*:			
7-Day Follow-Up: 6–17 Years	51.20%	51.20%	↔
18–64 Years	33.50%	38.06%	↑
30-Day Follow-Up: 6–17 Years	73.11%	72.82%	↓
18–64 Years	55.42%	58.17%	↑
Follow-Up After Emergency Department Visit for Mental Illness (FUM)*:			
7-Day Follow-Up: 6–17 Years	47.88%	48.26%	↑
18–64 Years	34.95%	33.08%	↓
30-Day Follow-Up: 6–17 Years	67.74%	67.09%	↓
18–64 Years	50.07%	48.31%	↓
Follow-Up After High-Intensity Care for Substance Use Disorder (FUI)*:			
7-Day Follow-Up: 13–17 Years	6.35%	7.65%	↑
18–64 Years	42.26%	48.86%	↑
30-Day Follow-Up: 13–17 Years	18.25%	19.39%	↑
18–64 Years	62.03%	70.35%	↑
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence (FUA)*:			
7-Day Follow-Up: 13–17 Years	2.88%	4.16%	↑

Table 1.a. HEDIS MY2020 Weighted State Rates: Effectiveness of Care Measures			
Measure	**Weighted State Rate**		**Change from HEDIS 2020 to HEDIS MY2020**
	HEDIS 2020	**HEDIS MY2020**	
18 Years and Older	5.23%	5.97%	↑
Total	**5.04%**	**5.84%**	↑
30-Day Follow-Up: 13–17 Years	5.75%	5.30%	↓
18 Years and Older	8.24%	9.90%	↑
Total	**8.04%**	**9.57%**	↑
Pharmacotherapy for Opioid Use Disorder (POD)*: 16–64 Years	16.05%	34.47%	↑
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)	85.00%	79.54%	↓
Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD)	74.67%	70.57%	↓
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (SMC)	84.51%	75.82%	↓
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)	59.12%	64.11%	↑
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM):			
Blood Glucose Testing: 1–11 Years	46.97%	38.90%	↓
12–17 Years	64.07%	56.05%	↓
Total	**58.05%**	**50.38%**	↓
Cholesterol Testing: 1–11 Years	37.77%	31.40%	↓
12–17 Years	47.29%	40.97%	↓
Total	**43.94%**	**37.81%**	↓
Blood Glucose and Cholesterol Testing: 1–11 Years	34.11%	27.35%	↓
12–17 Years	44.59%	38.17%	↓
Total	**40.90%**	**34.59%**	↓
Overuse/Appropriateness			
Appropriate Treatment for Upper Respiratory Infection (URI):			
3 Months–17 Years	86.22%	88.25%	↑
18–64 Years	67.89%	72.44%	↑
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB):			
3 Months–17 Years	62.99%	67.00%	↑

Table 1.a. HEDIS MY2020 Weighted State Rates: Effectiveness of Care Measures			
Measure	**Weighted State Rate**		**Change from HEDIS 2020 to HEDIS MY2020**
	HEDIS 2020	**HEDIS MY2020**	
18–64 Years	37.22%	39.68%	⬆
Use of Imaging Studies for Low Back Pain (LBP)	68.32%	68.27%	⬇
Measures Collected Though CAHPS			
Flu Vaccinations for Adults Ages 18 to 64 (FVA)	44.72%	37.83%	⬇
Medical Assistance With Smoking and Tobacco Use Cessation (MSC):			
Advising Smokers and Tobacco Users to Quit	80.74%	78.13%	⬇
Discussing Cessation Medications	49.84%	47.50%	⬇
Discussing Cessation Strategies	44.21%	43.35%	⬇
Supplemental Data - % Current Smokers†	36.98%	35.68%	⬇

** NCQA indicated trending with caution due to changes in measure specifications for HEDIS MY2020.*
*** NCQA indicated a break in trending to prior years due to significant changes in measure specifications for HEDIS MY2020.*
**** First-year measure for HEDIS MY2020.*
† For this measure, the rate is not intended to indicate good or poor performance, but for informative purposes to monitor the population of current smokers.

For the Effectiveness of Care Measures presented in **Table 1.b**, a lower rate is an indication of better performance (⬆). A decrease in rates from the prior year also indicates improvement.

Table 1.b. HEDIS MY2020 Weighted State Rates: Measures Where Lower Rates Indicate Better Performance			
Measure	**Weighted State Rate**		**Change from HEDIS 2020 to HEDIS MY2020**
	HEDIS 2020	**HEDIS MY2020**	
Diabetes			
Comprehensive Diabetes Care (CDC):			
HbA1c Poor Control (>9.0%)*	37.76%	39.28%	⬇
Overuse/Appropriateness			
Non-Recommended Cervical Cancer Screening in Adolescent Females (NCS)	1.30%	0.88%	⬆
Use of Opioids at High Dosage (HDO)*	6.19%	5.70%	⬆

Table 1.b. HEDIS MY2020 Weighted State Rates: Measures Where Lower Rates Indicate Better Performance			
Measure	**Weighted State Rate**		**Change from HEDIS 2020 to HEDIS MY2020**
	HEDIS 2020	**HEDIS MY2020**	
Use of Opioids From Multiple Providers (UOP)*:			
Multiple Prescribers	23.60%	20.59%	↑
Multiple Pharmacies	2.72%	1.58%	↑
Multiple Prescribers and Pharmacies	1.20%	0.84%	↑
Risk of Continued Opioid Use (COU)*:			
18–64 Years: ≥15 days/30-day period	1.65%	2.42%	↓
≥ 31 days/62-day period	1.36%	2.00%	↓

** NCQA indicated trending with caution due to changes in measure specifications for HEDIS MY2020.*

Table 2 summarizes results for the Access/Availability Domain of Care.

Table 2. HEDIS MY2020 Weighted State Rates: Access/Availability of Care Measures			
Measure	**Weighted State Rate**		**Change from HEDIS 2020 to HEDIS MY2020**
	HEDIS 2020	**HEDIS MY2020**	
Adults' Access to Preventive/Ambulatory Health Services (AAP):			
20–44 Years	79.14%	76.45%	↓
45–64 Years	87.66%	86.06%	↓
Initiation and Engagement of Alcohol and Other Drug (AOD) Dependence Treatment (IET)—Initiation of AOD Treatment*:			
13–17 Years: Alcohol	47.60%	45.80%	↓
Opioid	53.19%	67.65%	↑
Other drug	47.08%	48.44%	↑
Total	**46.09%**	**47.05%**	↑
18+ Years: Alcohol	47.63%	47.56%	↓
Opioid	58.88%	61.38%	↑
Other drug	47.89%	48.23%	↑
Total	**48.93%**	**50.26%**	↑
Initiation Total: Alcohol	47.63%	47.51%	↓

Table 2. HEDIS MY2020 Weighted State Rates: Access/Availability of Care Measures			
Measure	**Weighted State Rate**		**Change from HEDIS 2020 to HEDIS MY2020**
	HEDIS 2020	**HEDIS MY2020**	
Opioid	58.85%	61.40%	↑
Other drug	47.81%	48.25%	↑
Total	**48.77%**	**50.08%**	↑
Initiation and Engagement of Alcohol and Other Drug (AOD) Dependence Treatment (IET)—Engagement of AOD Treatment*:			
13–17 Years: Alcohol	20.40%	14.88%	↓
Opioid	21.28%	17.65%	↓
Other drug	23.28%	24.43%	↑
Total	**21.98%**	**22.91%**	↑
18+ Years: Alcohol	11.77%	13.54%	↑
Opioid	30.58%	33.77%	↑
Other drug	14.52%	14.43%	↓
Total	**17.69%**	**19.15%**	↑
Engagement Total: Alcohol	12.01%	13.58%	↑
Opioid	30.53%	33.71%	↑
Other drug	15.32%	15.31%	↓
Total	**17.94%**	**19.36%**	↑
Prenatal and Postpartum Care (PPC)*:			
Timeliness of Prenatal Care	83.68%	81.92%	↓
Postpartum Care	70.20%	72.67%	↑
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP):			
1–11 Years	61.27%	57.34%	↓
12–17 Years	63.04%	59.75%	↓
Total	**62.34%**	**58.88%**	↓

** NCQA indicated trending with caution due to changes in measure specifications for HEDIS MY2020.*

Table 3 summarizes results for the Utilization measures included in the Utilization and Risk-Adjusted Utilization Domain of Care.

Table 3. HEDIS MY2020 Weighted State Rates: Utilization Measures

Measure	Weighted State Rate		Change from HEDIS 2020 to HEDIS MY2020
	HEDIS 2020	HEDIS MY2020	
Well-Child Visits in the First 30 Months of Life (W30)††:			
First 15 Months**		53.55%	
15 Months–30 Months		67.69%	
Child and Adolescent Well-Care Visits (WCV)††:			
3–11 Years**		58.78%	
12–17 Years**		49.98%	
18–21 Years**		25.88%	
Total**		**51.18%**	

†† Revised and renamed measures for HEDIS MY2020.

***NCQA indicated a break in trending to prior years due to significant changes in measure specifications for HEDIS MY2020.*

Individual Plan Performance—HEDIS Measures

This section is intended to provide an overview of individual plan performance using appropriate and available comparison data. The results highlight those areas where each MCO is performing in relation to the MY2020 NCQA National Benchmarks for select MCO-reported HEDIS measures. Qsource uses these data to determine overall TennCare plan performance in a distribution of statistical values that represent the lowest to highest percentiles achieved. For example, the 50th percentile represents the point at which half of the reported rates are below and half of the reported rates are above that value.

Tables 5.a, 5.b, 6, and 7 display the plan-specific performance rates for each measure selected from the Effectiveness of Care, Access/Availability of Care, and Utilization and Risk-Adjusted Utilization domains. **Table 4** details the potential color-coding and measure designations used in the tables to indicate the MCO percentile achieved, and provides additional related information. While Medical Assistance With Smoking and Tobacco Use Cessation is an Effectiveness of Care measure, results are reported through the CPA, as noted in Tables 1.a and 5.a.

Table 4. HEDIS MY2020 Measure Designations

Color Designation	National Percentile Achieved	Additional Comments
	Greater than 75th percentile	No additional comments
	25th to 75th	No additional comments
	Less than 25th	No additional comments
	No Rating Available	Benchmarking data not available

Measure Designation	Definition
R	Reportable: a reportable rate was submitted for the measure.
NA	Not Applicable: the MCO followed the specifications, but the denominator was too small (<30) to report a valid rate; thus, results are not presented.
NB	No Benefit: the MCO did not offer the health benefit required by the measure (e.g., mental health, chemical dependency).
NR	Not Reported: the MCO chose not to report the measure.
NQ	Not Required: the MCO was not required to report the measure.
BR	Biased Rate: the calculated rate was materially biased.
UN	Un-Audited: the MCO chose to report a measure that is not required to be audited. This result applies to only a limited set of measures.

Table 5.a. HEDIS MY2020 Plan-Specific Rates: Effectiveness of Care Measures										
Measure	**AGE**	**AGM**	**AGW**	**BCE**	**BCM**	**BCW**	**TCS**	**UHCE**	**UHCM**	**UHCW**
Prevention and Screening										
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)*:										
BMI Percentile: 3–11 Years	77.73%	83.11%	70.63%	86.78%	79.48%	86.27%	85.43%	74.33%	79.15%	83.27%
12–17 Years	71.61%	80.00%	78.87%	75.59%	76.76%	81.90%	78.71%	73.33%	84.87%	78.38%
Total	75.43%	82.24%	73.48%	82.77%	78.44%	84.91%	82.04%	73.97%	81.27%	81.51%
Counseling for Nutrition: 3–11 Years	70.31%	78.38%	60.97%	76.21%	69.87%	69.02%	67.34%	68.97%	74.90%	72.62%
12–17 Years	61.29%	73.04%	65.49%	68.50%	66.90%	62.93%	59.90%	63.33%	76.97%	66.22%
Total	66.91%	76.89%	62.53%	73.45%	68.73%	67.12%	63.59%	66.91%	75.67%	70.32%
Counseling for Physical Activity: 3–11 Years	66.41%	69.93%	55.76%	67.40%	66.38%	62.75%	60.80%	63.22%	69.50%	67.68%
12–17 Years	59.35%	69.57%	61.97%	62.20%	68.31%	65.52%	55.45%	61.33%	78.29%	64.86%
Total	63.75%	69.83%	57.91%	65.54%	67.12%	63.61%	58.10%	62.53%	72.75%	66.67%
Childhood Immunization Status (CIS):										
DTaP/DT	72.99%	78.35%	63.26%	79.56%	70.32%	64.96%	63.26%	76.40%	78.35%	62.04%
IPV	87.83%	89.54%	84.18%	92.94%	86.37%	84.18%	81.75%	90.02%	91.73%	84.18%
MMR	83.94%	85.64%	82.97%	91.24%	84.91%	81.51%	74.70%	87.83%	89.78%	81.75%
HiB	84.43%	86.37%	78.83%	88.81%	82.73%	81.27%	77.37%	87.10%	89.29%	79.32%
HepB	91.00%	89.78%	88.56%	93.43%	88.32%	88.32%	84.18%	90.75%	91.73%	84.91%
VZV	84.18%	85.16%	82.97%	89.54%	84.91%	81.27%	74.45%	86.62%	88.56%	81.75%
PCV	73.72%	79.08%	64.96%	81.75%	72.26%	68.37%	65.21%	79.08%	82.48%	62.77%
HepA	83.70%	85.64%	82.73%	89.05%	84.18%	81.27%	75.91%	86.62%	88.08%	81.02%
RV	72.26%	72.75%	64.48%	74.94%	70.80%	65.21%	49.64%	77.13%	80.05%	65.94%
Flu	42.34%	53.77%	33.09%	46.47%	47.93%	30.17%	47.93%	46.72%	53.04%	32.60%
Combination 2	70.07%	76.40%	61.80%	77.62%	68.61%	62.77%	62.29%	75.91%	75.18%	60.83%
Combination 3	67.40%	73.48%	59.12%	73.97%	66.18%	59.85%	60.10%	74.21%	73.72%	58.15%
Combination 4	65.69%	73.48%	58.88%	73.24%	65.69%	59.61%	60.10%	73.97%	73.48%	57.66%
Combination 5	61.07%	64.72%	50.61%	64.72%	57.91%	50.61%	39.17%	65.21%	66.91%	48.42%
Combination 6	36.74%	49.88%	28.22%	42.09%	40.63%	25.30%	39.42%	41.61%	48.18%	25.30%
Combination 7	59.37%	64.72%	50.36%	64.48%	57.66%	50.36%	39.17%	64.96%	66.91%	47.93%

Table 5.a. HEDIS MY2020 Plan-Specific Rates: Effectiveness of Care Measures										
Measure	**AGE**	**AGM**	**AGW**	**BCE**	**BCM**	**BCW**	**TCS**	**UHCE**	**UHCM**	**UHCW**
Combination 8	36.50%	49.88%	27.98%	41.61%	40.39%	25.30%	39.42%	41.61%	47.93%	25.30%
Combination 9	33.82%	45.26%	24.33%	38.20%	37.47%	22.63%	25.55%	37.96%	44.28%	22.14%
Combination 10	33.58%	45.26%	24.09%	37.96%	37.47%	22.63%	25.55%	37.96%	44.28%	22.14%
Immunization for Adolescents (IMA):										
Meningococcal	82.48%	79.81%	72.51%	78.83%	74.70%	73.24%	70.32%	76.89%	80.29%	71.29%
Tdap/Td	87.35%	87.10%	81.75%	84.43%	85.89%	82.48%	77.13%	85.40%	88.56%	82.24%
HPV	38.44%	38.20%	31.39%	35.04%	33.33%	29.44%	34.31%	30.66%	40.15%	25.55%
Combination 1	81.75%	78.83%	71.53%	77.13%	74.21%	72.51%	68.86%	75.91%	79.81%	70.07%
Combination 2	36.98%	36.50%	29.68%	34.06%	31.87%	27.74%	33.82%	30.17%	39.66%	24.09%
Lead Screening in Children (LSC)	68.61%	78.35%	66.18%	79.32%	70.32%	67.15%	66.42%	72.02%	79.08%	63.26%
Breast Cancer Screening (BCS)*	40.37%	47.33%	46.83%	55.30%	53.18%	58.43%	47.29%	53.59%	52.36%	52.13%
Cervical Cancer Screening (CCS)*	55.23%	56.69%	57.18%	66.96%	64.69%	64.66%	29.93%	59.37%	53.53%	56.45%
Chlamydia Screening in Women (CHL):										
16–20 Years	47.95%	49.57%	57.69%	42.38%	43.87%	52.35%	51.51%	46.37%	49.64%	54.43%
21–24 Years	55.46%	58.41%	66.38%	47.86%	48.63%	57.72%	45.83%	55.61%	56.68%	63.46%
Total	50.73%	53.40%	61.25%	44.79%	45.76%	54.78%	51.14%	49.80%	52.57%	58.33%
Respiratory Conditions										
Appropriate Testing for Pharyngitis (CWP)*:										
3–17 Years	86.21%	86.47%	87.10%	88.70%	89.43%	90.61%	88.47%	88.82%	91.26%	89.50%
18–64 Years	76.84%	74.45%	66.53%	78.22%	77.57%	76.18%	74.49%	78.67%	80.85%	72.55%
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)	28.13%	20.50%	20.38%	30.41%	21.20%	33.49%	NA	28.21%	21.29%	28.86%
Pharmacotherapy Management of COPD Exacerbation (PCE):										
Systemic Corticosteroid	65.56%	59.62%	67.87%	71.31%	68.21%	65.53%	NA	68.47%	69.60%	69.83%
Bronchodilator	75.73%	72.44%	79.22%	79.38%	75.67%	81.66%	NA	83.46%	84.11%	82.92%
Asthma Medical Ratio (AMR):										
5–11 Years	83.78%	81.65%	77.75%	85.95%	82.42%	83.86%	85.95%	81.94%	77.71%	77.16%
12–18 Years	78.73%	72.73%	69.78%	79.31%	75.29%	74.66%	85.32%	70.14%	66.32%	71.21%

Table 5.a. HEDIS MY2020 Plan-Specific Rates: Effectiveness of Care Measures										
Measure	**AGE**	**AGM**	**AGW**	**BCE**	**BCM**	**BCW**	**TCS**	**UHCE**	**UHCM**	**UHCW**
19–50 Years	51.53%	49.60%	48.85%	57.84%	48.70%	45.92%	75.00%	57.44%	54.55%	50.90%
51–64 Years	55.56%	39.05%	60.32%	46.72%	49.35%	54.95%	NA	57.24%	48.36%	48.98%
Total	71.13%	66.16%	65.70%	74.50%	68.68%	67.28%	84.67%	68.59%	64.90%	65.33%
Cardiovascular Conditions										
Controlling High Blood Pressure (CBP)**	58.88%	58.15%	53.28%	67.40%	60.83%	65.94%	71.23%	66.67%	67.15%	57.42%
Persistence of Beta-Blocker Treatment after a Heart Attack (PBH)	79.31%	77.14%	64.00%	86.52%	81.25%	86.05%	NA	91.58%	87.50%	81.82%
Statin Therapy for Patients with Cardiovascular Disease (SPC)*:										
Received Statin Therapy: Males 21–75 Years	77.25%	74.93%	76.65%	76.37%	80.49%	80.49%	NA	81.09%	81.26%	80.36%
Females 40–75 Years	68.85%	71.95%	72.20%	75.61%	79.02%	77.46%	NA	79.83%	79.47%	75.85%
Total	73.82%	73.51%	74.58%	75.96%	79.72%	78.76%	NA	80.48%	80.35%	78.03%
Statin Adherence 80%: Males 21-75 Years	60.96%	70.03%	52.28%	71.76%	62.46%	61.95%	NA	76.83%	78.62%	69.77%
Females 40–75 Years	60.34%	63.78%	57.14%	68.76%	61.73%	58.47%	NA	77.93%	72.29%	70.90%
Total	60.72%	67.10%	54.47%	70.16%	62.07%	60.00%	NA	77.36%	75.44%	70.34%
Cardiac Rehabilitation (CRE)*:** 18–64 Years										
Initiation	3.25%	1.74%	3.32%	1.54%	1.43%	2.56%	NA	2.52%	2.26%	0.36%
Engagement 1	1.95%	1.04%	2.37%	1.32%	1.79%	1.71%	NA	1.37%	0.85%	1.44%
Engagement 2	0.97%	0.69%	0.95%	0.66%	2.15%	0.43%	NA	1.37%	0.85%	1.08%
Achievement	0.00%	0.69%	0.47%	0.22%	0.72%	0.43%	NA	0.46%	0.28%	1.08%
Diabetes										
Comprehensive Diabetes Care (CDC):										
HbA1c Testing*	86.62%	86.62%	81.51%	85.82%	80.54%	82.73%	78.26%	89.05%	90.51%	87.59%
HbA1c Control (<8.0%)*	44.53%	48.18%	38.44%	53.79%	44.28%	50.61%	50.17%	54.74%	56.69%	53.53%
Retinal Eye Exam Performed*	33.09%	40.15%	35.28%	49.14%	43.31%	43.31%	54.85%	56.20%	55.72%	56.20%
Blood Pressure Control (<140/90 mm Hg)**	63.02%	63.50%	52.80%	63.81%	55.96%	61.31%	69.23%	67.64%	70.32%	61.07%
Kidney Health Evaluation for Patients With Diabetes (KED)*:** 18–64 Years	27.95%	25.61%	29.63%	27.57%	25.09%	27.05%	20.21%	25.34%	26.97%	26.30%
Statin Therapy for Patients with Diabetes (SPD)*:										

Table 5.a. HEDIS MY2020 Plan-Specific Rates: Effectiveness of Care Measures										
Measure	**AGE**	**AGM**	**AGW**	**BCE**	**BCM**	**BCW**	**TCS**	**UHCE**	**UHCM**	**UHCW**
Received Statin Therapy	60.42%	61.00%	61.95%	62.71%	60.80%	62.61%	60.92%	67.00%	63.91%	66.83%
Statin Adherence 80%	60.59%	61.32%	53.55%	64.17%	62.87%	58.51%	88.68%	74.85%	72.53%	70.10%
Behavioral Health										
Antidepressant Medication Management (AMM):										
Effective Acute Phase Treatment	50.52%	45.56%	41.19%	49.99%	47.08%	43.63%	40.54%	58.74%	56.37%	49.61%
Effective Continuation Phase Treatment	35.63%	31.55%	26.09%	34.25%	29.73%	26.83%	22.70%	44.99%	41.42%	35.57%
Follow-Up Care for Children Prescribed ADHD Medication (ADD)*:										
Initiation Phase	50.11%	55.43%	41.72%	51.65%	44.75%	42.93%	46.19%	52.75%	48.63%	47.21%
Continuation and Maintenance Phase	62.71%	68.08%	64.77%	61.94%	57.81%	64.56%	57.49%	64.86%	62.50%	65.18%
Follow-Up After Hospitalization for Mental Illness (FUH)*:										
7-Day Follow-Up: 6–17 Years	59.01%	55.00%	45.75%	63.61%	65.16%	47.88%	39.19%	51.20%	59.93%	42.42%
18–64 Years	32.62%	40.06%	31.11%	42.97%	42.56%	35.43%	47.45%	36.51%	40.41%	35.00%
30-Day Follow-Up: 6–17 Years	82.43%	76.07%	63.97%	85.90%	85.16%	67.80%	59.19%	78.80%	84.48%	64.77%
18–64 Years	54.15%	60.41%	47.76%	63.77%	64.88%	54.21%	64.86%	57.44%	62.39%	52.90%
Follow-Up After Emergency Department Visit for Mental Illness (FUM)*:										
7-Day Follow-Up: 6–17 Years	51.18%	46.75%	42.22%	53.67%	55.88%	41.86%	52.45%	36.71%	43.61%	30.00%
18–64 Years	26.40%	34.55%	46.67%	29.84%	30.92%	40.72%	38.68%	31.23%	30.03%	35.50%
30-Day Follow-Up: 6–17 Years	72.35%	70.78%	62.22%	69.50%	67.65%	53.49%	70.98%	63.29%	60.15%	48.00%
18–64 Years	44.80%	46.84%	58.00%	47.30%	49.00%	51.50%	51.89%	47.00%	46.33%	49.11%
Follow-Up After High-Intensity Care for Substance Use Disorder (FUI)*:										
7-Day Follow-Up: 13–17 Years	NA	NA	NA	16.13%	NA	NA	NA	NA	NA	NA
18–64 Years	46.53%	47.98%	43.53%	57.55%	45.44%	49.68%	29.41%	36.13%	46.74%	48.70%
30-Day Follow-Up: 13–17 Years	NA	NA	NA	35.48%	NA	NA	NA	NA	NA	NA
18–64 Years	66.18%	67.71%	62.28%	78.37%	69.72%	75.16%	41.18%	59.41%	68.99%	63.28%
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)*:										
7-Day Follow-Up: 13–17 Years	NA	NA	NA	NA	NA	NA	3.17%	NA	5.71%	NA
18 Years and Older	9.16%	5.49%	4.85%	4.14%	4.52%	7.94%	5.26%	4.56%	6.82%	6.67%
Total	9.01%	5.59%	4.66%	3.90%	4.47%	7.49%	4.17%	4.81%	6.75%	6.34%
30-Day Follow-Up: 13–17 Years	NA	NA	NA	NA	NA	NA	4.76%	NA	5.71%	NA

Table 5.a. HEDIS MY2020 Plan-Specific Rates: Effectiveness of Care Measures										
Measure	**AGE**	**AGM**	**AGW**	**BCE**	**BCM**	**BCW**	**TCS**	**UHCE**	**UHCM**	**UHCW**
18 Years and Older	14.94%	9.61%	9.69%	6.57%	8.54%	11.90%	5.26%	8.39%	10.92%	9.41%
Total	14.41%	9.46%	9.32%	6.19%	8.47%	11.24%	5.00%	8.70%	10.58%	8.96%
Pharmacotherapy for Opioid Use Disorder (POD)*: 16–64 Years	36.50%	33.52%	41.97%	34.20%	39.98%	43.09%	NA	26.84%	31.25%	40.52%
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication (SSD)	78.32%	81.43%	73.48%	79.50%	79.33%	77.55%	82.52%	81.87%	83.91%	76.02%
Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD)	69.80%	70.88%	60.19%	75.65%	69.46%	64.08%	81.48%	74.18%	75.77%	68.97%
Cardiovascular Monitoring for People With CVD and Schizophrenia (SMC)	NA	71.88%	NA	79.03%	NA	78.43%	NA	75.41%	75.47%	78.69%
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)	51.63%	67.12%	49.47%	64.06%	61.74%	60.70%	84.65%	72.19%	73.27%	64.27%
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM):										
Blood Glucose Testing: 1–11 Years	39.67%	36.57%	31.91%	38.62%	41.55%	36.62%	44.33%	35.68%	34.93%	31.14%
12–17 Years	54.64%	57.63%	49.26%	57.57%	51.02%	48.22%	60.82%	50.89%	58.67%	52.48%
Total	49.83%	50.20%	43.34%	51.08%	47.75%	44.32%	55.81%	45.56%	49.92%	45.49%
Cholesterol Testing: 1–11 Years	34.24%	30.86%	27.66%	30.84%	31.88%	25.82%	35.07%	27.70%	31.88%	26.95%
12–17 Years	37.37%	40.50%	27.57%	42.73%	34.69%	34.20%	48.06%	38.99%	38.78%	36.73%
Total	36.36%	37.10%	27.60%	38.66%	33.72%	31.39%	44.11%	35.03%	36.23%	33.53%
Blood Glucose and Cholesterol Testing: 1–11 Years	30.98%	29.14%	20.57%	25.36%	28.50%	23.00%	31.29%	23.47%	27.07%	22.75%
12–17 Years	33.25%	38.32%	25.37%	39.88%	31.12%	31.35%	45.56%	35.19%	36.73%	34.11%
Total	32.52%	35.08%	23.73%	34.91%	30.22%	28.55%	41.22%	31.09%	33.17%	30.39%
Overuse/Appropriateness										
Appropriate Treatment for Upper Respiratory Infection (URI):										
3 Months–17 Years	87.03%	92.32%	89.48%	83.68%	90.71%	85.47%	84.44%	86.54%	91.45%	89.08%
18–64 Years	70.65%	77.92%	75.18%	65.00%	75.06%	70.03%	78.06%	67.83%	78.59%	72.58%
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB):										
3 Months–17 Years	58.02%	67.29%	84.05%	50.84%	67.53%	80.22%	57.45%	58.18%	67.08%	81.20%
18–64 Years	39.94%	43.88%	46.86%	30.26%	37.63%	40.14%	38.55%	38.93%	41.81%	48.04%

Table 5.a. HEDIS MY2020 Plan-Specific Rates: Effectiveness of Care Measures										
Measure	**AGE**	**AGM**	**AGW**	**BCE**	**BCM**	**BCW**	**TCS**	**UHCE**	**UHCM**	**UHCW**
Use of Imaging Studies for Low Back Pain (LBP)	70.00%	70.24%	72.27%	67.13%	67.15%	66.67%	66.35%	67.24%	67.84%	66.85%
Measures Collected Through CAHPS Health Plan Survey										
Flu vaccinations for adults ages 18 to 64 (FVA)	35.59%	40.49%	37.11%	42.51%	40.91%	37.50%	NA	35.19%	39.75%	30.69%
Medical Assistance with Smoking and Tobacco Use Cessation (MSC):										
Advising Smokers and Tobacco Users to Quit	81.22%	77.91%	78.82%	75.00%	80.39%	70.34%	NA	81.39%	78.57%	78.70%
Discussing Cessation Medications	47.16%	48.84%	46.47%	45.90%	45.45%	46.98%	NA	50.86%	49.41%	46.75%
Discussing Cessation Strategies	46.07%	45.35%	40.00%	40.22%	47.40%	44.14%	NA	46.09%	39.05%	41.72%
Supplemental Data - % Current Smokers†	40.38%	29.93%	44.50%	40.21%	38.50%	31.09%	10.58%	41.18%	39.16%	28.79%

** NCQA indicated trending with caution due to changes in measure specifications for HEDIS MY2020.*

*** NCQA indicated a break in trending to prior years due to significant changes in measure specifications for HEDIS MY2020.*

**** First-year measure for HEDIS MY2020.*

† For this measure, the rate is not intended to indicate good or poor performance, but for informative purposes to monitor the population of current smokers.

For the Effectiveness of Care Measures presented in **Table 5.b**, a lower rate indicates better performance.

Table 5.b. HEDIS MY2020 Plan-Specific Rates: Effectiveness of Care Measures Where Lower Rates Indicate Better Performance

Measure	AGE	AGM	AGW	BCE	BCM	BCW	TCS	UHCE	UHCM	UHCW
Diabetes										
Comprehensive Diabetes Care (CDC):										
HbA1c Poor Control (>9.0%)*	45.26%	40.88%	53.77%	35.45%	43.55%	41.85%	42.47%	35.77%	32.36%	35.04%
Overuse/Appropriateness										
Non-Recommended Cervical Cancer Screening in Adolescent Females (NCS)	0.44%	0.32%	0.93%	0.62%	0.25%	1.48%	0.56%	1.54%	1.13%	1.87%
Use of Opioids at High Dosage (HDO)*	6.16%	5.43%	1.32%	5.87%	4.21%	2.62%	3.23%	8.86%	7.31%	2.42%
Use of Opioids From Multiple Providers (UOP)*:										
Multiple Prescribers	15.12%	27.08%	14.05%	16.32%	30.06%	16.94%	36.67%	16.64%	25.71%	15.23%
Multiple Pharmacies	1.06%	1.81%	3.77%	0.89%	1.96%	1.42%	6.67%	1.04%	1.54%	2.76%
Multiple Prescribers and Pharmacies	0.60%	1.05%	1.43%	0.39%	1.34%	0.42%	6.67%	0.63%	0.94%	1.18%
Risk of Continued Opioid Use (COU)*:										
18–64 Years: ≥15 days/30-day period	2.10%	2.86%	1.44%	1.45%	2.14%	1.21%	0.89%	3.96%	4.00%	2.61%
≥ 31 days/62-day period	1.64%	2.42%	1.19%	1.19%	1.89%	1.00%	0.53%	3.14%	3.54%	1.91%

** NCQA indicated trending with caution due to changes in measure specifications for HEDIS MY2020.*

Table 6 presents rates for Access/Availability of Care Measures.

Table 6. HEDIS MY2020 Plan-Specific Rates: Access/Availability of Care Measures										
Measure	**AGE**	**AGM**	**AGW**	**BCE**	**BCM**	**BCW**	**TCS**	**UHCE**	**UHCM**	**UHCW**
Adults' Access to Preventive/Ambulatory Health Services (AAP):										
20–44 Years	72.87%	76.61%	72.69%	80.09%	77.50%	78.57%	44.13%	77.83%	78.87%	74.00%
45–64 Years	80.70%	85.75%	81.79%	88.43%	86.27%	88.37%	47.13%	87.59%	88.66%	85.71%
Initiation and Engagement of Alcohol and Other Drug (AOD) Dependence Treatment (IET)—Initiation of AOD Treatment*:										
13–17 Years: Alcohol	34.29%	NA	NA	35.48%	NA	NA	60.00%	NA	NA	NA
Opioid	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Other drug	44.03%	50.00%	50.94%	44.13%	57.50%	37.61%	55.70%	38.71%	47.76%	45.65%
Total	41.77%	47.33%	49.55%	42.79%	56.65%	38.21%	55.03%	36.43%	46.00%	44.66%
18+ Years: Alcohol	47.71%	48.44%	57.47%	47.60%	45.96%	48.32%	43.06%	41.86%	44.41%	50.06%
Opioid	68.78%	65.75%	74.86%	57.29%	59.96%	55.22%	46.43%	52.99%	65.71%	66.67%
Other drug	50.51%	53.65%	50.68%	43.86%	51.12%	44.80%	48.21%	42.95%	51.75%	46.12%
Total	54.62%	53.99%	55.19%	48.14%	50.27%	47.50%	45.45%	44.91%	51.75%	48.83%
Initiation Total: Alcohol	47.19%	48.48%	57.54%	47.23%	46.42%	47.83%	49.57%	41.53%	44.51%	50.00%
Opioid	68.66%	65.81%	74.86%	57.30%	60.06%	55.29%	52.94%	52.95%	65.68%	66.51%
Other drug	50.03%	53.42%	50.70%	43.88%	51.67%	44.19%	51.84%	42.69%	51.48%	46.09%
Total	54.02%	53.73%	54.90%	47.91%	50.61%	47.02%	49.74%	44.61%	51.51%	48.65%
Initiation and Engagement of Alcohol and Other Drug (AOD) Dependence Treatment (IET)—Engagement of AOD Treatment*:										
13–17 Years: Alcohol	8.57%	NA	NA	12.90%	NA	NA	31.11%	NA	NA	NA
Opioid	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Other drug	23.13%	24.14%	17.92%	26.82%	29.38%	13.68%	33.23%	16.94%	24.63%	14.13%
Total	20.89%	22.14%	17.12%	23.88%	27.75%	13.82%	32.84%	15.00%	22.67%	12.62%
18+ Years: Alcohol	15.48%	15.31%	15.22%	13.23%	12.78%	11.59%	13.89%	12.31%	13.56%	12.19%
Opioid	44.33%	35.67%	40.33%	29.16%	28.13%	25.59%	25.00%	31.91%	39.18%	33.81%
Other drug	15.40%	19.91%	12.41%	13.02%	17.02%	11.20%	17.56%	11.98%	16.57%	10.08%
Total	23.87%	22.30%	17.36%	18.49%	18.51%	14.67%	16.99%	18.35%	21.85%	14.04%
Engagement Total: Alcohol	15.21%	15.08%	15.35%	13.22%	12.97%	11.54%	20.51%	12.11%	13.69%	12.00%
Opioid	44.25%	35.61%	40.33%	29.08%	28.18%	25.55%	25.00%	31.89%	39.10%	33.73%

Table 6. HEDIS MY2020 Plan-Specific Rates: Access/Availability of Care Measures										
Measure	**AGE**	**AGM**	**AGW**	**BCE**	**BCM**	**BCW**	**TCS**	**UHCE**	**UHCM**	**UHCW**
Other drug	15.97%	20.18%	12.84%	14.01%	18.08%	11.41%	25.15%	12.28%	17.11%	10.34%
Total	23.73%	22.30%	17.35%	18.72%	18.99%	14.62%	24.07%	18.23%	21.88%	13.98%
Prenatal and Postpartum Care (PPC)*:										
Timeliness of Prenatal Care	88.81%	83.45%	73.24%	89.29%	83.45%	84.18%	79.27%	82.73%	74.94%	69.34%
Postpartum Care	75.18%	73.72%	64.48%	75.67%	75.18%	76.40%	62.55%	76.16%	67.40%	66.67%
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP):										
1–11 Years	49.32%	52.63%	54.10%	66.97%	71.83%	58.82%	55.71%	49.45%	61.64%	51.39%
12–17 Years	69.28%	71.28%	56.41%	72.00%	64.23%	64.03%	53.27%	53.60%	61.29%	43.44%
Total	62.83%	64.24%	55.62%	70.07%	67.01%	61.83%	54.06%	51.85%	61.42%	46.39%

** NCQA indicated trending with caution due to changes in measure specifications for HEDIS MY2020.*

Table 7 results are for utilization measures that are included in the Utilization and Risk-Adjusted Utilization Domain of Care.

Table 7. HEDIS MY2020 Plan-Specific Rates: Use of Services Measures										
Measure	**AGE**	**AGM**	**AGW**	**BCE**	**BCM**	**BCW**	**TCS**	**UHCE**	**UHCM**	**UHCW**
Well-Child Visits in the First 30 Months of Life (W30)††:										
First 15 Months**	59.94%	61.76%	37.70%	71.93%	66.47%	49.64%	48.42%	46.40%	42.46%	26.12%
15 Months–30 Months	67.14%	73.18%	54.14%	75.23%	73.34%	55.30%	63.44%	71.08%	74.21%	53.96%
Child and Adolescent Well-Care Visits (WCV)††:										
3–11 Years**	57.11%	64.26%	48.55%	64.14%	61.37%	52.72%	58.27%	59.59%	63.38%	51.23%
12–17 Years**	48.20%	53.90%	41.75%	54.76%	52.61%	45.57%	52.85%	49.52%	52.61%	44.00%
18–21 Years**	24.35%	27.04%	21.60%	28.79%	28.55%	24.96%	27.29%	25.92%	26.72%	20.30%
Total**	49.37%	55.81%	42.77%	55.87%	53.93%	46.18%	51.13%	50.92%	55.15%	44.65%

†† Revised and renamed measures for HEDIS MY2020.

***NCQA indicated a break in trending to prior years due to significant changes in measure specifications for HEDIS MY2020.*

Individual Plan Performance—CAHPS

Table 8 details the color-coding and any additional comments for **Tables 9**, 10, and 11. These tables display the plan-specific performance rates for the CAHPS survey results.

Table 8. MY2020 CAHPS Rating Measure Designations

Color Designation	National Percentile Achieved	Additional Comments
	Greater than 75th percentile	No additional comments
	25th to 75th	No additional comments
	Less than 25th	No additional comments
	No Rating Available	Benchmarking data were not available
Measure Designation	**Definition**	
NA	Not Applicable. Health plans must achieve a denominator of at least 100 responses to obtain a reportable result. If the denominator for a particular survey result calculation is less than 100, NCQA assigns a measure result of NA.	

Table 9. MY2020 CAHPS 5.0H Adult Medicaid Survey Results

AGE	AGM	AGW	BCE	BCM	BCW	TCS	UHCE	UHCM	UHCW
1. Getting Needed Care (Always + Usually)									
85.42%	84.32%	85.37%	84.14%	86.65%	85.11%	NA	90.03%	NA	83.32%
2. Getting Care Quickly (Always + Usually)									
85.58%	84.39%	NA	85.56%	NA	86.63%	NA	90.63%	NA	80.07%
3. How Well Doctors Communicate (Always + Usually)									
90.39%	87.16%	89.87%	92.29%	96.42%	93.65%	NA	90.51%	95.31%	92.47%
4. Customer Service (Always + Usually)									
NA	NA	NA	90.74%	NA	94.65%	NA	NA	NA	NA
5. Rating of All Health Care (9+10)									
54.55%	56.73%	52.76%	63.41%	61.67%	63.78%	NA	61.94%	63.56%	57.81%
6. Rating of Personal Doctor (9+10)									
63.24%	62.26%	66.87%	76.99%	70.25%	73.71%	NA	69.66%	75.00%	67.53%
7. Rating of Specialist Seen Most Often (9+10)									
65.38%	70.00%	NA	73.91%	NA	69.83%	NA	NA	NA	NA

Table 9. MY2020 CAHPS 5.0H Adult Medicaid Survey Results									
AGE	AGM	AGW	BCE	BCM	BCW	TCS	UHCE	UHCM	UHCW
8. Rating of Health Plan (9+10)									
56.76%	59.70%	60.55%	70.50%	65.84%	68.94%	63.46%	65.92%	70.41%	63.64%
9. Coordination of Care (Always + Usually)									
NA	NA	NA	NA	NA	86.24%	NA	NA	NA	NA

Table 10. MY2020 CAHPS 5.0H Child Medicaid Survey Results (General Population)									
AGE	AGM	AGW	BCE	BCM	BCW	TCS	UHCE	UHCM	UHCW
1. Getting Needed Care (Always + Usually)									
91.62%	88.66%	88.92%	94.21%	84.29%	87.00%	89.82%	91.95%	NA	NA
2. Getting Care Quickly (Always + Usually)									
91.90%	90.11%	88.29%	93.64%	89.97%	89.20%	91.72%	92.38%	NA	NA
3. How Well Doctors Communicate (Always + Usually)									
95.08%	92.79%	93.30%	97.23%	94.67%	94.66%	93.47%	95.09%	91.92%	93.86%
4. Customer Service (Always + Usually)									
91.48%	91.53%	89.57%	NA	NA	NA	NA	NA	NA	NA
5. Rating of All Health Care (9+10)									
79.27%	79.87%	74.74%	80.20%	84.68%	74.05%	75.76%	79.70%	75.94%	71.30%
6. Rating of Personal Doctor (9+10)									
80.04%	78.43%	77.49%	82.51%	85.11%	75.37%	79.12%	79.70%	83.74%	74.00%
7. Rating of Specialist Seen Most Often (9+10)									
78.07%	76.23%	NA	85.09%	NA	NA	77.62%	NA	NA	NA
8. Rating of Health Plan (9+10)									
74.76%	79.38%	75.58%	84.15%	81.60%	78.79%	77.85%	79.94%	83.33%	80.10%
9. Coordination of Care (Always + Usually)									
85.51%	78.74%	NA	84.30%	NA	NA	86.29%	NA	NA	NA

Table 11. MY2020 CAHPS 5.0H Child Medicaid Survey Results (Children with Chronic Conditions)									
AGE	**AGM**	**AGW**	**BCE**	**BCM**	**BCW**	**TCS**	**UHCE**	**UHCM**	**UHCW**
1. Access to Specialized Services (Always + Usually)									
NA	NA	NA	NA	NA	NA	81.72%	NA	NA	NA
2. Family-Centered Care: Personal Doctor Who Knows Child (Yes)									
91.70%	90.86%	91.37%	92.28%	95.36%	91.79%	91.54%	92.84%	90.59%	88.51%
3. Coordination of Care for Children With Chronic Conditions (Yes)									
80.73%	76.13%	NA	NA	NA	NA	77.58%	NA	NA	NA
4. Family-Centered Care: Getting Needed Information (Always + Usually)									
92.91%	90.56%	93.81%	93.12%	90.71%	94.38%	92.13%	93.02%	88.36%	87.32%
5. Access to Prescription Medicines (Always + Usually)									
90.88%	92.48%	94.14%	94.85%	94.86%	94.48%	93.21%	94.58%	96.67%	91.50%

Medicaid HEDIS Trending—Statewide Weighted Rates

Each year of HEDIS reporting, Qsource has calculated the Medicaid statewide weighted averages for each measure by applying the size of the eligible population for each measure within a health plan to its reported rate. Using this methodology, plan-specific findings can be estimated from an overall TennCare statewide level, with each reporting health plan contributing to the statewide estimate proportionate to its eligible population size.

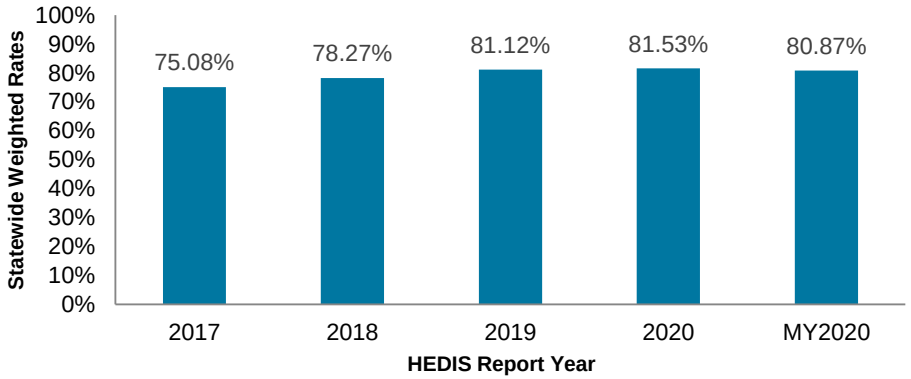
Generally and as stated in footnotes, factors should be considered while trending data, such as instances where measures were not reported (and thereby not plotted) for a particular year.

Trending for first-time measures is not possible and, therefore, is not presented in this section. Likewise, graphs are not presented for measures that had a break in trending for the current measurement year. Remaining measures are plotted to reflect the statewide performance of TennCare MCOs for five years. Trending for prior years is available in previous HEDIS reports.

Note: This report, which previously would have referred to the most recent data as HEDIS 2021, uses NCQA's new naming convention of HEDIS MY2020 to refer to data collected during calendar year 2020 and reported in calendar year 2021. To ensure consistency in the technical specifications and for easier reference to publications issued by NCQA, Qsource has retained NCQA's prior nomenclature to refer to previous years. For example, HEDIS 2020 remains as-is in this report and refers to data collected in MY2019.

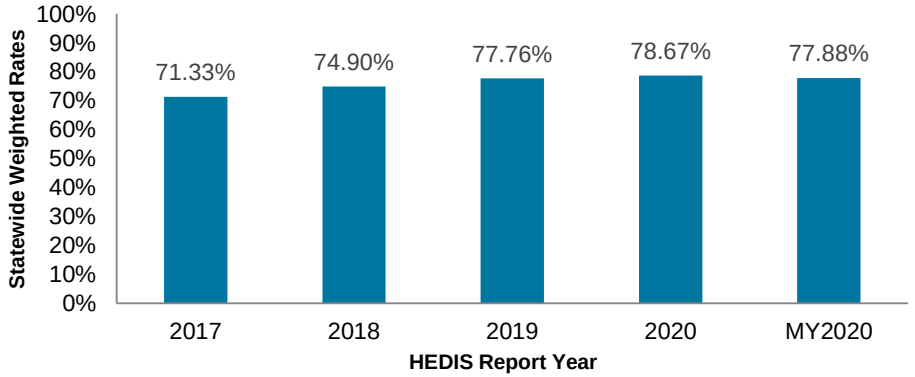
Effectiveness of Care Measures: Prevention and Screening

Fig. 1. Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)— BMI Percentile: 3–11 Years



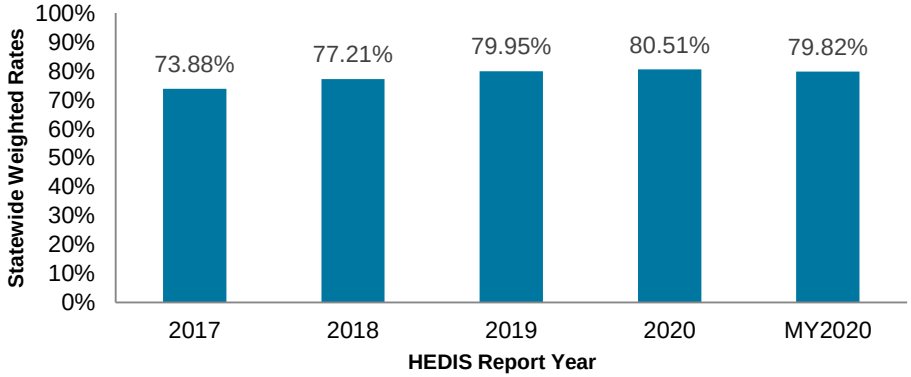
Footnote: Due to changes in measure specification, NCQA indicated trending between MY2020 and previous years should be considered with caution.

Fig. 2. WCC—BMI Percentile: 12–17 Years



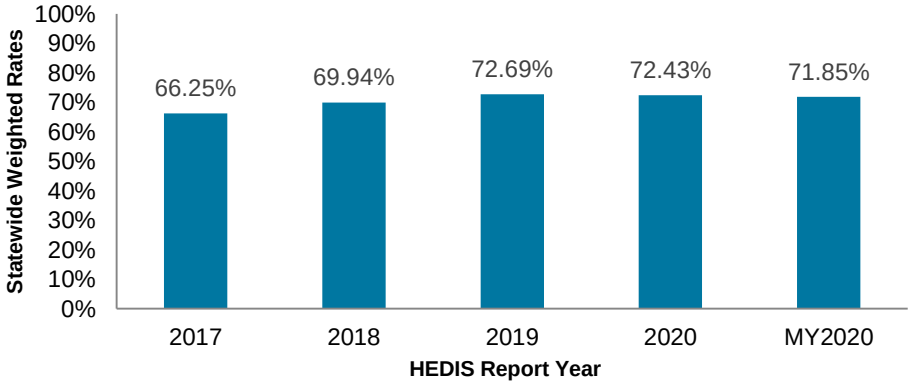
Footnote: Due to changes in measure specification, NCQA indicated trending between MY2020 and previous years should be considered with caution.

Fig. 3. WCC—BMI Percentile: Total



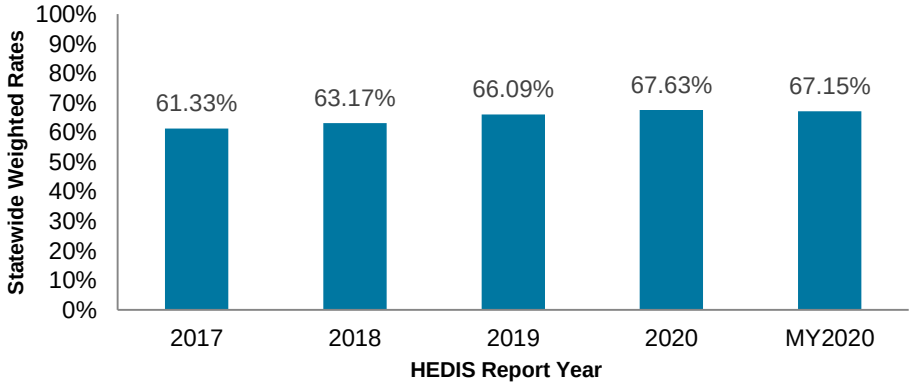
Footnote: Due to changes in measure specification, NCQA indicated trending between MY2020 and previous years should be considered with caution.

Fig. 4. WCC—Counseling for Nutrition: 3–11 Years



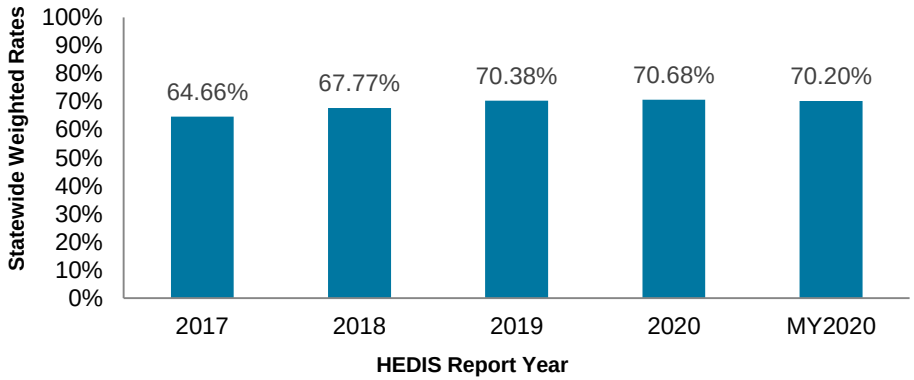
Footnote: Due to changes in measure specification, NCQA indicated trending between MY2020 and previous years should be considered with caution.

Fig. 5. WCC—Counseling for Nutrition: 12–17 Years



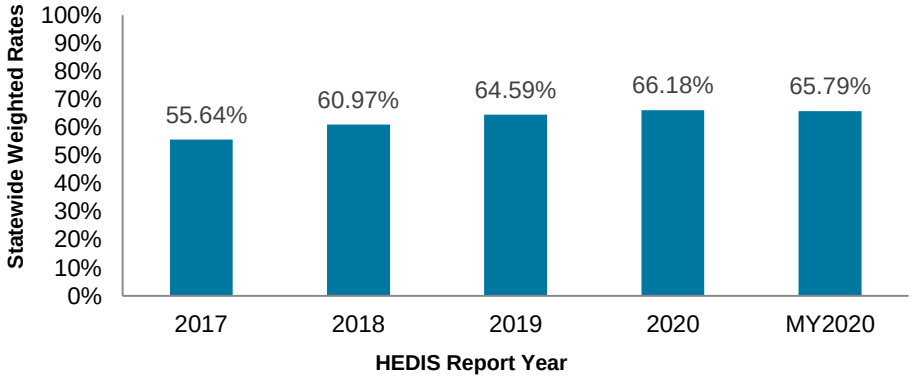
Footnote: Due to changes in measure specification, NCQA indicated trending between MY2020 and previous years should be considered with caution.

Fig. 6. WCC—Counseling for Nutrition: Total



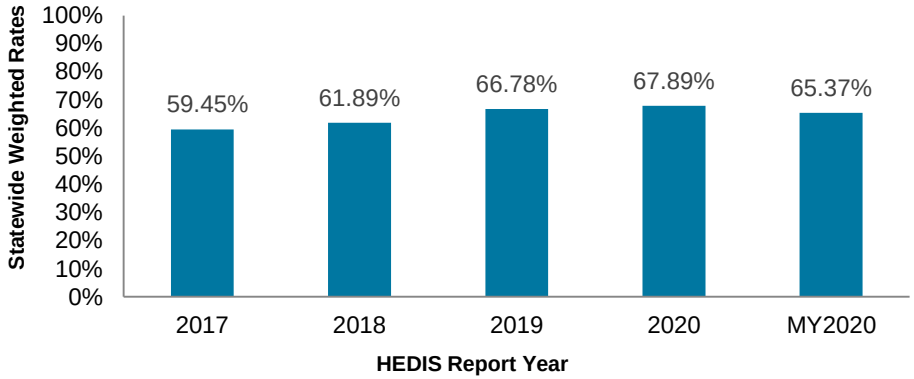
Footnote: Due to changes in measure specification, NCQA indicated trending between MY2020 and previous years should be considered with caution.

Fig. 7. WCC—Counseling for Physical Activity: 3–11 Years



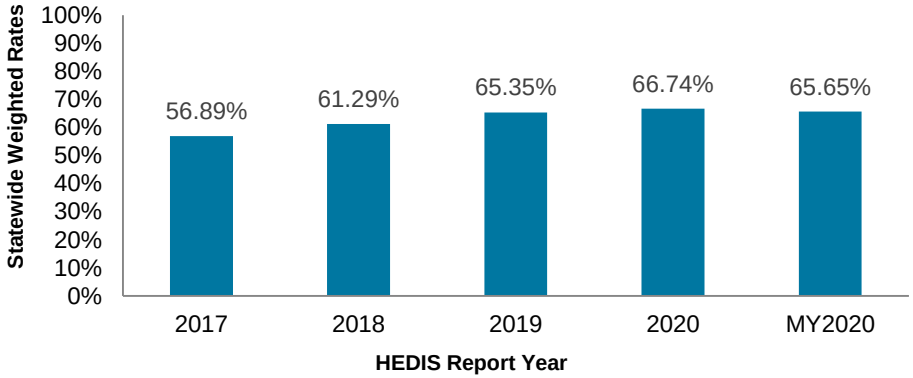
Footnote: Due to changes in measure specification, NCQA indicated trending between MY2020 and previous years should be considered with caution.

Fig. 8. WCC—Counseling for Physical Activity: 12–17 Years



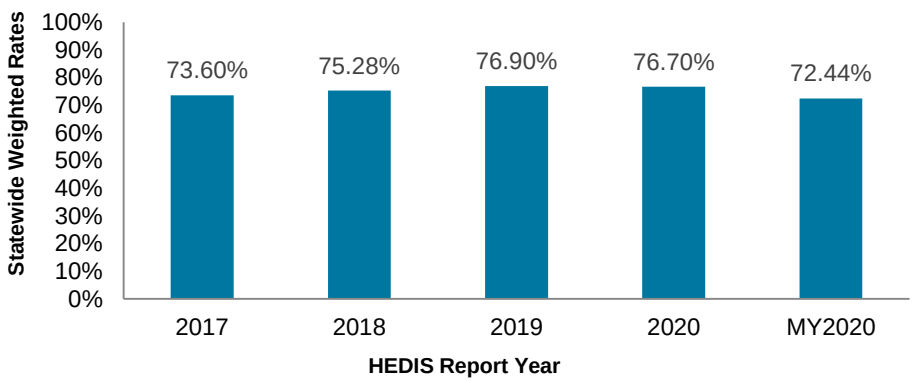
Footnote: Due to changes in measure specification, NCQA indicated trending between MY2020 and previous years should be considered with caution.

Fig. 9. WCC—Counseling for Physical Activity: Total



Footnote: Due to changes in measure specification, NCQA indicated trending between MY2020 and previous years should be considered with caution.

Fig. 10. Childhood Immunization Status (CIS): DTaP/DT



Footnote: Due to changes in measure specification, NCQA indicated trending between HEDIS 2019 and previous years should be considered with caution.

Fig. 11. CIS: IPV

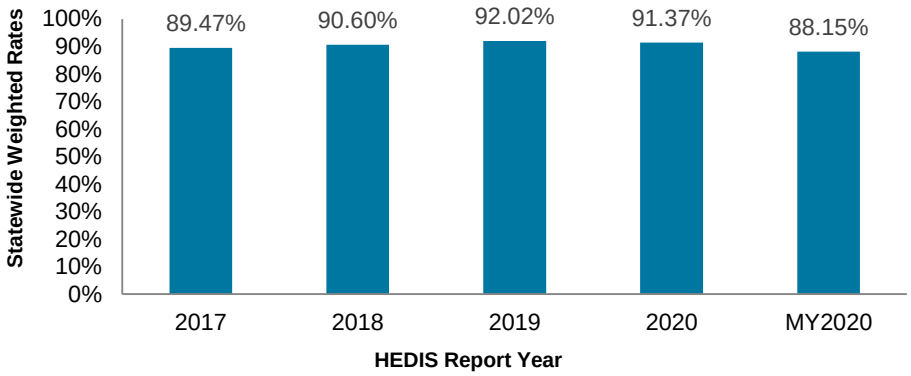
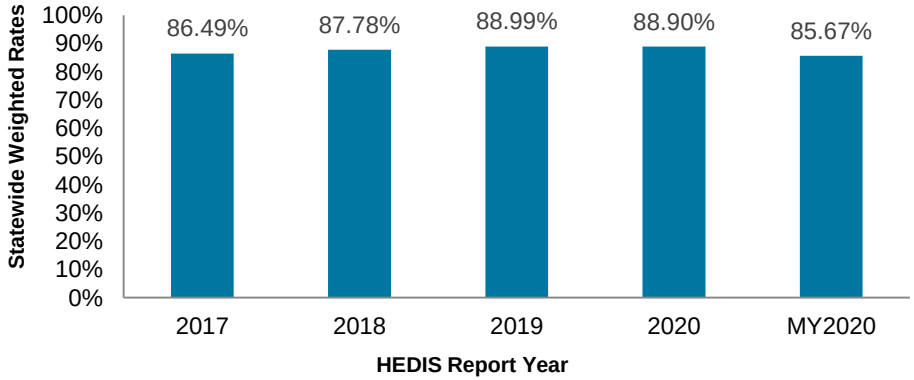


Fig. 12. CIS: MMR



Footnote: Due to changes in measure specification, NCQA indicated trending between HEDIS 2019 and previous years should be considered with caution.

Fig. 13. CIS: HiB

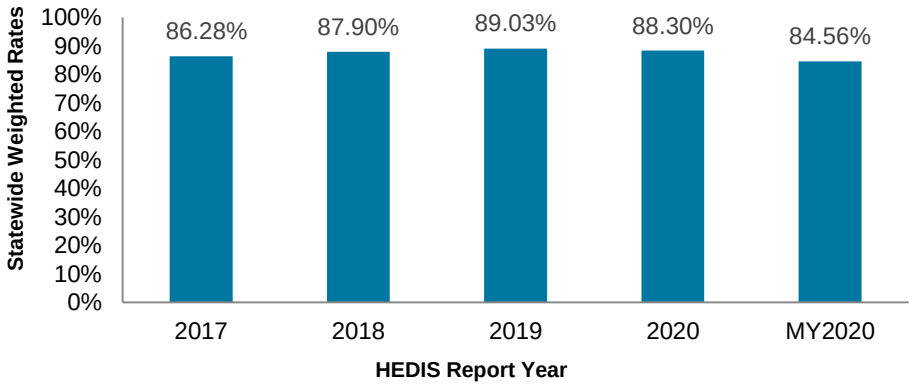


Fig. 14. CIS: HepB

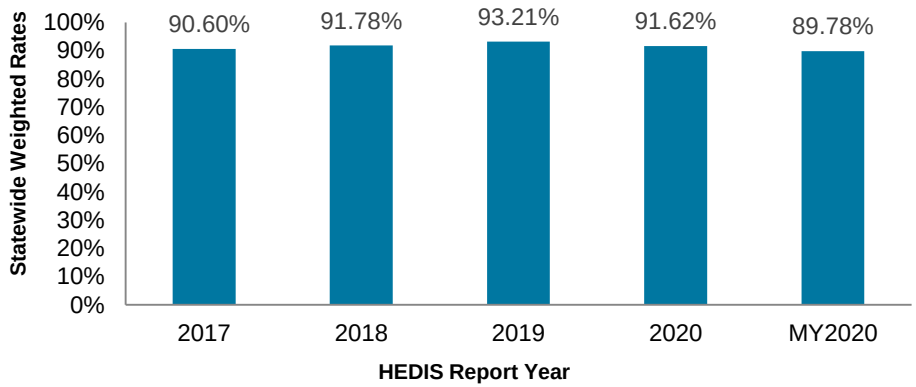


Fig. 15. CIS: VZV

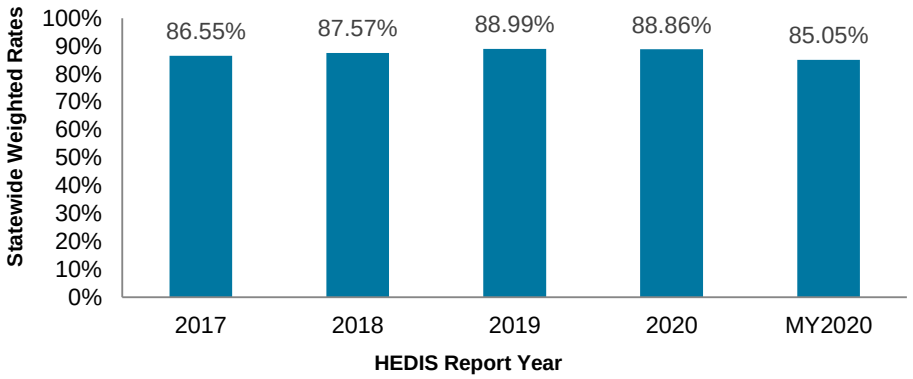


Fig. 16. CIS: PCV

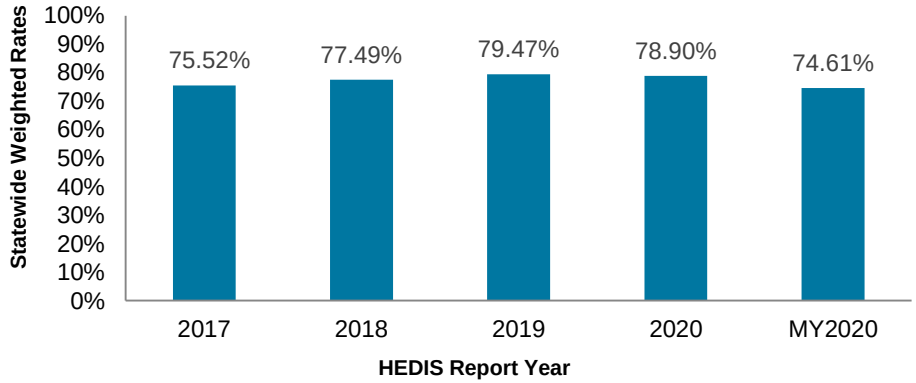
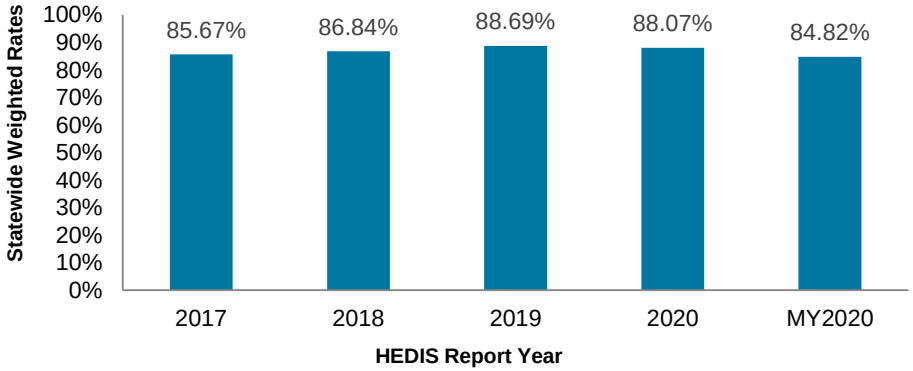


Fig. 17. CIS: HepA



Footnote: Due to changes in measure specification, NCQA indicated trending between HEDIS 2019 and previous years should be considered with caution.

Fig. 18. CIS: RV

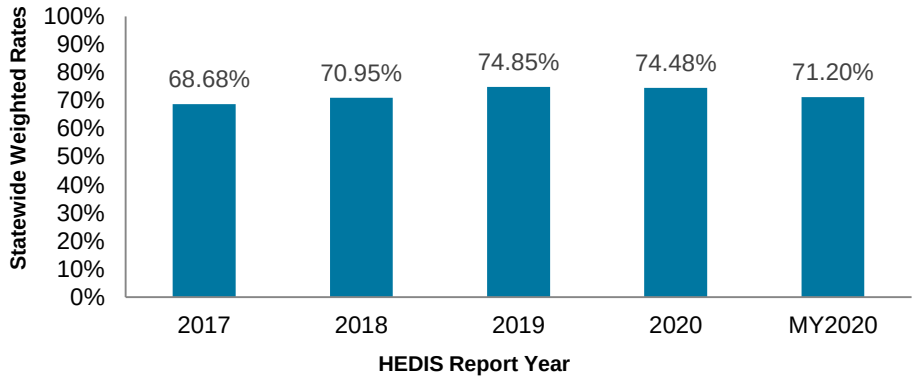


Fig. 19. CIS: Flu

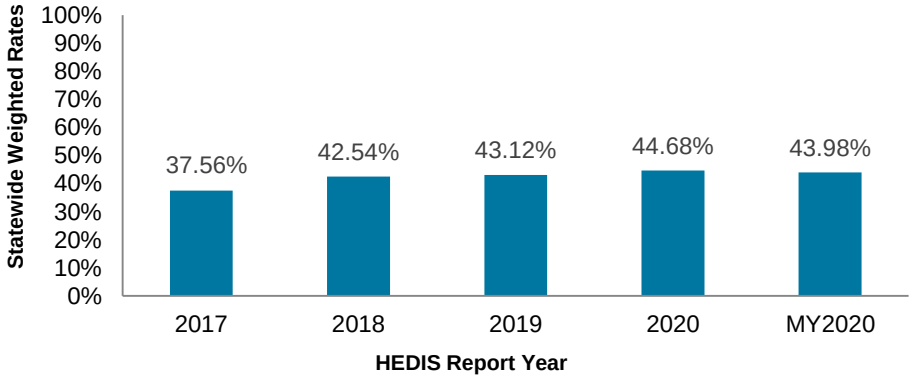
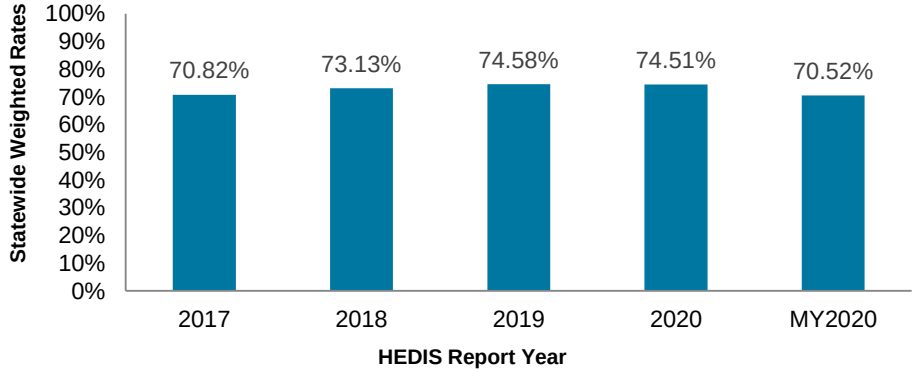
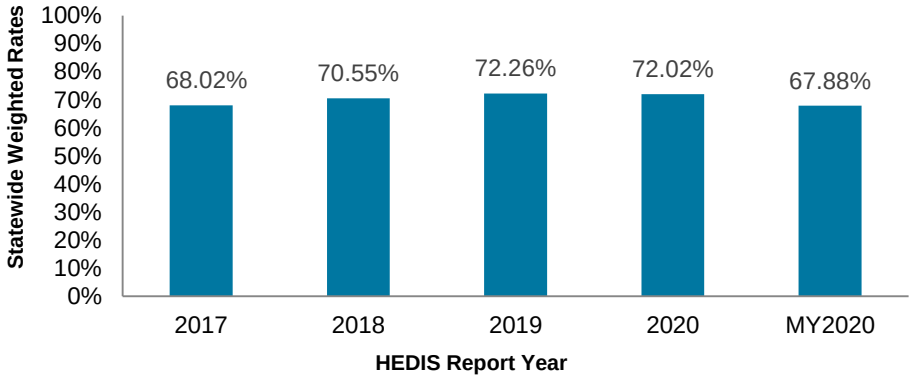


Fig. 20. CIS: Combination 2



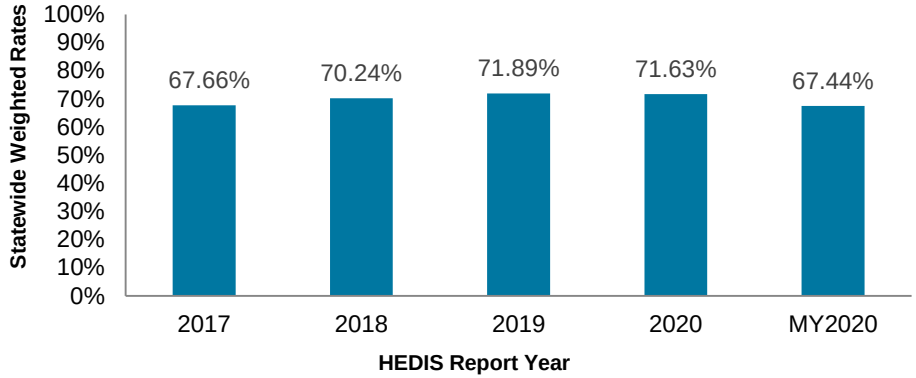
Footnote: Due to changes in measure specification, NCQA indicated trending between HEDIS 2019 and previous years should be considered with caution.

Fig. 21. CIS: Combination 3



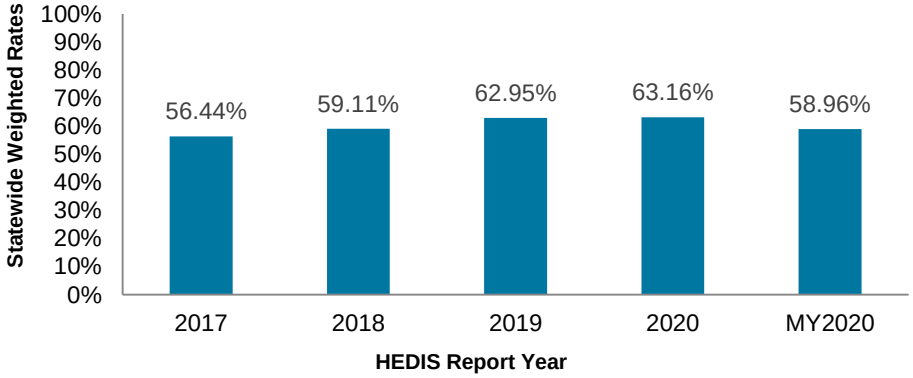
Footnote: Due to changes in measure specification, NCQA indicated trending between HEDIS 2019 and previous years should be considered with caution.

Fig. 22. CIS: Combination 4



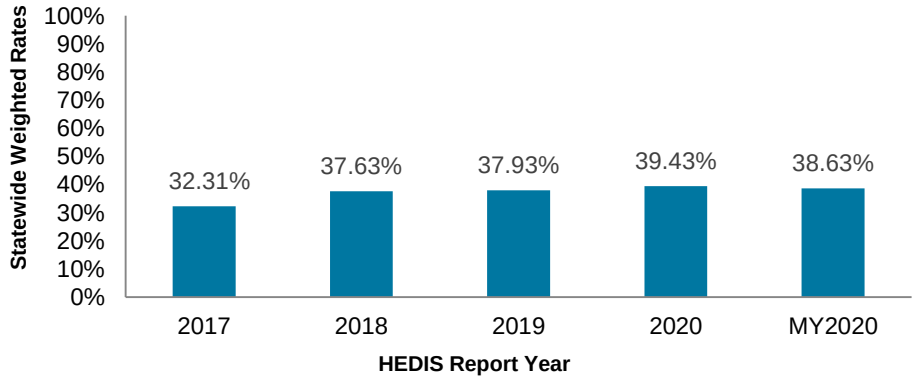
Footnote: Due to changes in measure specification, NCQA indicated trending between HEDIS 2019 and previous years should be considered with caution.

Fig. 23. CIS: Combination 5



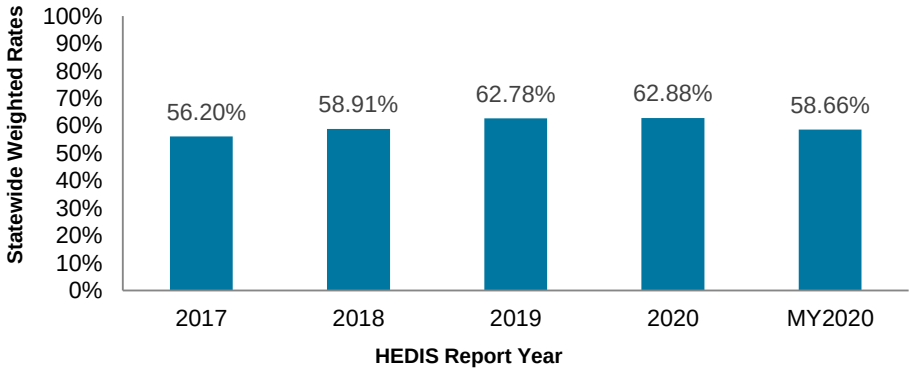
Footnote: Due to changes in measure specification, NCQA indicated trending between HEDIS 2019 and previous years should be considered with caution.

Fig. 24. CIS: Combination 6



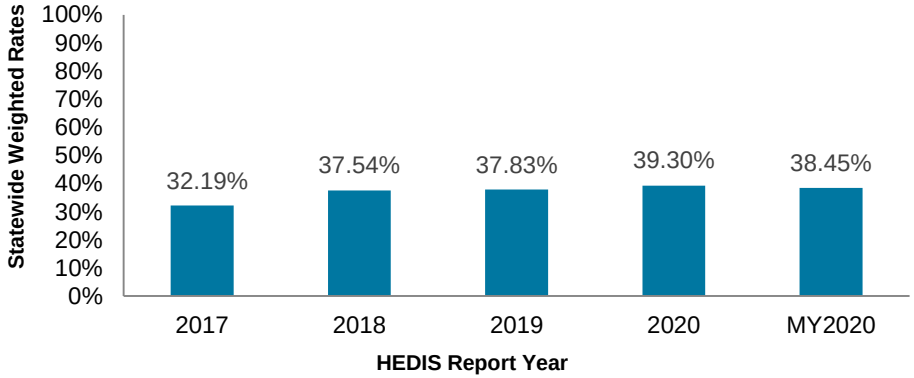
Footnote: Due to changes in measure specification, NCQA indicated trending between HEDIS 2019 and previous years should be considered with caution.

Fig. 25. CIS: Combination 7



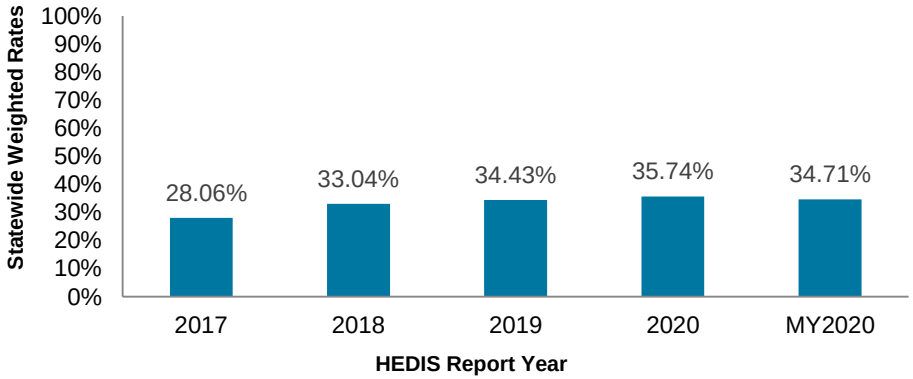
Footnote: Due to changes in measure specification, NCQA indicated trending between HEDIS 2019 and previous years should be considered with caution.

Fig. 26. CIS: Combination 8



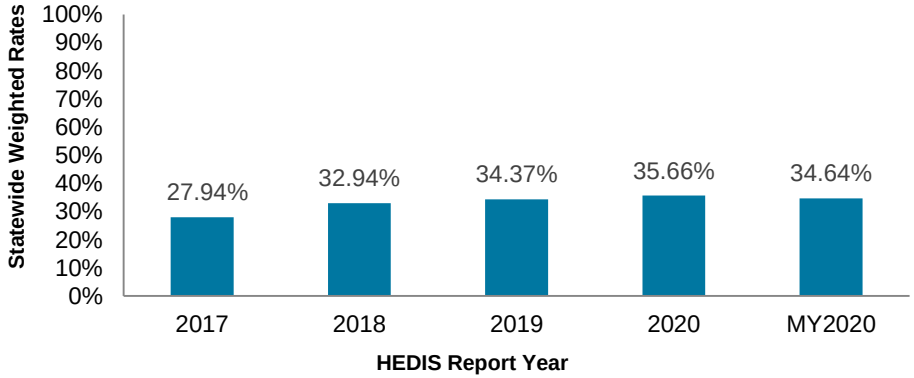
Footnote: Due to changes in measure specification, NCQA indicated trending between HEDIS 2019 and previous years should be considered with caution.

Fig. 27. CIS: Combination 9



Footnote: Due to changes in measure specification, NCQA indicated trending between HEDIS 2019 and previous years should be considered with caution.

Fig. 28. CIS: Combination 10



Footnote: Due to changes in measure specification, NCQA indicated trending between HEDIS 2019 and previous years should be considered with caution.

Fig. 29. Immunizations for Adolescents (IMA): Meningococcal

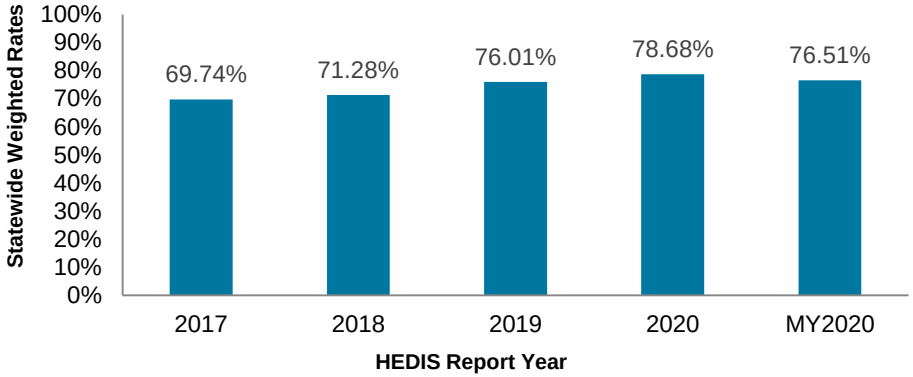


Fig. 30. IMA: Tdap/Td

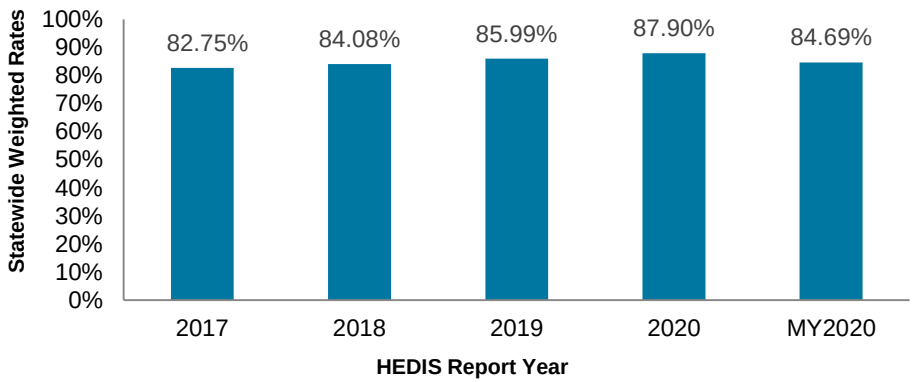


Fig. 31. IMA: HPV

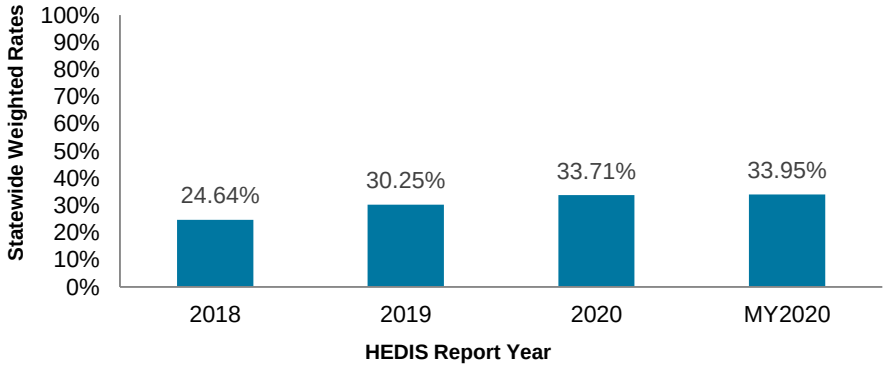
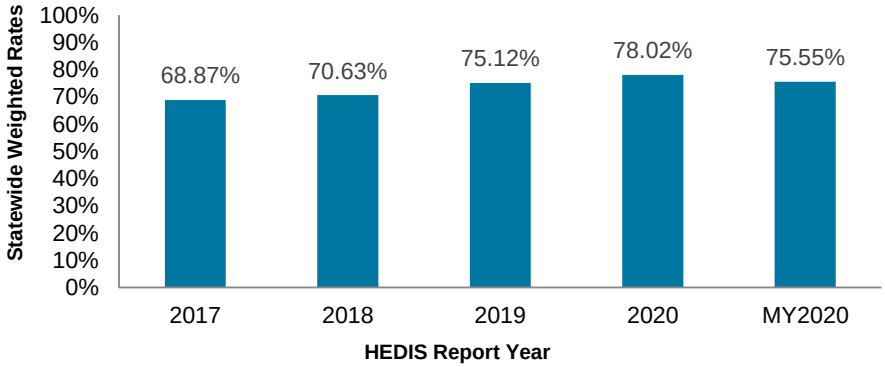
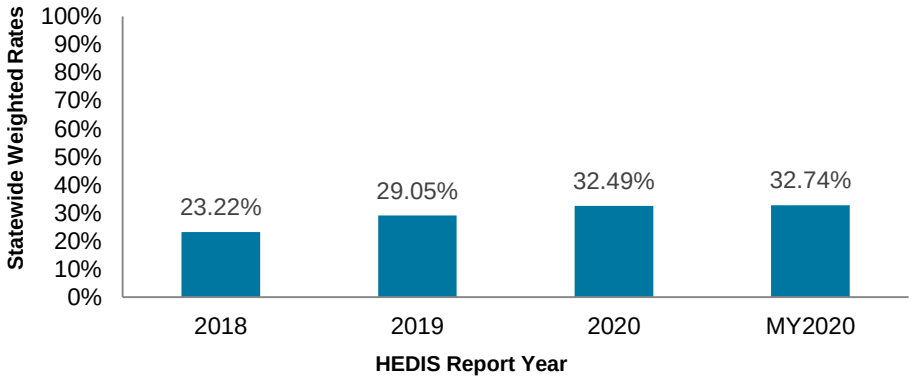


Fig. 32. IMA: Combination 1



Footnote: NCQA indicated a break in trending to prior years due to significant changes in measure specifications for HEDIS 2018.

Fig. 33. IMA: Combination 2



Footnote: NCQA indicated a break in trending to prior years due to significant changes in measure specifications for HEDIS 2018.

Fig. 34. Lead Screening in Children (LSC)

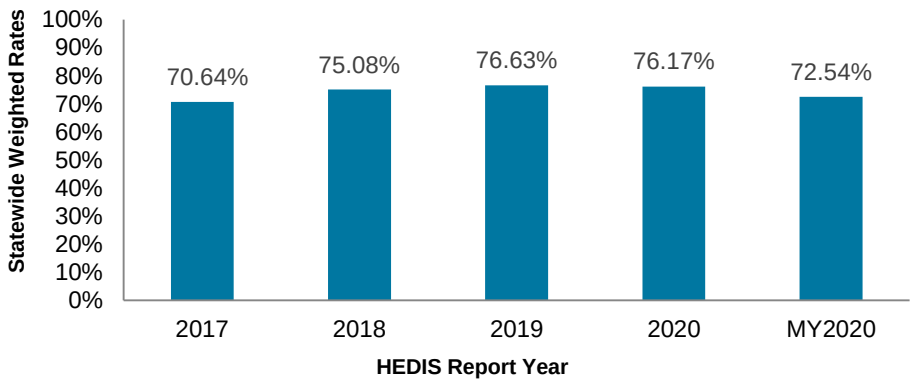
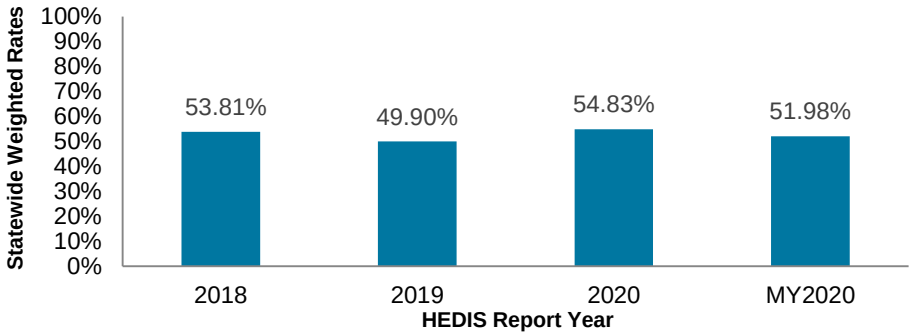
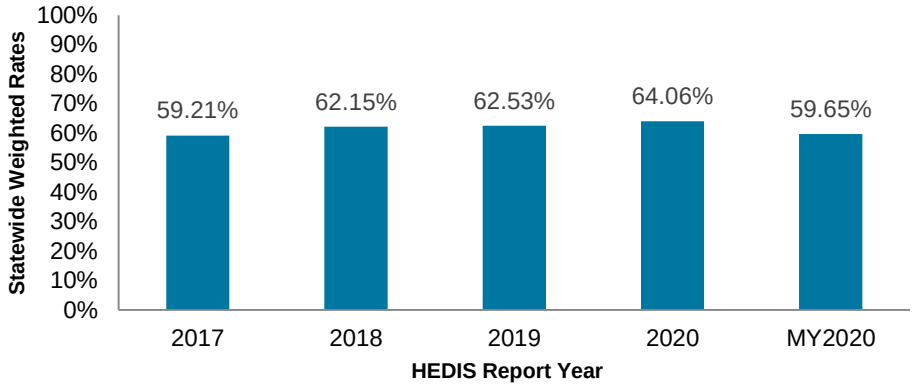


Fig. 35. Breast Cancer Screening (BCS)



Footnote: NCQA indicated a break in trending to prior years due to significant changes in measure specifications for HEDIS 2018. NCQA also indicated that trending between MY2020 and previous years should be considered with caution.

Fig. 36. Cervical Cancer Screening (CCS)



Footnote: Due to changes in measure specification, NCQA indicated trending between MY2020 and previous years should be considered with caution.

Fig. 37. Chlamydia Screening in Women (CHL): 16–20 Years

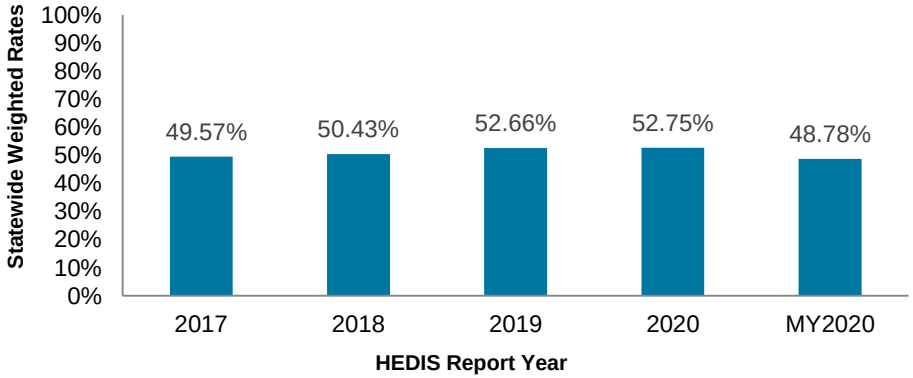


Fig. 38. CHL: 21–24 Years

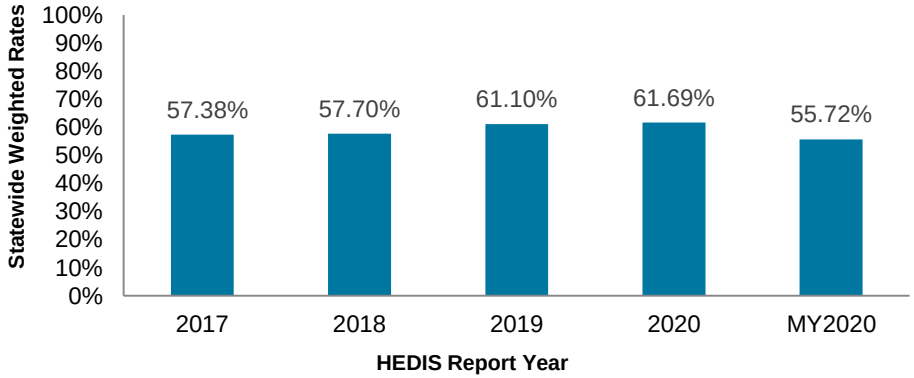
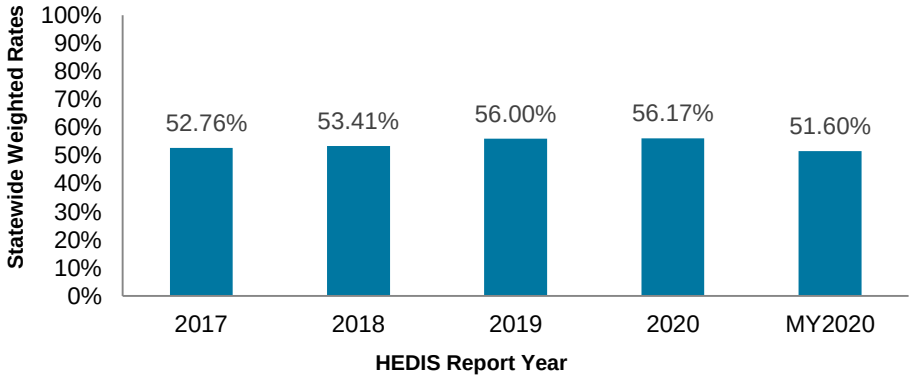
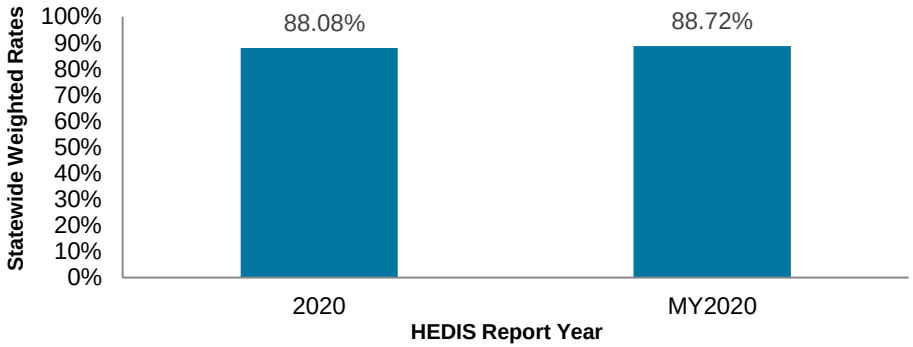


Fig. 39. CHL: Total



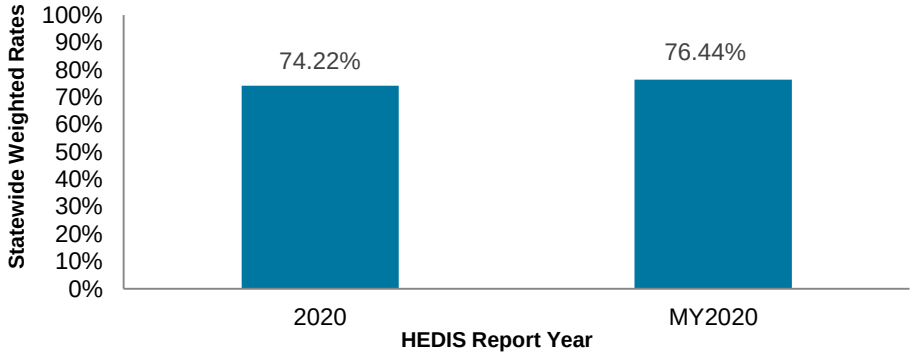
Effectiveness of Care Measures: Respiratory Conditions

Fig. 40. Appropriate Testing for Pharyngitis (CWP): 3–17 Years



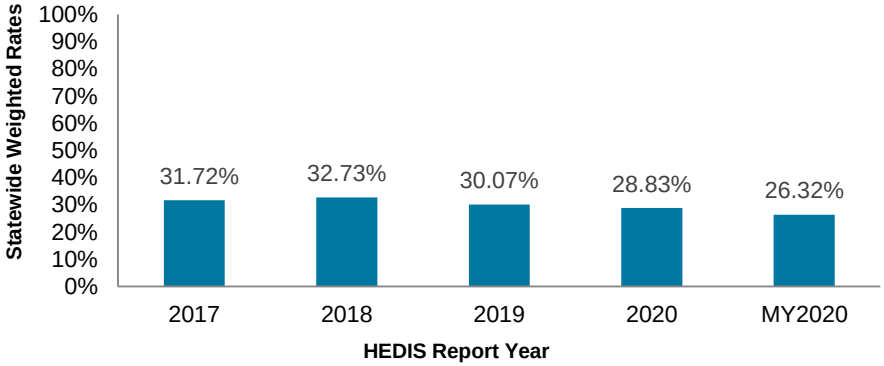
Footnote: Due to significant changes in measure specification for HEDIS 2020, NCQA indicated a break in trending to prior years. NCQA also indicated that trending between MY2020 and previous years should be considered with caution.

Fig. 41. CWP: 18-64 Years



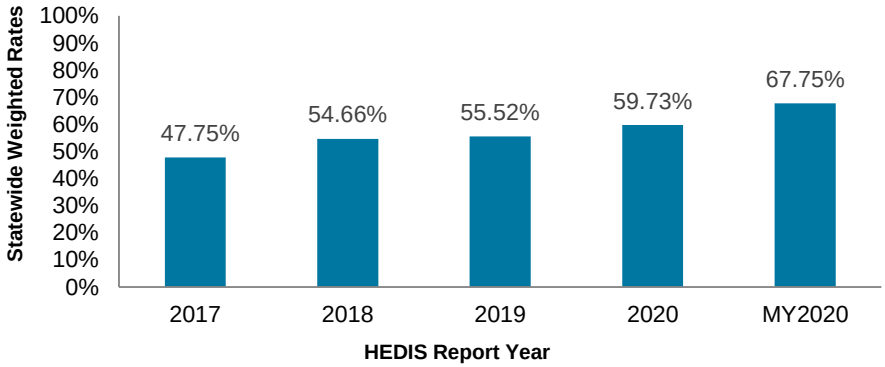
Footnote: Due to significant changes in measure specification for HEDIS 2020, NCQA indicated a break in trending to prior years. NCQA also indicated that trending between MY2020 and previous years should be considered with caution.

Fig. 42. Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)



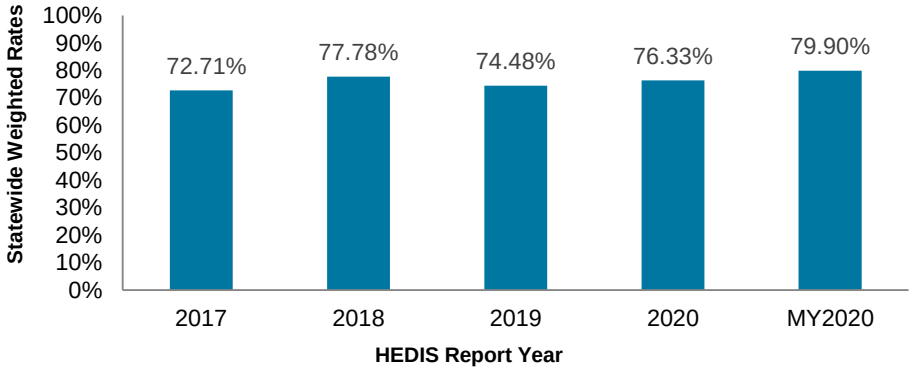
Footnote: Due to changes in measure specification, NCQA indicated trending between HEDIS 2019 and previous years should be considered with caution.

Fig. 43. Pharmacotherapy Management of COPD Exacerbation (PCE): Systemic Corticosteroid



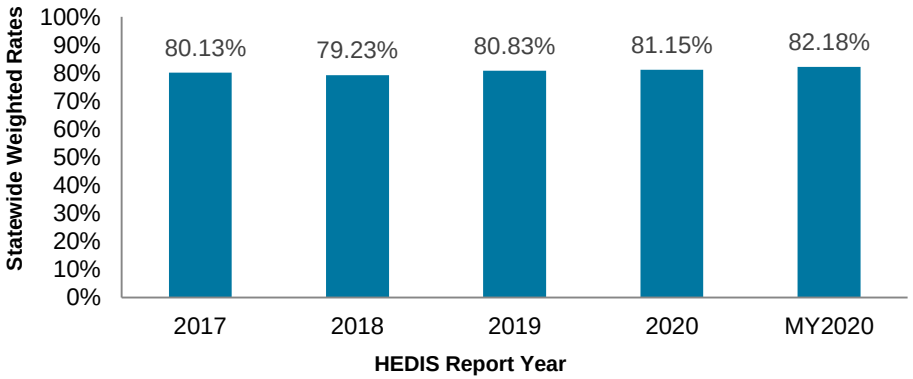
Footnote: For HEDIS 2017, criteria used to identify the COPD Episode Date in the event/diagnosis was revised; trending between prior years should be considered with caution.

Fig. 44. PCE: Bronchodilator



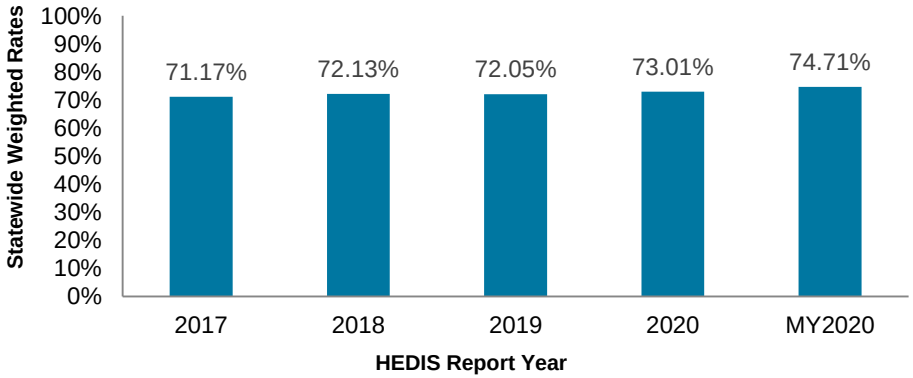
Footnote: For HEDIS 2017, criteria used to identify the COPD Episode Date in the event/diagnosis was revised; trending between prior years should be considered with caution.

Fig. 45. Asthma Medication Ratio (AMR): 5–11 Years



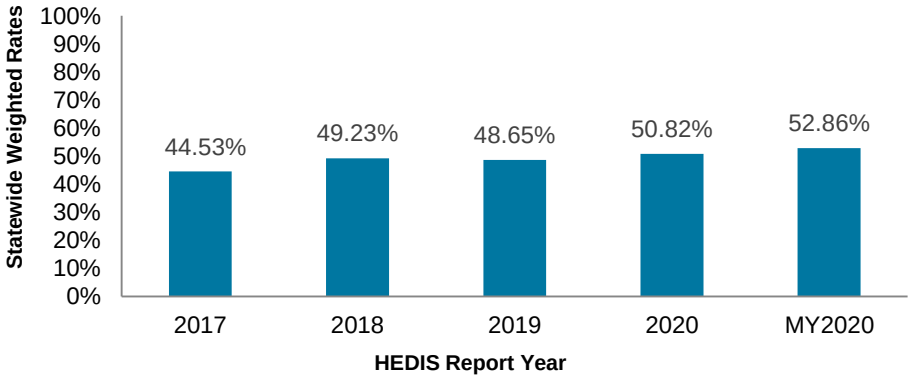
Footnote: Due to changes in measure specification, NCQA indicated trending between HEDIS 2019 and previous years should be considered with caution.

Fig. 46. AMR: 12–18 Years



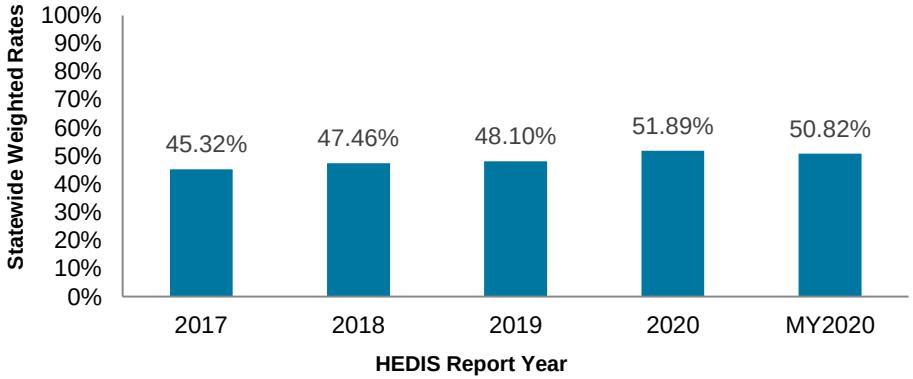
Footnote: Due to changes in measure specification, NCQA indicated trending between HEDIS 2019 and previous years should be considered with caution.

Fig. 47. AMR: 19–50 Years



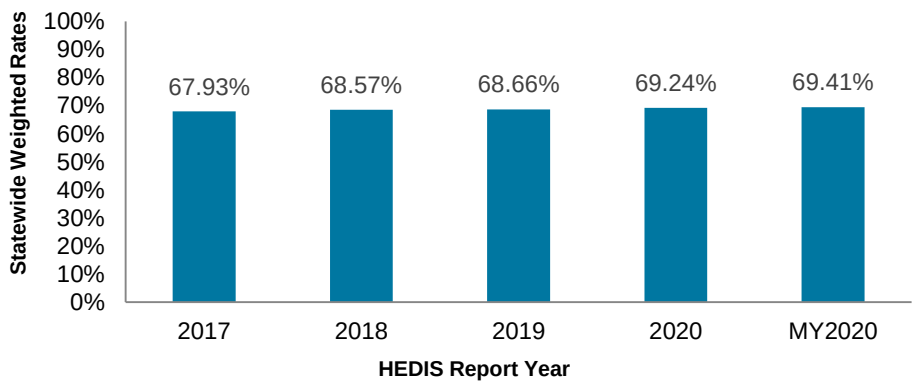
Footnote: Due to changes in measure specification, NCQA indicated trending between HEDIS 2019 and previous years should be considered with caution.

Fig. 48. AMR: 51–64 Years



Footnote: Due to changes in measure specification, NCQA indicated trending between HEDIS 2019 and previous years should be considered with caution.

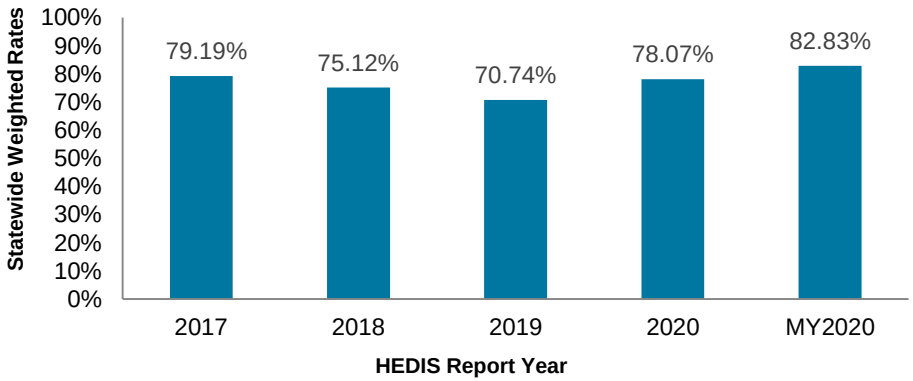
Fig. 49. AMR: Total



Footnote: Due to changes in measure specification, NCQA indicated trending between HEDIS 2019 and previous years should be considered with caution.

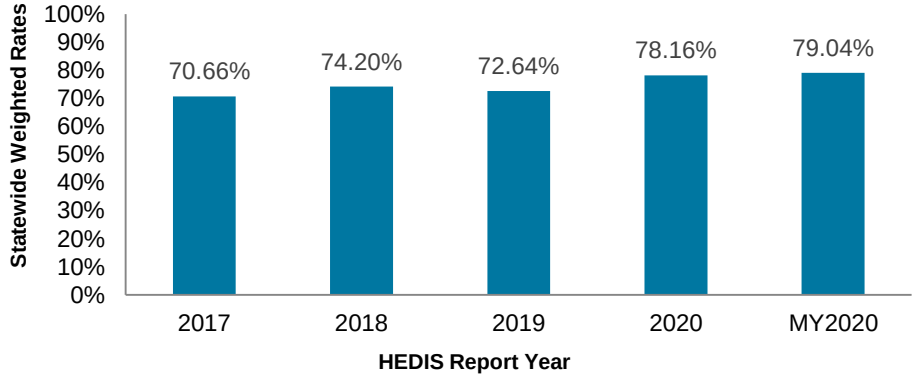
Effectiveness of Care Measures: Cardiovascular Conditions

Fig. 50. Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)



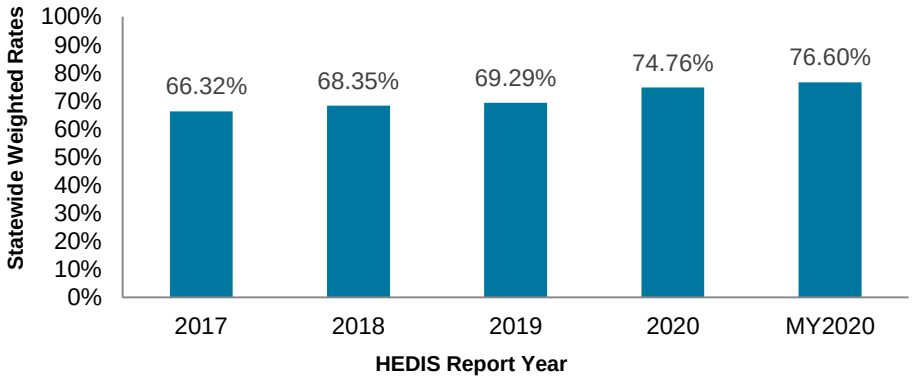
Footnote: Due to changes in measure specification, NCQA indicated trending between HEDIS 2019 and previous years should be considered with caution.

Fig. 51. Statin Therapy for Patients With Cardiovascular Disease (SPC)—Received Statin Therapy: Males 21–75 Years



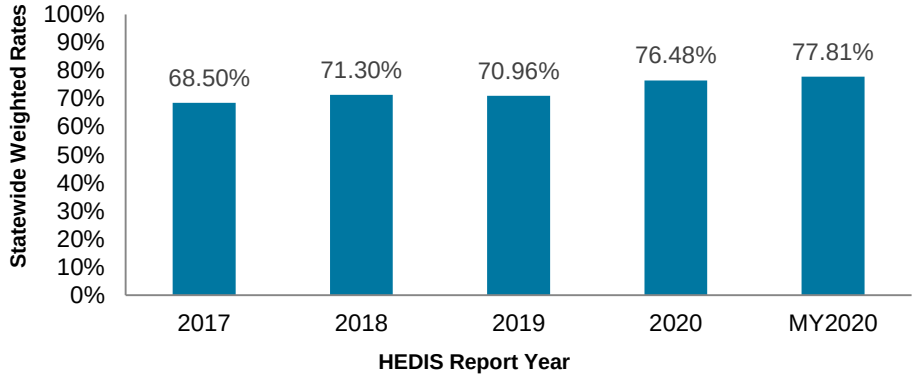
Footnote: Due to changes in measure specification, NCQA indicated trending between MY2020 and previous years should be considered with caution.

Fig. 52. SPC—Received Statin Therapy: Females 40–75 Years



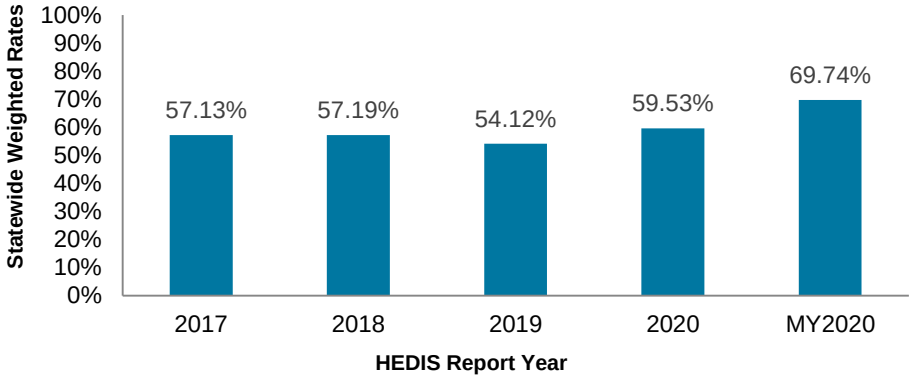
Footnote: Due to changes in measure specification, NCQA indicated trending between MY2020 and previous years should be considered with caution.

Fig. 53. SPC—Received Statin Therapy: Total



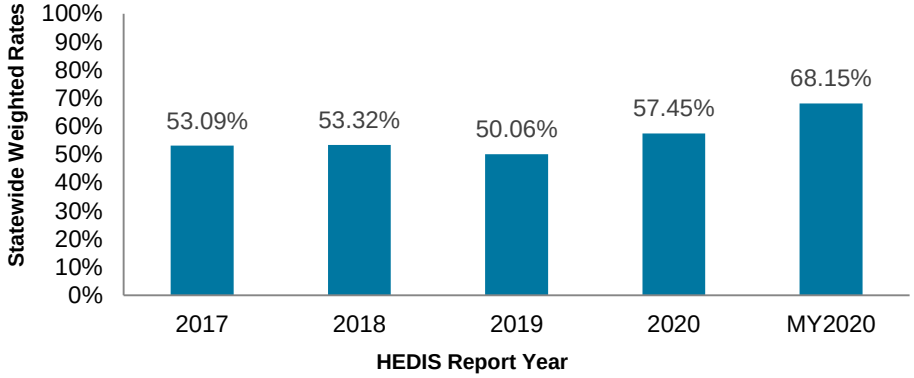
Footnote: Due to changes in measure specification, NCQA indicated trending between MY2020 and previous years should be considered with caution.

Fig. 54. SPC—Statin Adherence 80%: Males 21–75 Years



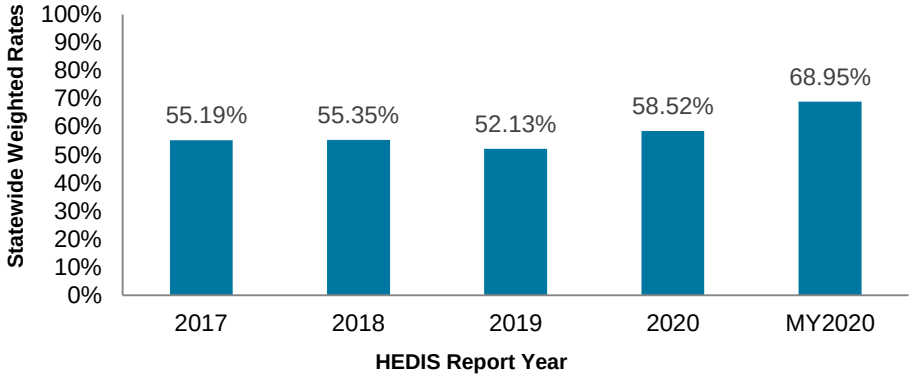
Footnote: Due to changes in measure specification, NCQA indicated trending between MY2020 and previous years should be considered with caution.

Fig. 55. SPC—Statin Adherence 80%: Females 40–75 Years



Footnote: Due to changes in measure specification, NCQA indicated trending between MY2020 and previous years should be considered with caution.

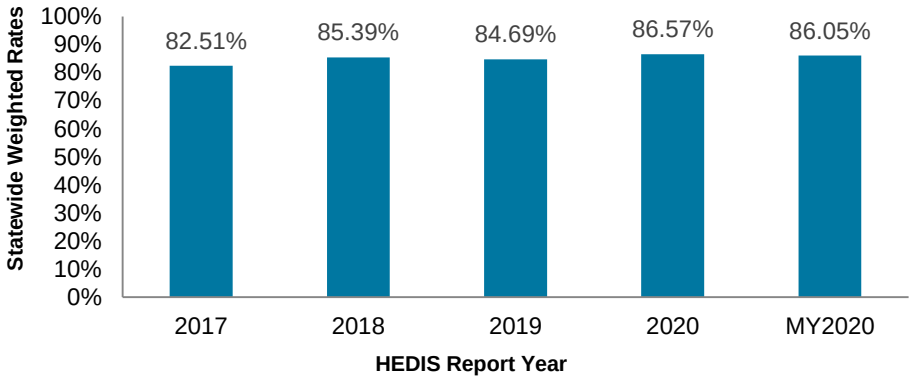
Fig. 56. SPC—Statin Adherence 80%: Total



Footnote: Due to changes in measure specification, NCQA indicated trending between MY2020 and previous years should be considered with caution.

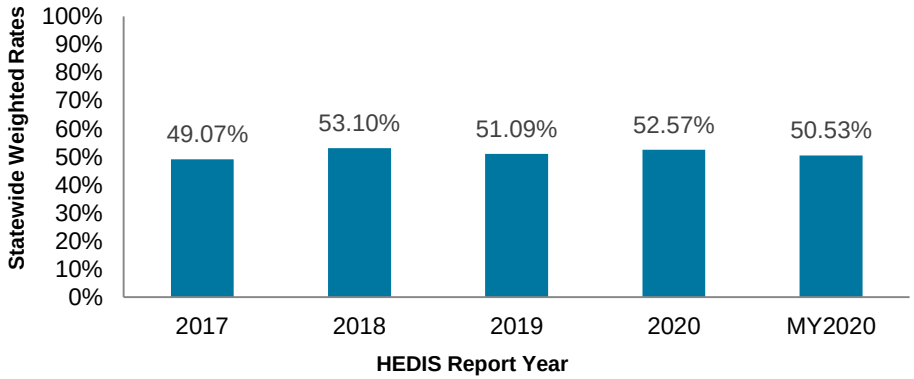
Effectiveness of Care Measures: Diabetes

Fig. 57. Comprehensive Diabetes Care (CDC): HbA1c Testing



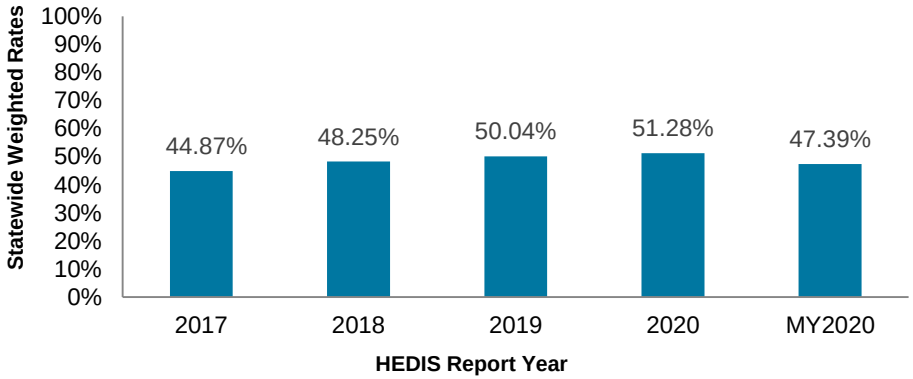
Footnote: Due to changes in measure specification, NCQA indicated trending between MY2020 and previous years should be considered with caution.

Fig. 58. CDC: HbA1c Control (<8.0%)



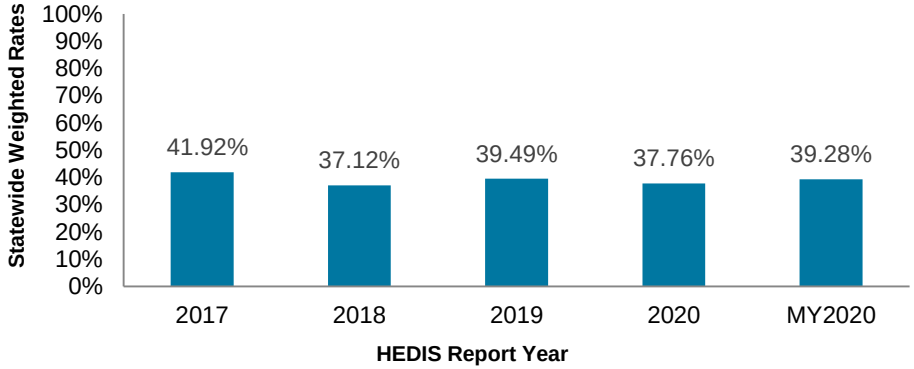
Footnote: Due to changes in measure specification, NCQA indicated trending between MY2020 and previous years should be considered with caution.

Fig. 59. CDC: Retinal Eye Exam Performed



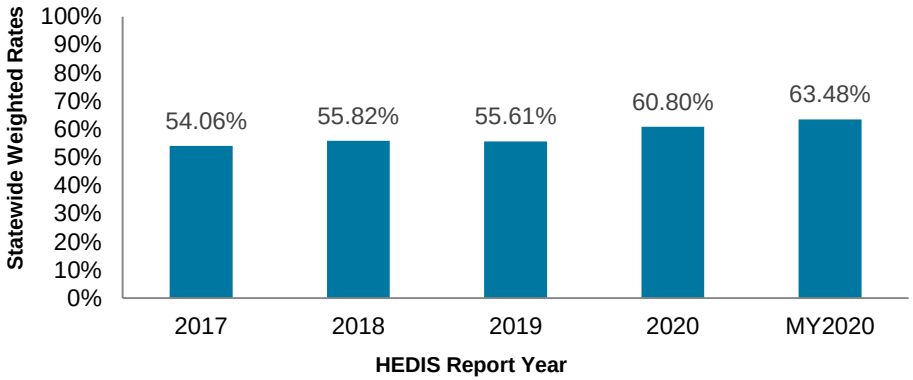
Footnote: Due to changes in measure specification, NCQA indicated trending between MY2020 and previous years should be considered with caution.

Fig. 60. CDC: HbA1c Poor Control (>9.0%)*



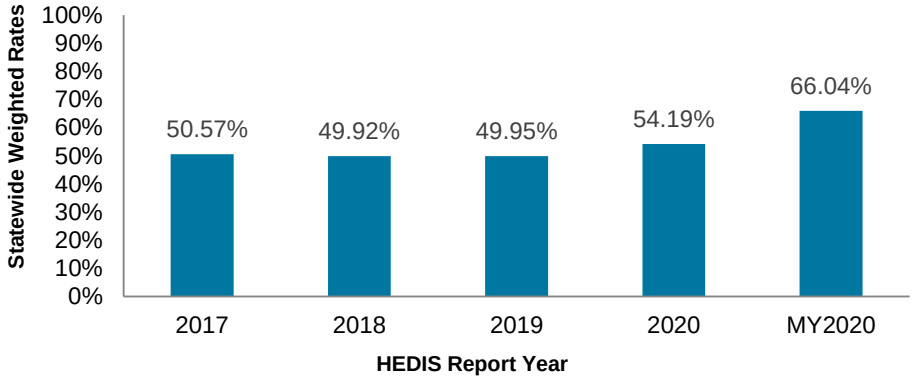
**Lower rates for this measure indicate better performance.*
Footnote: Due to changes in measure specification, NCQA indicated trending between MY2020 and previous years should be considered with caution.

Fig. 61. Statin Therapy for Patients with Diabetes (SPD): Received Statin Therapy



Footnote: Due to changes in measure specification, NCQA indicated trending between MY2020 and previous years should be considered with caution.

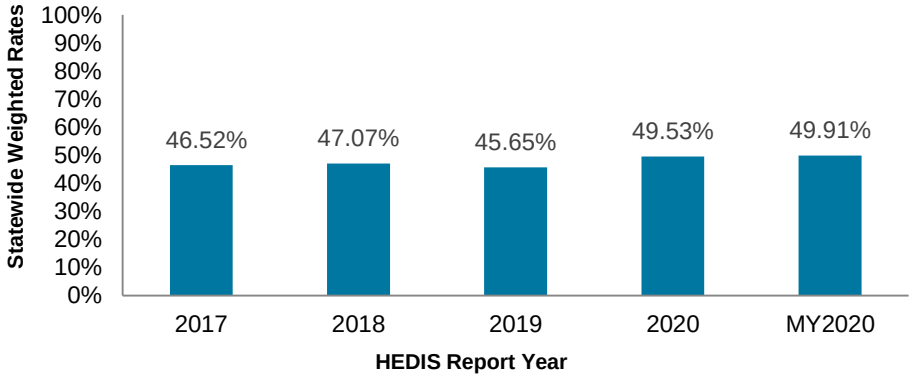
Fig. 62. SPD: Statin Adherence 80%



Footnote: Due to changes in measure specification, NCQA indicated trending between MY2020 and previous years should be considered with caution.

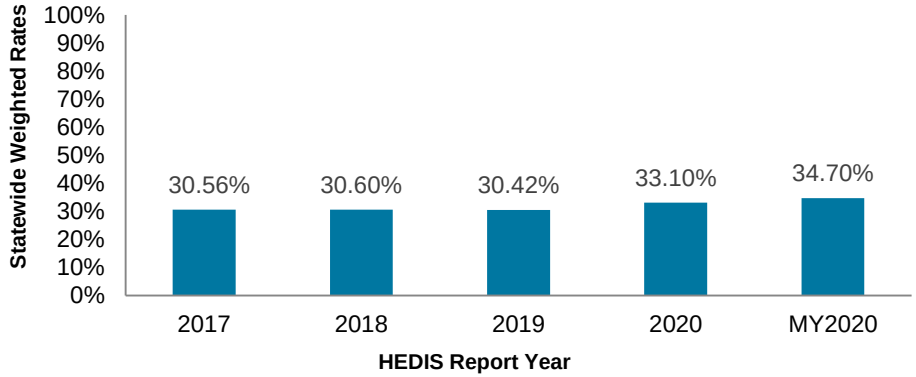
Effectiveness of Care Measures: Behavioral Health

Fig. 63. Antidepressant Medication Management (AMM): Effective Acute Phase Treatment



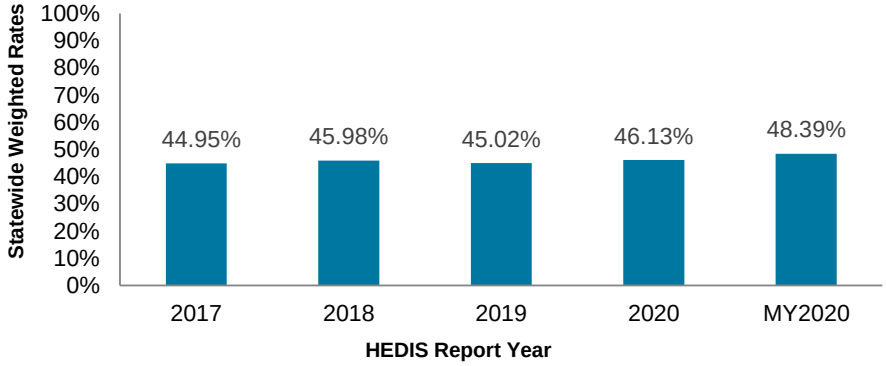
Footnote: Due to changes in measure specification, NCQA indicated trending between HEDIS 2018 and previous years should be considered with caution.

Fig. 64. AMM: Effective Continuation Phase Treatment



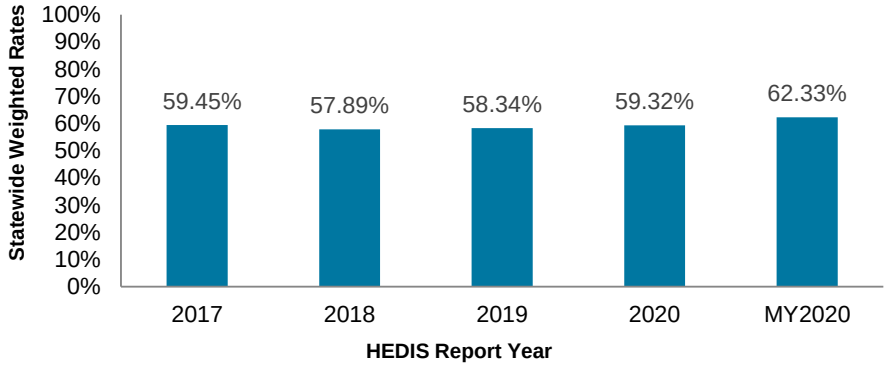
Footnote: Due to changes in measure specification, NCQA indicated trending between HEDIS 2018 and previous years should be considered with caution.

Fig. 65. Follow-Up Care for Children Prescribed ADHD Medication (ADD): Initiation Phase



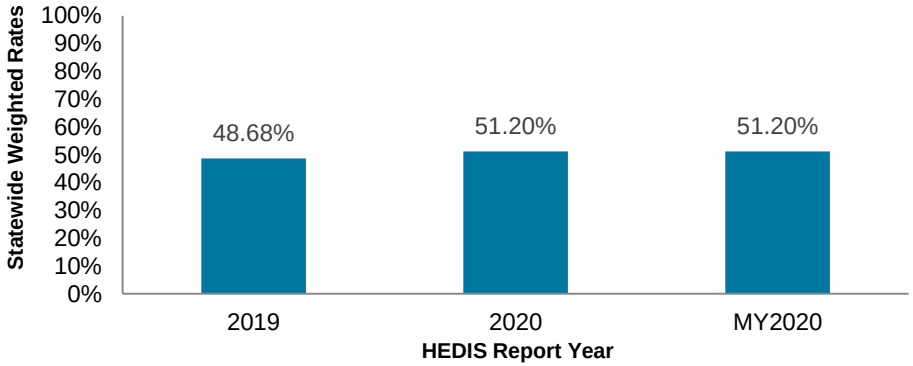
Footnote: Due to changes in measure specification, NCQA indicated trending between MY2020 and previous years should be considered with caution.

Fig. 66. ADD: Continuation and Maintenance Phase



Footnote: Due to changes in measure specification, NCQA indicated trending between MY2020 and previous years should be considered with caution.

Fig. 67. Follow-Up After Hospitalization for Mental Illness (FUH)—7-Day Follow-Up: 6–17 Years



Footnote: Since NCQA added age stratification to this measure for HEDIS 2019, trending with prior years is not possible. NCQA also indicated that trending between MY2020 and previous years should be considered with caution.

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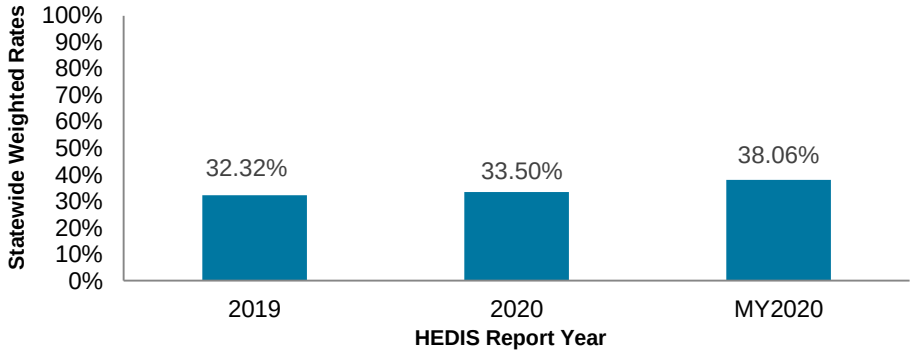
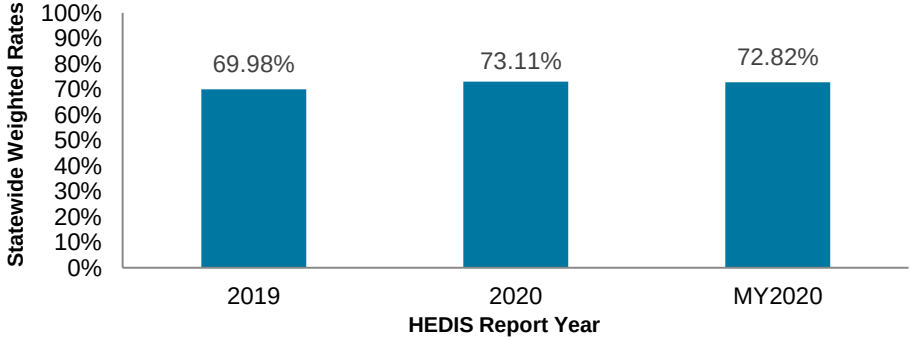
Fig. 68. FUH—7-Day Follow-Up: 18–64 Years



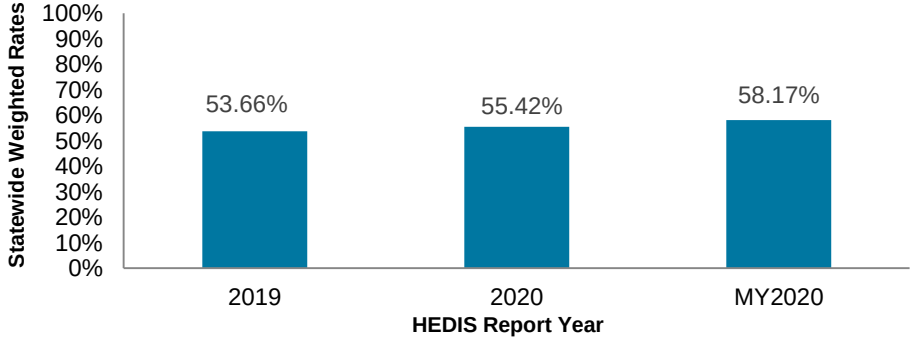
Footnote: Since NCQA added age stratification to this measure for HEDIS 2019, trending with prior years is not possible. NCQA also indicated that trending between MY2020 and previous years should be considered with caution.

Fig. 69. FUH—30-Day Follow-Up: 6–17 Years



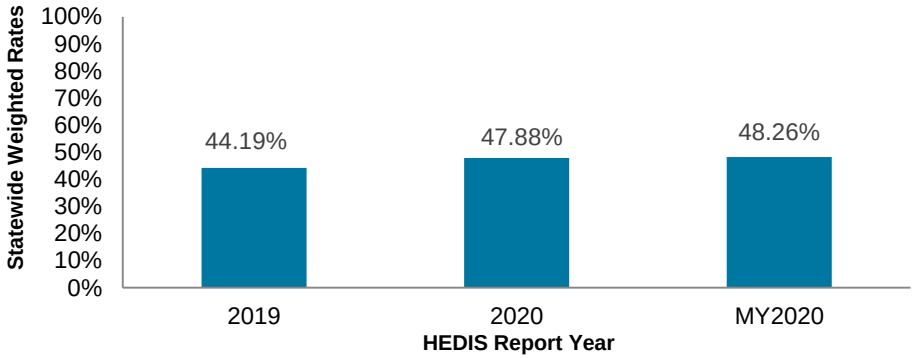
Footnote: Since NCQA added age stratification to this measure for HEDIS 2019, trending with prior years is not possible. NCQA also indicated that trending between MY2020 and previous years should be considered with caution.

Fig. 70. FUH—30-Day Follow-Up: 18–64 Years



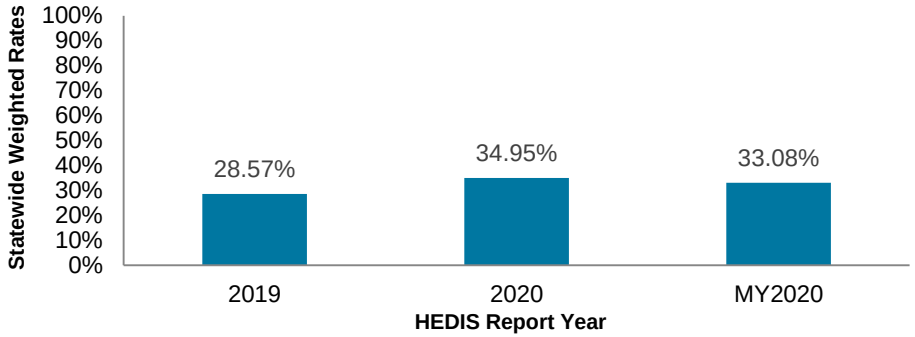
Footnote: Since NCQA added age stratification to this measure for HEDIS 2019, trending with prior years is not possible. NCQA also indicated that trending between MY2020 and previous years should be considered with caution.

Fig. 71. Follow-Up After Emergency Department Visit for Mental Illness (FUM)—7-Day Follow-Up: 6–17 Years



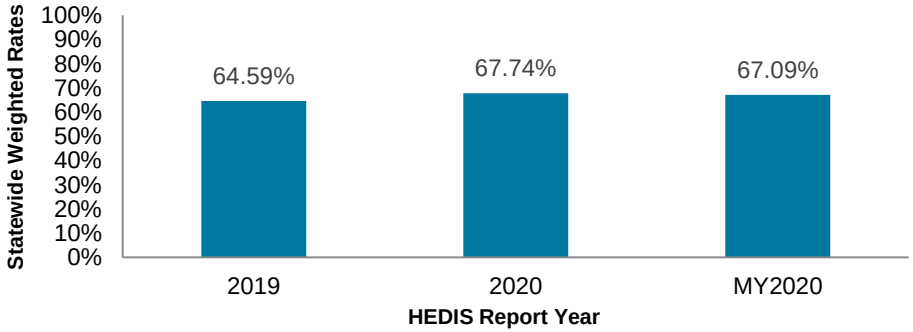
Footnote: Due to significant changes in measure specifications for HEDIS 2019, NCQA indicated a break in trending to prior years. NCQA also indicated that trending between MY2020 and previous years should be considered with caution.

Fig. 72. FUM—7-Day Follow-Up: 18–64 Years



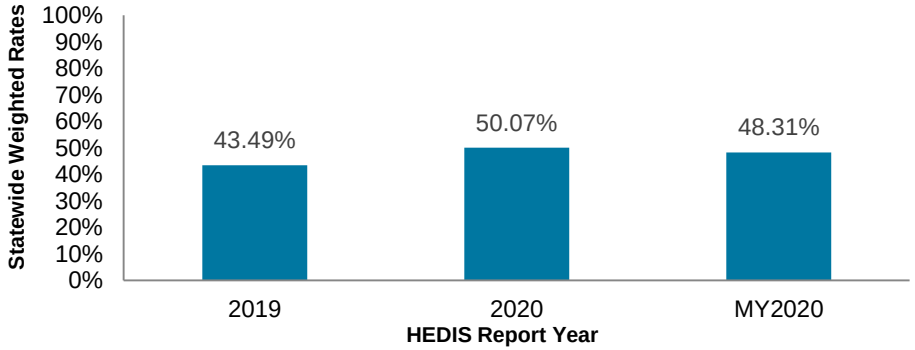
Footnote: Due to significant changes in measure specifications for HEDIS 2019, NCQA indicated a break in trending to prior years. NCQA also indicated that trending between MY2020 and previous years should be considered with caution.

Fig. 73. FUM—30-Day Follow-Up: 6–17 Years



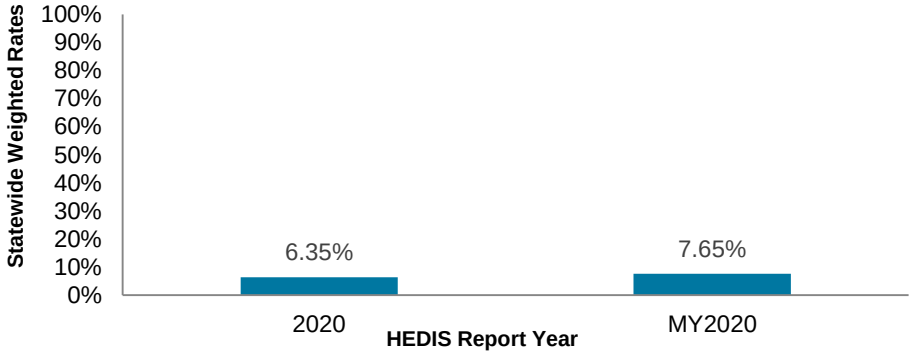
Footnote: Due to significant changes in measure specifications for HEDIS 2019, NCQA indicated a break in trending to prior years. NCQA also indicated that trending between MY2020 and previous years should be considered with caution.

Fig. 74. FUM—30-Day Follow-Up: 18–64 Years



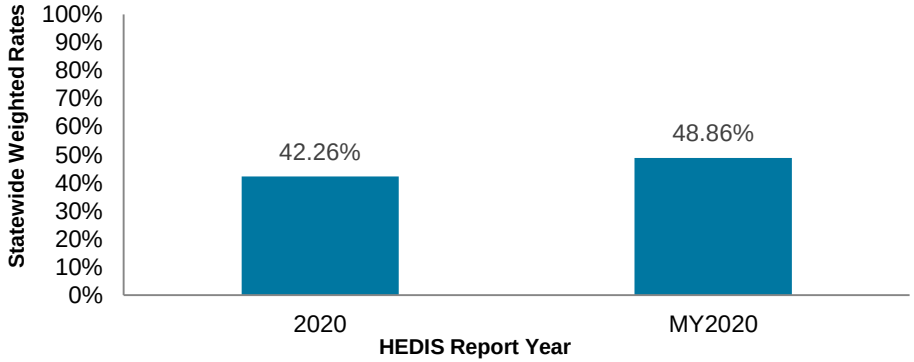
Footnote: Due to significant changes in measure specifications for HEDIS 2019, NCQA indicated a break in trending to prior years. NCQA also indicated that trending between MY2020 and previous years should be considered with caution.

Fig. 75. Follow-Up After High-Intensity Care for Substance Use Disorder (FUI)—7-Day Follow-Up: 13–17 Years



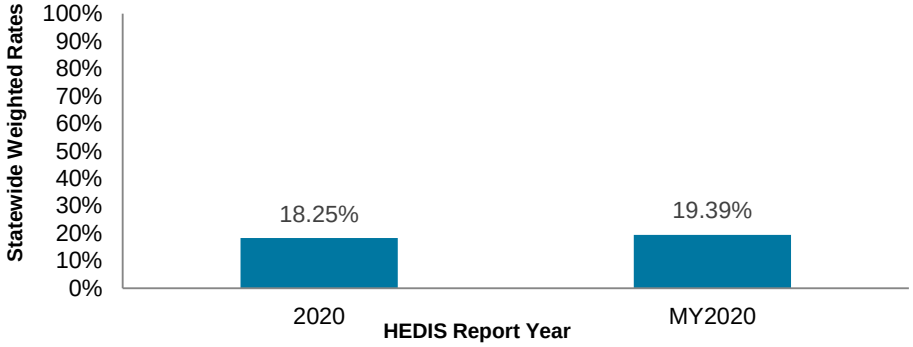
Footnote: First-year measure for HEDIS 2020. Due to changes in measure specification, NCQA indicated trending between MY2020 and previous years should be considered with caution.

Fig. 76. FUI—7-Day Follow-Up: 18–64 Years



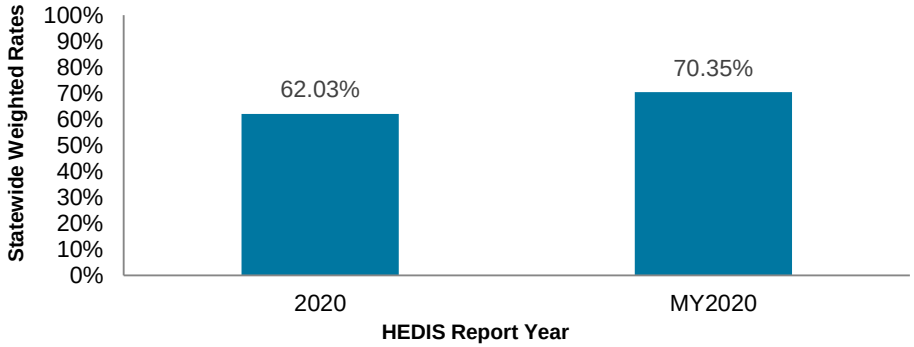
Footnote: First-year measure for HEDIS 2020. Due to changes in measure specification, NCQA indicated trending between MY2020 and previous years should be considered with caution.

Fig. 77. FUI—30-Day Follow-Up: 13–17 Years



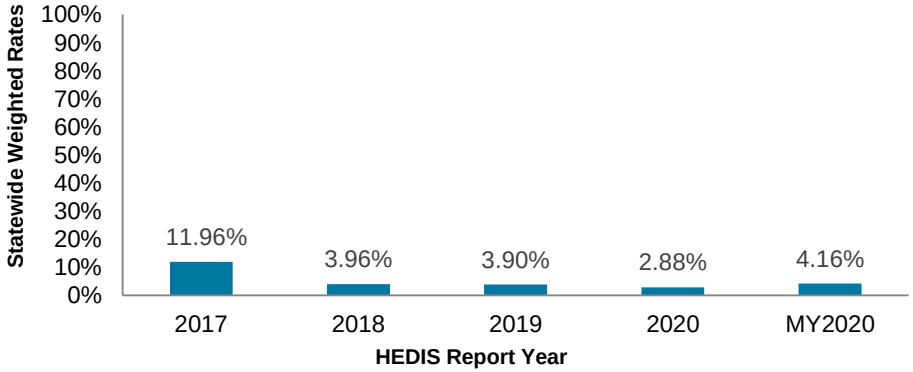
Footnote: First-year measure for HEDIS 2020. Due to changes in measure specification, NCQA indicated trending between MY2020 and previous years should be considered with caution.

Fig. 78. FUI—30-Day Follow-Up: 18–64 Years



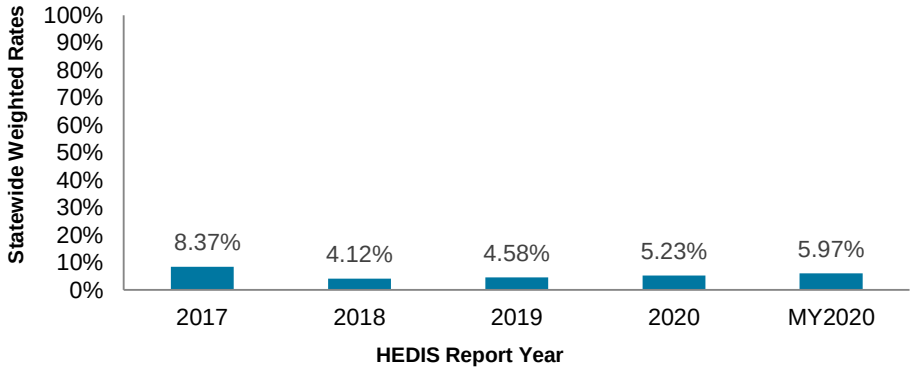
Footnote: First-year measure for HEDIS 2020. Due to changes in measure specification, NCQA indicated trending between MY2020 and previous years should be considered with caution.

Fig. 79. Follow-Up After ED Visit for Alcohol and Other Drug (AOD) Abuse or Dependence (FUA)—7-Day Follow-Up: 13–17 Years



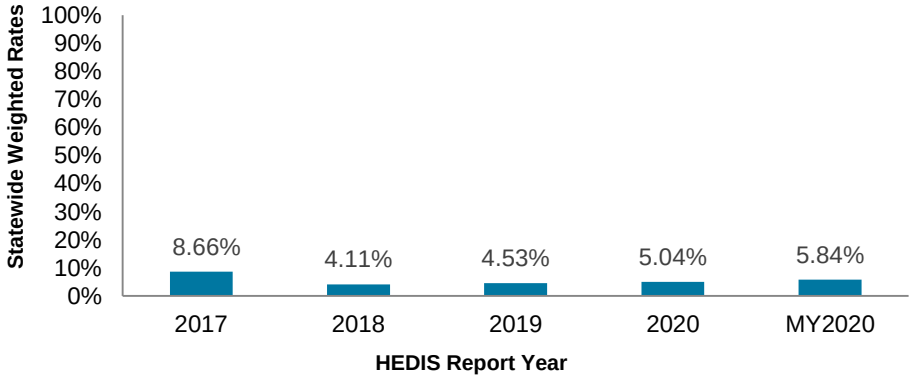
Footnote: Due to changes in measure specification, NCQA indicated trending between MY2020 and previous years should be considered with caution.

Fig. 80. FUA—7-Day Follow-Up: ≥18 Years



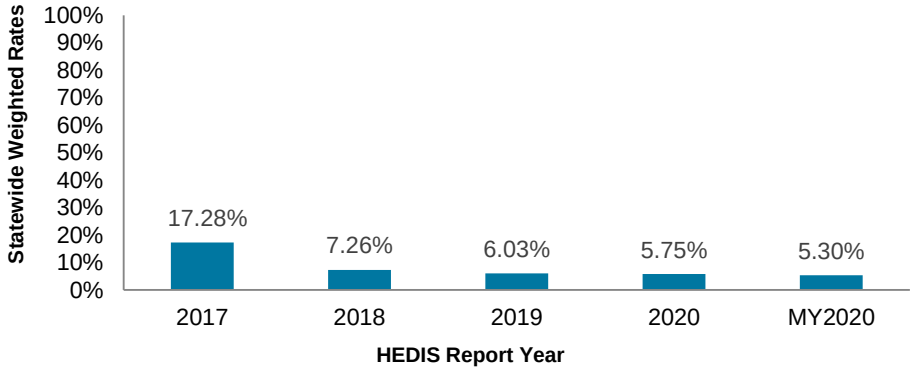
Footnote: Due to changes in measure specification, NCQA indicated trending between MY2020 and previous years should be considered with caution.

Fig. 81. FUA—7-Day Follow-Up: Total



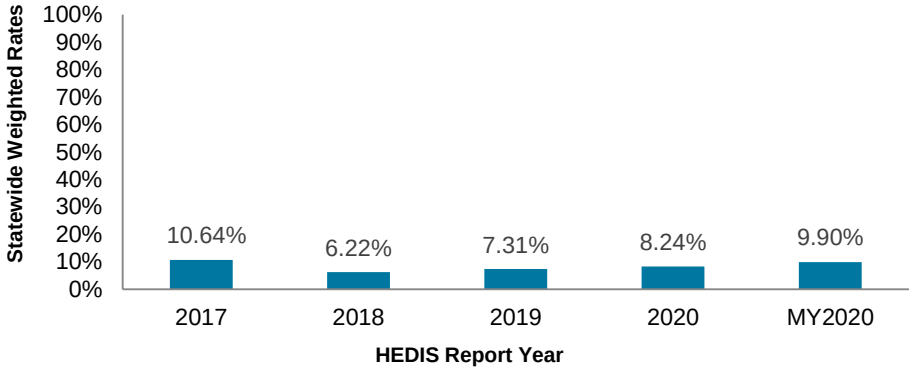
Footnote: Due to changes in measure specification, NCQA indicated trending between MY2020 and previous years should be considered with caution.

Fig. 82. FUA—30-Day Follow-Up: 13–17 Years



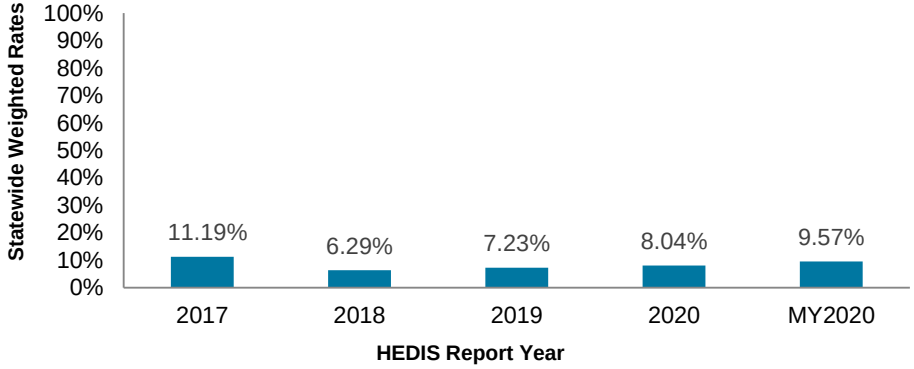
Footnote: Due to changes in measure specification, NCQA indicated trending between MY2020 and previous years should be considered with caution.

Fig. 83. FUA—30-Day Follow-Up: ≥18 Years



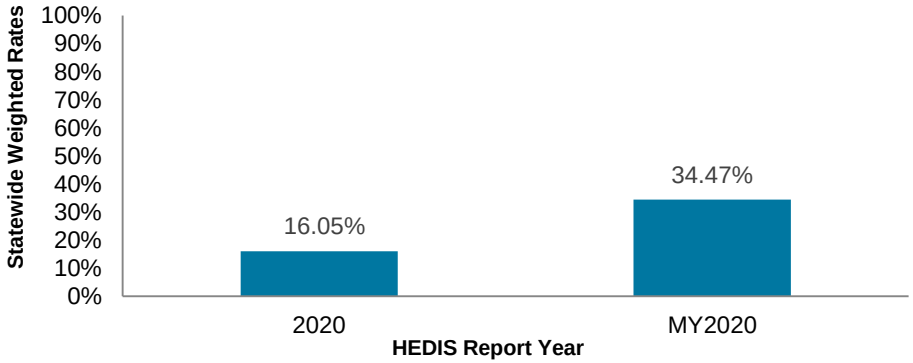
Footnote: Due to changes in measure specification, NCQA indicated trending between MY2020 and previous years should be considered with caution.

Fig. 84. FUA—30-Day Follow-Up: Total



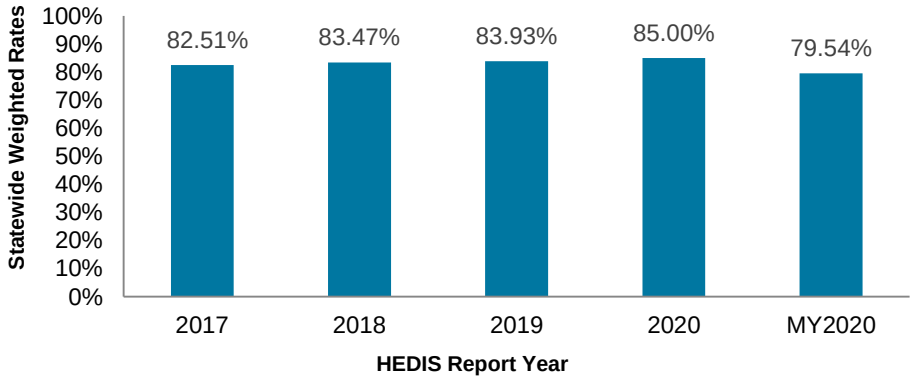
Footnote: Due to changes in measure specification, NCQA indicated trending between MY2020 and previous years should be considered with caution.

Fig. 85. Pharmacotherapy for Opioid Use Disorder (POD)



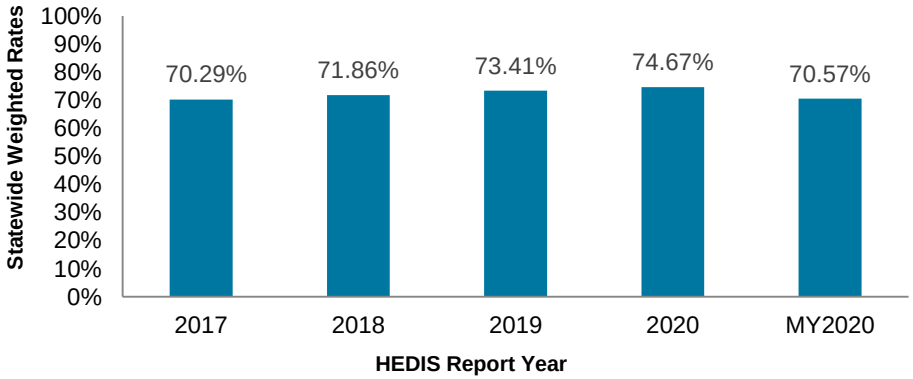
Footnote: First-year measure for HEDIS 2020. Due to changes in measure specification, NCQA indicated trending between MY2020 and previous years should be considered with caution.

Fig. 86. Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication (SSD)



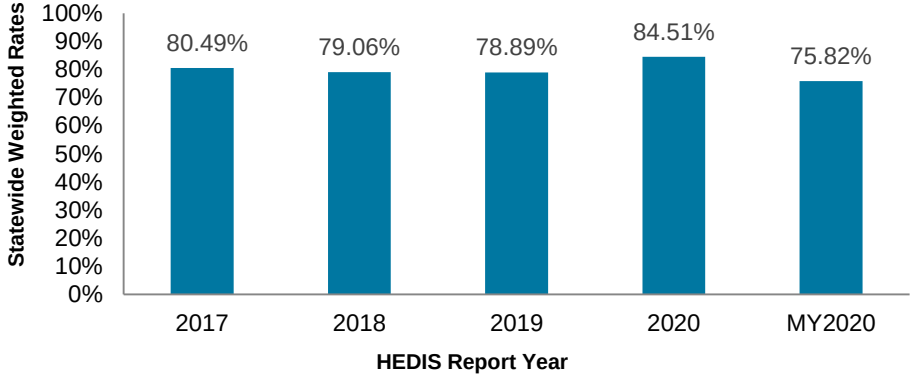
Footnote: Due to changes in measure specification, NCQA indicated trending between HEDIS 2019 and previous years should be considered with caution.

Fig. 87. Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD)



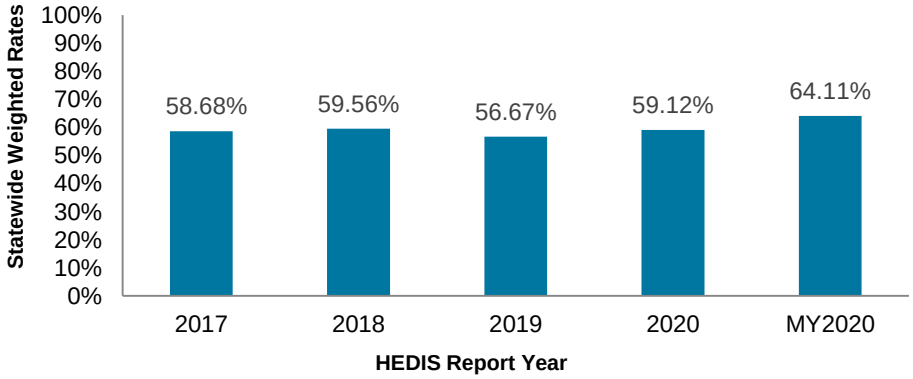
Footnote: Due to changes in measure specification, NCQA indicated trending between HEDIS 2019 and previous years should be considered with caution.

Fig. 88. Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (SMC)



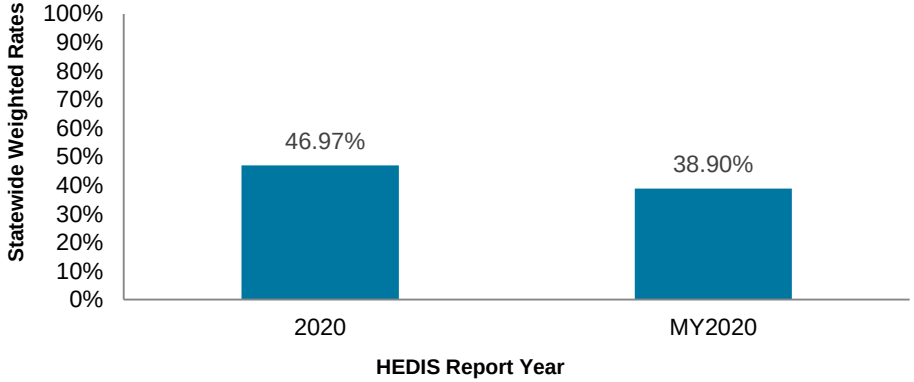
Footnote: Due to changes in measure specification, NCQA indicated trending between HEDIS 2019 and previous years should be considered with caution.

Fig. 89. Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)



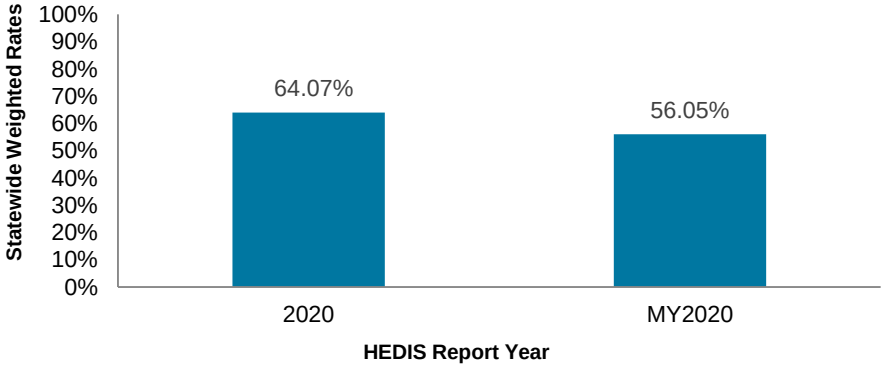
Footnote: Due to changes in measure specification, NCQA indicated trending between HEDIS 2019 and previous years should be considered with caution.

Fig. 90. Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)—Blood Glucose Testing: 1–11 Years



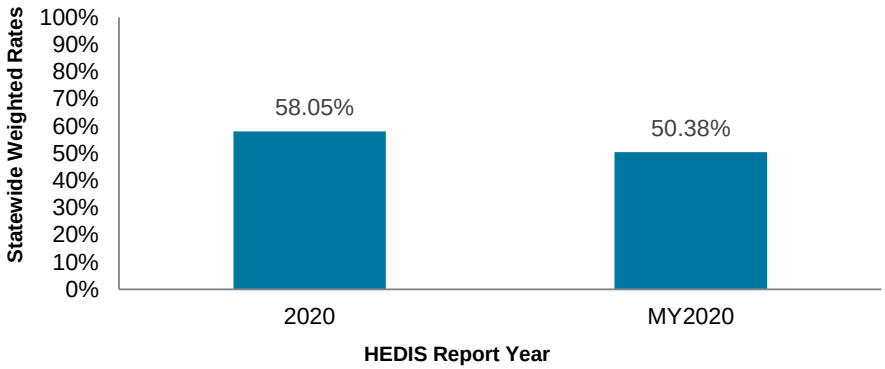
Footnote: Since age stratifications/measure indicators were changed for this measure for HEDIS 2020, trending with prior years is not possible.

Fig. 91. APM—Blood Glucose Testing: 12–17 Years



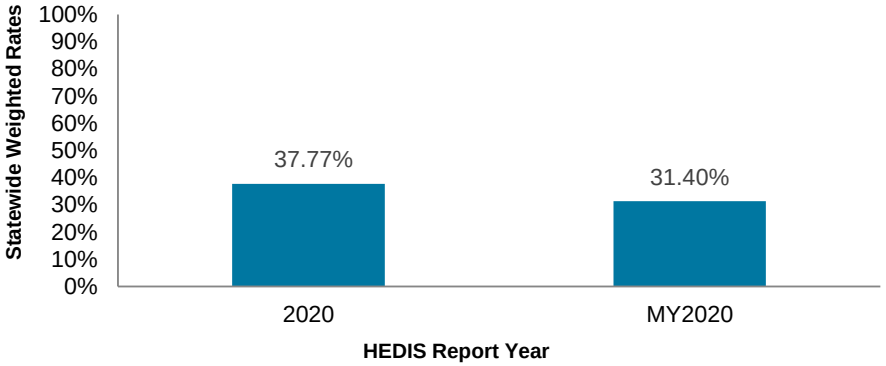
Footnote: Since age stratifications/measure indicators were changed for this measure for HEDIS 2020, trending with prior years is not possible.

Fig. 92. APM—Blood Glucose Testing: Total



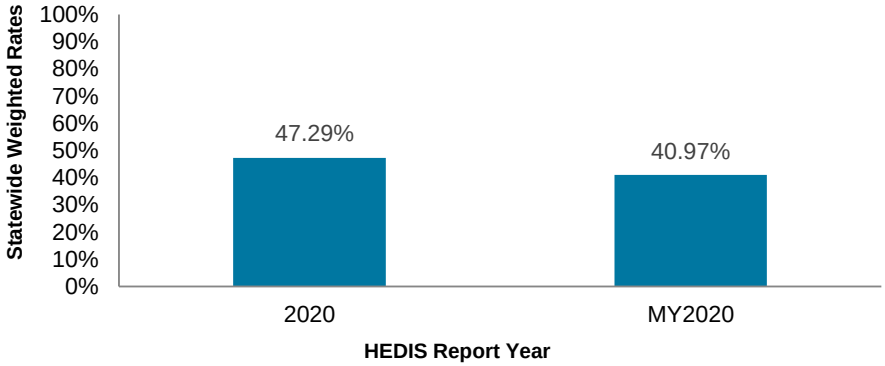
Footnote: Since age stratifications/measure indicators were changed for this measure for HEDIS 2020, trending with prior years is not possible.

Fig. 93. APM—Cholesterol Testing: 1-11 Years



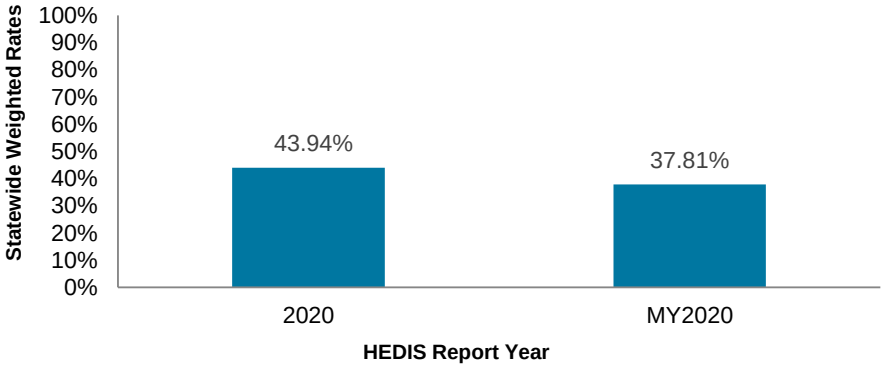
Footnote: Since age stratifications/measure indicators were changed for this measure for HEDIS 2020, trending with prior years is not possible.

Fig. 94. APM—Cholesterol Testing: 12-17 Years



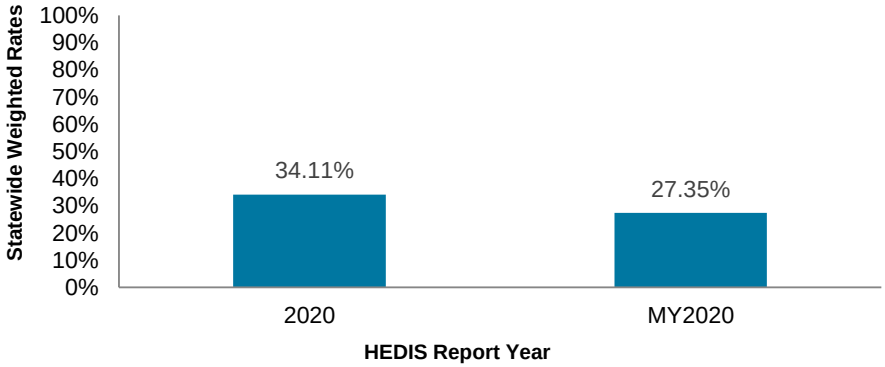
Footnote: Since age stratifications/measure indicators were changed for this measure for HEDIS 2020, trending with prior years is not possible.

Fig. 95. APM—Cholesterol Testing: Total



Footnote: Since age stratifications/measure indicators were changed for this measure for HEDIS 2020, trending with prior years is not possible.

Fig. 96. APM—Blood Glucose and Cholesterol Testing: 1-11 Years



Footnote: Since age stratifications/measure indicators were changed for this measure for HEDIS 2020, trending with prior years is not possible.

Fig. 97. APM—Blood Glucose and Cholesterol Testing: 12-17 Years

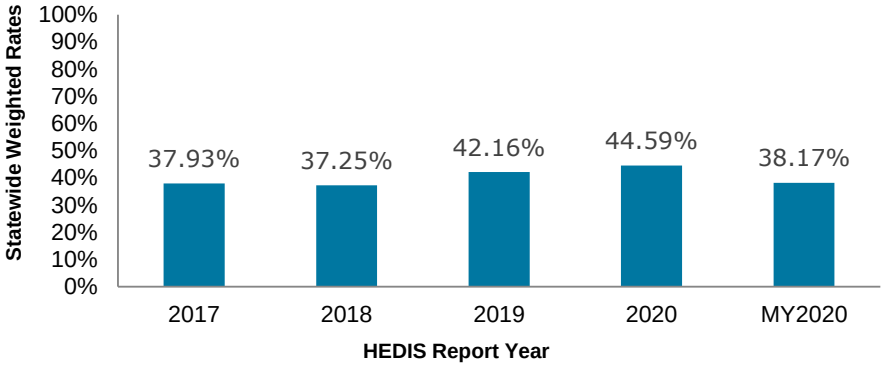
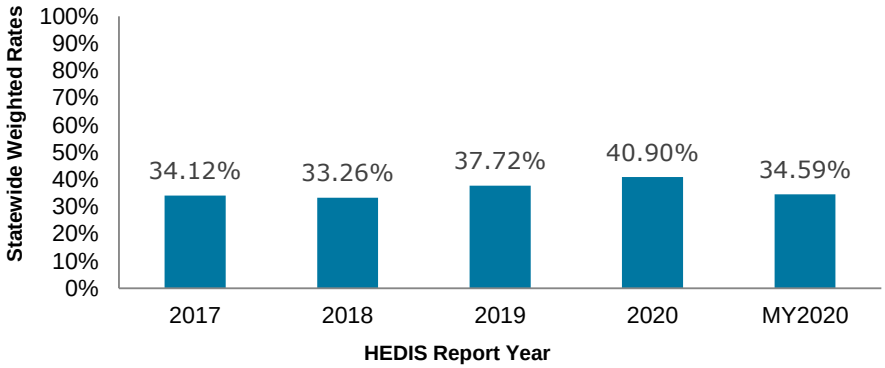
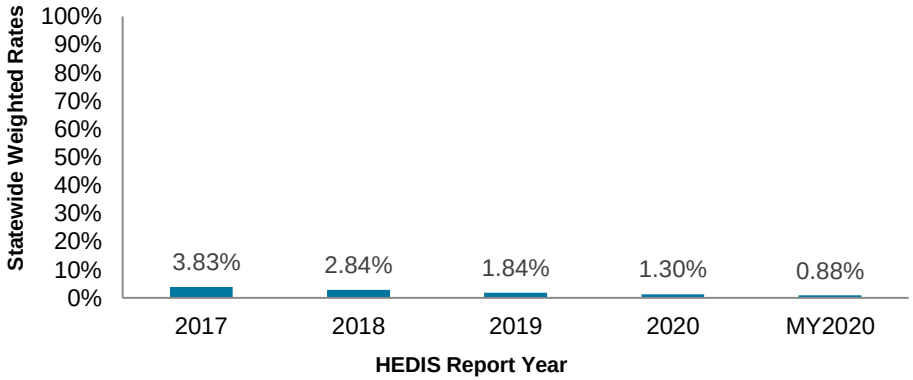


Fig. 98. APM: Blood Glucose and Cholesterol Testing: Total



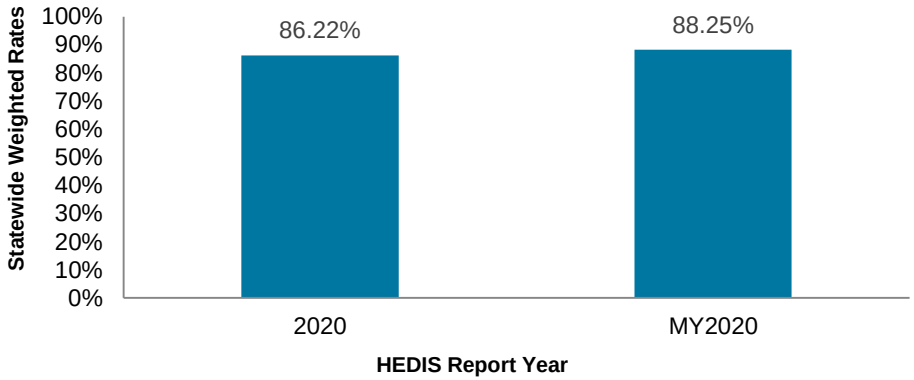
Effectiveness of Care Measures: Overuse/Appropriateness

Fig. 99. Non-Recommended Cervical Cancer Screening in Adolescent Females (NCS)*



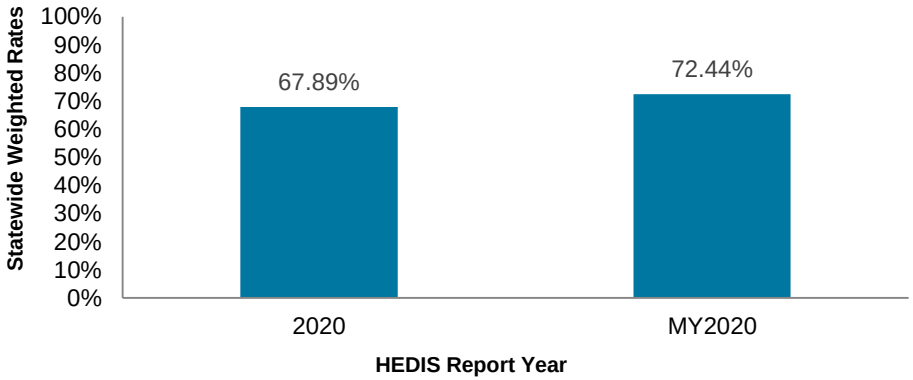
**Lower rates for this measure indicate better performance*.

Fig. 100. Appropriate Treatment for Upper Respiratory Infection (URI): 3 Months–17 Years



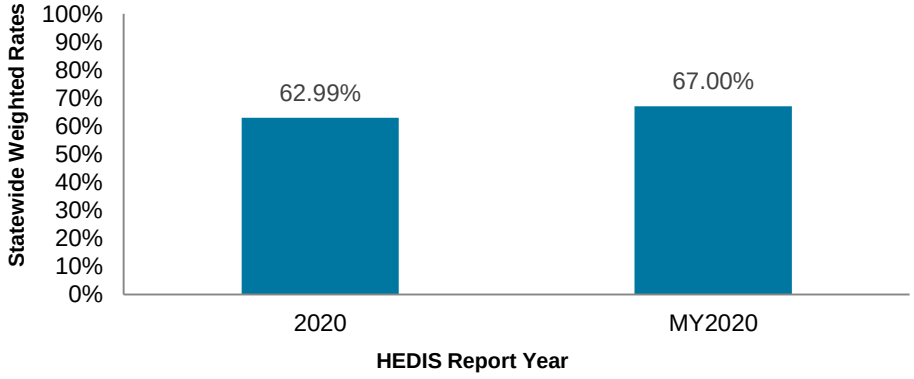
Footnote: Due to significant changes in measure specification for HEDIS 2020, NCQA indicated a break in trending to prior years.

Fig. 101. URI: 18–64 Years



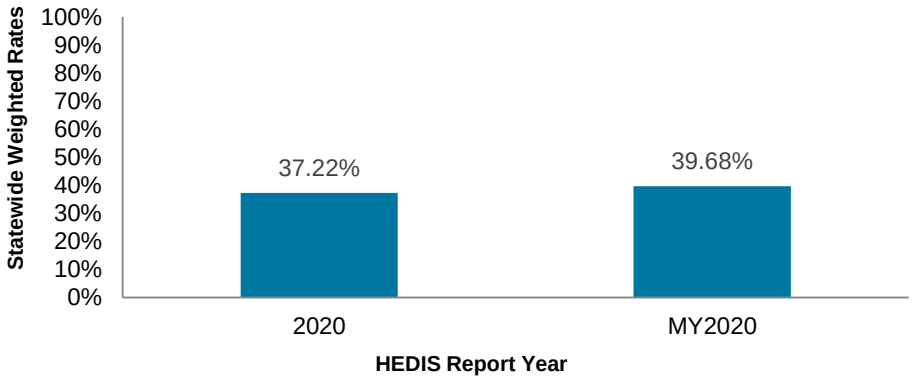
Footnote: Due to significant changes in measure specification for HEDIS 2020, NCQA indicated a break in trending to prior years.

Fig. 102. Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB): 3 Months–17 Years



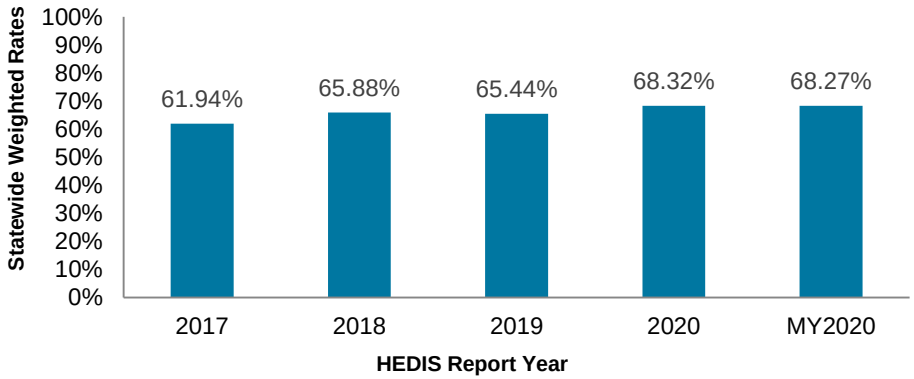
Footnote: Due to significant changes in measure specification for HEDIS 2020, NCQA indicated a break in trending to prior years.

Fig. 103. AAB: 18–64 Years



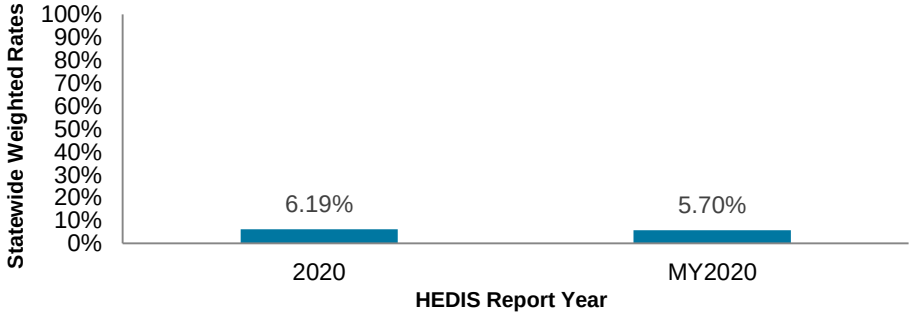
Footnote: Due to significant changes in measure specification for HEDIS 2020, NCQA indicated a break in trending to prior years.

Fig. 104. Use of Imaging Studies for Low Back Pain (LBP)



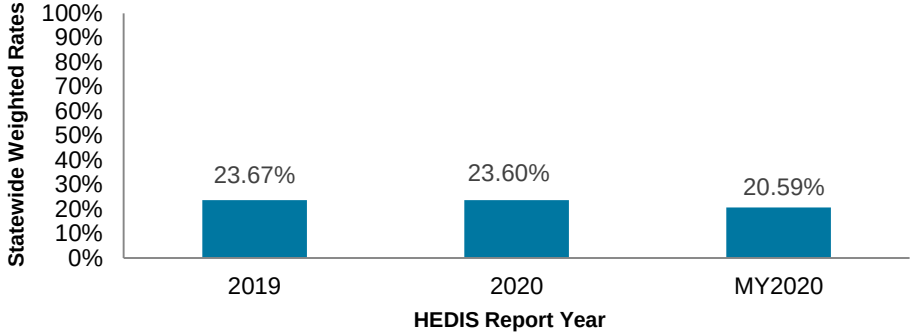
Footnote: Due to changes in measure specification, NCQA indicated trending between HEDIS 2018 and previous years should be considered with caution.

Fig. 105. Use of Opioids at High Dosage (HDO)*



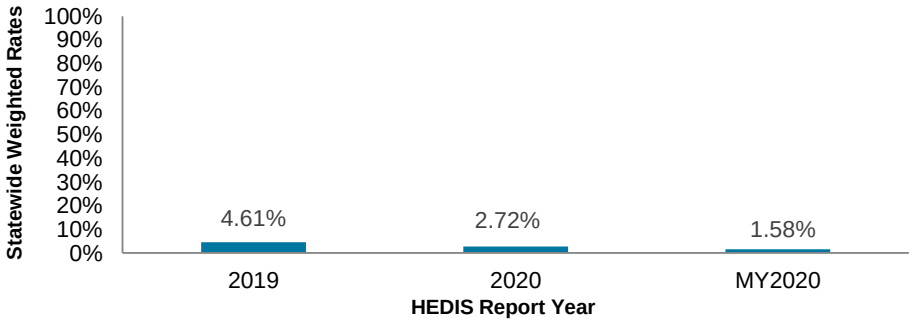
**Lower rates for this measure indicate better performance.*
Footnote: Due to significant changes in measure specification for HEDIS 2020, NCQA indicated a break in trending to prior years. NCQA also indicated trending between MY2020 and previous years should be considered with caution.

Fig. 106. Use of Opioids from Multiple Providers (UOP): Multiple Prescribers*



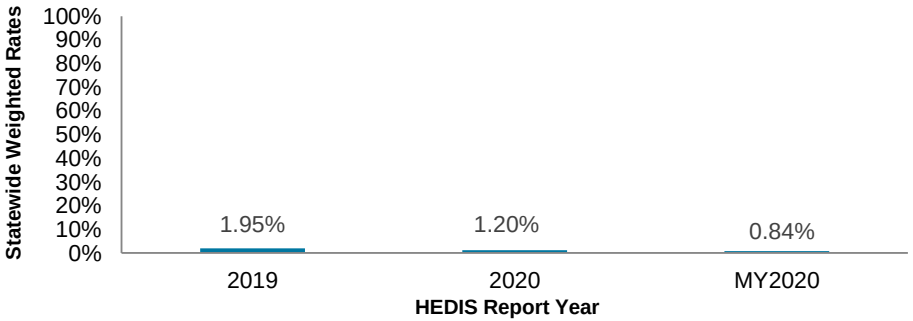
**Lower rates for this measure indicate better performance.*
Footnote: NCQA indicated a break in trending for HEDIS 2019 due to measure results being displayed as a percentage. Due to changes in measure specification, NCQA indicated trending between MY2020 and previous years should be considered with caution.

Fig. 107. UOP: Multiple Pharmacies*



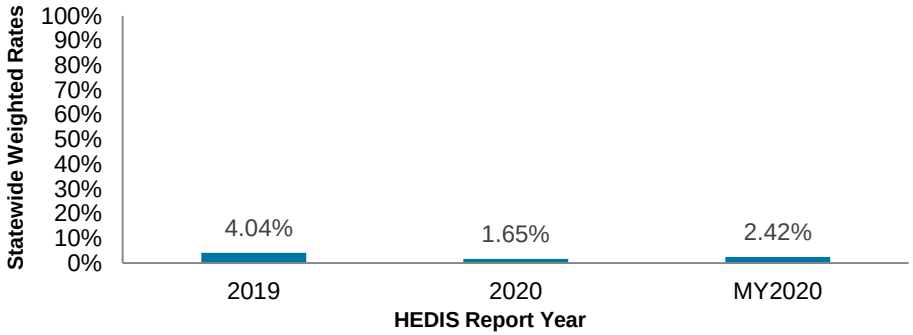
**Lower rates for this measure indicate better performance.*
Footnote: NCQA indicated a break in trending for HEDIS 2019 due to measure results being displayed as a percentage. Due to changes in measure specification, NCQA indicated trending between MY2020 and previous years should be considered with caution.

Fig. 108. UOP: Multiple Prescribers and Pharmacies*



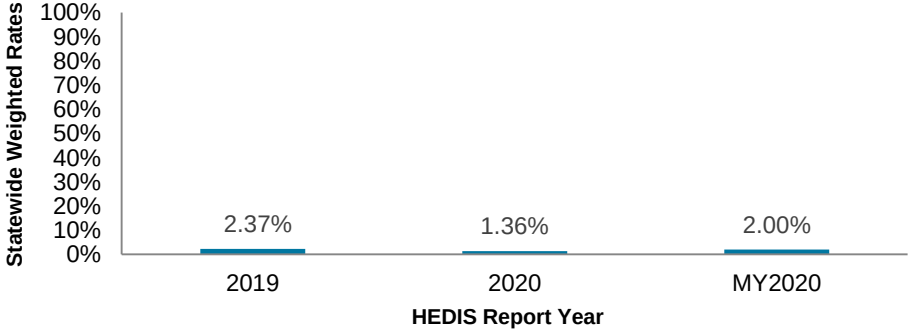
**Lower rates for this measure indicate better performance.*
Footnote: NCQA indicated a break in trending for HEDIS 2019 due to measure results being displayed as a percentage. Due to changes in measure specification, NCQA indicated trending between MY2020 and previous years should be considered with caution.

Fig. 109. Risk of Continued Opioid Use (COU): ≥15 days/30-day period*



**Lower rates for this measure indicate better performance.*
Footnote: First-year measure for HEDIS 2019. Due to changes in measure specification, NCQA indicated trending between MY2020 and previous years should be considered with caution.

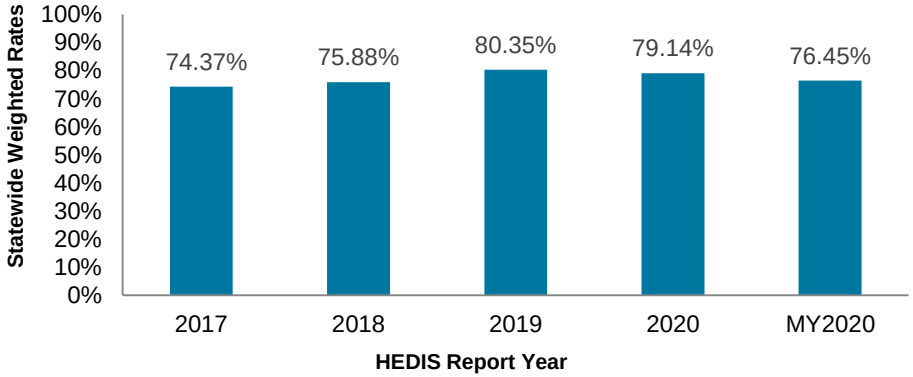
Fig. 110. COU: ≥ 31 days/62-day period*



**Lower rates for this measure indicate better performance.*
Footnote: First-year measure for HEDIS 2019. Due to changes in measure specification, NCQA indicated trending between MY2020 and previous years should be considered with caution.

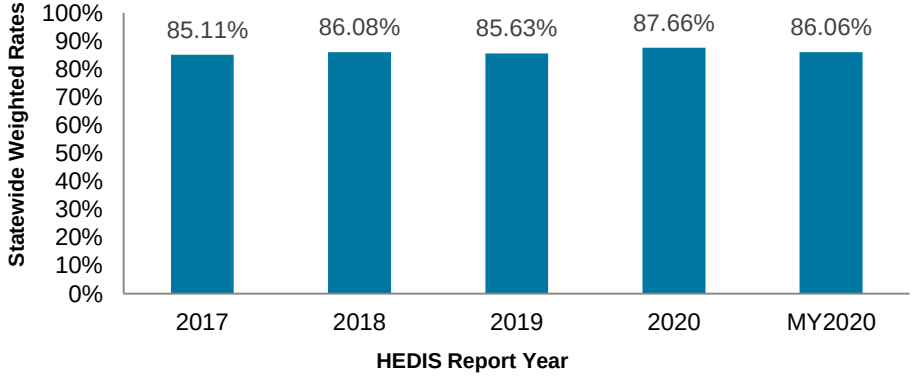
Access/Availability of Care Measures

Fig. 111. Adults' Access to Preventive/Ambulatory Health Services (AAP): 20–44 Years



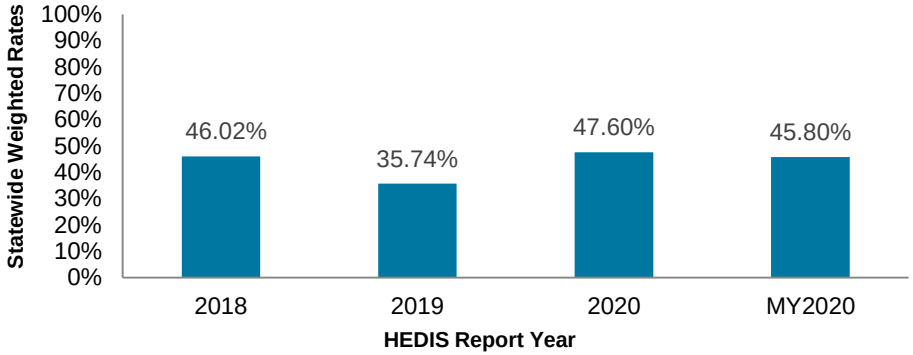
Footnote: Due to changes in measure specification, NCQA indicated trending between HEDIS 2019 and previous years should be considered with caution.

Fig. 112. AAP: 45–64 Years



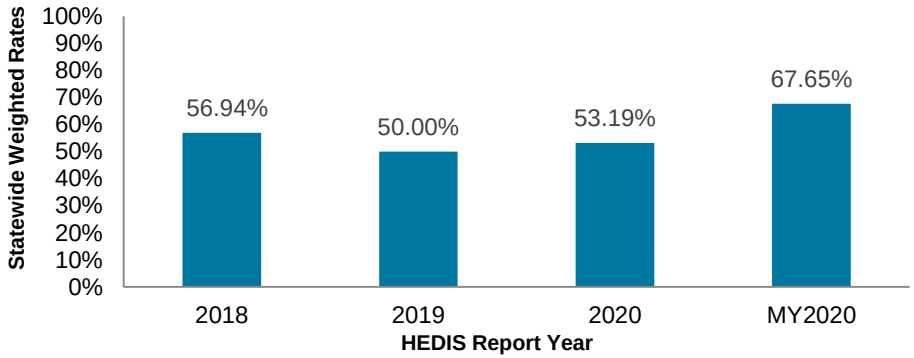
Footnote: Due to changes in measure specification, NCQA indicated trending between HEDIS 2019 and previous years should be considered with caution.

Fig. 113. Initiation and Engagement of Alcohol and Other Drug (AOD) Dependence Treatment (IET)—Initiation: 13–17 Years: Alcohol



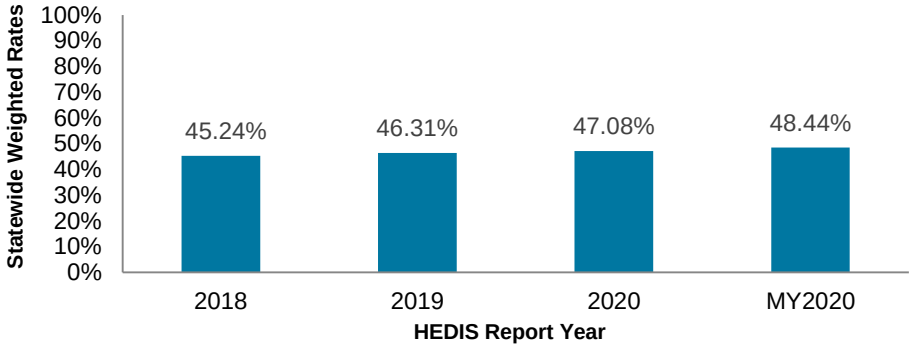
Footnote: Since cohorts and other specifications were added to this measure for HEDIS 2018, trending with prior years is not possible. Due to changes in measure specification, NCQA indicated trending between MY2020 and previous years should be considered with caution.

Fig. 114. IET—Initiation: 13–17 Years: Opioid



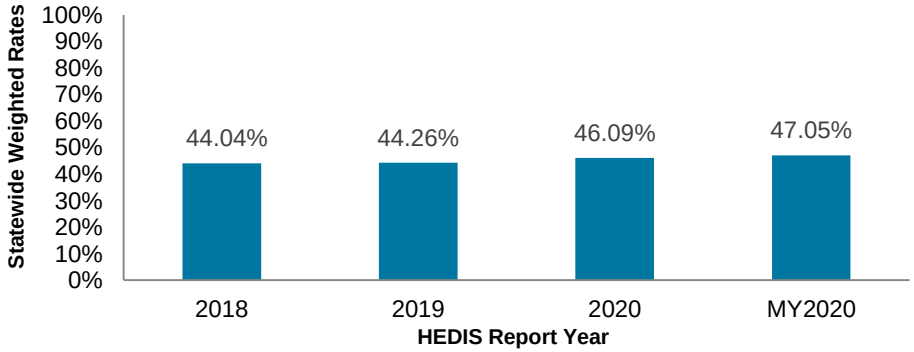
Footnote: Since cohorts and other specifications were added to this measure for HEDIS 2018, trending with prior years is not possible. Due to changes in measure specification, NCQA indicated trending between MY2020 and previous years should be considered with caution.

Fig. 115. IET—Initiation: 13–17 Years: Other Drug



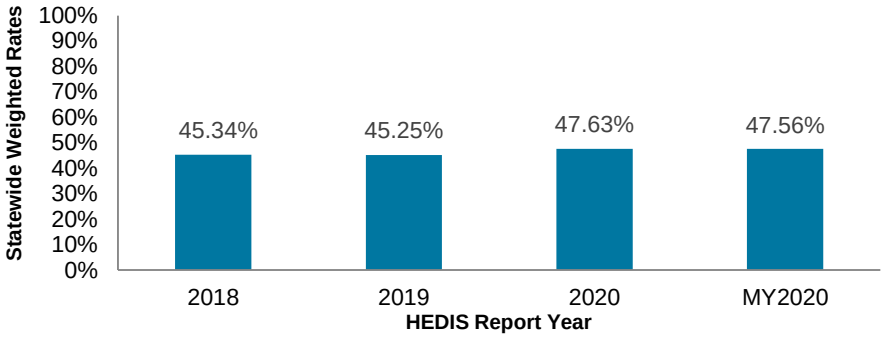
Footnote: Since cohorts and other specifications were added to this measure for HEDIS 2018, trending with prior years is not possible. Due to changes in measure specification, NCQA indicated trending between MY2020 and previous years should be considered with caution.

Fig. 116. IET—Initiation: 13–17 Years: Total



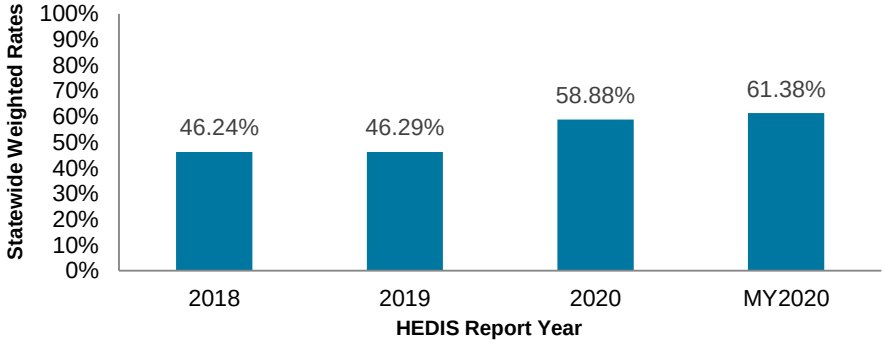
Footnote: Since cohorts and other specifications were added to this measure for HEDIS 2018, trending with prior years is not possible. Due to changes in measure specification, NCQA indicated trending between MY2020 and previous years should be considered with caution.

Fig. 117. IET—Initiation: ≥18 Years: Alcohol



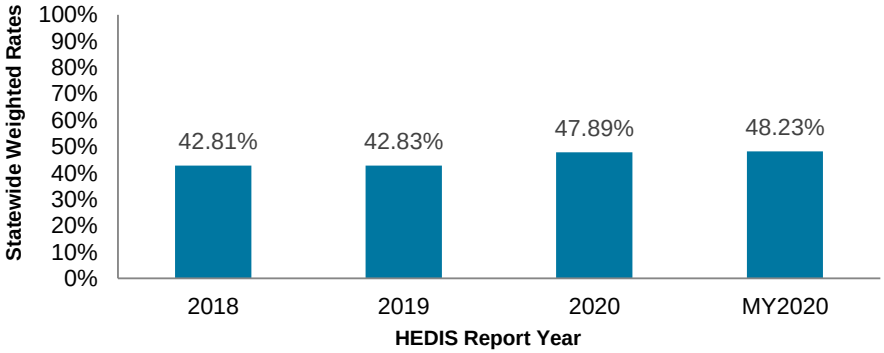
Footnote: Since cohorts and other specifications were added to this measure for HEDIS 2018, trending with prior years is not possible. Due to changes in measure specification, NCQA indicated trending between MY2020 and previous years should be considered with caution.

Fig. 118. IET—Initiation: ≥18 Years: Opioid



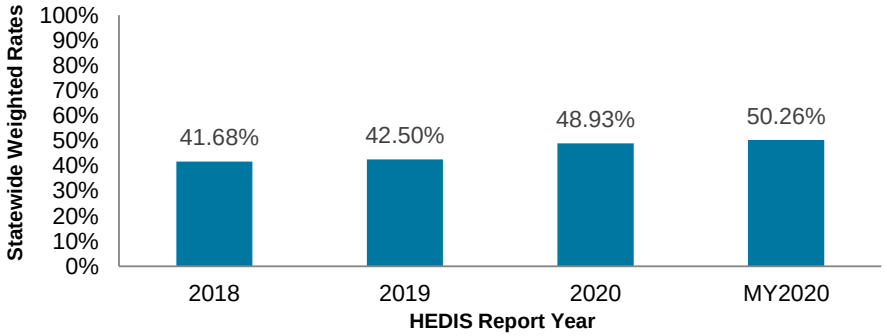
Footnote: Since cohorts and other specifications were added to this measure for HEDIS 2018, trending with prior years is not possible. Due to changes in measure specification, NCQA indicated trending between MY2020 and previous years should be considered with caution.

Fig. 119. IET—Initiation: ≥18 Years: Other Drug



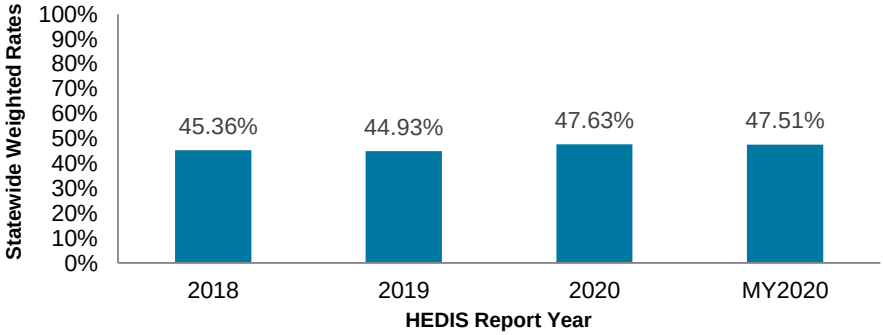
Footnote: Since cohorts and other specifications were added to this measure for HEDIS 2018, trending with prior years is not possible. Due to changes in measure specification, NCQA indicated trending between MY2020 and previous years should be considered with caution.

Fig. 120. IET—Initiation: ≥18 Years Total



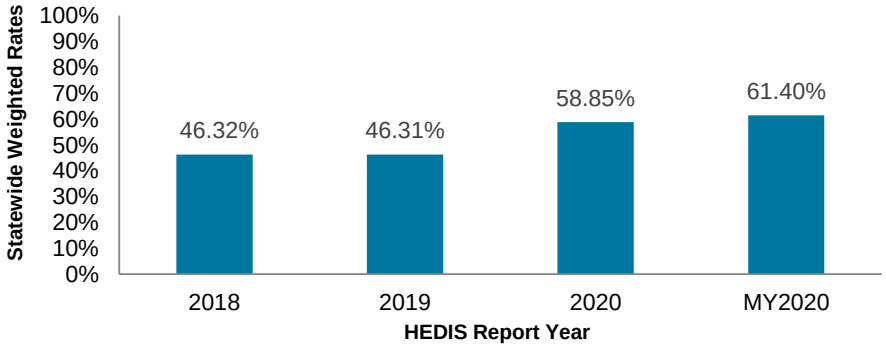
Footnote: Since cohorts and other specifications were added to this measure for HEDIS 2018, trending with prior years is not possible. Due to changes in measure specification, NCQA indicated trending between MY2020 and previous years should be considered with caution.

Fig. 121. IET—Initiation: Total: Alcohol



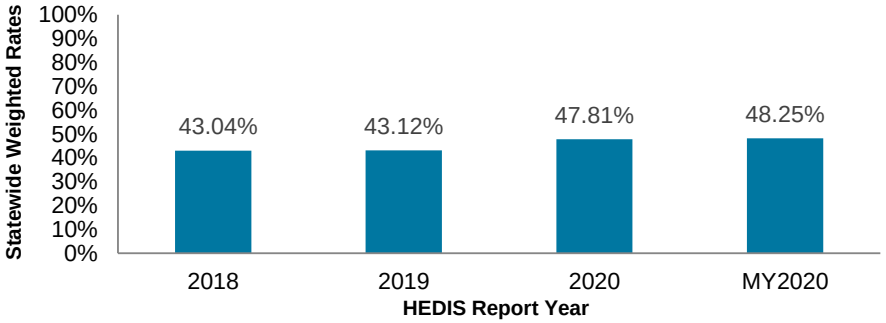
Footnote: Since cohorts and other specifications were added to this measure for HEDIS 2018, trending with prior years is not possible. Due to changes in measure specification, NCQA indicated trending between MY2020 and previous years should be considered with caution.

Fig. 122. IET—Initiation: Total: Opioid



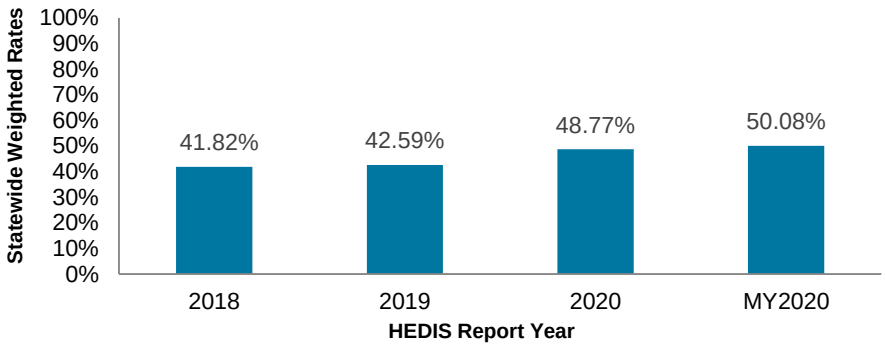
Footnote: Since cohorts and other specifications were added to this measure for HEDIS 2018, trending with prior years is not possible. Due to changes in measure specification, NCQA indicated trending between MY2020 and previous years should be considered with caution.

Fig. 123. IET—Initiation: Total: Other Drug



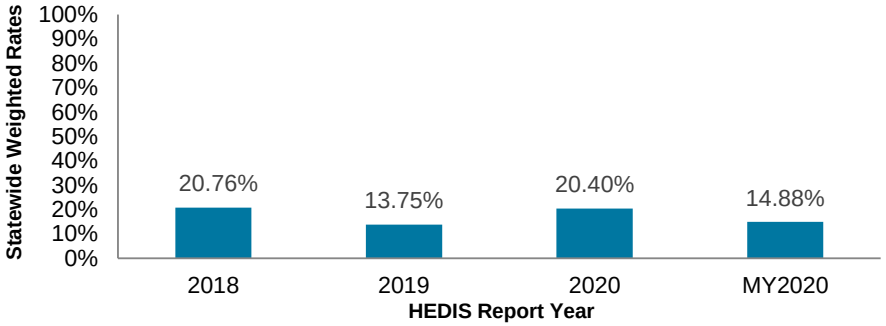
Footnote: Since cohorts and other specifications were added to this measure for HEDIS 2018, trending with prior years is not possible. Due to changes in measure specification, NCQA indicated trending between MY2020 and previous years should be considered with caution.

Fig. 124. IET—Initiation: Total



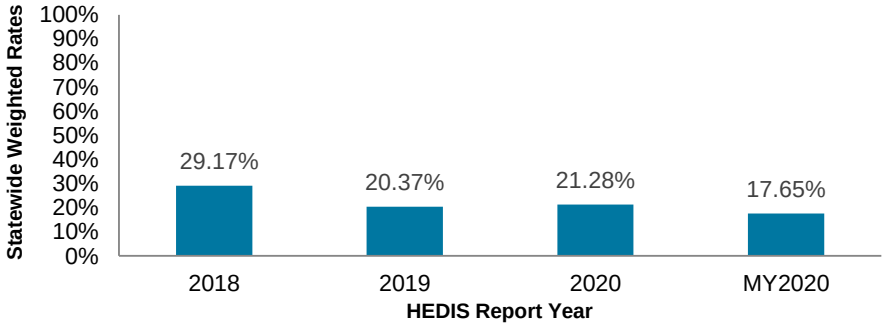
Footnote: Since cohorts and other specifications were added to this measure for HEDIS 2018, trending with prior years is not possible. Due to changes in measure specification, NCQA indicated trending between MY2020 and previous years should be considered with caution.

Fig. 125. IET—Engagement: 13–17 Years: Alcohol



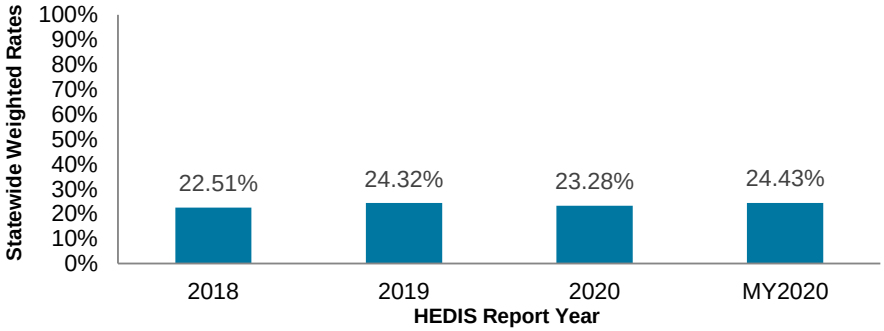
Footnote: Since cohorts and other specifications were added to this measure for HEDIS 2018, trending with prior years is not possible. Due to changes in measure specification, NCQA indicated trending between MY2020 and previous years should be considered with caution.

Fig. 126. IET—Engagement: 13–17 Years: Opioid



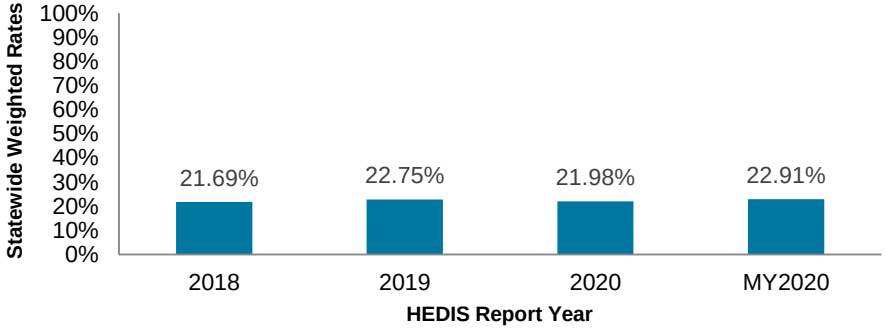
Footnote: Since cohorts and other specifications were added to this measure for HEDIS 2018, trending with prior years is not possible. Due to changes in measure specification, NCQA indicated trending between MY2020 and previous years should be considered with caution.

Fig. 127. IET—Engagement: 13–17 Years: Other Drug



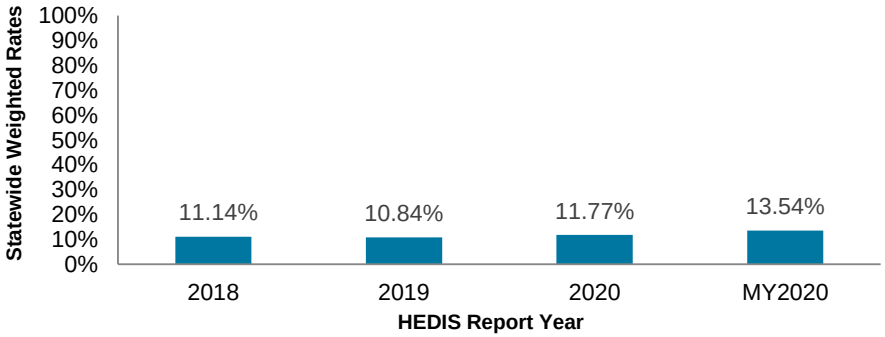
Footnote: Since cohorts and other specifications were added to this measure for HEDIS 2018, trending with prior years is not possible. Due to changes in measure specification, NCQA indicated trending between MY2020 and previous years should be considered with caution.

Fig. 128. IET—Engagement: 13–17 Years: Total



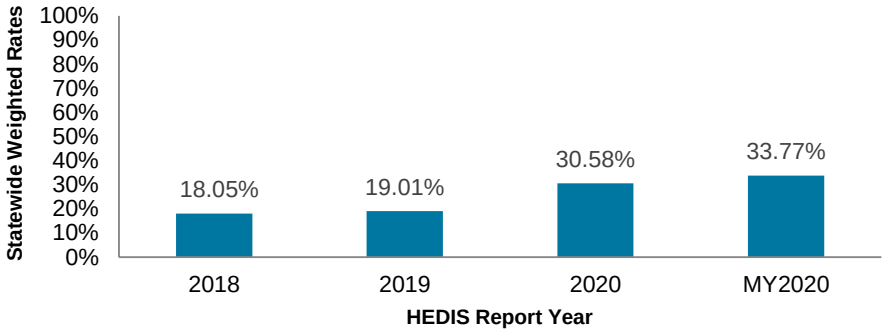
Footnote: Since cohorts and other specifications were added to this measure for HEDIS 2018, trending with prior years is not possible. Due to changes in measure specification, NCQA indicated trending between MY2020 and previous years should be considered with caution.

Fig. 129. IET—Engagement: ≥18 Years: Alcohol



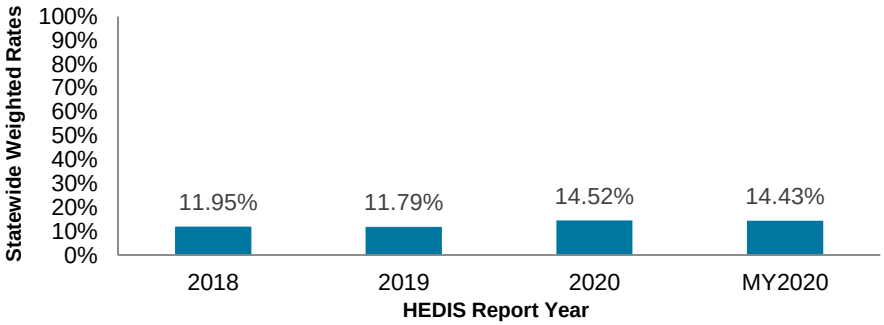
Footnote: Since cohorts and other specifications were added to this measure for HEDIS 2018, trending with prior years is not possible. Due to changes in measure specification, NCQA indicated trending between MY2020 and previous years should be considered with caution.

Fig. 130. IET—Engagement: ≥18 Years: Opioid



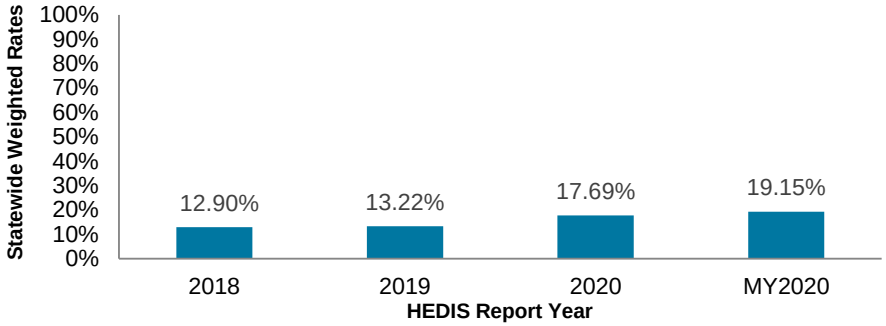
Footnote: Since cohorts and other specifications were added to this measure for HEDIS 2018, trending with prior years is not possible. Due to changes in measure specification, NCQA indicated trending between MY2020 and previous years should be considered with caution.

Fig. 131. IET—Engagement: ≥18 Years: Other Drug



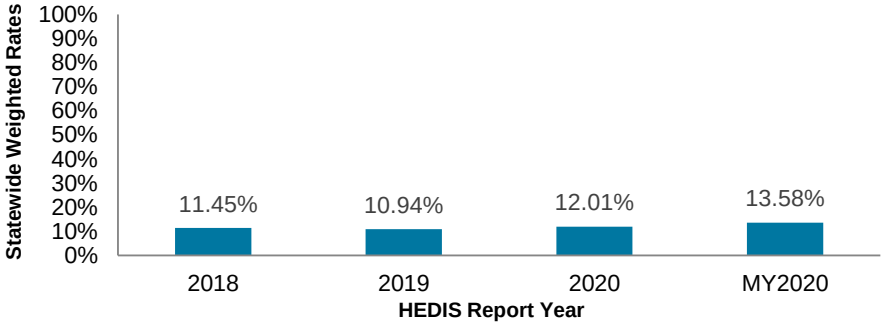
Footnote: Since cohorts and other specifications were added to this measure for HEDIS 2018, trending with prior years is not possible. Due to changes in measure specification, NCQA indicated trending between MY2020 and previous years should be considered with caution.

Fig. 132. IET—Engagement: ≥18 Years: Total



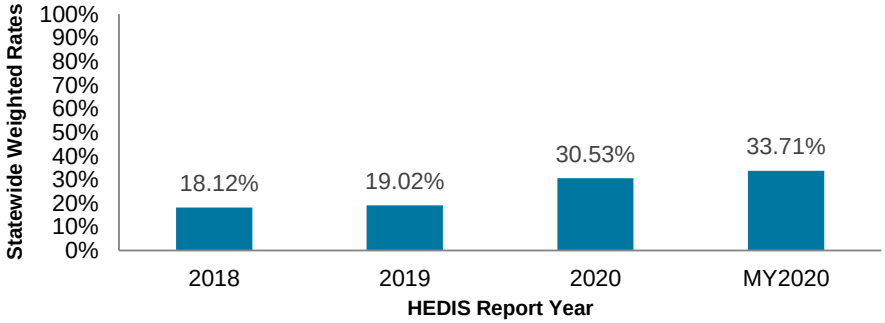
Footnote: Since cohorts and other specifications were added to this measure for HEDIS 2018, trending with prior years is not possible. Due to changes in measure specification, NCQA indicated trending between MY2020 and previous years should be considered with caution.

Fig. 133. IET—Engagement: Total: Alcohol



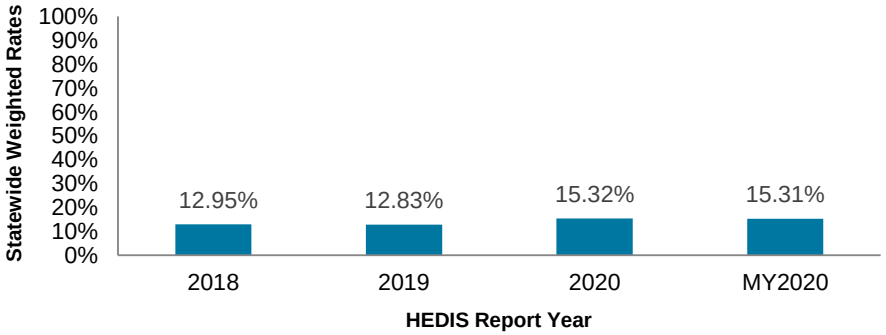
Footnote: Since cohorts and other specifications were added to this measure for HEDIS 2018, trending with prior years is not possible. Due to changes in measure specification, NCQA indicated trending between MY2020 and previous years should be considered with caution.

Fig. 134. IET—Engagement: Total: Opioid



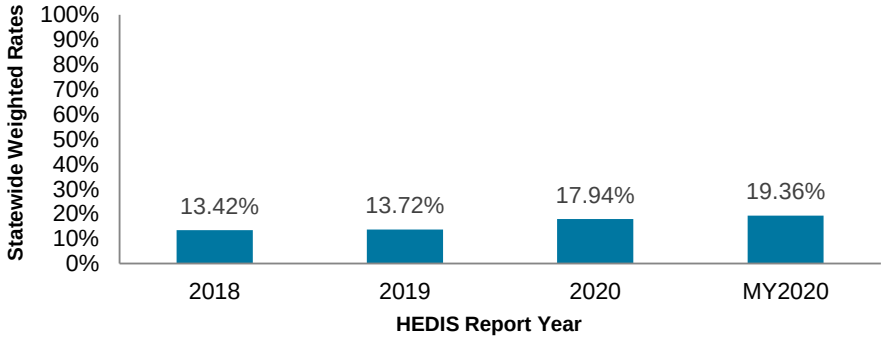
Footnote: Since cohorts and other specifications were added to this measure for HEDIS 2018, trending with prior years is not possible. Due to changes in measure specification, NCQA indicated trending between MY2020 and previous years should be considered with caution.

Fig. 135. IET—Engagement: Total: Other Drug



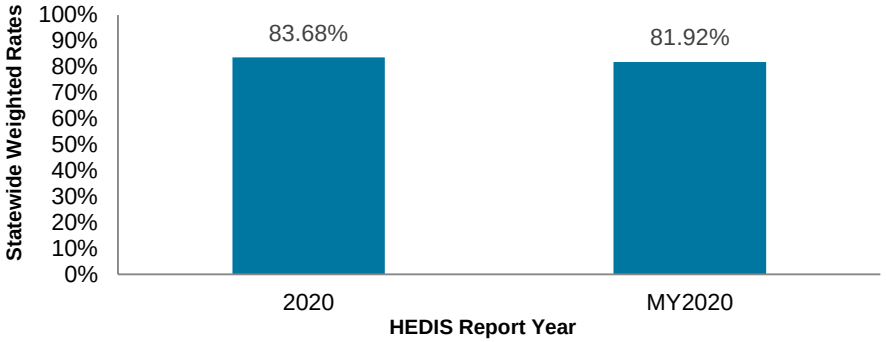
Footnote: Since cohorts and other specifications were added to this measure for HEDIS 2018, trending with prior years is not possible. Due to changes in measure specification, NCQA indicated trending between MY2020 and previous years should be considered with caution.

Fig. 136. IET—Engagement: Total



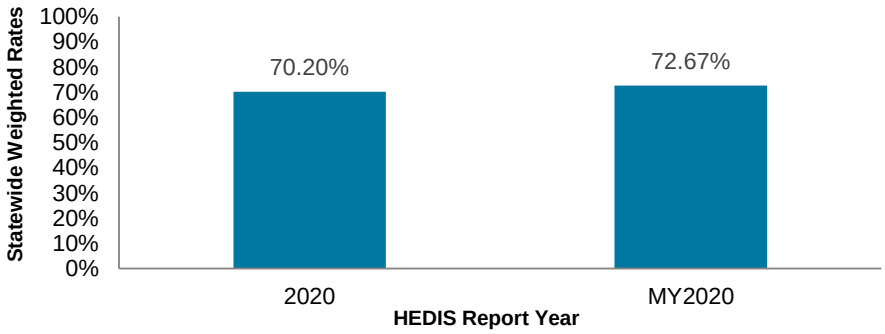
Footnote: Since cohorts and other specifications were added to this measure for HEDIS 2018, trending with prior years is not possible. Due to changes in measure specification, NCQA indicated trending between MY2020 and previous years should be considered with caution.

Fig. 137. Prenatal and Postpartum Care (PPC): Timeliness of Prenatal Care



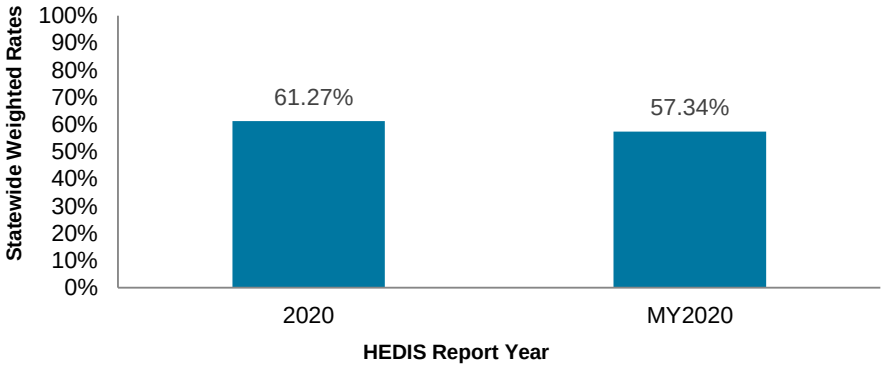
Footnote: Due to significant changes in measure specification for HEDIS 2020, NCQA indicated a break in trending to prior years. NCQA also indicated trending between MY2020 and previous years should be considered with caution.

Fig. 138. PPC: Postpartum Care



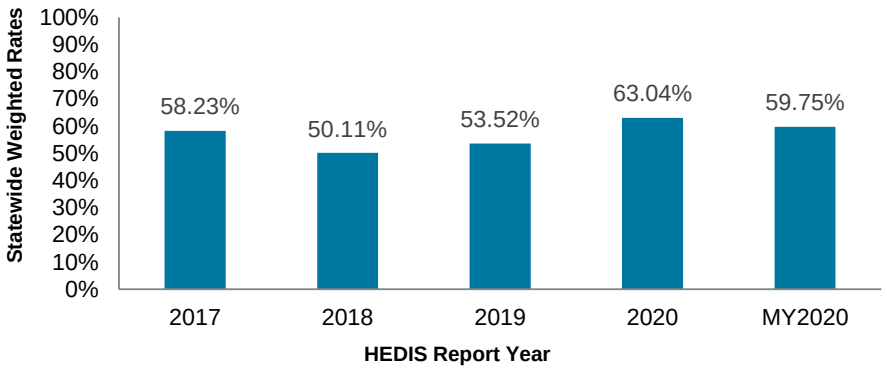
Footnote: Due to significant changes in measure specification for HEDIS 2020, NCQA indicated a break in trending to prior years. NCQA also indicated trending between MY2020 and previous years should be considered with caution.

Fig. 139. Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP): 1–11 Years



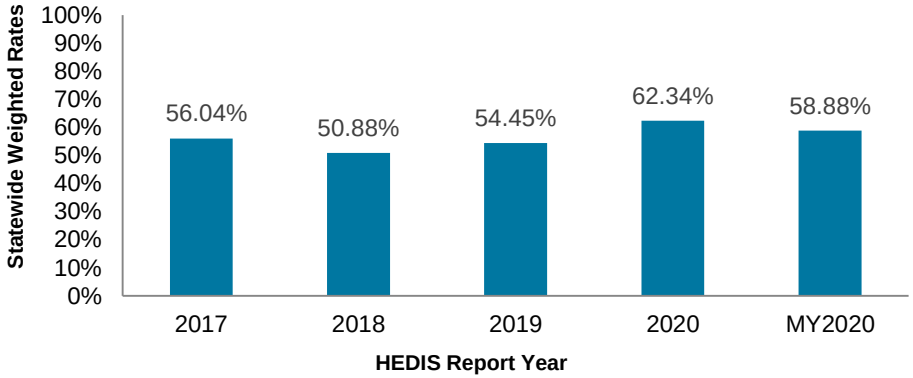
Footnote: Due to changes in the age stratification, trending between HEDIS 2020 and previous years is not possible.

Fig. 140. APP: 12–17 Years



Footnote: Due to changes in measure specification, NCQA indicated trending between HEDIS 2020 and previous years should be considered with caution.

Fig. 141. APP: Total



Footnote: Due to changes in measure specification, NCQA indicated trending between HEDIS 2020 and previous years should be considered with caution.

CHIP HEDIS/CAHPS Results

HEDIS definitions for measures apply to all CoverKids lines of business. For CoverKids, BlueCare (**CK BC**) was the only health plan administrator (HPA) and the only plan reporting HEDIS/CAHPS measures for MY2020, so no comparative statewide data are available.

Note: This report, which previously would have referred to the most recent data as HEDIS 2021, uses NCQA's new naming convention of HEDIS MY2020 to refer to data collected during calendar year 2020 and reported in calendar year 2021. To ensure consistency in the technical specifications and for easier reference to publications issued by NCQA, Qsource has retained NCQA's prior nomenclature to refer to previous years. For example, HEDIS 2020 remains as-is in this report and refers to data collected in MY2019.

In **Table 12**, the column titled "Change from HEDIS 2020 to HEDIS MY2020" indicates whether there was an improvement (⬆), a decline (⬇), or no change (⬌) in performance from HEDIS 2020 to HEDIS MY2020 when measure data are available for both years. Cells are shaded gray for those measures that were not calculated or for which data were not reported. Scores are presented in **bold** where MY2018 data were reported by MCOs for HEDIS 2020. NA is used for Not Applicable, indicating the denominator was too small (<30) to report a valid rate, and therefore results are not presented.

Table 12. HEDIS MY2020 CHIP Rates

Measure	Rate		Change from HEDIS 2020 to HEDIS MY2020
	HEDIS 2020	HEDIS MY2020	
Effectiveness of Care Measures			
Prevention and Screening			
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)*:			
BMI Percentile: 3–11 years	**76.55%**	79.07%	⬆
12–17 years	**73.22%**	77.42%	⬆
Total	**75.06%**	78.30%	⬆
Counseling for Nutrition: 3–11 years	**63.27%**	65.58%	⬆
12–17 years	**59.56%**	68.82%	⬆
Total	**61.61%**	67.08%	⬆
Counseling for Physical Activity: 3–11 years	**56.64%**	58.14%	⬆
12–17 years	**60.66%**	66.67%	⬆
Total	**58.44%**	62.09%	⬆

Table 12. HEDIS MY2020 CHIP Rates			
Measure	**Rate**		**Change from HEDIS 2020 to HEDIS MY2020**
	HEDIS 2020	**HEDIS MY2020**	
Childhood Immunization Status (CIS):			
DTaP/DT	83.70%	79.81%	↓
IPV	89.54%	90.75%	↑
MMR	91.73%	89.05%	↓
HiB	89.29%	88.08%	↓
HepB	87.10%	91.24%	↑
VZV	90.75%	88.32%	↓
PCV	84.18%	81.02%	↓
HepA	91.00%	87.83%	↓
RV	78.83%	78.35%	↓
Flu	54.74%	53.77%	↓
Combination 2	78.10%	76.89%	↓
Combination 3	76.64%	74.21%	↓
Combination 4	76.16%	73.72%	↓
Combination 5	70.07%	67.15%	↓
Combination 6	48.18%	47.69%	↓
Combination 7	69.59%	66.67%	↓
Combination 8	48.18%	47.45%	↓
Combination 9	46.23%	43.80%	↓
Combination 10	46.23%	43.55%	↓
Immunizations for Adolescents (IMA):			
Meningococcal	75.67%	78.83%	↑
Tdap/Td	86.37%	85.16%	↓
HPV	27.49%	25.55%	↓
Combination 1	75.18%	77.62%	↑
Combination 2	26.03%	24.57%	↓
Lead Screening in Children (LSC)	69.10%	68.61%	↓
Breast Cancer Screening (BCS)*	NA	NA	
Cervical Cancer Screening (CCS)*	**75.22%**	67.41%	↓
Chlamydia Screening in Women (CHL):			
16–20 Years	40.38%	34.77%	↓
21–24 Years	64.46%	51.23%	↓

Table 12. HEDIS MY2020 CHIP Rates			
Measure	**Rate**		**Change from HEDIS 2020 to HEDIS MY2020**
	HEDIS 2020	**HEDIS MY2020**	
Total	43.11%	40.56%	↓
Respiratory Conditions			
Appropriate Testing for Pharyngitis (CWP)*			
3–17 years	91.29%	91.95%	↑
18–64 years	80.91%	83.95%	↑
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)	NA	NA	
Pharmacotherapy Management of COPD Exacerbation (PCE):			
Systemic Corticosteroid	NA	NA	
Bronchodilator	NA	NA	
Asthma Medication Ratio (AMR):			
5–11 Years	89.22%	89.47%	↑
12–18 Years	72.67%	84.80%	↑
19–50 Years	NA	NA	
51–64 Years	NA	NA	
Total	80.79%	85.89%	↑
Cardiovascular Conditions			
Controlling High Blood Pressure (CBP)**		63.64%	
Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)	NA	NA	
Statin Therapy for Patients With Cardiovascular Disease (SPC)*:			
Received Statin Therapy: 21-75 Years (Male)	NA	NA	
40–75 Years (Female)	NA	NA	
Total	NA	NA	
Statin Adherence 80%: 21-75 Years (Male)	NA	NA	
40–75 Years (Female)	NA	NA	
Total	NA	NA	
Cardiac Rehabilitation (CRE)*:** 18–64 Years			
Initiation		NA	
Engagement 1		NA	
Engagement 2		NA	
Achievement		NA	

Table 12. HEDIS MY2020 CHIP Rates			
Measure	**Rate**		**Change from HEDIS 2020 to HEDIS MY2020**
	HEDIS 2020	**HEDIS MY2020**	
Diabetes			
Comprehensive Diabetes Care (CDC):			
Hemoglobin A1c (HbA1c) Testing*	**82.93%**	67.48%	↓
HbA1c Control (<8.0%)*	**36.59%**	42.94%	↑
Eye Exam (Retinal) Performed*	**63.41%**	14.72%	↓
Blood Pressure Control (<140/90 mm Hg)**		64.42%	
Kidney Health Evaluation for Patients With Diabetes (KED)***: 18–64 Years		14.02%	
Statin Therapy for Patients With Diabetes (SPD)*:			
Received Statin Therapy	NA	NA	
Statin Adherence 80%	NA	NA	
Behavioral Health			
Antidepressant Medication Management (AMM):			
Effective Acute Phase Treatment	61.02%	44.44%	↓
Effective Continuation Phase Treatment	45.76%	27.16%	↓
Follow-Up Care for Children Prescribed ADHD Medication (ADD)*:			
Initiation Phase	44.87%	49.16%	↑
Continuation and Maintenance (C&M) Phase	55.68%	65.00%	↑
Follow-Up After Hospitalization for Mental Illness (FUH)*:			
7-Day Follow-Up: 6–17 Years	58.06%	68.04%	↑
18–64 Years	35.42%	NA	
30-Day Follow-Up: 6–17 Years	79.84%	84.54%	↑
18–64 Years	54.17%	NA	
Follow-Up After Emergency Department Visit for Mental Illness (FUM)*:			
7-Day Follow-Up: 6–17 Years	39.62%	46.88%	↑
18–64 Years	NA	NA	
30-Day Follow-Up: 6–17 Years	62.26%	87.50%	↑
18–64 Years	NA	NA	
Follow-Up After High-Intensity Care for Substance Use Disorder (FUI)*:			
7-Day Follow-Up: 13-17 Years	NA	NA	
18–64 Years	NA	NA	
30-Day Follow-Up: 13-17 Years	NA	NA	
18–64 Years	NA	NA	

Table 12. HEDIS MY2020 CHIP Rates			
Measure	**Rate**		**Change from HEDIS 2020 to HEDIS MY2020**
	HEDIS 2020	**HEDIS MY2020**	
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)*:			
7-Day Follow-Up: 13–17 Years	NA	NA	
18 Years and Older	NA	NA	
Total	NA	NA	
30-Day Follow-Up: 13–17 Years	NA	NA	
18 Years and Older	NA	NA	
Total	NA	NA	
Pharmacotherapy for Opioid Use Disorder (POD)*: 16–64 years	NA	NA	
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication (SSD)	NA	NA	
Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD)	NA	NA	
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (SMC)	NA	NA	
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)	NA	NA	
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM):			
Blood Glucose Testing: 1–11 Years	34.00%	32.50%	↓
12–17 Years	59.48%	53.76%	↓
Total	51.81%	47.37%	↓
Cholesterol Testing: 1–11 Years	38.00%	25.00%	↓
12–17 Years	43.97%	41.94%	↓
Total	42.17%	36.84%	↓
Blood Glucose and Cholesterol Testing: 1–11 Years	30.00%	22.50%	↓
12–17 Years	39.66%	37.63%	↓
Total	36.75%	33.08%	↓
Overuse/Appropriateness			
Appropriate Treatment for Upper Respiratory Infection (URI):			
3 Months-17 Years	83.87%	86.63%	↑
18–64 Years	78.72%	79.26%	↑
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB):			
3 Months-17 Years	45.01%	49.14%	↑
18–64 Years	42.22%	45.31%	↑
Use of Imaging Studies for Low Back Pain (LBP)	76.12%	82.56%	↑

Table 12. HEDIS MY2020 CHIP Rates			
Measure	**Rate**		**Change from HEDIS 2020 to HEDIS MY2020**
	HEDIS 2020	**HEDIS MY2020**	
Access/Availability of Care			
Adults' Access to Preventive/Ambulatory Health Services (AAP):			
20-44 Years	50.69%	62.16%	↑
45-64 Years	NA	56.25%	
Initiation and Engagement of AOD Abuse or Dependence Treatment (IET)—Initiation of AOD Treatment*:			
13-17 Years: Alcohol	NA	NA	
Opioid	NA	NA	
Other Drug	45.83%	36.36%	↓
Total	49.12%	34.21%	↓
18+ Years: Alcohol	NA	NA	
Opioid	NA	NA	
Other Drug	49.09%	67.74%	↑
Total	46.27%	56.52%	↑
Initiation Total: Alcohol	55.88%	NA	
Opioid	NA	NA	
Other Drug	47.57%	51.56%	↑
Total	47.58%	46.43%	↓
Initiation and Engagement of AOD Abuse or Dependence Treatment (IET)—Engagement of AOD Treatment*:			
13-17 Years: Alcohol	NA	NA	
Opioid	NA	NA	
Other Drug	22.92%	21.21%	↓
Total	21.05%	18.42%	↓
18+ Years: Alcohol	NA	NA	
Opioid	NA	NA	
Other Drug	14.55%	22.58%	↑
Total	13.43%	17.39%	↑
Engagement Total: Alcohol	17.65%	NA	
Opioid	NA	NA	
Other Drug	18.45%	21.88%	↑
Total	16.94%	17.86%	↑

Table 12. HEDIS MY2020 CHIP Rates			
Measure	**Rate**		**Change from HEDIS 2020 to HEDIS MY2020**
	HEDIS 2020	**HEDIS MY2020**	
Prenatal and Postpartum Care (PPC)*:			
Timeliness of Prenatal Care	66.67%	66.67%	⬌
Postpartum Care	78.35%	77.13%	⬇
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP):			
1–11 Years	NA	NA	
12–17 Years	55.32%	NA	
Total	50.00%	57.14%	⬆
Utilization			
Well-Child Visits in the First 30 Months of Life (W30) ††:			
First 15 Months**		62.56%	
15 Months–30 Months		75.86%	
Child and Adolescent Well-Care Visits (WCV) ††:			
3–11 Years**		54.54%	
12–17 Years**		48.64%	
18–21 Years**		27.45%	
Total**		49.37%	

** NCQA indicated trending with caution due to changes in measure specifications for HEDIS MY2020.*

*** NCQA indicated a break in trending to prior years due to significant changes in measure specifications for HEDIS MY2020.*

**** First-year measure for HEDIS MY2020.*

†† Revised and renamed measures for HEDIS MY2020.

For the Effectiveness of Care Measures presented in **Table 13**, a lower rate is an indication of better performance (⬆). A decrease in rates from the prior year also indicates improvement.

Table 13. HEDIS MY2020 CHIP Rates: Measures Where Lower Rates Indicate Better Performance

Measure	Rate		Change from HEDIS 2020 to HEDIS MY2020
	HEDIS 2020	HEDIS MY2020	
Effectiveness of Care Measures			
Diabetes			
Comprehensive Diabetes Care (CDC): HbA1c Poor Control (>9.0%)*	**53.66%**	52.15%	⬆
Overuse/Appropriateness			
Non-Recommended Cervical Cancer Screening in Adolescent Females (NCS)	1.00%	0.85%	⬆
Use of Opioids at High Dosage (HDO)*	NA	NA	
Use of Opioids From Multiple Providers (UOP)*:			
Multiple Prescribers	NA	NA	
Multiple Pharmacies	NA	NA	
Multiple Prescribers and Multiple Pharmacies	NA	NA	
Risk of Continued Opioid Use (COU)*:			
18–64 years: ≥15 days/30-day period	0.08%	0.00%	⬆
≥ 31 days/62-day period	0.00%	0.00%	⬌

** NCQA indicated trending with caution due to changes in measure specifications for HEDIS MY2020.*

APPENDIX A | Medicaid Utilization Results

Additional Utilization Measure Descriptions

Frequency of Selected Procedure (FSP)

FSP summarizes the utilization of frequently performed procedures that often show wide regional variation and have generated concern regarding potentially inappropriate utilization.

Ambulatory Care (AMB)

AMB summarizes utilization of ambulatory care in the following categories:

- Outpatient Visits including telehealth
- ED Visits

Inpatient Utilization – General Hospital/Acute Care (IPU)

IPU summarizes utilization of acute IP care and services in the following categories:

- Total IP
- Medicine
- Surgery
- Maternity

Identification of Alcohol and Other Drug Services (IAD)

IAD summarizes the number and percentage of members with an AOD claim who received the following chemical dependency services during the MY:

- Any services
- IP
- Telehealth
- Outpatient or medication treatment
- Intensive outpatient or partial hospitalization
- ED

Mental Health Utilization (MPT)

MPT summarizes the number and percentage of members receiving the following mental health services during the MY:

- Any services
- IP
- Telehealth
- Outpatient
- ED
- Intensive outpatient or partial hospitalization

Antibiotic Utilization (ABX)

ABX summarizes the following data on outpatient utilization of antibiotic prescriptions during the MY, stratified by age and gender:

- Total number of and average (Avg.) number of antibiotic prescription per member per year (PMPY)
- Total and avg. days supplied for all antibiotic prescriptions
- Total number of prescriptions and avg. number of prescriptions PMPY for antibiotics of concern
- Percentage of antibiotic of concern for all antibiotics prescriptions
- Avg. number of antibiotics PMPY reported by drug class:
  - For selected 'antibiotics of concern'
  - For all other antibiotics

Utilization Measures: Medicaid Plan-Specific Rates

In **Table A.1**, cells are shaded gray for those measures that were not calculated or for which data were not reported.

Table A.1. HEDIS MY2020 Medicaid Plan-Specific Rates: Utilization Measures

Measure by Age	Sex	AGE	AGM	AGW	BCE	BCM	BCW	TCS	UHCE	UHCM	UHCW
Frequency of Selected Procedures (FSP)											
Bariatric Weight Loss Surgery: Procedures/1,000 Member Years											
0–19	M	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
20–44		0.03	0.02	0.00	0.05	0.05	0.03	0.00	0.05	0.03	0.00
45–64		0.06	0.03	0.02	0.04	0.02	0.02	0.00	0.06	0.08	0.03
0–19	F	0.00	0.00	0.00	0.00	0.00	0.01	0.01	0.00	0.00	0.00
20–44		0.21	0.15	0.12	0.25	0.19	0.18	0.05	0.25	0.17	0.10
45–64		0.23	0.14	0.06	0.24	0.25	0.13	0.00	0.25	0.13	0.08
Tonsillectomy: Procedures/1,000 Member Years											
0–9	M&F	0.72	0.60	0.41	0.78	0.62	0.40	0.87	0.77	0.57	0.40
10–19		0.35	0.23	0.15	0.40	0.26	0.20	0.25	0.36	0.19	0.20
Hysterectomy—Abdominal (A) and Vaginal (V): Procedures/1,000 Member Years											
15–44 (A)	F	0.05	0.05	0.09	0.07	0.06	0.12	0.01	0.07	0.08	0.08
45–64 (A)		0.09	0.03	0.19	0.07	0.11	0.27	0.00	0.05	0.10	0.21
15–44 (V)	F	0.13	0.07	0.08	0.16	0.09	0.14	0.01	0.16	0.11	0.06
45–64 (V)		0.13	0.08	0.12	0.11	0.11	0.19	0.00	0.16	0.08	0.06
Cholecystectomy—Open (O) and Closed (C)/Laparoscopic: Procedures/1,000 Member Years											
30–64 (O)	M	0.02	0.01	0.04	0.01	0.00	0.02	0.00	0.03	0.03	0.02
15–44 (O)	F	0.00	0.01	0.01	0.01	0.00	0.01	0.01	0.00	0.01	0.00
45–64 (O)		0.05	0.02	0.00	0.01	0.00	0.02	0.00	0.02	0.02	0.01
30–64 (C)	M	0.28	0.23	0.12	0.34	0.29	0.20	0.00	0.42	0.40	0.18
15–44 (C)	F	0.71	0.56	0.38	0.87	0.71	0.49	0.32	0.70	0.63	0.47
45–64 (C)		0.48	0.50	0.32	0.59	0.49	0.39	0.21	0.77	0.48	0.32
Back Surgery: Procedures/1,000 Member Years											
20–44	M	0.14	0.34	0.12	0.16	0.29	0.25	0.00	0.18	0.27	0.20
	F	0.18	0.19	0.07	0.17	0.24	0.09	0.11	0.22	0.26	0.10

Table A.1. HEDIS MY2020 Medicaid Plan-Specific Rates: Utilization Measures											
Measure by Age	**Sex**	**AGE**	**AGM**	**AGW**	**BCE**	**BCM**	**BCW**	**TCS**	**UHCE**	**UHCM**	**UHCW**
45–64	M	0.43	0.65	0.42	0.59	1.27	0.46	0.29	0.60	1.03	0.33
	F	0.58	0.50	0.31	0.67	1.10	0.42	0.21	0.73	1.13	0.33
Mastectomy: Procedures/1,000 Member Years											
15–44	F	0.02	0.02	0.05	0.07	0.02	0.05	0.00	0.06	0.04	0.04
45–64		0.13	0.33	0.13	0.39	0.24	0.42	0.00	0.13	0.31	0.27
Lumpectomy: Procedures/1,000 Member Years											
15–44	F	0.06	0.06	0.08	0.12	0.08	0.10	0.03	0.05	0.07	0.08
45–64		0.20	0.32	0.13	0.38	0.30	0.46	0.00	0.20	0.31	0.24
Ambulatory Care: Total (AMB)											
Total: Visits/1,000 Member Months											
Outpatient		274.53	299.95	236.23	382.57	323.21	318.98	276.35	382.96	366.51	308.79
ED		48.06	40.14	44.49	51.40	46.11	50.52	38.74	52.36	47.13	51.27
Inpatient Utilization—General Hospital/Acute Care: Total (IPU)											
Total Inpatient											
Per 1,000 Member Months											
Discharges		5.03	5.07	5.46	6.98	6.46	7.03	4.35	7.23	6.48	6.64
Days		24.21	22.77	26.69	28.49	25.94	30.90	25.71	36.99	29.84	36.61
Length of Stay (LoS): Average # of Days											
Average LoS		4.81	4.49	4.89	4.08	4.01	4.39	5.91	5.12	4.60	5.51
Medicine											
Per 1,000 Member Months											
Discharges		3.15	2.87	3.15	2.77	2.55	2.61	2.47	3.76	2.83	3.09
Days		19.63	16.58	20.87	12.08	10.58	11.44	12.44	20.97	15.26	18.47
LoS: Average # of Days											
Average LoS		6.23	5.77	6.62	4.36	4.15	4.38	5.04	5.57	5.39	5.98
Surgery											
Per 1,000 Member Months											
Discharges		0.00	0.01	0.01	1.41	1.29	1.45	1.28	1.68	1.36	1.46

Table A.1. HEDIS MY2020 Medicaid Plan-Specific Rates: Utilization Measures											
Measure by Age	**Sex**	**AGE**	**AGM**	**AGW**	**BCE**	**BCM**	**BCW**	**TCS**	**UHCE**	**UHCM**	**UHCW**
Days		0.01	0.03	0.06	9.89	8.86	12.02	11.78	11.85	8.83	13.12
LoS: Average # of Days											
Average LoS		3.80	3.79	6.83	7.04	6.85	8.31	9.19	7.05	6.48	9.00
Maternity											
Per 1,000 Member Months											
Discharges		2.76	3.45	3.52	4.39	4.17	4.71	0.95	2.65	3.64	3.27
Days		6.72	9.69	8.83	10.19	10.33	11.79	2.37	6.19	9.14	7.83
LoS: Average # of Days											
Average LoS		2.44	2.81	2.51	2.32	2.48	2.50	2.50	2.33	2.51	2.40
Identification of Alcohol and Other Drug Services: Total (IAD)											
Any Services											
Total	**M**	5.72%	3.98%	3.63%	4.43%	4.00%	3.32%	3.51%	5.81%	4.36%	4.17%
	F	7.00%	5.47%	3.94%	7.66%	5.85%	4.42%	3.72%	7.29%	6.02%	4.05%
	M&F	6.44%	4.84%	3.81%	6.34%	5.07%	3.98%	3.60%	6.66%	5.32%	4.10%
Inpatient											
Total	**M**	1.70%	1.30%	1.37%	1.23%	1.39%	1.12%	0.76%	1.60%	1.57%	1.60%
	F	1.94%	1.60%	1.11%	2.16%	1.83%	1.19%	0.85%	2.06%	1.83%	1.16%
	M&F	1.83%	1.47%	1.22%	1.78%	1.65%	1.17%	0.80%	1.87%	1.72%	1.34%
Intensive											
Total	**M**	0.42%	0.39%	0.29%	0.35%	0.43%	0.22%	0.49%	0.38%	0.43%	0.40%
	F	0.70%	0.62%	0.33%	0.86%	0.73%	0.39%	0.84%	0.63%	0.76%	0.42%
	M&F	0.58%	0.52%	0.32%	0.65%	0.61%	0.32%	0.64%	0.52%	0.62%	0.41%
Outpatient/Medication											
Total	**M**	3.68%	2.38%	1.81%	2.90%	2.21%	1.79%	1.81%	3.97%	2.62%	2.09%
	F	4.73%	3.50%	2.16%	5.25%	3.48%	2.51%	2.07%	5.07%	4.02%	2.25%
	M&F	4.27%	3.03%	2.02%	4.29%	2.95%	2.23%	1.92%	4.60%	3.43%	2.19%

Table A.1. HEDIS MY2020 Medicaid Plan-Specific Rates: Utilization Measures											
Measure by Age	**Sex**	**AGE**	**AGM**	**AGW**	**BCE**	**BCM**	**BCW**	**TCS**	**UHCE**	**UHCM**	**UHCW**
ED											
Total	**M**	1.50%	1.08%	1.29%	0.90%	1.07%	0.97%	0.78%	1.45%	1.23%	1.34%
	F	1.34%	1.11%	1.19%	1.25%	1.18%	1.09%	0.79%	1.32%	1.33%	1.17%
	M&F	1.41%	1.10%	1.23%	1.11%	1.13%	1.04%	0.79%	1.37%	1.29%	1.24%
Telehealth											
Total	**M**	1.72%	1.43%	0.68%	1.41%	1.36%	0.74%	1.12%	1.75%	1.26%	0.75%
	F	2.67%	2.49%	0.88%	2.86%	2.51%	1.17%	1.27%	2.57%	2.47%	0.91%
	M&F	2.26%	2.04%	0.80%	2.27%	2.03%	1.00%	1.19%	2.22%	1.96%	0.84%
Mental Health Utilization: Total (MPT)											
Any Services											
Total	**M**	12.16%	10.52%	6.99%	13.33%	11.64%	8.68%	31.88%	12.90%	11.23%	7.95%
	F	13.23%	12.35%	7.16%	15.61%	13.10%	10.23%	27.10%	15.19%	13.68%	8.54%
	M&F	12.76%	11.58%	7.09%	14.68%	12.49%	9.62%	29.84%	14.21%	12.65%	8.30%
Inpatient											
Total	**M**	0.95%	0.89%	1.15%	0.78%	0.82%	0.99%	2.27%	1.04%	0.92%	1.26%
	F	1.04%	0.94%	0.89%	1.04%	1.06%	0.97%	2.35%	1.13%	1.18%	1.10%
	M&F	1.00%	0.92%	0.99%	0.93%	0.96%	0.98%	2.31%	1.09%	1.07%	1.17%
Intensive											
Total	**M**	0.05%	0.07%	0.23%	0.06%	0.10%	0.12%	0.34%	0.04%	0.09%	0.56%
	F	0.06%	0.10%	0.24%	0.08%	0.16%	0.16%	0.47%	0.07%	0.18%	0.52%
	M&F	0.05%	0.09%	0.24%	0.07%	0.13%	0.14%	0.40%	0.06%	0.14%	0.53%
Outpatient											
Total	**M**	8.67%	8.01%	4.85%	10.19%	8.91%	6.76%	26.52%	10.44%	9.47%	5.72%
	F	8.74%	8.63%	4.51%	10.82%	8.67%	7.36%	21.01%	11.54%	10.72%	5.79%
	M&F	8.71%	8.37%	4.65%	10.56%	8.77%	7.12%	24.17%	11.07%	10.20%	5.76%
ED											
Total	**M**	0.00%	0.03%	0.00%	0.00%	0.02%	0.00%	0.01%	0.06%	0.08%	0.01%
	F	0.01%	0.02%	0.00%	0.00%	0.02%	0.00%	0.03%	0.06%	0.16%	0.00%

Table A.1. HEDIS MY2020 Medicaid Plan-Specific Rates: Utilization Measures											
Measure by Age	**Sex**	**AGE**	**AGM**	**AGW**	**BCE**	**BCM**	**BCW**	**TCS**	**UHCE**	**UHCM**	**UHCW**
	M&F	0.01%	0.02%	0.00%	0.00%	0.02%	0.00%	0.02%	0.06%	0.12%	0.00%
Telehealth											
Total	**M**	6.72%	5.52%	2.84%	6.93%	5.79%	3.34%	15.57%	5.24%	4.06%	3.22%
	F	8.24%	7.52%	3.66%	9.37%	8.03%	4.87%	15.58%	7.05%	6.26%	4.01%
	M&F	7.58%	6.67%	3.32%	8.37%	7.09%	4.27%	15.57%	6.28%	5.34%	3.69%
Antibiotic Utilization: Total (ABX)											
Antibiotic Utilization											
Average Scripts PMPY for Antibiotics											
Total	**M**	0.55	0.49	0.40	0.73	0.56	0.57	0.61	0.66	0.56	0.49
	F	0.91	0.82	0.78	1.19	0.96	1.08	0.85	1.14	0.95	0.90
	M&F	0.75	0.68	0.62	1.00	0.79	0.88	0.72	0.93	0.79	0.73
Average Days Supplied per Antibiotic Script											
Total	**M**	9.83	10.11	9.96	9.95	10.04	9.98	11.67	10.02	10.31	10.00
	F	9.09	8.83	8.35	9.18	8.92	8.62	10.88	9.30	9.00	8.58
	M&F	9.32	9.22	8.78	9.41	9.25	8.97	11.27	9.51	9.39	8.98
Average Scripts PMPY for Antibiotics of Concern											
Total	**M**	0.25	0.21	0.17	0.34	0.23	0.24	0.24	0.31	0.24	0.21
	F	0.39	0.34	0.30	0.53	0.39	0.43	0.31	0.52	0.39	0.36
	M&F	0.33	0.28	0.24	0.45	0.33	0.36	0.27	0.43	0.33	0.30
Percentage of Antibiotics of Concern of All Antibiotic Scripts											
Total	**M**	45.29%	41.98%	42.09%	46.25%	41.95%	43.21%	38.46%	46.64%	42.18%	42.48%
	F	43.12%	40.80%	38.31%	44.49%	40.92%	39.98%	36.18%	45.45%	41.32%	39.90%
	M&F	43.80%	41.16%	39.31%	45.01%	41.22%	40.80%	37.30%	45.80%	41.57%	40.61%
Antibiotics of Concern Utilization (Average Scripts PMPY)											
Quinolones											
Total	**M**	0.02	0.02	0.02	0.02	0.02	0.02	0.01	0.03	0.02	0.03
	F	0.04	0.04	0.04	0.06	0.04	0.06	0.02	0.07	0.05	0.06
	M&F	0.03	0.03	0.03	0.04	0.03	0.04	0.01	0.06	0.04	0.04

Table A.1. HEDIS MY2020 Medicaid Plan-Specific Rates: Utilization Measures

Measure by Age	Sex	AGE	AGM	AGW	BCE	BCM	BCW	TCS	UHCE	UHCM	UHCW
Cephalosporins 2nd–4th Generation											
Total	M	0.06	0.05	0.03	0.09	0.06	0.06	0.06	0.07	0.05	0.04
	F	0.07	0.06	0.04	0.11	0.08	0.06	0.08	0.09	0.07	0.05
	M&F	0.07	0.06	0.04	0.10	0.07	0.06	0.07	0.08	0.06	0.04
Azithromycins and Clarithromycins											
Total	M	0.07	0.06	0.05	0.10	0.07	0.08	0.07	0.09	0.07	0.06
	F	0.12	0.11	0.11	0.16	0.13	0.16	0.10	0.15	0.13	0.12
	M&F	0.10	0.09	0.08	0.13	0.10	0.12	0.09	0.12	0.10	0.10
Amoxicillin/Clavulanates											
Total	M	0.07	0.06	0.04	0.09	0.06	0.06	0.06	0.08	0.06	0.05
	F	0.11	0.08	0.06	0.14	0.09	0.09	0.07	0.13	0.10	0.08
	M&F	0.09	0.07	0.05	0.12	0.08	0.08	0.07	0.11	0.08	0.07
Ketolides											
Total	M	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	F	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	M&F	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Clindamycins											
Total	M	0.03	0.02	0.02	0.03	0.02	0.03	0.02	0.04	0.03	0.03
	F	0.05	0.04	0.05	0.06	0.05	0.06	0.03	0.07	0.05	0.05
	M&F	0.04	0.03	0.04	0.05	0.04	0.05	0.03	0.05	0.04	0.04
Misc. Antibiotics of Concern											
Total	M	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	F	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.01	0.00	0.00
	M&F	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.01	0.00	0.00
All Other Antibiotics Utilization (Average Scripts PMPY)											
Absorbable Sulfonamides											
Total	M	0.04	0.04	0.03	0.06	0.04	0.04	0.05	0.06	0.04	0.03
	F	0.08	0.07	0.05	0.11	0.08	0.07	0.09	0.10	0.08	0.06
	M&F	0.07	0.05	0.04	0.09	0.06	0.06	0.07	0.08	0.06	0.05

Table A.1. HEDIS MY2020 Medicaid Plan-Specific Rates: Utilization Measures											
Measure by Age	**Sex**	**AGE**	**AGM**	**AGW**	**BCE**	**BCM**	**BCW**	**TCS**	**UHCE**	**UHCM**	**UHCW**
Aminoglycosides											
Total	**M**	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	F	0.00	0.00	0.00	0.00	0.00	0.00	0.01	0.00	0.00	0.00
	M&F	0.00	0.00	0.00	0.00	0.00	0.00	0.01	0.00	0.00	0.00
1st Generation Cephalosporins											
Total	**M**	0.04	0.05	0.03	0.05	0.05	0.04	0.05	0.05	0.05	0.04
	F	0.07	0.08	0.06	0.09	0.09	0.08	0.07	0.09	0.09	0.07
	M&F	0.06	0.06	0.05	0.07	0.07	0.07	0.06	0.07	0.07	0.06
Lincosamides											
Total	**M**	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	F	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	M&F	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Macrolides (not azith. or clarith.)											
Total	**M**	0.00	0.00	0.00	0.00	0.00	0.00	0.02	0.00	0.00	0.00
	F	0.00	0.00	0.00	0.00	0.00	0.00	0.02	0.00	0.00	0.00
	M&F	0.00	0.00	0.00	0.00	0.00	0.00	0.02	0.00	0.00	0.00
Penicillins											
Total	**M**	0.16	0.16	0.13	0.23	0.19	0.19	0.19	0.17	0.18	0.16
	F	0.18	0.16	0.16	0.23	0.20	0.22	0.22	0.19	0.19	0.18
	M&F	0.17	0.16	0.15	0.23	0.19	0.21	0.21	0.18	0.18	0.17
Tetracyclines											
Total	**M**	0.04	0.03	0.03	0.05	0.03	0.04	0.05	0.06	0.04	0.04
	F	0.07	0.05	0.05	0.09	0.06	0.07	0.03	0.10	0.07	0.06
	M&F	0.05	0.04	0.04	0.07	0.05	0.06	0.04	0.08	0.05	0.05
Misc. Antibiotics											
Total	**M**	0.01	0.01	0.01	0.01	0.01	0.01	0.01	0.01	0.01	0.01
	F	0.12	0.12	0.16	0.15	0.14	0.20	0.10	0.14	0.14	0.16
	M&F	0.07	0.08	0.10	0.09	0.09	0.12	0.05	0.09	0.08	0.10

As a Risk-Adjusted Utilization measure, PCR rates in **Table A.2** represent percentages of members who were readmitted for any diagnosis within 30 days of discharge from a hospital, broken into age stratifications.

Table A.2. HEDIS MY2020 Plan All-Cause Readmissions (PCR)

Measure by Age	AGE	AGM	AGW	BCE	BCM	BCW	TCS	UHCE	UHCM	UHCW
Plan Population: Observed Readmission Rate										
18-44	7.22%	7.96%	8.47%	7.77%	8.99%	7.86%	10.86%	9.62%	10.66%	9.87%
45-54	9.71%	10.45%	9.74%	9.75%	10.87%	10.29%	11.11%	11.86%	10.12%	15.51%
55-64	6.99%	9.02%	10.56%	11.52%	10.64%	12.84%	12.90%	13.52%	14.90%	16.71%
Total	7.64%	8.69%	9.24%	9.14%	9.77%	9.51%	10.96%	11.22%	11.72%	12.95%

APPENDIX B | Medicaid MCO Population

Table B.1. HEDIS MY2020 MCO Medicaid Population Reported in Member Months by Age and Sex

Age Group	Sex	AGE	AGM	AGW	BCE	BCM	BCW	TCS	UHCE	UHCM	UHCW
<1	M	22,204	34,341	22,794	45,960	36,290	33,309	4,227	22,088	35,112	22,348
	F	20,813	33,283	21,625	42,959	35,120	32,270	3,923	21,168	33,968	22,420
	M & F	43,017	67,624	44,419	88,919	71,410	65,579	8,150	43,256	69,080	44,768
1–4	M	90,343	134,028	85,930	167,871	133,154	120,766	43,559	84,788	131,799	87,191
	F	86,996	128,101	83,541	159,836	129,145	114,886	38,713	80,439	125,860	83,648
	M & F	177,339	262,129	169,471	327,707	262,299	235,652	82,272	165,227	257,659	170,839
5–9	M	115,820	152,949	115,190	161,136	136,812	116,739	73,162	111,191	144,394	106,433
	F	110,939	150,976	113,927	155,386	134,097	114,121	49,024	107,135	141,255	103,036
	M & F	226,759	303,925	229,117	316,522	270,909	230,860	122,186	218,326	285,649	209,469
10–14	M	114,107	142,129	106,341	152,482	137,817	109,182	83,898	108,530	132,199	98,015
	F	110,680	136,560	105,457	148,779	134,097	109,882	52,485	107,469	129,936	97,630
	M & F	224,787	278,689	211,798	301,261	271,914	219,064	136,383	215,999	262,135	195,645
15–17	M	63,629	65,257	53,188	76,024	72,194	52,640	57,639	57,264	61,231	45,242
	F	61,771	64,179	53,912	75,742	72,318	57,258	34,945	54,533	61,240	46,036
	M & F	125,400	129,436	107,100	151,766	144,512	109,898	92,584	111,797	122,471	91,278
18–19	M	32,163	37,507	27,225	41,426	34,725	29,167	34,532	33,526	33,865	25,701
	F	35,954	41,295	30,173	46,620	39,213	35,197	21,749	34,050	36,928	27,935
	M & F	68,117	78,802	57,398	88,046	73,938	64,364	56,281	67,576	70,793	53,636
20–24	M	22,827	31,733	22,277	37,054	23,443	27,600	16,151	28,352	28,318	22,845
	F	53,966	75,572	52,796	98,039	65,780	71,848	14,474	56,414	66,544	51,482
	M & F	76,793	107,305	75,073	135,093	89,223	99,448	30,625	84,766	94,862	74,327
25–29	M	18,199	16,551	12,360	14,992	13,088	9,448	2,518	14,842	13,137	10,823
	F	68,773	84,866	72,218	109,517	82,857	77,324	6,788	61,221	77,499	64,462
	M & F	86,972	101,417	84,578	124,509	95,945	86,772	9,306	76,063	90,636	75,285
30–34	M	22,004	22,259	13,276	21,422	16,434	12,074	2,447	21,008	19,649	14,116
	F	70,269	88,489	76,699	103,224	80,087	71,168	7,198	62,221	82,317	58,906
	M & F	92,273	110,748	89,975	124,646	96,521	83,242	9,645	83,229	101,966	73,022
35–39	M	23,150	24,553	13,235	25,749	19,429	14,174	2,599	21,417	23,462	13,070
	F	55,066	77,005	50,511	86,668	61,142	68,502	5,501	59,499	74,031	50,260
	M & F	78,216	101,558	63,746	112,417	80,571	82,676	8,100	80,916	97,493	63,330
40–44	M	20,904	23,338	12,773	24,673	16,085	12,490	1,613	22,510	24,224	14,170
	F	39,131	55,787	30,710	62,792	41,404	48,889	3,314	48,489	53,151	41,709

Table B.1. HEDIS MY2020 MCO Medicaid Population Reported in Member Months by Age and Sex

Age Group	Sex	AGE	AGM	AGW	BCE	BCM	BCW	TCS	UHCE	UHCM	UHCW
	M & F	60,035	79,125	43,483	87,465	57,489	61,379	4,927	70,999	77,375	55,879
45–49	M	17,646	18,377	10,973	21,936	14,089	10,822	1,160	21,410	18,637	13,140
	F	27,390	32,011	21,129	43,736	27,273	29,042	1,814	37,412	34,564	25,802
	M & F	45,036	50,388	32,102	65,672	41,362	39,864	2,974	58,822	53,201	38,942
50–54	M	17,484	16,007	11,451	19,428	12,817	10,128	934	21,721	18,477	12,457
	F	22,620	22,182	17,236	35,432	22,712	20,943	1,301	31,930	27,192	19,866
	M & F	40,104	38,189	28,687	54,860	35,529	31,071	2,235	53,651	45,669	32,323
55–59	M	20,774	17,631	15,977	20,462	14,484	11,868	845	23,108	20,424	17,091
	F	21,358	20,739	17,120	33,403	20,090	20,602	1,030	32,578	26,277	20,303
	M & F	42,132	38,370	33,097	53,865	34,574	32,470	1,875	55,686	46,701	37,394
60–64	M	16,788	14,933	14,319	17,045	11,752	10,556	610	21,431	16,845	15,547
	F	14,416	16,021	13,084	24,938	13,654	16,278	728	26,326	22,105	18,231
	M & F	31,204	30,954	27,403	41,983	25,406	26,834	1,338	47,757	38,950	33,778
65–69	M	3,086	4,213	3,870	4,401	3,266	3,020	0	10,107	6,396	6,858
	F	2,959	4,915	3,826	7,793	3,896	4,910	37	14,846	9,749	8,126
	M & F	6,045	9,128	7,696	12,194	7,162	7,930	37	24,953	16,145	14,984
70–74	M	943	2,124	1,047	1,920	753	853	12	5,596	2,897	3,363
	F	1,252	3,362	1,686	3,507	1,519	2,117	24	10,146	6,301	5,908
	M & F	2,195	5,486	2,733	5,427	2,272	2,970	36	15,742	9,198	9,271
75–79	M	319	1,178	444	1,065	497	403	0	3,046	1,798	1,502
	F	683	1,946	801	2,049	1,082	1,471	41	6,830	4,196	4,010
	M & F	1,002	3,124	1,245	3,114	1,579	1,874	41	9,876	5,994	5,512
80–84	M	189	423	140	393	291	312	0	1,405	1,012	665
	F	444	1,130	514	1,223	787	726	8	3,866	2,368	2,353
	M & F	633	1,553	654	1,616	1,078	1,038	8	5,271	3,380	3,018
85–89	M	94	167	54	173	111	115	0	496	502	272
	F	250	889	231	586	460	545	0	2,582	1,343	1,444
	M & F	344	1,056	285	759	571	660	0	3,078	1,845	1,716
≥90	M	29	56	54	87	94	27	0	255	192	115
	F	184	373	151	184	425	298	0	1,726	935	963
	M & F	213	429	205	271	519	325	0	1,981	1,127	1,078
Total	**M**	**622,702**	**759,754**	**542,918**	**855,699**	**697,625**	**585,693**	**325,906**	**634,091**	**734,570**	**530,964**
	F	**805,914**	**1,039,681**	**767,347**	**1,242,413**	**967,158**	**898,277**	**243,097**	**860,880**	**1,017,759**	**754,530**
	M & F	**1,428,616**	**1,799,435**	**1,310,265**	**2,098,112**	**1,664,783**	**1,483,970**	**569,003**	**1,494,971**	**1,752,329**	**1,285,494**

APPENDIX C | ECDS and LTSS Measure Results

Table C.1 presents MCO results for HEDIS MY2020 ECDS measures. TennCare required LTSS measures to be reported for the first time for HEDIS 2020. *Note: AG's measure designations were NR.*

Table C.1. HEDIS MY2020 Medicaid Plan-Specific Rates: ECDS Measures

Measure	BCE	BCM	BCW	TCS	UHCE	UHCM	UHCW
Breast Cancer Screening (BCS-E)	54.88%	52.95%	58.15%	47.29%	53.39%	52.16%	52.03%
Follow-Up Care for Children Prescribed ADHD Medication (ADD-E):							
Initiation Phase	51.55%	44.75%	42.87%	46.14%	52.75%	48.58%	47.06%
Continuation and Maintenance Phase	61.85%	57.81%	64.56%	57.49%	65.12%	62.34%	65.18%
Depression Screening and Follow-Up for Adolescents and Adults (DSF-E)							
Depression Screening	0.00%	0.00%	0.16%	0.03%	0.01%	0.00%	0.05%
Follow-Up on Positive Screen	NA	NA	NA	NA	NA	NA	NA
Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults (DMS-E)							
Assessment Period 1	0.00%	0.00%	0.88%	0.00%	0.01%	0.00%	0.51%
Assessment Period 2	0.00%	0.00%	0.57%	0.00%	0.02%	0.00%	0.20%
Assessment Period 3	0.00%	0.00%	0.22%	0.00%	0.00%	0.00%	0.00%
Total	0.00%	0.00%	0.55%	0.00%	0.01%	0.00%	0.23%
Depression Remission or Response for Adolescents and Adults (DRR-E)							
Follow-Up	NA	NA	NA	NA	NA	NA	NA
Depression Remission	NA	NA	NA	NA	NA	NA	NA
Depression Response	NA	NA	NA	NA	NA	NA	NA
Unhealthy Alcohol Use Screening and Follow-Up (ASF-E)							
Alcohol Use Screening	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Counseling or Other Follow-up Positive Screen	NA	NA	NA	NA	NA	NA	NA
Adult Immunization Status (AIS-E)							
Influenza	13.65%	12.41%	11.94%	8.32%	14.58%	14.52%	10.75%
Td or Tdap	41.73%	29.9%	36.47%	31.17%	31.95%	30.04%	26.26%

Table C.1. HEDIS MY2020 Medicaid Plan-Specific Rates: ECDS Measures							
Measure	**BCE**	**BCM**	**BCW**	**TCS**	**UHCE**	**UHCM**	**UHCW**
Zoster	0.51%	0.64%	0.52%	0.31%	0.74%	0.81%	0.41%
Prenatal Immunization Status (PRS-E)							
Influenza	25.46%	24.37%	21.93%	21.03%	26.65%	23.88%	17.03%
Tdap	52.96%	42.63%	41.88%	42.06%	53.40%	42.00%	33.22%
Combination	19.94%	18.65%	16.42%	15.45%	20.19%	18.03%	12.55%
Prenatal Depression Screening and Follow-Up (PND-E)							
Depression Screening	0.00%	0.00%	0.03%	0.00%	0.00%	0.00%	0.00%
Follow-Up on Positive Screen	NA	NA	NA	NA	NA	NA	NA
Postpartum Depression Screening and Follow-Up (PDS-E)							
Depression Screening	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Follow-Up on Positive Screen	NA	NA	NA	NA	NA	NA	NA

Table C.2 presents statewide MCO results for HEDIS MY2020 LTSS measures. *Note: TCS does not have members who receive LTSS.*

Table C.2. HEDIS MY2020 Medicaid Plan-Specific Rates: LTSS Measures			
Measure	**AG**	**BC**	**UHC**
Comprehensive Assessment and Update (LTSS-CAU):			
Assessment of Core Elements	98.96%	90.63%	89.58%
Assessment of Supplemental Elements	98.96%	90.63%	89.58%
Comprehensive Care Plan and Update (LTSS-CPU):			
Care Plan with Core Elements Documented	100%	97.92%	87.50%
Care Plan with Supplemental Elements Documented	96.88%	97.92%	87.50%
Reassessment/Care Plan Update After Inpatient Discharge (LTSS-RAC):			
Reassessment After Inpatient Discharge	29.17%	45.83%	30.21%
Reassessment and Care Plan Update After Inpatient Discharge	26.04%	41.67%	28.13%
Shared Care Plan With Primary Care Practitioner (LTSS-SCP)	0.00%	44.79%	83.33%

APPENDIX D | Measure Reporting Options

Table D.1 presents the reporting options for each measure: administrative and/or hybrid. Currently, when the hybrid option is available, TennCare MCOs are required to use the hybrid method.

Table D.1. HEDIS MY2020 Measure Reporting Options: Administrative/Hybrid

Measure	Administrative	Hybrid
HEDIS Effectiveness of Care		
Prevention and Screening		
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)	✓	✓
Childhood Immunization Status (CIS)	✓	✓
Immunizations for Adolescents (IMA)	✓	✓
Lead Screening in Children (LSC)	✓	✓
Breast Cancer Screening (BCS)	✓	
Cervical Cancer Screening (CCS)	✓	✓
Chlamydia Screening in Women (CHL)	✓	
Respiratory Conditions		
Appropriate Testing for Pharyngitis (CWP)	✓	
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)	✓	
Pharmacotherapy Management of COPD Exacerbation (PCE)	✓	
Asthma Medication Ratio (AMR)	✓	
Cardiovascular Conditions		
Controlling High Blood Pressure (CBP)	✓	✓
Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)	✓	
Statin Therapy for Patients with Cardiovascular Disease (SPC)	✓	
Cardiac Rehabilitation (CRE)	✓	
Diabetes		
Comprehensive Diabetes Care (CDC)	✓	✓
Kidney Health Evaluation for Patients With Diabetes (KED)	✓	
Statin Therapy for Patients with Diabetes (SPD)	✓	
Behavioral Health		
Antidepressant Medication Management (AMM)	✓	
Follow-Up Care for Children Prescribed ADHD Medication (ADD)	✓	
Follow-Up After Hospitalization for Mental Illness (FUH)	✓	

Table D.1. HEDIS MY2020 Measure Reporting Options: Administrative/Hybrid		
Measure	**Administrative**	**Hybrid**
Follow-Up After Emergency Department Visit for Mental Illness (FUM)	✓	
Follow-Up After High-Intensity Care for Substance Use Disorder (FUI)	✓	
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence (FUA)	✓	
Pharmacotherapy for Opioid Use Disorder (POD)	✓	
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication (SSD)	✓	
Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD)	✓	
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (SMC)	✓	
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)	✓	
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)	✓	
Overuse/Appropriateness		
Non-Recommended Cervical Cancer Screening in Adolescent Females (NCS)	✓	
Appropriate Treatment for Upper Respiratory Infection (URI)	✓	
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB)	✓	
Use of Imaging Studies for Low Back Pain (LBP)	✓	
Use of Opioid at High Dosage (HDO)	✓	
Use of Opioids From Multiple Providers (UOP)	✓	
Risk of Continued Opioid Use (COU)	✓	
Measures Collected Through CAHPS Health Plan Survey		
Flu vaccinations for adults ages 18 to 64 (FVA)		
Medical Assistance With Smoking Cessation (MSC)		
HEDIS Access/Availability of Care Measures		
Adults' Access to Preventive/Ambulatory Health Services (AAP)	✓	
Initiation and Engagement of Alcohol and Other Drug (AOD) Dependence Treatment (IET)	✓	
Prenatal and Postpartum Care (PPC)	✓	✓
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)	✓	
HEDIS Utilization and Risk-Adjusted Utilization Measures		
Well-Child Visits in the First 30 Months of Life (W30)	✓	
Child and Adolescent Well-Care Visits (WCV)	✓	

Table D.2 presents the hybrid measures that were reported by MCOs with either MY2018 or MY2019 data for HEDIS 2020.

Table D.2. HEDIS 2020 Hybrid Measures Data Reporting (MY2018 or MY2019)

Measure	AGE	AGM	AGW	BCE	BCM	BCW	TCS	UHCE	UHCM	UHCW	CK BC
HEDIS Effectiveness of Care											
Prevention and Screening											
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)	**MY2018**	**MY2018**	**MY2018**	**MY2018**	**MY2018**	**MY2018**	**MY2018**	MY2019	MY2019	MY2019	**MY2018**
Childhood Immunization Status (CIS)	**MY2018**	MY2019	**MY2018**	**MY2018**	MY2019	MY2019	MY2019	MY2019	**MY2018**	MY2019	MY2019
Immunizations for Adolescents (IMA)	MY2019	MY2019	**MY2018**	MY2019	MY2019	MY2019	MY2019	MY2019	MY2019	MY2019	MY2019
Lead Screening in Children (LSC)	**MY2018**	MY2019	**MY2018**	**MY2018**	**MY2018**	MY2019	MY2019	**MY2018**	**MY2018**	**MY2018**	MY2019
Cervical Cancer Screening (CCS)	**MY2018**	**MY2018**	**MY2018**	**MY2018**	**MY2018**	**MY2018**	MY2019	MY2019	MY2019	MY2019	**MY2018**
Cardiovascular Conditions											
Controlling High Blood Pressure (CBP)	**MY2018**	**MY2018**	**MY2018**	**MY2018**	**MY2018**	**MY2018**	**MY2018**	**MY2018**	**MY2018**	**MY2018**	**MY2018**
Diabetes											
Comprehensive Diabetes Care (CDC)	**MY2018**	**MY2018**	**MY2018**	**MY2018**	**MY2018**	**MY2018**	**MY2018**	MY2019	MY2019	MY2019	**MY2018**
HEDIS Access/Availability of Care Measures											
Prenatal and Postpartum Care (PPC)	MY2019	**MY2018**	MY2019	MY2019	MY2019	MY2019	MY2019	MY2019	MY2019	MY2019	MY2019

APPENDIX E | CHIP Results

Rates reported in the following tables are for **CK BC**, the only HPA during HEDIS MY2020. Cells are shaded gray for those measures that were not calculated or for which data were not reported. HEDIS definitions for measures apply to all lines of business.

Table E.1. HEDIS MY2020 Utilization Measures: CHIP Plan-Specific Rates for the HPA

Frequency of Selected Procedures (FSP)

Age	Sex	Procedures/1,000 Member Months	Age	Sex	Procedures/1,000 Member Months
Bariatric Weight Loss Surgery:			**Cholecystectomy—Open (O) and Laparoscopic (L):**		
0–19	M	0.00	30–64 (O)	M	0.00
	F	0.00	15–44 (O)	F	0.01
20–44	M	0.00	45–64 (O)		0.00
	F	0.00	30–64 (L)	M	0.00
45–64	M		15–44 (L)	F	0.64
	F	0.00	45–64 (L)		2.25
Tonsillectomy:			**Back Surgery:**		
0–9	M&F	0.76	20–44	M	0.00
10–19		0.23		F	0.02
Hysterectomy—Abdominal (A) and Vaginal (V):			45–64	M	
15–44 (A)	F	0.06		F	0.00
45–64 (A)		0.00	**Mastectomy:**		
15–44 (V)	F	0.00	15–44	F	0.01
45–64 (V)		2.25	45–64	F	0.00
Lumpectomy:					
15–44	F	0.01	45–64	F	0.00

Ambulatory Care: Total (AMB)

Total: Visits/1,000 Member Months	Outpatient Visits	ED Visits
	212.74	19.60

Table E.1. HEDIS MY2020 Utilization Measures: CHIP Plan-Specific Rates for the HPA

Inpatient Utilization—General Hospital/Acute Care: Total (IPU)

Per 1,000 Members Months		Average # of Days:	Per 1,000 Members Months		Average # of Days:
Discharges	**Days**	**Average Length of Stay**	**Discharges**	**Days**	**Average Length of Stay**
Total Inpatient			***Medicine***		
12.04	29.32	2.44	0.42	1.34	3.19
Surgery			***Maternity***		
0.30	1.76	5.94	17.69	40.96	2.32

Identification of Alcohol and Other Drug Services: Total (IAD)

Sex	Any Services	Inpatient	Intensive	Outpatient/Medication	ED	Telehealth
M	0.44%	0.07%	0.05%	0.21%	0.11%	0.12%
F	0.46%	0.16%	0.03%	0.23%	0.11%	0.06%
Total	**0.45%**	**0.12%**	**0.04%**	**0.22%**	**0.11%**	**0.09%**

Mental Health Utilization: Total (MPT)

Sex	Any Services	Inpatient	Intensive	Outpatient	ED	Telehealth
M	8.26%	0.30%	0.07%	6.81%	0.00%	3.48%
F	5.91%	0.41%	0.04%	4.35%	0.03%	3.09%
Total	**6.88%**	**0.36%**	**0.05%**	**5.37%**	**0.01%**	**3.25%**

Antibiotic Utilization: Total (ABX)

Sex	*Antibiotics*		*Antibiotics of Concern*	
	Average Scripts PMPY	**Average Days Supplied Script**	**Average Scripts PMPY**	**% of All Antibiotic Scripts**
M	0.44	10.98	0.18	41.03%
F	0.52	9.93	0.19	36.15%
Total	**0.49**	**10.32**	**0.19**	**37.97%**

Antibiotics of Concern Utilization (Average Scripts PMPY)

Sex	Quinolones	Cephalosporins 2nd-4th Generation	Azithromycins and Clarithromycins	Amoxicillin/ Clavulanates	Ketolides	Clindamycins	Misc. Antibiotics of Concern
M	0.00	0.06	0.06	0.05	0.00	0.01	0.00
F	0.01	0.05	0.07	0.05	0.00	0.01	0.00
Total	**0.00**	**0.06**	**0.06**	**0.05**	**0.00**	**0.01**	**0.00**

Table E.1. HEDIS MY2020 Utilization Measures: CHIP Plan-Specific Rates for the HPA								
All Other Antibiotics Utilization (Average Scripts PMPY)								
Sex	**Absorbable Sulfonamides**	**Amino-glycosides**	**1st Generation Cephalosporins**	**Lincosamides**	**Macrolides (not azith. or clarith.)**	**Penicillins**	**Tetracyclines**	**Misc. Antibiotics**
M	0.02	0.00	0.04	0.00	0.00	0.17	0.03	0.00
F	0.03	0.00	0.05	0.00	0.00	0.14	0.03	0.08
Total	**0.03**	**0.00**	**0.04**	**0.00**	**0.00**	**0.15**	**0.03**	**0.05**

Table E.2. HEDIS MY2020 HPA Rates: PCR	
Measure by Age	**CK BC**
Plan Population: Observed Readmission Rate	
18–44	1.67%
45–54	33.33%
55–64	
Total	3.17%

Table E.3. HEDIS MY2020 CHIP Population in HPA Member Months

Age Group	Sex	CK BC
<1	M	2,836
	F	2,772
	M & F	5,608
1–4	M	31,884
	F	31,124
	M & F	63,008
5–9	M	54,697
	F	52,412
	M & F	107,109
10–14	M	62,356
	F	60,514
	M & F	122,870
15–17	M	33,609
	F	33,399
	M & F	67,008
18–19	M	14,896
	F	18,513
	M & F	33,409
20–24	M	832
	F	21,290
	M & F	22,122
25–29	M	0
	F	25,532
	M & F	25,532
30–34	M	0
	F	22,003
	M & F	22,003
35–39	M	2
	F	14,725
	M & F	14,727
40–44	M	0
	F	4,493
	M & F	4,493

Table E.3. HEDIS MY2020 CHIP Population in HPA Member Months

Age Group	Sex	CK BC
45–49	M	0
	F	418
	M & F	418
50–54	M	0
	F	27
	M & F	27
55–59	M	0
	F	0
	M & F	0
60–64	M	0
	F	0
	M & F	0
65–69	M	0
	F	0
	M & F	0
70–74	M	0
	F	0
	M & F	0
75–79	M	0
	F	0
	M & F	0
80–84	M	0
	F	0
	M & F	0
85–89	M	0
	F	0
	M & F	0
≥90	M	0
	F	0
	M & F	0
Total	**M**	**201,112**
	F	**287,222**
	M & F	**488,334**

The HPA had the option to report ECDS measure results for HEDIS MY2020, which are presented in **Table E.4**.

Table E.4. HEDIS MY2020 HPA Rates: ECDS Measures

Measure	CK BC
Breast Cancer Screening (BCS-E)	NA
Follow-Up Care for Children Prescribed ADHD Medication (ADD-E):	
Initiation Phase	49.16%
Continuation and Maintenance Phase	65.00%
Depression Screening and Follow-Up for Adolescents and Adults (DSF-E):	
Depression Screening	0.01%
Follow-Up on Positive Screen	NA
Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults (DMS-E):	
Assessment Period 1	0.00%
Assessment Period 2	0.00%
Assessment Period 3	0.00%
Total	0.00%
Depression Remission or Response for Adolescents and Adults (DRR-E):	
Follow-Up	NA
Depression Remission	NA
Depression Response	NA
Unhealthy Alcohol Use Screening and Follow-Up (ASF-E):	
Alcohol Use Screening	0.00%
Counseling or Other Follow-up Positive Screen	NA
Adult Immunization Status (AIS-E):	
Influenza	28.00%
Td or Tdap	51.32%
Zoster	NA
Prenatal Immunization Status (PRS-E):	
Influenza	33.43%
Tdap	54.26%
Combination	28.90%
Prenatal Depression Screening and Follow-Up (PND-E):	
Depression Screening	0.00%
Follow-Up on Positive Screen	NA

Table E.4. HEDIS MY2020 HPA Rates: ECDS Measures	
Measure	**CK BC**
Postpartum Depression Screening and Follow-Up (PDS-E):	
Depression Screening	0.00%
Follow-Up on Positive Screen	NA

Attachment L:
2021 Update to the Quality Assessment and Performance Improvement Strategy

2021 UPDATE TO THE QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT STRATEGY

TABLE OF CONTENTS

Per 42 CFR 438.202(a), each state contracting with a Managed Care Organization (MCO) or Prepaid Inpatient Health Plan (PIHP) must have a written strategy for assessing and improving the quality of managed care services offered by all MCOs and PIHPs.

SECTION I: INTRODUCTION

Managed Care Goals, Objectives, and Overview

CMS Requirement: Include a brief history of the State's Medicaid managed care programs.

On January 1, 1994, Tennessee launched TennCare, a new health care reform program. This original TennCare waiver, TennCare I, essentially replaced the Medicaid program in Tennessee, moving almost the entire Medicaid program into a managed care model.

TennCare I was implemented as a five-year demonstration program and received several extensions after the initial waiver expiration date of December 30, 1999. TennCare I extended coverage to large numbers of uninsured and uninsurable people, and almost all benefits were delivered by Managed Care Organizations (MCOs) of varying size, operating at full risk. Enrollees under the TennCare program are eligible to receive only those medical items and services that are within the scope of defined benefits for which the enrollee is eligible and determined by the TennCare program to be medically necessary.

TennCare II, the demonstration program that started on July 1, 2002, revised the structure of the original program in several important ways. The program was divided into "TennCare Medicaid" and "TennCare Standard." TennCare Medicaid serves Medicaid eligibles, while TennCare Standard serves the demonstration population.

In 2004, in the face of projections that TennCare's growth would soon make it impossible for the state to meet its obligations in other critical areas, Governor Phil Bredesen proposed a TennCare Reform package to accomplish goals such as "rightsizing" program enrollment and reducing the dramatic growth in pharmacy spending. With approval from the Centers for Medicare & Medicaid Services (CMS), the state began implementing these modifications in 2005.

On October 5, 2007, the waiver for the TennCare II extension was approved for three additional years. Subsequent extensions of the TennCare II managed care demonstration were approved in 2009 and 2013.

On July 22, 2009 TennCare received approval from CMS for a demonstration amendment to implement the CHOICES program outlined by the State's Long-Term Care Community Choices Act of 2008. Under the CHOICES program, the State provides Nursing Facility (NF) services, as well as community-based alternatives to people who would otherwise require Medicaid-reimbursed care in a NF, and to those at risk of NF placement. The CHOICES program utilizes the existing Medicaid MCOs to provide eligible individuals with NF services or home and community-based services (HCBS). Tennessee was one of the first states in the country to implement managed Medicaid long-term services and supports (LTSS) and in a manner that

does not require enrollees to change their MCO.

With implementation of the CHOICES program, the MCOs became responsible for coordination of all covered medical, behavioral, and LTSS provided to their members, age 65 and older and adults age 21 and older with physical disabilities enrolled in the program.

Effective July 1, 2016, the Employment and Community First CHOICES program was added to the managed care demonstration. Employment and Community First CHOICES is an integrated managed LTSS program that is specifically geared to align incentives toward promoting and supporting integrated, competitive employment and independent, integrated community living as the first and preferred option for individuals with I/DD.

The newest iteration of the TennCare demonstration waiver, known as "TennCare III," was approved by CMS in January 2021. TennCare III extends the life of Tennessee's managed care program for 10 more years. Today, TennCare is a mature, data-driven managed care program with well-functioning component parts and a stable, established infrastructure that delivers high-quality care to many of the state's most vulnerable citizens. In its current approval period, TennCare retains its commitment to the program's core values, including broad access to care, improved health status of program participants, and cost-effective use of resources.

All Medicaid and demonstration eligibles are enrolled in TennCare, including those full benefit dually eligible for TennCare and Medicare. There are approximately 1.49 million persons currently enrolled in TennCare as of December 2020. There are several TennCare eligibility categories.

TennCare Medicaid serves Tennesseans who are eligible for a Medicaid program. Some of the groups TennCare Medicaid covers include:

- Low income children under age 19
- Women who are pregnant
- Caretakers of a minor child
- Individuals who need treatment for breast or cervical cancer
- People who receive Supplemental Security Income (SSI).
- People who have received both an SSI check and a Social Security check for the same month at least once since April 1977 AND who still receive a Social Security check
- People who live in a nursing home and have income below $2,349 per month (300% of SSI benefit) OR receive other long-term care services that TennCare pays for

TennCare Standard is available for children under age 19 who are losing their TennCare Medicaid AND lack access to group health insurance through their parents' employer.

CMS Requirement: Include an overview of the quality management structure that is in place at the state level.

TennCare's commitment to quality and continuous improvement in the lives of Tennesseans are reflected in its Vision and Mission Statements:

Vision Statement: "A healthier Tennessee"

Mission Statement: "Improving lives through high-quality cost-effective care."

Core Values:

- **C**ommitment: Ensuring that Tennessee taxpayers receive value for their tax dollars
- **A**gility: Be nimble when situations require change
- **R**espect: Treat everyone as we would like to be treated
- **I**ntegrity: Be truthful and accurate
- **N**ew Approaches: Identify innovative solutions
- **G**reat customer service: Exceed expectations

All quality improvement activities are consistent with the "three aims" outlined in the National Quality Strategy for better care, healthy people/healthy communities, and affordable care. Stephen Smith is the Deputy Commissioner and Director of TennCare for the State of Tennessee. The Chief Medical Officer for TennCare, Victor Wu, M.D., M.P.H, reports to Director Stephen Smith and in turn provides supervision for the Quality Improvement, Pharmacy, Dental, Provider Services, TennCare Solutions Unit, and Medical Appeals Divisions of TennCare. The Division of Quality Improvement is led by Karly Campbell and is comprised of a staff of 20 individuals.

The Division of Quality Improvement (QI) is responsible for leading the quality strategy for TennCare working across the Division to coordinate and support quality measurement and reporting. Additionally, the QI Division monitors many of the activities of the MCOs and enforces quality requirements defined in the MCO Contractor Risk Agreement. This Division is also responsible for developing and monitoring the External Quality Review Organization (EQRO) contract as well as contracts with the Tennessee Department of Health.

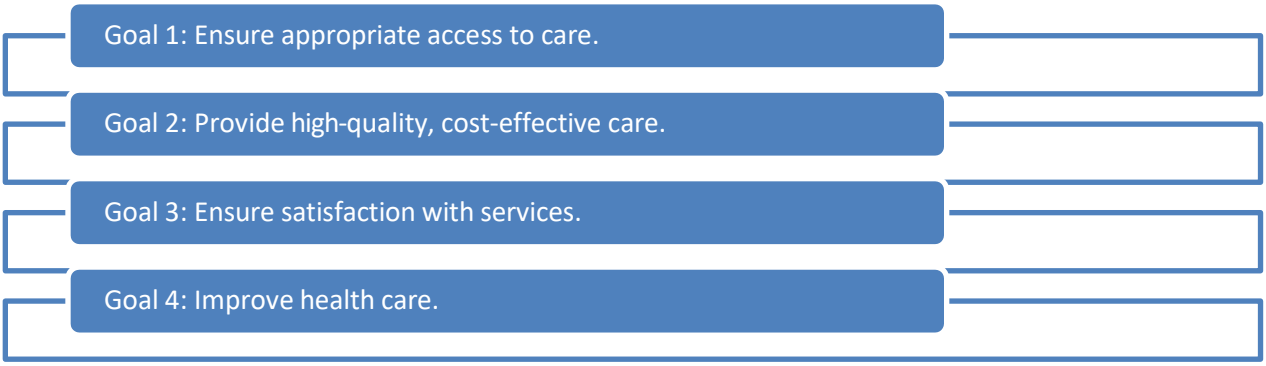
CMS Requirement: Include general information about the state's decision to contract with MCOs/PIHPs (i.e., to address issues of cost, quality, and/or access). Include the reasons why the state believes the use of a managed care system will positively impact the quality of care delivered in Medicaid.

The State's decision to contract with MCOs and a Prepaid Inpatient Health Plan (PIHP) for most services, as well as two PAHPs for pharmacy and dental, is rooted in more than 20 years of experience with managed care in Tennessee. The use of these Managed Care Contractors (MCCs) has allowed the State to move from the role of being primarily a payer of claims to a role of orchestrating and coordinating an entire system of care. The use of MCCs without appropriate oversight and direction cannot guarantee a cost-effective system that delivers quality care. However, we have learned that when the state is willing and able to leverage meaningful oversight strategies, managed care offers the best chance of delivering

the kind of system we want. Goals addressing cost, quality, and access can be built into the system, along with carrots and sticks to make sure these goals are reached. Such levers are largely unavailable in a fee-for-service system.

CMS Requirement: Include a description of the goals and objectives of the state's managed care program. This description should include priorities, strategic partnerships, and quantifiable performance driven objectives. These objectives should reflect the state's priorities and areas of concern for the population covered by the MCO/PIHP contracts.

Four primary goals for TennCare enrollees shape the Quality Strategy. Ensuring appropriate access to care, providing quality, cost-effective care, and assuring satisfaction with services are processes that ultimately contribute to the fourth goal of improving health care.



These four goals and their associated objectives align with the three aims of the National Quality Strategy:

- ***Better Care*** **-** Improve the overall quality of care by making health care more patient-centered, reliable, accessible, and safe.
- ***Healthy People/Healthy Communities*** **-** Improve the health of the United States population by supporting proven interventions to address behavioral, social, and environmental determinants of health in addition to delivering higher-quality care.
- ***Affordable Care*** **-** Reduce the cost of quality health care for individuals, families, employers, and government.

Progress toward these four goals is gauged by physical health, behavioral health, and long-term services and support performance measures. The objectives are drawn from nationally recognized and respected measure sets. Many of the strategy objectives are statewide weighted Healthcare Effectiveness Data and Information Set (HEDIS) rates. The MCOs annually complete and submit all applicable HEDIS measures designated by the National Committee for Quality Assurance (NCQA) as relevant to Medicaid. The MCOs are required to contract with an NCQA-certified HEDIS auditor that validates the processes of the health plan in accordance with NCQA requirements.

Strategy Goals and Objectives

The tables below present the Quality Strategy goals and objectives established by the State for physical and behavioral health as well as Long Term Services and Supports.

Physical and Behavioral Health Goals	
Goal 1: Ensure appropriate access to care for enrollees	
Objective 1.1: The CMS-416 EPSDT screening rate will show incremental improvement through 2021 and beyond, bringing the statewide rate to the CMS standard of 80% in the coming years. 2020 Update: CMS-416 ESPDT screening rate increased from 77% to 79% from FFY18 to FFY19. In FY18 there were 16 counties with screening rates between 61-69%, and had shown similar, if not lower, rates in previous years. In FY19, 5 of the 16 counties showed improvement between 5-9% points, 8 of the 16 counties showed improvement between 2-4% points, and the remaining 3 counties showed a decrease in their screening rate. Overall, 7 of the 16 counties improved to at least a 70% screening rate in FY19. 2021 Goal: Continued goal of reaching the 80% benchmark for the statewide rate, with an added focus of increasing the statewide participant ratio. The statewide participant ratio for FY19 is 61%.	Data Sources: MCO Claims Data Report: A Comparative Analysis of Audited Results from TennCare MCOs and CMC-416
Objective 1.2: TennCare will establish and begin monitoring travel time standards to augment existing travel distance standards for primary care (adult and pediatric), OB/GYN, behavioral health, specialist (adult and pediatric), hospital, pharmacy, and pediatric dental networks. 2020 Update: All managed care plans achieved 100% compliance or have an approved corrective action plan in place. 2021 Goal: All managed care plans will establish a separate provider network for the Children's Health Insurance Program (CHIP), known as the CoverKids membership transitioning to the plans effective 1/1/2021. TennCare will monitor travel time and travel distance standards for primary care, behavioral health, specialist, hospital and other provider types for compliance.	Data Source: TennCare Provider Services

Objective 1.3: By 2023, at least 45% of TennCare members will be cared for through a Patient Centered Medical Home (PCMH) model. All participating sites will provide care delivery services that ensure appropriate access to care for members as evidenced by achieving or renewing NCQA PCMH recognition. 2020 Update: All of the MCOs met the requirement to have 37% of their membership attributed to a PCMH organization. Approximately 42% of TennCare members are served by a PCMH organization. 93% of sites have NCQA PCMH recognition. PCMH family practices, pediatric practices, and adult-only practices are measured on 13, 8, and 5, quality metrics, respectively. All PCMH organizations are provided quarterly Provider Reports showing their performance compared to other PCMH organizations statewide on total cost of care (including TCOC categories), behavioral health spend (including behavioral health categories), and all quality and efficiency measures. 2021 Goal: By 2021, the following will be maintained at a minimum: • 37% of TennCare members will be served by a PCMH organization • 90% of sites will have NCQA PCMH recognition	Data Source: TennCare Quality Improvement, PCMH quality data, PCMH NCQA reports
Goal 2: Provide high-quality, cost effective care to enrollees	
Objective 2.1: By 2021, statewide HEDIS rates for timeliness of prenatal care, frequency of ongoing prenatal care (≥81% of expected visits), and postpartum care will improve to the national medians: 2017 Baseline and 2020 Update: • Timeliness of prenatal care: from 76.94% to 83.68% • Postpartum care: from 59.35% to 70.20% 2021 Goal: • Timeliness of prenatal care: 87.38% • Postpartum care: 75.22%	Data Source: HEDIS/ CAHPS Report: A Comparative Analysis of Audited Results from TennCare MCOs. *

Objective 2.2: In 2021, TennCare will update the quality metrics in its perinatal episode of care, based on both provider feedback and clinical best practices. 2020 Update: • In 2020, TennCare implemented opioid related quality metrics for all procedural episodes of care. These are in quarterly performance reports, so providers can see how their performance compares to their peers.	Data Source: TennCare Strategic Planning and Innovation Group
Objective 2.3: Through 2020, the number of TennCare members enrolled in the Tennessee Health Link program for members with the highest behavioral health needs will remain at least 60,000 members each month. 2020 Update: • Health Link practices were measured on 10 quality metrics in 2019: 8 core NCQA HEDIS measures and 2 custom measures.	Data Source: TennCare Behavioral Health enrollment data
• Out of the 8 core quality measures that are both in 2018 and 2019, only two measures showed improvement across all of the providers. • From 2018 to 2019 there was no improvement in all 4 behavioral health measures • From 2018 to 2019, of the 4 physical health measures, 2 improved and 2 decreased. • All 19 providers received quarterly reports about performance. Over 70,000 members have been consistently enrolled in THL every month	
2021 Goal: Health Link practices will be measured on 9 quality metrics, and 100% providers will be given quarterly updates on how their performance compares to their peers statewide.	

Objective 2.4: By 2024 statewide HEDIS rates for the following child and adolescent immunization measures will improve to the 75th percentile. • Childhood Immunization Status (CIS) Combo 10 • Immunizations for Adolescents (IMA) Combo 2 2020 Baseline: • CIS Combo 10: 35.66% • IMA Combo 2: 32.49% 2021 Goals: • CIS Combo 10: 39.17 (66.67th Percentile) • IMA Combo 2: 34.43% (50th Percentile)	Data Source: HEDIS/ CAHPS Report: A Comparative Analysis of Audited Results from TennCare MCOs. *
Goal 3: Ensure enrollees' satisfaction with services.	
Objective 3.1: Through 2021, the number of TennCare enrollees who expressed satisfaction with TennCare will remain at least 95%. 2020 Update: Due to the COVID-19 pandemic, this survey was delayed. TennCare enrollee satisfaction with TennCare was 94% in the most recent survey of TennCare recipients, conducted in 2019. 2021 Goal: TennCare enrollee satisfaction with TennCare will reach 95% or higher in the annual survey of TennCare recipients.	Data source: The Impact of TennCare: A Survey of Recipients.
Objective 3.2: The statewide average for CAHPS measures Getting Needed Care (responding "Always" or "Usually") will remain above 82.48% for the adult Medicaid population and 86.82% for the child Medicaid population. 2020 Update: The measure for Getting Needed Care ("Always" and "Usually") in CAHPS 2020 (MY 2019) was 85.77% for the adult Medicaid population and 88.84% for the child Medicaid population. 2021 Goal: CAHPS measure for Getting Needed Care ("Always" and "Usually") will remain above 83.42% for the adult Medicaid population and 86.5% for the child Medicaid population.	Data Source: HEDIS/ CAHPS Report: A Comparative Analysis of Audited Results from TennCare MCOs. * NCQA Quality Compass
Goal 4: Improve health care for program enrollees	

Objective 4.1: By 2024, the statewide HEDIS rates related to child and adolescent weight management will improve to the 75th percentile: 2020 Baseline: • BMI Percentile Documentation: 80.51% • Counseling for Nutrition: 70.68% • Counseling for Physical Activity 66.74% 2021 Goal: • BMI percentile documentation: 83.45% (66.67th Percentile) • Counseling for nutrition75.67% (66.67th Percentile) • Counseling for physical activity: 71.53% (66.67th Percentile)	Data Source: HEDIS/ CAHPS Report: A Comparative Analysis of Audited Results from TennCare MCOs. *
Objective 4.2: TennCare members will show improvement across the following Population Health outcome measures: 2017 Baseline and 2020 Update: • Emergency department visits per 1000 members: 643.2 to 593 • Readmissions (within 30 days) per 100 members: 12.2 to 13.6 • End stage renal disease per 100 members with diabetes: 7.4 to 7.8 2021 Goals: • Emergency department visits per 1000 members: improve to 582 in CY 2020 • Readmissions (within 30 days) per 100 members: improve to 10.7 in CY 2020 • End stage renal disease per 100 members with diabetes: improve to 7.0 in CY 2020	Data Source: TennCare Informatics Population Health Outcome Measures

* Note, NCQA allowed health plans to report 2018 rates in 2019 for some HEDIS measures.

Long-Term Services and Supports

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

measures of compliance with federal and/or state requirements. Upon implementation of Employment and Community First CHOICES, these performance measures were expanded to encompass the new program.

In addition, we have incorporated quality components of the Medicaid Managed Care Rule specified in 42 C.F.R. § 438.330. More recently, STC 46 to the TennCare II Demonstration, *Quality Improvement Strategy for 1915(c) or 1915(i)-approvable HCBS Services*, requires that ***"****the state's Quality Assessment and Performance Improvement Plan must encompass LTSS-specific measures set forth in the federal rule and should also reflect how the State will assess and improve performance to demonstrate compliance with applicable federal waiver assurances set forth in 42 CFR 441.301 and 441.302."*

The following sections state the performance measurement goals and objectives for the State's two MLTSS programs – CHOICES and Employment and Community First CHOICES.

Long-Term Services and Support		
Goal 1: CHOICES and Employment and Community First CHOICES members have a level of care determination indicating the need for institutional services or being "At-Risk" for institutional placement, as applicable, prior to enrollment in CHOICES or Employment and Community First CHOICES, as applicable, and receipt of Medicaid-reimbursed HCBS.		
Domain	**Performance Measure**	**Measurement Method**
Level of Care	100% (or all) of CHOICES and Employment and Community First CHOICES members will have an approved CHOICES Pre-Admission Evaluation (i.e., nursing facility or At-Risk level of care eligibility, as applicable) prior to enrollment in CHOICES or Employment and Community First CHOICES and receipt of Medicaid-reimbursed HCBS. 100% remediation of all individual findings is expected; compliance percentage at or below 85% requires a quality improvement plan.	Data Source: MMIS report Sampling Approach: 100% of all CHOICES and Employment and Community First CHOICES members enrolled
Goal 2: CHOICES members are offered a choice between institutional (NF) services and HCBS.		
Domain	**Performance Measure**	**Measurement Method**

Service Plan	100% (or all) of CHOICES Group 2 member records will have an appropriately completed and signed freedom of choice form that specifies choice was offered between institutional services and HCBS. 100% remediation of all individual findings is expected; compliance percentage at or below 85% requires a quality improvement plan.	Data Source: Member Record Review Sampling Approach: Stratified, with strata comprised of newly enrolled and existing CHOICES Group 2 members enrolled in each of the MCOs per region serving the CHOICES Group 2 HCBS population. A 90% confidence level, based on a 10% margin of error, will be achieved. Any records used previously in an existing member record review will be excluded.

Goal 3: LTSS Assessment Composite		
Domain	**Performance Measure**	**Measurement Method**
Service Plan	100% (or all) of CHOICES Group 2 and 3 and Employment and Community First CHOICES members will have a comprehensive assessment that meets requirements specified in the CRA and/or TennCare protocol, completed within the timeframes specified in the CRA. 100% remediation of all individual findings is expected; compliance percentage at or below 85% requires a quality improvement plan.	Data Source: Member Record Review Sampling Approach: Stratified, with strata comprised of newly enrolled and existing CHOICES Groups 2 and 3 and Employment and Community First CHOICES members enrolled in each of the MCOs per region serving the CHOICES and/or Employment and Community First CHOICES population. A 90% confidence level, based on a 10% margin of error, will be achieved. Any records used previously in a member record review will be excluded.
Goal 4: LTSS Person Centered Support Plan Composite		
Domain	**Performance Measure**	**Measurement Method**

Service Plan	100% (or all) of CHOICES Group 2 and 3 and Employment and Community First CHOICES members will have a PCSP that meets requirements specified by the CRA and/or in TennCare protocol. 100% remediation of all individual findings is expected; compliance percentage at or below 85% requires a quality improvement plan.	Data Source: Member Record Review Sampling Approach: Stratified, with strata comprised of newly enrolled and existing CHOICES Group 2 and 3 and Employment and Community First CHOICES members enrolled in each of the MCOs per region servicing the CHOICES HCBS and/or Employment and Community First CHOICES population. A 90% confidence level, based on a 10% margin of error, will be achieved. Any records used previously in an existing member record review will be excluded.
Goal 5: Plans of Care are reviewed/updated at least annually.		
Domain	**Performance Measure**	**Measurement Method**
Service Plan	100% (or all) of CHOICES Groups 2 and 3 and Employment and Community First CHOICES members will have a PCSP that was reviewed and updated prior to the member's annual review date. as the individual's needs change significantly, and per the individual's request. 100% remediation of all individual findings is expected; compliance percentage at or below 85% requires a quality improvement plan.	Data Source: Member Record Review Sampling Approach: Stratified, with strata comprised of newly enrolled and existing CHOICES Group 2 and 3 and Employment and Community First CHOICES members enrolled in each of the MCOs per region servicing the CHOICES HCBS and/or Employment and Community First CHOICES population. A 90% confidence level, based on a 10% margin of error, will be achieved. Any records used previously in an existing member record review will be excluded.
Goal 6: Person-Centered Support Plan (PCSP) reflect member goals, needs and preferences.		
Domain	**Performance Measures**	**Measurement Method**

Service Plan	100% (or all) of CHOICES Groups 2 and 3 and Employment and Community First CHOICES members will have a PCSP that clearly identifies the member's needs, preferences and timed and measurable goals, along with services and supports that are consistent with the member's needs, preferences, and goals. 100% remediation of all individual findings is expected; compliance percentage below 85% requires a quality improvement plan.	Data Source: Member Record Review Sampling Approach: Stratified, with strata comprised of newly enrolled and existing CHOICES Group 2 and 3 and Employment and Community First CHOICES members enrolled in each of the MCOs per region servicing the CHOICES HCBS and/or Employment and Community First CHOICES population. A 90% confidence level, based on a 10% margin of error, will be achieved. Any records used previously in an existing member record review will be excluded.

Goal 7: Employment and Community First CHOICES members of working age participate in an employment informed choice process to help them understand and explore individual integrated employment and self-employment options.		
Domain	**Performance Measure**	**Measurement Method**
Service Plan	100% (or all) of Employment and Community First CHOICES members of working age will have signed documentation that indicates the employment informed choice process was initiated for individuals needing community integration supports and/or independent living skills training services, or that employment services were authorized and initiated concurrently with community integration supports and/or independent living skills training services. 100% remediation of all individual findings is expected; compliance percentage below 85% requires a quality improvement plan.	Data Source: Member Record Review Sampling Approach: Stratified, with strata comprised of newly enrolled and existing and Employment and Community First CHOICES members enrolled in each of the MCOs per region servicing the Employment and Community First CHOICES population. A 90% confidence level, based on a 10% margin of error, will be achieved. Any records used previously in an existing member record review will be excluded.
Goal 8: CHOICES Group 2 and 3 and Employment and Community First CHOICES members (or their family member/authorized representative, as applicable) receive education/information at least annually about how to identify and report instances of abuse, neglect, and exploitation.		
Domain	**Performance Measure**	**Measurement Method**

Health and Welfare	100% (or all) of CHOICES Group 2 and 3 and Employment and Community First member records will document that the member (or their family member/authorized representative, as applicable) received education/information at least annually regarding how to identify and report abuse, neglect and exploitation. 100% of remediation of all individual findings is expected; compliance percentage below 85% requires a quality improvement plan.	Data Source: Member Record Review Sampling Approach: Stratified, with strata comprised of newly enrolled and existing CHOICES Group 2 and 3 and Employment and Community First CHOICES members enrolled in each of the MCOs per region servicing the CHOICES HCBS and/or Employment and Community First CHOICES population. A 90% confidence level, based on a 10% margin of error, will be achieved. Any records used previously in an existing member record review will be excluded.
Goal 9: CHOICES Critical Incidents and Employment and Community First CHOICES Reportable Events are reported within timeframes specified in the Contractor Risk Agreement.		
Domain	**Performance Measure**	**Measurement Method**
Health and Welfare	100% (or all) of CHOICES and Employment and Community First CHOICES Reportable Event records will indicate the incident/event was reported within timeframes specified in the CRA. 100% remediation of all individual findings is expected; compliance percentage at or below 85% requires a quality improvement plan.	Data Source: Sample Record Review Sampling Approach: Stratified, with strata comprised of reported incidents for CHOICES Group 2 and 3 and Employment and Community First CHOICES members enrolled in each of the MCOs per region. The sample size will be based on a 90% confidence level with a 10% margin of error. A minimum of 20 records will be reviewed per MCO for each program.
Goal 10: CHOICES and Employment and Community First CHOICES members are informed of and afforded the right to request a Fair Hearing when services are denied, reduced, suspended, or terminated.		
Domain	**Performance Measure**	**Measurement Method**

Participant Rights	100% (or all) of CHOICES Group 2 and 3 and Employment and Community First CHOICES member records in which HCBS were denied, reduced, suspended, or terminated as evidenced in the PCSP as applicable will document that the member was informed of and afforded the right to request a Fair Hearing as determined by the presence of a notice of action. 100% remediation of all individual findings is expected; compliance percentage at or below 85% requires a quality improvement plan.	Data Source: Member Record Review Sampling Approach: Stratified, with strata comprised of newly enrolled and existing CHOICES Group 2 and 3 and Employment and Community First CHOICES members enrolled in each of the MCOs per region servicing the CHOICES HCBS and/or Employment and Community First CHOICES population. A 90% confidence level, based on a 10% margin of error, will be achieved. Any records used previously in an existing member record review will be excluded.

Additional information about the approach to these objectives can be found in Attachment VI: Additional Information on LTSS Objectives and Measurement.

Development and Review of Quality Strategy

CMS Requirement: Include a description of the formal process used to develop the quality strategy. This must include a description of how the state obtained the input of beneficiaries and other stakeholders in the development of the quality strategy. (42 CFR § 438.202(b))

CMS Requirement: Include a description of how the state made (or plans to make) the quality strategy available for public comment before adopting it in final. (42 CFR § 438.202(b))

TennCare develops its Quality Strategy with leadership from all divisions throughout TennCare. The Quality Improvement team within the Chief Medical Office is responsible for gathering information about goals, programs and initiatives from all the various divisions within TennCare. Additionally, TennCare uses the reports and findings from its EQRO to inform many aspects of the Quality Strategy.

Steps for revising the TennCare Quality Strategy include:

- Collaboration with appropriate divisions within TennCare, with the Division of Quality Improvement holding responsibility for creating the draft.
- Review of the draft by TennCare's Chief Medical Officer.
- After a final draft is completed, the Quality Strategy will be posted on TennCare's website for public review.
- After the designated time frame has elapsed, a final report will be developed including appropriate recommendations made during the public review period. The final Quality Strategy will be posted on TennCare's website.

CMS Requirement: Include an evaluation of the effectiveness of the quality strategy (e.g., monthly, quarterly, annually) and make results available on a website. (CFR § 438.340 (c)(2))

The effectiveness of the Quality Strategy is assessed at least once every three years by the state's External Quality Review Organization. The most recent copy of this assessment can be found in Attachment VII.

CMS Requirement: Include a timeline for modifying or updating the quality strategy. If this is based on an assessment of "significant changes," include the state's definition of "significant changes." (42 CFR § 438.202(d))

TennCare will update its quality strategy annually and will include significant changes that have occurred as well as updated evaluation data. Significant changes are defined as changes that: 1) alter the structure of the TennCare Program; 2) change benefits; and 3) include changes in MCCs. Updated interventions/activities will also be provided. Every three years, TennCare will coordinate a comprehensive review and update.

CMS Requirement: The state must discuss how updates to the quality strategy take into consideration the recommendations provided by an External Quality Review Organization (EQRO) pursuant to 42 CFR 438.364(a)(4). 42 CFR 438.340(c)(2)(iii) and 457.1240(e)

TennCare will update its quality strategy with recommendations identified in the EQRO's Quality Strategy Effectiveness Evaluation. The Chief Quality Officer and Chief Medical Officer will review the recommendations and indicate which recommendations TennCare will adopt in the following year's Quality Strategy.

SECTION II: ASSESSMENT

Quality and Appropriateness of Care

CMS Requirement: Summarize state procedures that assess the quality and appropriateness of care and services furnished to all Medicaid enrollees under the MCO and PIHP contracts, and to individuals with special health care needs. This must include the state's definition of special health care needs. (42 CFR § 438.204(b)(1)).

Since TennCare's inception, a continuous quality improvement (QI) process has been in place and has been refined over time. Assessment occurs in a variety of ways. Examples of these are listed below.

- TennCare requires all MCOs to be NCQA accredited. MCOs are required, by contract, to provide TennCare with the entire accreditation survey and associated results. They are also required to submit to TennCare their annual NCQA Accreditation update. Accreditation information is available here: https://www.tn.gov/tenncare/members-applicants/managed-care-organizations.html
- All contracted MCOs are required to submit a full set of HEDIS and CAHPS data to TennCare annually. This information is also provided to Qsource, Tennessee's EQRO, for review and trending. Qsource then prepares an annual report of findings for TennCare. TennCare publishes outcomes on all HEDIS measures to its website annually. These results can be viewed here: https://www.tn.gov/tenncare/information-statistics/mco-quality-data.html
- QSource conducts Performance Measure Validation (PMV) on an annual basis for two HEDIS metrics chosen by TennCare.
- The MCOs are contractually required to submit a variety of reports to various divisions within TennCare. The reports include performance improvement projects (PIPs), Population Health, EPSDT, dental, CHOICES care coordination, annual quality improvement/utilization management (QI/UM) descriptions, evaluations and work plans, provider satisfaction surveys, dual eligible care coordination, etc. These reports are reviewed throughout the year by subject matter experts within TennCare.
- Tennessee's EQRO, Qsource, conducts an Annual Quality Survey (AQS) for each MCO, the Dental Benefits Manager, and the Pharmacy Benefits Manager, that evaluates contractual requirements related to quality and federal requirements.
- Annual audits are conducted to monitor compliance with federal requirements for Abortions, Sterilizations, and Hysterectomies (ASH).
- Long-Term Services and Supports staff conduct MCO audits related to compliance with the federal Special Terms and Conditions and requirements for TennCare's CHOICES and Employment and Community First CHOICES programs.
- Collaborative workgroups with all MCOs are held periodically. These workgroups address issues related to Population Health, EPSDT outreach, and high-risk maternity.
- Periodic meetings are held collaboratively with both MCOs and Dual Eligible Special Needs Populations Plans (D-SNPs) to discuss improved opportunities for coordinating care.

Coordination of Care for Dual Eligible Special Needs Plans (D-SNPs) Members

Since withdrawing from the Financial Alignment Demonstration in late 2012; Tennessee leverages Medicare Part C authority and the D-SNP platform, to help align members in the same health plan for Medicare and Medicaid benefits. Historically, D-SNP members disproportionately face barriers to care and increased risks related to health needs. LTSS utilizes the Medicare Improvements for Patients and Providers Act (MIPPA) agreement to require activities designed to support improved coordination of benefits across both programs for aligned members as well as members enrolled in a non-aligned D-SNP.

To promote member alignment in MCO and D-SNP enrollment, TennCare has employed the following strategies:

- ***Procurement-*** Beginning in 2015, all plans were required to have a statewide companion D-SNP or to include a plan for establishing a statewide companion D-SNP by 2016 in their proposals. All three MCOs have fully operational statewide D-SNPs. In 2018, United HealthCare began operating a Fully Integrated Dual Eligible Special Needs Plan (FIDE SNP) specific to the CHOICES population. United HealthCare implemented a D-SNP specific to Employment and Community First CHOICES members in 2019. The contractual requirements for this D-SNP are equivalent to a FIDE SNP. However, because the Employment and Community First CHOICES program is not yet capitated, and because Employment and Community First CHOICES does not contain an institutional benefit, the plan will not technically be a FIDE SNP. On January 1, 2020 BlueCare went live with their FIDE SNP plan specific to the CHOICES population and Amerigroup is currently seeking approval to begin their FIDE plan on January 1, 2021.
- ***Member Reassignment-*** With the implementation of the statewide Medicaid contracts, TennCare reassigned members to new MCOs in each grand region of the state to equalize membership enrollment across all MCOs. A key priority in the statewide implementation was reassignment to a Medicaid MCO that would achieve alignment with the member's D-SNP enrollment. Reassignment notices included explanations to help selected members understand why they might want to proceed with reassignment to aligned enrollment, rather than opting to remain with their current Medicaid MCO.
- ***MIPPA Contracting-*** While TennCare will continue to maintain MIPPA agreements with current D-SNPs, TennCare will not contract with any new D-SNPs that are not contracted (through a competitive procurement process) to also provide Medicaid benefits.
- ***Member Education-*** process for sending educational letters to Medicaid members in advance of their attaining Medicare eligibility encourages them to enroll in an aligned D-SNP.

Default Enrollment- All TennCare's aligned D-SNPs have been approved by CMS and are actively engaged in default enrollment. TennCare works with the contracted Medicaid plans that have companion D-SNPs to support them in default enrollment of Medicaid enrollees attaining Medicare eligibility pursuant to federal requirements. Prospective Medicare enrollment dates derived from the Medicare Modernization Act (MMA) file submission process is submitted to assist them in identifying their members attaining Medicare eligibility. Upon notification of a Medicaid member's prospective Medicare eligibility date, the State also sends a letter to the member informing them of their upcoming Medicare enrollment and the benefits of enrolling in an aligned D-SNP.

The State has implemented several quality improvement efforts relative to default enrollment.

- ***D-SNP Alignment Report Utilization-*** The State continuously monitor and analyze the D-SNP Alignment report to determine whether alignment is increasing among plans that have both D-SNP and Medicaid lines of business.
- ***Continuity of Care Provisions-*** The State has built continuity of care provisions into the MIPPA Agreement for D-SNPs relating to members enrolled through default enrollment. These requirements include a 30-day continuity of care period for all full benefit dual eligible (FBDE) members seamlessly enrolled (regardless of providers' network participation), extended as necessary to allow time for completion of Health Risk Assessment, network contracting, or seamless transition to network providers.
- ***Provider Network Development-*** The MIPPA Agreement requires D-SNPs to develop a provider network that specifically targets substantial overlap of D-SNP providers with its TennCare MCO to ensure seamless access to care for FBDE members who are enrolled through default enrollment into the D-SNP plan.
- ***Default Enrollment Reports-*** The State requires D-SNPs to provide information on continuity of care for Primary Care Providers (PCP) and certain specialists for members enrolled through default enrollment. The list of specialists was developed through consultation with medical officers from the respective plans to include types of specialists where continuity would be of high concern. These specialist types are: Cardiologists, Gastro-Intestinal Physicians, Pulmonologists, Endocrinologists, Nephrologists, Oncologists/Radiation, Infectious Disease, Rheumatologists, and Wound Care specialists.
- ***Research Study Participation-*** TennCare participated in a study conducted by Vanderbilt University Medical Center with funding from the US Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation to evaluate how participation in aligned arrangements impacted utilization of services across both the Medicaid and Medicare programs during 2011-2016 as aligned D-SNPS became more widely available. The findings of this study were provided in 2019 and suggested that "the effect of increased plan alignment varied across different types of services and age groups." A few key findings from the report share that "before adjustment for selection into aligned plans, use of LTSS and health care services varied by alignment status. Most notably, aligned plan members were much less likely than dual-eligible beneficiaries with traditional Medicare to use nursing home services, suggesting that there may be adverse selection into traditional Medicare for nursing home users. The rapid growth in aligned plan participation suggests this is a popular option for many dual-eligible beneficiaries in Tennessee. New availability of a D-SNP in a county was associated with greater likelihood of being in an aligned plan. Aligned plan membership was associated in increased HCBS use among aligned plan enrollees, but no other changes in health care or LTSS use among aligned plan enrollees in either age group. Some key populations, though, including nursing home users, were much less likely to participate in aligned plans, raising questions about whether this model is reaching the highest cost, highest need beneficiaries. Increased aligned plan participation was associated with small decreases in nursing home use and increases in HCBS use among older adults, which is consistent with Tennessee's goal of rebalancing LTSS towards more home-based settings. "Key findings shared in the final report will be used to drive improvement through continuing to assess how alignment strategies, and the criteria for evaluating their impact may be tailored to the

diverse needs of dual eligibles. [1]

- ***Coordination of Benefits-*** TennCare exchanges full Medicaid enrollment files with all D-SNPs to ensure they are aware of the member's Medicaid MCO assignment. Medicare enrollment data is also provided to Medicaid MCOs for the same purposes. MIPPA agreements specify strengthened coordination requirements for D-SNPs, including:
    - Discharge planning, including education for caregivers upon discharge and medication reconciliation.
    - Care transitions designed to ensure continuity of care.
    - Use of LTSS, including requirements for D-SNPs to identify candidates appropriate for Medicaid LTSS programs and make timely referrals to the appropriate MCO.
    - Medicare data, including D-SNP encounter data required by the Medicaid agency, is also provided to the MCOs for care coordination purposes.
    - D-SNPs are required to exchange daily inpatient admission and discharge reports, including observation stays, to help facilitate timely discharge planning.
    - Requires the submission of a Quarterly Dual Coordination Report, a Quarterly Default Enrollment Report (for aligned D-SNPs), a Quarterly D-SNP Appeals and Grievances Report, and a clinical audit of a sample of individuals with multiple re-admissions during a quarterly period conducted by TennCare LTSS staff. This audit samples members identified in the Quarterly Dual Coordination Report having multiple readmissions during a quarter to determine whether adequate coordination occurred to reduce preventable readmissions.

For members enrolled in aligned D-SNPs, coordination requirements further require integrating the Medicare Health Risk Assessment and Plan of Care with the Medicaid Comprehensive Assessment and PCSP for Medicaid recipients in the Employment and Community First CHOICES or CHOICES program.

CMS Requirement: Detail the methods or procedures the state uses to identify the age, race, ethnicity, sex, primary language, and disability statuses for each Medicaid enrollee. States must provide this information to the MCO and PIHP for each Medicaid enrollee at the time of enrollment. (42 CFR § 438.340(b)(6))

TennCare has taken steps to identify the age, race, ethnicity, sex, primary language, and disability statuses for each enrollee at the time of enrollment. Eligibility for TennCare and other Medicaid programs is determined by TennCare. The application includes questions about age, race, ethnicity, sex, primary language, and disability statuses and instructs the applicant that responses to the race, ethnicity, and language questions are voluntary.

Pursuant to the eligibility and enrollment data exchange requirements in CRA § A.2.23.5, the MCOs must

[1] Keohane, L., Zhou, Z., Stevenson, D. (2019). Final Report: Financial Alignment for Dual-eligible Beneficiaries in Tennessee.

receive, process, and update enrollment files that are sent daily by TennCare to the MCOs daily. Within twenty-four (24) hours of receipt of enrollment files, the MCOs must update the eligibility/enrollment databases.

The MCOs and their providers and subcontractors that provide services to members participate in TennCare's efforts to promote the delivery of services in a culturally competent manner to all enrollees, including those with Limited English Proficiency, disabilities, and diverse cultural and ethnic backgrounds regardless of a member's gender or sex status. This includes the MCOs emphasizing the importance of network providers to have the capabilities to ensure physical access, accommodations, and accessible equipment for the furnishing services to members with physical or mental disabilities.

CMS Requirement: Document any efforts or initiatives that the state or MCO/PIHP has engaged in to reduce disparities in health care. The federal Medicaid managed care regulations also require the state to identify, evaluate, and reduce, to the extent practicable, health disparities (social and health needs) based on age, race, ethnicity, sex, primary language, and disability status. 42 C.F.R. § 438.340(b)(6).

TennCare addresses disparities in healthcare through tracking the rates of illness and chronic conditions in relation to key demographic factors. TennCare contractually requires the MCOs to include QM/QI activities to address healthcare disparities identified through data collection and requires them to include the methodology utilized for collecting the data as well as interventions taken to enhance the accuracy of the data collected. Additionally, TennCare is directly working to reduce healthcare disparities through contractually requiring its MCOs to provide essential networks and services required to address disparity issues. These requirements include:

- Ensuring an adequate medical provider network of appropriately credentialed providers increasingly committed to evidence-based practices to improve access to care and higher quality outcomes.
- Requiring opt-out Population Health services to be available to all TennCare members while providing intensive case management to those high-risk members who choose to opt-in to certain aspects of the program.
- Proactively promoting health screenings and preventive healthcare services to all TennCare members.
- Providing care coordination and direct support services for CHOICES HCBS enrollees. CHOICES Care Coordinators are responsible for assessing each CHOICES member's psychosocial needs and for identifying in the plan of care and facilitating access to social support services and assistance (e.g., housing or income assistance) needed in order to ensure the member's health, safety and welfare, and as applicable, to delay or prevent the need for more expensive institutional placement.
- CHOICES care coordination provides access to several important resources often lacking for our long-term care population, including:
    - Nutritious food delivered by local meals-on-wheels programs or prepared by homecare providers;

    - Safer home environments by building ramps and installing safety equipment, providing Personal Emergency Response Systems (PERS) and pest control services, and providing light housekeeping support; and
    - Personal care and other medical, behavioral, and long-term care services identified as needed through regular home visits by care coordinators.
- Providing support coordination and direct support services for Employment and Community First CHOICES HCBS enrollees. Support Coordinators are responsible for assessing each member's psychosocial needs and for identifying in the plan of care and facilitating access to the social support services and assistance (e.g., vocational rehabilitation, housing or income assistance) that are necessary to enable the member to achieve his/her desired lifestyle, goals for community involvement, employment and independent living, and wellness, and to address identified needs.
- In addition, Employment and Community First CHOICES support coordination provides access to several important resources often lacking for our long-term care population, including:
    - Supports to achieve competitive, integrated employment;
    - Personal Assistance and Supportive Home Care;
    - Safer home environments by building ramps and installing safety equipment or making minor home modifications; and
    - Assistive technology, adaptive equipment, and supplies.
- Dual Eligible Special Needs Plans (D-SNPs) are also charged with coordinating health-related social supports that may impact dual eligible members' health-related behaviors, outcomes and/or utilization, and/or members' ability to live in the community, using integrated care management, enhanced (including home-based) primary care and specialty care network methods for high-risk beneficiaries, and partnerships with providers and Community-Based Organizations (CBOs) to address social support needs and improve health and quality of life outcomes, including but not limited to partnership and engagement, which may include co-location of Contractor staff, with providers and CBOs (e.g., positioning care coordination staff within providers and/or CBOs, and/or embedding CBO staff as part of the Contractor's integrated care teams and the use of community peers and health outreach outworkers to provide in-person assistance to members in order to improve coordination of physical and behavioral health, LTSS, and social support needs).

Develop and implement TennCare member and provider social and health needs surveys Each of the TennCare MCOs has achieved NCQA Distinction in Multicultural Health Care. This distinction identifies organizations that lead the market in providing culturally and linguistically sensitive services, and work to reduce health care disparities. To achieve this distinction, each MCO has demonstrated to NCQA acceptable performance on the following standards: collecting race/ethnicity and language data, providing language assistance, cultural responsiveness, quality improvement of culturally and linguistically appropriate services (CLAS), and reduction of health care disparities.

Amerigroup Community Care of Tennessee ("Amerigroup"), BlueCross BlueShield of Tennessee

("BlueCare"), and UnitedHealthcare Community Plan of Tennessee ("United") were generous in their support and outreach efforts to address health care disparities and to promote the 2019 Social Conditions and Health Needs Surveys for TennCare members and providers. The MCOs are highly dedicated to promoting opportunities for improving and empowering the health of all Tennesseans. Below is an overview of each MCOs' efforts to address health care disparities (social and health needs) based on age, race, ethnicity, sex, primary language, and disability status.

Amerigroup Community Care of Tennessee ("Amerigroup")

Amerigroup's Cultural and Linguistic Program's mission is to help enhance the health status of its members by ensuring customer-focused and customer-driven services that are both culturally competent and linguistically appropriate.

Amerigroup recognizes the increasing importance of delivering culturally relevant health care benefits, solutions and education that address the diverse needs of individuals and families in the communities we serve. An interdepartmental approach and collaboration helps to ensure the implementation of culturally and linguistically appropriate health care related services to members with diverse health beliefs and practices, limited English proficiency (LEP) and variable literacy levels.

In addition to goal and measurement identification, the Quality Management (QM) department, in collaboration with other key departments, establishes an annual written evaluation of the CLAS improvement and health disparities reduction goals and measurements. The annual evaluation includes:

- A description of completed and ongoing activities for CLAS and health disparities reduction
- Trending of measures to assess performance
- Analysis of results and initiatives, including barrier analysis
- Evaluation of overall effectiveness of the program and of the interventions to address CLAS and health disparities.

At Amerigroup, one of our core values is a commitment to innovation. In order to be a truly innovative company, we must understand and address the needs of the diverse population we are privileged to serve. Our commitment to diversity and our ability to benefit and learn from our own collective backgrounds and experiences is critical to achieving our vision to be America's valued health partner.

Our Diversity & Inclusion team continues to focus on equipping leaders with the tools and information they need so we can reap the benefits of a diverse workforce. Leadership has built diversity initiatives into their 2017 goals, and leadership training is available to help make more objective decisions about talent and create a more inclusive environment. Our associates can take advantage of information and resources on the Diversity & Inclusion community online through our internal website, and they can join any of our nine Associate Resource Group (ARG) communities, groups that play such an important role in engaging associates in diversity initiatives. In our ARG communities there are professional and personal development opportunities, where associates benefit from different perspectives and innovative ideas connect culture to business decisions.

In 2017, a Diversity and Inclusion Toolbox was made available to all Amerigroup associates. These tools

include a wealth of resources such as job aids, articles of interest, infographics, research and benchmarking that can help to improve the understanding and appreciation of cultural norms and differences that affect behaviors, needs, preferences and perspectives among Amerigroup associates, our members, clients and customers.

Amerigroup contracts with providers and other health professionals who are committed to serving a diverse population. These individuals have the ability to meet the cultural, ethnic, racial and language/communication needs of Amerigroup's members. To support this effort, training about acknowledging and respecting cultural differences (cultural competency training) is provided during orientation and on an ongoing basis in many formats (webinars, online resources in the provider portal, individual training as needed).

In addition, Amerigroup seeks to maintain a provider network that reflects the make-up of its members and can support the needs of different members. The determination of whether or not Amerigroup has enough providers is based on the languages that members speak.

Amerigroup's provider database includes languages spoken at provider offices. Information on the languages that a provider can either speak or hire interpreters for is required on the provider applications, and the information is entered into a database system, which is used to produce and update the Provider Directory. Updates to provider demographic data, including language, are entered into the database as received from provider offices. Members can use the Provider Directory to obtain information on languages spoken by provider offices, or they can contact the Customer Care Center (CCC)/Member Services.

Reducing health disparities requires systematic change that is targeted to the needs of individual members. Amerigroup continues to look for innovative ways to reduce disparities in care.

BlueCross BlueShield of Tennessee ("BlueCare" or "BCT")

Population Health Activities and Resources (Serving a Diverse Membership)

All BlueCare members are provided with an appropriate level of Population Health services. The appropriate level of Population Health activities are integrated with CHOICES and ECF CHOICES Care Coordination processes using BCT resources and staff. BCT takes into consideration the cultural and linguistic needs of these members with the following objectives:

- To reduce health care disparities in clinical areas
- To improve cultural competency through materials and communications
- To improve network adequacy to meet the needs of underserved groups
- To improve other areas of needs as deemed appropriate

A. Healthcare Equity

Healthcare equity is achieved when all individuals achieve their full health potential. BCT understands that, as a healthcare organization, it plays a significant role in achieving health equity through the ability

to address disparities at the point of care and impact many of the social determinants that contribute to these disparities. A much greater risk for poor health outcomes evolves when members are faced with multiple disparities. The term disparities is often used to refer to racial or ethnic disparities, yet many dimensions of disparities exist that impact overall health. Social risk factors such as poverty and crime provide significant impact on health and wellness. BCT focuses targeted effective strategies to address disparities across Tennessee's geographical, ethnic, racial, and illness-based areas from the most heavily populated areas of the state to those areas so rural that even the most basic services are difficult to provide. These targeted strategies include:

1. **Community and Health Equity Advisory Panels** – BCT's Community Advisory Panels are comprised of local community, faith-based leaders, and providers across Tennessee already engaged in working to eliminate disparities in their own communities. The panels convene regionally two (2) times a year and discuss targeted efforts to promote health equity.

2. **Faith-based Toolkit** – The goal of the Faith-based Tool Kit is to develop an intervention to increase engagement among BCT members and faith-based communities and to improve the health literacy of members within the community.

3. **Disparities Education** – BCT offers extensive education to its personnel and providers to promote awareness of healthcare disparities and improve cultural competency by means of the Social Determinants Empathy Workshop™ by Consilience Group, LLC and Quality Interactions. The training is offered to BCT member facing employees and participating providers.

The Social Determinants Empathy Workshop™ is designed to increase understanding of social determinants and related factors in improving population health disparities. Another version of the workshop tailored for BlueCare, Reducing Healthcare Disparities through Trusting Relationships, is designed for front-line professionals working directly with members to provide resources for improved health and wellness. It emphasizes the practice of empathy in direct encounters that, cumulatively, create a long-term trusting relationship between healthcare organizations and those they serve. Quality Interactions is an e-learning program that provides effective cultural competency and cross-cultural communication training for physicians, nurses, and health care professionals. The interactive programs are designed to train physicians, nurses, and other health care professionals, with the tools and skills of effective cross-cultural communication. Training modules for both clinical and non-clinical healthcare staff are incorporated into the program.

4. Data Collection Strategy – In-depth data analyses and collection of population-specific metrics is utilized, which serves as the foundation for a culturally and linguistically diverse membership. The analysis of significant healthcare disparity data in various clinical areas functions as the foundation of BCT's population health management programs and guides all ethnic, racial, and illness-based disparity reduction efforts.

Various data sources are utilized to complete the assessment including enrollment data, United States Census data and the Consumer Assessment of Healthcare Providers and Systems® (CAHPS) survey data. Information Delivery Department follows a hierarchal priority list placing

priority on the following:

1) Self-reported data (Care Communication Management Services)

2) 834 eligibility file

3) Third-party Census Tracts

4) Additional supplemental third-party lifestyle, demographic, and consumer preferences data

Social risk factors are identified through the Health Plan Insights Report, the Racial Health Disparity Population Assessment, and the Assessment of Practitioner Availability for BlueCare and TennCare*Select* Members' Cultural Needs and Preferences, all of which are internally developed annual reports. Researching healthcare disparities and modifying QI interventions are essential to BCT's strategic goal of increasing member activation and community partnerships by allowing a greater understanding of member's needs. BCT also utilizes external reports, such as those developed by the United States Geological Service, the Environmental Protection Agency, the United States Department of Agriculture, and the Agency for Healthcare Research and Quality, in the identification of social determinants. Transportation is a significant social risk factor that impacts both rural and urban areas. BlueCare Tennessee provides transportation services as a benefit to address this barrier to care.

Racial/Ethnic Health Disparity Population Assessment **-** An annual Racial/Ethnic Health Disparity Population Assessment is conducted with the intention of gaining a deeper understanding of clinical conditions and outcomes based on race and ethnicity among BCT's complete member base. This information is used to determine the scope of disparities in the BCT population and to develop improved strategies to reduce disparities in communities at greatest risk.

Annual Assessment of Practitioner Availability for BCT Members' Cultural Needs and Preferences – Annually, BCT assesses the availability of network providers for meeting the racial, cultural/ethnic, gender, and linguistic needs of the member population. The intent of the report is to ensure that BCT maintains an adequate network of providers and monitors how effectively this network meets the cultural and linguistic needs and preferences of its members.

Social risk factor information is also collected during member interactions utilizing select questions from the Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE) tool. The PRAPARE tool drives improvements through data collection, intervention development and partnerships to address patients' needs, community health, and assists in streamlining care management programs. Questions from the PRAPARE tool have been integrated into the CareAdvance system. This allows the clinician to assess the member's social determinants of health and provide needed resources.

5. Housing Alliance Care Coordination – The development of Housing Alliance Care Coordination is seen as a critical step in identifying and connecting BlueCare members that experience housing instability. This initiative began in one region of the state as behavioral

health noticed a pattern of readmissions and ED usage among a sub-set of members. One of the common features was that these members were identified as homeless on admission to facilities or had homeless shelters listed as their address at the time of discharge. The Behavioral Health (BH) Complex Community Care (CCC) supervisor began to connect her team to local agencies that serve the homeless population and developed a strong working relationship with local resources and this team experienced success in reducing homelessness in their membership in this region.

The BH CCC team now works statewide with each of the 10 Continuum of Care (COC) regions in the state to develop region specific, written processes. This collaboration is necessary due to the variations in processes and resources in each region. Behavioral Health is also working with the Medical CCC team because the medical case managers have members with similar profiles, in terms of experiencing housing instability, which impairs members' ability to comply with care plans. Members that struggle with housing instability also tend to experience significant social determinants that negatively impact health outcomes.

B. Community Care

BlueCare Tennessee (BCT) has established a structure and process, called Community Engagement that empowers BCT team members to engage a diverse group of local community stakeholders (relevant government agencies, providers, community social services, interest groups, etc.) to continuously identify, design and implement collaborative improvement initiatives that leverage and enhance existing community efforts in support of BCT quality aims. The focus of Community Engagement is to help members access community resources, referral services, training, and community contacts.

Through mobilizing internal and external stakeholders, BCT identifies resources and gaps and co-designs programs and services to meet identified member needs. BCT gains knowledge and understanding of member needs and preferences for engagement through advisory meetings and focus groups. BCT provides a platform for members to discuss recommendations to improve the service and quality of care they receive and to identify barriers to healthcare and interventions that would help them overcome those barriers. BCT often utilizes past CAHPS survey results to design its agendas. BCT ensures that quality is integrated into every aspect of its organization. BCT strives to maximize member attendance and participation in Advisory Group meetings through Advisory Group recruitment efforts, Face-to-Face Orientation Program, and rotation of meeting sites. BCT also conducts Member Focus Groups to gauge members' satisfaction as well as understanding of member materials.

The organization connects members with community resources or promotes community programs. Integrating community resources indicates the organization actively and appropriately responds to members' needs. Community resources correlate with member needs discovered during the population assessment, including Community Assistance, Government Health Agencies, and Health Lifestyle / Health & Wellness. Actively responding to member needs is more than posting a list of resources on the organization's website; active response includes referral services and helping members access community resources. Additional resources are made available to members through the 2-1-1 Tennessee Statewide Resource network, http://tn211.mycommunitypt.com/index.php/component/cpx/?Itemid=3.

UnitedHealthcare Community Plan of Tennessee ("United" or "UHCCP")

The (3) three most commonly identified Social Determinants of Health ("SDOH") needs for the UHCCP TN membership are: (1) inability to deal with stress, (2) social isolation, and (3) food insecurity.

1. Stress

If an individual identifies difficulty dealing with stress, the Care Manager (CM) first attempts to identify the source of the stress with the individual to determine if the stress may be alleviated by addressing other SDOH barriers. The CM connects the individual with the needed community resources based on the identified SDOH barrier. If the stress is caused by behavioral health concerns or is unable to be relieved by intervention from the community resources an internal behavioral health CM is assigned to review the case and give appropriate referrals for therapy and/or medication management.

2. Social Isolation

If an individual identifies social isolation as a concern, the CM determines the factors that cause the social isolation in order to connect the individual with the appropriate community resources. These include, but are not limited to, one-on-one and group community-based intervention programs, focusing on virtual options during COVID-19. Follow-up occurs to ensure the individual acknowledges an improvement in their social connectedness or if further action needs to be taken.

3. Food Insecurity, Access to Food, and Healthy Eating

United developed relationships with the five Feeding America food banks in Tennessee that serve all ninety-five (95) counties. Through these relationships, it can identify the closest food pantry to the individual. The food bank distributes to and connects with the individual. In some cases, there may not be a "brick and mortar" pantry close to the individual and United works with the food bank to locate a mobile food pantry in that area and explore food delivery resources for the individual. It also educates the individual on the benefits they may qualify for under the Supplemental Nutrition Assistance Program (SNAP) in addition to support from the local community nonprofit food pantries. United is aware that food deserts exist, and CM determine the accessibility of the closest food pantry and/or supermarket. United, through grant partnerships with the local food banks, help to combat food deserts and bring access to healthy food to identified areas with poor access to healthy foods. It also partners with organizations that support healthy eating initiatives through educating individuals how to prepare and choose healthy foods even when options may seem sparse. Educational materials for healthy eating are distributed through all demographics.

Beyond the top three identified needs, United has interventions specific to other SDOH categories:

- **Utilities**

  If an individual identifies difficulty paying their utility bill, the CM determines if the utility company offers any type of assistance programs. The individual is given the information to contact their utility company to apply for assistance as well as information for the Low-Income Home Energy Assistance Program (LIHEAP). If the utility company does not offer utility bill

assistance or the individual does not qualify, other community resources that offer utility assistance are explored. Follow-up occurs to ensure the individual was able to receive assistance.

- **Transportation**

United ensures that individuals are aware that transportation is a covered benefit to and from all health care visits, including pharmacy visits. If the individual states difficulty setting up their transportation, the CM provides a three-way call between the individual and transportation services. If transportation is needed for non-medical needs, United shares low cost ride services available in their area when available.

- **Housing**

United confirms whether individuals have connected with their local public housing authority, continuum of care agencies, Housing and Urban Development (HUD), Tennessee Housing Development Agency (THDA), or the United States Department of Agriculture (USDA) Rural Development agencies. Depending on the demographics of the individual, other local agencies may be considered. Once the best agency is identified a follow up will happen at two weeks and six weeks, with continuing follow-up until the individual is able to have their housing needs met.

- **Diaper Insecurity**

A SDOH barrier that has been identified by the United team is the significant need for diapers for a large subset of our membership. The average cost of diapers for one child per month is $85. Childcare centers will not accept a child whose caretaker cannot provide a full day of diapers, leading to barriers for the caretaker's employment and education and child's health when a baby is not able to be changed as needed. The higher stress levels that are caused by inadequate diapers can lead to intimate partner violence or child abuse. To help combat this, UHCCP has been identifying and partnering with diaper banks across the state along with developing and expanding an incentive program for new mothers to earn free diapers. If an individual identifies a diaper need, we share the closest diaper bank to them.

Health Inequity

UHCCP recognizes the importance of addressing racial and ethnic disparities in health care. United continues to collect data to understand member cultural characteristics, find gaps in our individuals' health to provide better programs, improve how we work with individuals based on their demographics. Specific efforts to acknowledge and support the impact culturally competent care has on improving health outcomes include:

- Analytics - Integrating age, gender, address, race/ethnicity, and language data with clinical data to identify any disparities in care that are associated with the aforementioned member demographics.
- Cultural Competence - providing clinical and non-clinical cultural competency training to staff to

create an awareness of the unique needs of individuals from various cultures resulting in the delivery of more personalized service.

- Outreach - customizing member materials and engagement strategies based on identified unique cultural needs and gaps in care. This focus on health literacy ensures communications are easily understandable and available in the individuals preferred language.
- Providers - fostering culturally competent care by United's contracted providers. Encouraging providers to adopt the use SDOH screenings and use of corresponding ICD-10-CM z-codes as a standard practice.

Trends

United noted several trends observed across all populations of the UHCCP TN health plan. There has been a sharp increase in food insecurity across all populations served due to COVID-19 and unemployment and an increase in social isolation among all our membership with the greatest impact in our senior population. Tornadoes impacted individuals in the middle and east regions impacting housing, utilities, access to providers, and food insecurity. Transportation also presented a challenge as public transportation either temporarily stopped running in some counties or scaled back their hours of operation due to COVID-19. Many individuals also would not take provided transportation due to fears concerning COVID-19, providers offices being closed also created transportation issues. United also saw an increased demand in individuals that were unable to get diapers in our pediatric population. A new trend that emerged in early 2020 concerning masks, with a mask being essential to every individual.

- To combat these growing trends in SDOH barriers, United implemented a food box program where individuals were screened for food insecurity and if needed, a food box with fourteen (14) meals was delivered with follow up and additional boxes sent as needed. Throughout the reporting period, 1,638 food boxes were sent to 817 UHCCP covered individuals.
- To combat social isolation United's CMs telephonically outreached to ensure the well-being of individuals as well as offering virtual check-ins through video conferencing services. The United Health Foundation and AARP Foundation launched a $5 million-dollar partnership to address social isolation and food insecurity with seniors (our most impacted population) during COVID-19. United also partnered with providers to make telehealth visits available to its members at no cost to individuals.
- Individuals in Middle and East Tennessee were impacted by tornadoes which caused food, housing, utility, and provider availability barriers. United reached out telephonically to individuals impacted by the tornadoes to make sure that basic needs were met, like providing transportation to alternative providers if their providers were unavailable.
- To help individuals with transportation during COVID-19, United followed up with any individuals that missed their scheduled transportation and kept an up to date list for our case management team of any providers that were closed due to COVID-19.
- Diaper insecurity is an issue we are becoming increasingly aware of as a MCO. United worked to identify community-based organizations across Tennessee that provide diapers and have

partnered to better understand and meet this growing need.

- Due to COVID-19, acquiring facemasks has become a new barrier in 2020. CMs were notified of any agencies that had masks available at no cost to individuals. The health plan recently worked to acquire 10,000 masks to be distributed to community-based organizations to get masks into the hands of those who need them across the state.
- As United continues to adapt its SDOH care model, it recognizes the way to have the most impact is by partnering with providers and community-based organizations. United hosted an outside, drive-through event with Connectus Health, Nashville Diaper Connection and Second Harvest Food Bank in June for families with children in need of immunizations, diapers, and food due to the COVID-19 pandemic and we are finalizing dates for future events.

National Performance Measures

CMS Requirement: Include a description of any required national performance measures and levels identified and developed by CMS in consultation with states and other stakeholders. (42 CFR § 438.204(c))

At this time, CMS has not identified any required national performance measures.

CMS Requirement: Indicate whether the state plans to voluntarily collect any of the CMS core performance measures for children and adults in Medicaid/CHIP. If so, identify state targets/goals for any of the core measures selected by the state for voluntary reporting.

The CMS Core performance measures for children and adults in Medicaid/CHIP encompass both the physical and mental health of Medicaid/CHIP measures. Demonstrating a commitment to high quality care, Tennessee measures and submits over 90% of the CMS performance measures for children and adults in Medicaid/CHIP each year. TennCare aims to show improvement each year on the CMS core measures, and sets goals based on improvement to or maintenance of the NCQA Quality Compass national benchmarks**.**

Note: Measurement Year 2019 was submitted to CMS at the end of CY2020. MY2020 goals were derived from the MY2019 Quality Compass data. Due to the COVID-19 Pandemic, the goals set for MY2020 may be difficult to reach.

Child Health Quality Measures

Measure Name	MY 2018	MY 2019	MY 2020 Goal
Timeliness of Prenatal Care	83.1%	83.7%	92.9%
Childhood Immunization Status			
DTaP/DT	76.9%	76.7%	81.7%
IPV	92.0%	91.4%	91.9%
MMR	89.0%	88.9%	91.7%
HiB	89.0%	88.3%	91.0%
Hepatitis B	93.2%	91.6%	92.7%
VZV	89.0%	88.9%	91.5%
Pneumococcal Conjugate	79.5%	78.9%	82.2%
Hepatitis A	88.7%	88.1%	89.3%
Rotavirus	74.9%	74.5%	76.4%
Influenza	43.1%	44.7%	58.4%
Combination 2	74.6%	74.5%	77.7%
Combination 3	72.3%	72.0%	75.2%
Combination 4	71.9%	71.6%	73.7%
Combination 5	63.0%	63.2%	65.9%
Combination 6	37.9%	39.4%	49.2%
Combination 7	62.8%	62.9%	64.5%
Combination 8	37.4%	39.3%	48.7%
Combination 9	34.4%	35.7%	44.3%
Combination 10	34.4%	35.7%	44.8%
Adolescent Immunization Status			
Meningococcal	76.0%	78.7%	89.1%
Tdap/Td	86.0%	87.9%	91.5%

Measure Name	MY 2018	MY 2019	MY 2020 Goal
HPV	30.3%	33.7%	45.6%
Combination 1	75.1%	78.0%	87.3%
Combination 2	29.1%	32.5%	43.1%
Weight Assessment and Counseling for Nutritional and Physical Activity for Children/Adolescents			
BMI Percentile (3 - 11 years)	81.1%	81.5%	87.8%
BMI Percentile (12 - 17 years)	77.8%	78.7%	86.2%
BMI Percentile (Total)	80.0%	80.5%	87.2%
Counseling for Nutrition (3 – 11 years)	72.7%	72.4%	80.7%
Counseling for Nutrition (12 – 17 years)	66.1%	67.6%	78.7%
Counseling for Nutrition (Total)	70.4%	70.7%	80.1%
Counseling for Physical Activity (3 – 11 years)	64.6%	66.2%	75.8%
Counseling for Physical Activity (12 – 17 years)	66.8%	67.9%	77.3%
Counseling for Nutrition (Total)	65.4%	66.7%	76.3%
Chlamydia Screening (16-20 years)	52.6%	52.8%	63.4%
Well-Child Visits in the First 15 Months of Life: Six or More Visits	68.4%	68.3%	73.0%
Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life	73.6%	75.5%	80.3%
Adolescent Well-Care Visits	57.3%	56.9%	64.7%
Follow-up Care for Children Prescribed Attention Deficit Hyperactivity Disorder (ADHD) Medication			
Initiation Phase	45.0%	46.1%	48.1%
Continuation and Follow-Up Phase	58.3%	59.3%	61.5%
Follow-Up After Hospitalization for Mental Illness (6-17 years)			
7-day follow- up	48.7%	51.2%	53.5%
30-day follow-up	70.0%	73.1%	77.2%
Ambulatory Care – Emergency Department Visits*	51.0%	50.1%	47.6%
Asthma Medication Ratio			
Ages 5-11	80.8%	81.2%	83.8%
Ages 12-18	72.1%	73.0%	75.8%
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics			
Ages 1-11	56.1%	61.3%	71.9%
Ages 12-17	53.5%	63.0%	73.0%
Total	54.5%	62.3%	72.5%
Consumer Assessment of Health Plans – Child Medicaid Survey			
Getting Needed Care (Always + Usually)	88.8%	88.8%	89.0%
Getting Care Quickly (Always + Usually)	91.3%	92.1%	93.4%
How Well Doctors Communicate (Always + Usually)	93.9%	95.5%	96.6%
Customer Service (Always + Usually)	89.5%	-	91.1%
Rating of All Health Care (9+10)	75.9%	73.9%	75.3%
Rating of Personal Doctor (9+10)	78.6%	80.0%	81.5%
Rating of Specialist Seen Most Often (9+10)	79.3%	-	75.0%
Rating of Health Plan (9+10)	78.2%	77.7%	75.5%
Consumer Assessment of Health Plans – Children With Chronic Conditions			
Getting Needed Care (Always + Usually)	89.5%	-	91.0%
Getting Care Quickly (Always + Usually)	93.9%	-	95.9%
How Well Doctors Communicate (Always + Usually)	94.7%	-	97.0%

Measure Name	MY 2018	MY 2019	MY 2020 Goal
Customer Service (Always + Usually)	90.7%	-	92.4%
Rating of All Health Care (9+10)	72.5%	-	74.9%
Rating of Personal Doctor (9+10)	78.2%	-	80.9%
Rating of Specialist Seen Most Often (9+10)	76.6%	-	79.8%
Rating of Health Plan (9+10)	74.3%	-	74.2%
Access to Specialized Services (Always + Usually)	79.8%	-	75.4%
FCC-Doctor or Nurse Who Knows Child (Yes)	91.8%	91.5%	93.7%
Coordination of Care (Yes)	78.8%	79.7%	79.0%
FCC – Getting Needed Information (Always + Usually)	91.4%	93.6%	94.7%
Access to Prescription Medicines (Always + Usually)	93.2%	93.6%	93.6%

*Measured as number of visits per 1,000 member months. Lower rate is better.

**In HEDIS 2020, NCQA decided to no longer produce general population results for the CCC population, as it was not used for accreditation.*

Adult Quality Measures:

Measure Name	MY 2018	MY 2019	MY 2020 Goal
Adult BMI Assessment	92.7%	94.1%	94.6%
Breast Cancer Screening	49.9%	54.8%	64.1%
Cervical Cancer Screening	62.5%	64.1%	67.4%
Chlamydia Screening in Women Ages 21-24	61.1%	61.7%	70.0%
Follow-Up After Hospitalization for Mental Illness (18-64 years)			
7-Day Follow-Up	32.3%	33.5%	38.5%
30-Day Follow-Up	53.7%	55.4%	61.3%
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence (Ages 18-64)			
7-Day Follow-Up	4.6%	5.5%	18.3%
30-Day Follow-Up	7.3%	8.2%	28.2%
Follow-Up After Emergency Department Visit for Mental Illness (Ages 18-64)			
7-Day Follow-Up	28.6%	35.0%	44.7%
30-Day Follow-Up	43.5%	50.1%	59.6%
Controlling High Blood Pressure	64.3%	64.3%	67.6%
Plan All-Cause Readmission*	1.136	1.074	<1
Adherence to Antipsychotics for Individuals with Schizophrenia	56.7%	59.1%	68.0%
Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are Using Antipsychotic Medications	83.9%	85.0%	87.9%
Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%) (lower rates are better)	39.5%	37.8%	32.9%
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment			
Initiation of AOD Treatment	42.5%	48.9%	52.6%
Engagement of AOD Treatment	13.2%	17.7%	18.7%
Prenatal and Postpartum Care: Postpartum Care Rate			
Postpartum Care	61.5%	70.2%	81.0%
Antidepressant Medication Management			
Effective Acute Phase Treatment	45.7%	49.5%	58.9%
Effective Continuation Phase Treatment	30.4%	33.1%	43.1%
Asthma Medication Ratio			
Ages 19-50	48.7%	50.8%	57.5%
Ages 51-64	48.1%	51.9%	59.9%
Flu Vaccinations for Adults Ages 18-64	43.2%	44.7%	48.1%
Medical Assistance with Smoking and Tobacco Use Cessation			
Advising Smokers and Tobacco Users to Quit	79.6%	80.7%	80.9%
Discussing Cessation Medications	49.8%	49.8%	59.4%
Discussing Cessation Strategies	43.8%	44.2%	53.9%
% Current Smokers	35.6%	37.0%	34.7%
Consumer Assessment of Health Plans Survey – Adult			
Getting Needed care (Always + Usually)	85.7%	85.8%	86.2%

Measure Name	MY 2018	MY 2019	MY 2020 Goal
Getting Care Quickly (Always + Usually)	84.0%	83.8%	86.1%
How Well Doctors Communicate (Always + Usually)	91.5%	92.0%	94.5%
Customer Service (Always + Usually)	92.7%	91.3%	91.2%
Rating of All Health Care (9+10)	57.6%	56.9%	61.4%
Rating of Personal Doctor (9+10)	69.8%	69.0%	72.4%
Rating of Specialist Seen Most Often (9+10)	66.8%	67.8%	73.7%
Rating of Health Plan (9 + 10)	65.5%	65.1%	66.5%

*Reported as the ratio of observed readmissions to expected readmissions. Lower rates are better.

**In HEDIS 2020, NCQA decided to no longer produce general population results for the CCC population, as it was not used for accreditation.*

Monitoring and Compliance

CMS Requirement: Detail procedures that account for the regular monitoring and evaluation of MCO and PIHP compliance with the standards of subpart D (access, structure and operations, and measurement and improvement standards). Some examples of mechanisms that may be used for monitoring include, but are not limited to: Member or provider surveys; HEDIS results; Report cards or profiles; Required MCO/PIHP reporting of performance measures; Required MCO/PIHP reporting on performance improvement projects; Grievance/Appeal logs, etc. (CFR § 438.204(b)(3))

NCQA Accreditation

Each MCO must obtain and maintain NCQA accreditation, and failure to obtain and/or maintain accreditation is considered to be a breach of the Contractor Risk Agreement (CRA) and will result in termination of the Agreement. Each MCO is required to submit every accreditation report immediately upon receipt of the written report from NCQA, at which point it is reviewed by staff to determine areas of deficiency. If the reviewer deems necessary, a Corrective Action Plan may be required.

LTSS Distinction

Effective January 1, 2019, MCOs were required to achieve LTSS Distinction as part of their NCQA Accreditation process. NCQA's LTSS Distinction designates that an MCO meets certain evidence-based standards in the coordination of LTSS in areas such as conducting comprehensive assessments, managing care transitions, performing person-centered assessments and planning and managing critical incidents.

Quarterly and Annual Reports from Managed Care Contractors

All MCCs are required to submit a variety of reports to TennCare throughout the year. Reports are received through a secure tracking system. Each report is reviewed by staff and a Corrective Action Plan is required for any report deemed deficient. Liquidated damages may be applied for deficient reports. Information from the reports is used by program staff to help monitor compliance with program requirements. Examples of reports include Population Health, EPSDT Outreach, Behavioral Health, Nursing Facility Diversion Activities, CHOICES Care Coordination, Member Complaints, and Provider Satisfaction.

HEDIS Results

Annually each MCO is required to submit all HEDIS measures designated by NCQA as relevant to Medicaid, with an exception for dental measures. Beginning in 2019, each MCO must also report the HEDIS LTSS Measures. The results must be reported separately for each Grand Region in which the MCO operates. The MCO must contract with an NCQA certified HEDIS auditor to validate the processes in accordance with NCQA requirement. HEDIS data is then submitted to both TennCare and the EQRO, which provides analyses of the data as well as a written comparative report. Using individual MCO results, the EQRO calculates the statewide weighted HEDIS rates and the statewide CAHPS averages in this annual report.

Performance Improvement Projects (PIPs)

All MCOs are required to submit at least two clinical and three non-clinical PIPs annually, as well as a PIP in the area of EPSDT. The two clinical PIPs must include one in the area of behavioral health that is relevant to one of the Population Health programs for bipolar disorder, major depression, or schizophrenia, and one in the area of either child health or perinatal (prenatal/postpartum) health. One of the three non-clinical PIPs must be in the area of long-term services and supports. If an MCO scores less than 100% on any element, a Corrective Action Plan must be submitted within two weeks of receipt of finding. All PIPs must be in accordance with CMS External Quality Review (EQR) Protocols for Performance Improvement Projects. After three years, a decision is made jointly between the MCO and TennCare on the continuation of the PIP.

TennCare's Annual EQRO Technical report includes more information on each of the PIPs conducted by the MCCs. Table 17 starting on p.47 provides a table of topics
https://www.tn.gov/content/dam/tn/tenncare/documents/AnnualEQROTechnicalReport.pdf

Annual Quality Survey

The EQRO is contractually required to conduct an Annual Quality Survey of each MCC to ensure compliance with contractual requirements. As part of the preparation for the survey, the EQRO, in conjunction with TennCare, reviews all contractual standards for changes that have occurred during the previous year and develops the criteria for review. EQRO staff conducts the survey and provides a detailed written report of findings for each MCO. If an MCO scores less than 100% on any element, a Corrective Action Plan must be submitted within two weeks of receipt of the findings. Both the EQRO and TennCare staff review the Corrective Action Plans to ensure the MCOs take appropriate action. Follow-up on the plans is conducted by the TennCare Division of Quality Improvement.

Site visits/collaborative work groups

Both the Division of Quality Improvement and the Behavioral Health Operations Unit conduct periodic site visits to learn about and monitor various aspects of MCC activities. On a semi-annual basis, or more frequently if needed, TennCare staff meet with each MCO to receive updates on different initiatives and special projects. The Division of Quality Improvement meets with the Quality Directors on a monthly basis to discuss issues, projects, etc. and participates on multiple workgroups facilitated by the Tennessee Department of Health. Other workgroups that TennCare Behavioral Health staff participates in include Tennessee Department of Mental Health and Substance Abuse Services (TDMHSAS) Planning and Policy Council, State Epidemiological Outcomes Workgroup, Tennessee Interagency Council on Homelessness, Tennessee Suicide Prevention Network (TSPN), Children's Cabinet state-wide, multi-agency Collaboration Pilot, Department of Children's Services/TennCare Select Coordination of Care Meeting, and Tennessee Association of Mental Health (TAMHO) Finance and Administration meetings.

Audits/Medical Record Reviews

Either annually or semi-annually the following Medical Record Reviews (MRRs) are conducted by the EQRO, the Division of Quality Improvement or the Division of Long-Term Services and Supports:

- A sample of provider records is reviewed to determine compliance with Abortion, Sterilization, and Hysterectomy (ASH) federal regulations.
- New Member Record Review (NMRR) is conducted annually by LTSS for both the CHOICES (Groups 2 and 3 only) and Employment and Community First CHOICES programs. The NMRR reviews compliance with CRA requirements related to specific elements for newly enrolled members.
- Existing Member Record Review (MRR) is conducted by LTSS for both the CHOICES (Groups 2 and 3 only) and Employment and Community First CHOICES programs using random sampling. The MRR reviews compliance with CRA requirements related to specific elements for existing members. Compliance is evaluated using a standard scoring tool with ongoing intra-rater reliability. MCOs develop and implement quality improvement plans to address scores of less than 90%.

Provider Data Validation Surveys

TennCare's EQRO is required to conduct a quarterly provider data validation (PDV) survey. The purpose of this activity is to determine the accuracy of the provider data files submitted by the TennCare MCCs and to use the results as a proxy to determine the extent to which providers are available and accessible to TennCare members. Liquidated damages are recommended each quarter if data for more than 10% of providers is incorrect for each data element.

Provider Satisfaction Surveys

Each MCO is required to submit an annual Provider Satisfaction Survey Report that encompasses physical health, behavioral health, and LTSS (including both CHOICES and ECF CHOICES) providers. The report must summarize the provider survey methods and findings that include the greatest and least satisfied areas, by region, for each provider type. Additionally, the survey must provide an analysis of opportunities for improvement throughout the next year, and progress they made toward the previous year's improvement areas.

Customer Satisfaction Surveys

- **CAHPS Survey**- Annually each MCO must conduct a CAHPS survey utilizing a vendor that is certified by NCQA. The surveys conducted are the CAHPS Adult Survey, the CAHPS Child Survey, and the CAHPS Children with Chronic Conditions Survey. The data is then submitted to both TennCare and the EQRO, which provides analyses of the data as well as a written report.
- **The Impact of TennCare**- TennCare contracts with The University of Tennessee Boyd Center for Business and Economic Research to conduct an annual survey of 5,000 Tennesseans to gather information on their insurance status, how they engage in the health care process and satisfaction with TennCare. The design for the survey is a "household sample," and the interview is conducted with the head of the household. The report, The Impact of TennCare: A Survey of Recipients allows comparison between responses from all households and households receiving TennCare.
- **NCI and NCI AD**- TennCare has contracted with Advancing States (formerly NASUAD) since 2015 to

participate in the NCI-AD consumer satisfaction survey for older adults and adults with disabilities. TennCare contracts with the nine Area Agencies on Aging and Disability (AAADs) to conduct the face-to-face interviews that inform the NCI-AD results. The Human Services Research Institute (HSRI) completes the data analysis as a component of the contract with NASUAD. This NCI-AD survey measures CHOICES members' satisfaction with services, their ability to access services, their understanding of their rights, and their ability to live the life they intend with the necessary supports in place to help them achieve their desired health and psycho-social outcomes. LTSS engages in a strategic sampling strategy that enables performance comparisons among MCOs and by all CHOICES group to evaluate experiences across settings. Plans to include those served through the PACE program and Dual Eligible Special Needs Plans (D-SNPs) have been adjusted for the 2020-2021 NCI-AD survey cycle as a result of pausing in person survey administration due to COVID-19.

In late 2019 and early 2020, LTSS implemented the NCI survey (for persons with I/DD) to assess outcomes of services, measure and track performance. TennCare includes all five Employment and Community First CHOICES groups in the sample to evaluate experiences across settings. TennCare contracted with The Arc of Tennessee to use their People Talking to People surveyors, a program staffed mostly by employees with disabilities to conduct face to face, peer to peer surveys.

For both NCI and NCI-AD, HSRI will conduct an initial analysis that is presented in a publicly available state specific and national report. Participation allows for national LTSS data comparison, yet another resource that provides information needed to support quality improvement efforts. LTSS requires MCOs present key trends that are used to drive data guided action plans and build on promising practices. In effort to create a continuous improvement culture, in 2019, LTSS began adding specific indicators to all three MCO action plans to ensure a collective statewide effort. In 2020, LTSS is fast tracking improvement by learning from the outcomes of the action plans and spreading ideas and processes with the intent of shifting best practices to common practices.

- ***QuILTSS Satisfaction Survey-*** As a component of the Quality Improvement in Long-Term Services and Supports (QuILTSS) Value Based Payment (VBP) initiative with nursing facilities, survey data for satisfaction and culture change/quality of life outcomes-based measures are collected annually from residents, families, and staff using a standardized instrument and process administered by NRC Health. The performance of participating nursing facilities on these surveys is a component of the nursing facility payment determination methodology. Facilities receive individual analyses of their data as well as tools and support to help develop and drive their quality improvement plans.

Prior approval of all member materials

The Division of Quality Improvement, in conjunction with Managed Care Operations and Member Communications staff, reviews all member materials that have clinical information included, as well as member materials with programmatic content. Staff reviews information for clinical and programmatic accuracy, culturally appropriate information, and appropriateness of clinical references. All member materials must be approved by TennCare before distribution can occur. Through a variety of feedback platforms, including advisory boards and surveys, TennCare LTSS continuously seeks opportunities to

improve materials for LTSS programs given the complexity of the programs and potential vulnerabilities of those served. In addition, Beneficiary Support System (BSS) provides insight into additional education topics or needed modifications to member materials to improve clarity and understanding of benefits and services for those served in LTSS programs.

Tennessee Department of Commerce and Insurance (TDCI)

The TDCI TennCare Quality Oversight Division is considered to be a Health Oversight Authority under the guidelines of the Health Insurance Portability and Accountability Act. As such the release of protected health information without authorization is permitted under 45 CFR § 164.512 for the purposes of regulation. The TDCI TennCare Oversight Division is responsible for:

- Acting upon licensure applications;
- Examining HMOs at least once every five years (examinations are currently conducted once every two years);
- Reviewing and analyzing quarterly and annual financial reports filed by the TennCare HMOs to ensure they meet financial reserve requirements;
- Processing provider complaints and eligible requests for independent review of denied TennCare provider claims;
- Facilitating referral of Applicant and Enrollee requests for assistance to the appropriate MCC and/or the Division of TennCare
- Reviewing and either approving or disapproving material modifications to organization documents, including but not limited to, provider agreements, subcontracts, provider manuals, provider newsletters, evidences of coverage, marketing materials, and any other item that would materially change the operations of the HMO;
- Reviewing and either approving or disapproving transactions within each HMO's holding company system in accordance with the Insurance Holding Company System Act found at TCA § 56-11-101 et. seq;
- Administering and enforcing the TennCare Prompt Pay Act found at TCA § 56-32-126;
- Performing monthly claims payment accuracy testing;
- Performing quarterly tests of the TennCare HMOs' episode of care gain/risk share calculations; and
- Provide support services to the Selection Panel for TennCare Reviewers which appoints and sets compensation for Independent Reviewers, pursuant to the TennCare Prompt Pay Act.
- Oversight of the Annual Network Adequacy EQRO deliverable for MCOs and DBM.

Policies and Procedures

Policies and Procedures are developed by the MCOs and are reviewed by TennCare staff upon readiness review for new contracts or programs and as needed throughout the life of their contracts.

LTSS Quality Monitoring

TennCare's LTSS Division has an established quality monitoring system, including reports and audits; to monitor the quality and appropriateness of care delivered to members in the CHOICES and Employment and Community First CHOICES programs. The quality monitoring system aligns with the quality components of the Medicaid Managed Care Rule specified in 42 C.F.R. § 438.330. Specifically, TennCare's LTSS Division monitors MCO performance by assessing care between settings, comparing services and supports with those in the member's plan, incorporating MCOs into efforts to prevent, detect, and remediate critical incidents; and assessing member QOL, rebalancing, and community integration activities. TennCare's LTSS Division monitors these four quality components through an extensive collection of internal reports that fall under the following categories:

- Assessing Care between Settings
- Transitioning from an Institutional Setting to the Community
- Transitioning to Community Living Supports (CLS) or Community Living Supports-Family Model (CLS-FM)
- Transitioning from the Community to an Institutional Setting
- Comparing Services and Supports with Those in the Member's Service Plan
- Incorporating MCOs into Efforts to Prevent, Detect, and Remediate Critical Incidents
- Assessing Member Quality of Life, Rebalancing, and Community Integration Activities
- Assessing Member Quality of Life (QOL)
- Rebalancing efforts
- Employment and Community Integration Activities

Dental Benefits Manager (DBM) Reports and Other Deliverables

The DBM is responsible for submitting a variety of monthly, quarterly, and annual reports and other deliverables through Team Track, TennCare's secure tracking system. These reports are reviewed by the appropriate business owner at TennCare and a Corrective Action Plan is issued for reports or other deliverables deemed deficient. Liquidated damages may be applied for deficiencies. Examples of DBM reports included in the current DBM contract include but are not limited to: Fraud and Abuse activities, QMP Committee Meeting minutes, Outreach Activities, Case Referral and Corrective Action Assistance, Enrollee Cost Sharing, Quarterly Non-discrimination Compliance, Annual Member Satisfaction Surveys, Annual Provider Satisfaction Surveys, Annual Outreach Plan, and Annual QMP Report.

- The DBM is required to submit two PIPs related to children's clinical dental care or administrative process annually. After three years, a decision will be made jointly between the DBM and TennCare on the continuation of the PIP.
- Qsource conducts an Annual Quality Survey of the DBM to ensure compliance with contractual requirements. A detailed written report of findings is provided by the EQRO. If the DBM scores less than 100% on any element, a Corrective Action Plan must be submitted and is reviewed by both Qsource and TennCare to ensure the DBM takes appropriate action.The DBM is required to conduct both a Customer Satisfaction Survey and a Provider Satisfaction Survey and report on

the findings annually.

- The DBM is responsible for maintaining and managing an adequate statewide dental provider network, processing and paying claims, managing program data, conducting utilization management and utilization review, and detecting fraud and abuse, as well as meeting utilization benchmarks for annual dental screening percentages, annual dental participation ratios, or outreach efforts calculated to ensure participation of all children who have not received screenings.
- Qsource conducts an Annual Network Adequacy of the DBM to ensure compliance with contractual requirements. A detailed written report of findings is provided by the EQRO. For CoverKids, if DBM scores less than 100% on any element, a Corrective Action Plan must be submitted and is reviewed by both Qsource and Quality Improvement to ensure the DBM takes appropriate action.

External Quality Review

CMS Requirement: Include a description of the state's arrangements for an annual, external, independent quality review of the quality, access, and timeliness of the services covered under each MCO and PIHP contract. Identify what entity will perform the EQR and for what period of time. (42 CFR § 438.204(d))

Tennessee contracts with Qsource to provide External Quality Review (EQR) activities. The services to be provided under this contract include multiple tasks and deliverables that are consistent with applicable federal EQR regulations and protocols for Medicaid Managed Care Organizations and state-specific requirements. This contract allows the State to be compliant with Federal EQR regulations and rules and to measure MCC-specific compliance with the TennCare Section 1115 Waiver.

The Annual Quality Survey must include, but not be limited to, review of enrollee rights and protections, quality assessment and performance improvement, structure and operation standards, measurement and improvement standards, and compliance with the appeal process. The survey process includes document review, interviews with key MCC personnel, and an assessment of the adequacy of information management systems. In addition to this survey, QSource conducts Performance Improvement Project validations and Performance Measure Validation in accordance with federal requirements. Qsource also conducts an Annual Network Adequacy Survey to determine the extent to which the MCCs' networks are compliant with contractual requirements. The EQRO provides these reviews for all MCOs, DBM, and the PBM.

CMS Requirement: Identify what, if any optional EQR activities the state has contracted with the External Quality Review Organization (EQRO) to perform. The five optional activities include: validation of encounter data reported by an MCO or PIHP; administration or validation of consumer or provider surveys of quality of care; calculation of performance measures in addition to those reported by an MCO or PIHP and validated by an EQRO; conduct of performance improvement projects (PIPs) in addition to those conducted by an MCO or PIHP and validated by an EQRO; and conduct of studies on quality and focus on a particular aspect of clinical or nonclinical services at a point in time.

While Tennessee has not required the EQRO to conduct any of the specified optional activities, Qsource has assisted TennCare with a number of other activities that are not required by CMS. These activities are as follows:

- Participation in MCO collaborative workgroups.
- Training of MCO staff on conducting Performance Improvement Projects.
- Quarterly validation of the accuracy of provider information reported by the MCOs.
- Annual survey that gathers information on the MAT provider network adequacy for TennCare members
- Annual audits are conducted to monitor compliance with federal requirements for Abortions, Sterilizations, and Hysterectomies (ASH).
- Preparation of an annual comparative analysis of HEDIS measures and CAHPS measures provided to TennCare by D-SNPS who have signed a MIPPA Agreement. Because the health plans are

required to submit the measures listed above and because of improved statistical capability within TennCare, the measures that QSource might otherwise calculate are limited.

- Planning and execution of an educational meeting three times a year for TennCare's Quality Improvement staff as well as all MCOs and the DBM.
- Analysis of the CHOICES and Employment and Community First Baseline Data Reports.
- Assisting the Division of Quality Improvement with its strategic planning sessions and Quality Strategy development.
- Employs 2 Certified HEDIS Compliance Auditors that provide technical assistance to MCCs on a variety of topics including HEDIS and CAHPS reporting.

CMS requirement: If applicable, identify the standards for which the EQRO will use information from Medicare or private accreditation reviews. This must include an explanation of the rationale for why the Medicare or private accreditation standards are duplicative to those in 42 CFR § 438.204(g). (42 CFR § 438.360(b))

TennCare exercises the non-duplication option in 42 CFR 438.360 for EQR-related activities, specifically the required compliance review also referred to as the TennCare Annual Quality Survey, and the annual review for network adequacy.

Every year, Qsource updates compliance assessment tools based on current Protocol 3: Review of Compliance with Medicaid and CHIP Managed Care Regulations, titled Annual Quality Survey (AQS), for TennCare, and based on the most recent contractual obligations between the State and managed care organizations (MCOs). After the AQS tools are updated, Qsource compares the evaluation elements with elements in the applicable NCQA Accreditation standards. AQS elements with the same requirements as NCQA elements are deemed to prevent duplication. All Tennessee MCOs are required to have NCQA Health Plan Accreditation. These processes prevent duplication of activities for the MCO TennCare program participants. The full list of deemable items can be found in Attachment VIII.

SECTION III: STATE STANDARDS

Access Standards

CMS Requirement: This section should include a discussion of the standards that the state has established in the MCO/PIHP contracts for access to care, as required by 42 CFR, Part 438, subpart D. These standards should relate to the overall goals and objectives listed in the quality strategy's introduction. States may either reference the access to care provisions from the state's managed care contracts or provide a summary description of the contract provisions. CMS recommends states minimize reference to contract language in the quality strategy. However, if the state chooses the latter option, the summary description must be sufficiently detailed to offer a clear picture of the specific contract provisions and be written in language that may be understood by stakeholders who are interested in providing input as part of the public comment process.

STATE ACCESS STANDARDS AS REQUIRED BY 42 CFR, PART 438, SUBPART D
42 CFR § 438.206 AVAILABILITY OF SERVICES
42 CFR § 438.206(b)(1) Maintains and monitors a network of appropriate providers
The Contractor Risk Agreement (CRA) between TennCare and the MCOs addresses provider networks in section 2.11 including primary care providers, specialty service providers, prenatal care providers, behavioral health services, long-term services & supports providers, and safety net providers; credentialing and other certification; and network notice requirements. CRA § 2.12 addresses provider agreements. CRA § 2.18 addresses customer service for members, including member services toll-free phone line, interpreter/translation services, cultural competency, and member involvement with behavioral health services. CRA Attachment III addresses general access standards and CRA Attachment IV addresses specialty network standards. CRA Attachment V addresses access and availability for behavioral health services.
42 CFR § 438.206(b)(2) Female enrollees have direct access to a women's health specialist
CRA § 2.11.5.1 States that a sufficient number of providers must be enrolled in the TennCare program so that prenatal or other medically necessary covered services are not delayed or denied to pregnant women at any time, including during their presumptive eligibility period. Additionally, the CONTRACTOR shall make services available from non-contract providers, if necessary, to provide medically necessary covered services to a woman enrolled in the CONTRACTOR's MCO.
42 CFR § 438.206(b)(3) Provides for a second opinion from a qualified health care professional
CRA § 2.6.4 Provides for a second opinion in any situation where there is a question concerning a diagnosis or the options for surgery or other treatment of a health condition when requested by a member, parent, and/or legally appointed representative. The second opinion must be provided by a contracted qualified health care professional or the MCO shall arrange for a member to obtain one from a non-contract provider. The second opinion shall be provided at no cost to the member.

42 CFR § 438.206(b)(4) Adequate and timely coverage of services not available in network
CRA § 2.11.1.9 States if the MCO is unable to provide medically necessary covered services to a particular member using contract providers, it must adequately and timely cover these services for that member using non-contract providers, for as long as the provider network is unable to provide them. At such time that the required services become available within the CONTRACTOR's network and the member can be safely transferred, the CONTRACTOR may transfer the member to an appropriate contract provider as specified in § A.2.9.4.
42 CFR § 438.206 (b)(5) Out of network providers coordinate with the MCO or PIHP with respect to
CRA § 2.13.12-15 Address circumstances under which out-of-network providers may seek payment from the MCO. It states the following: • The MCO shall pay for any medically necessary covered services provided to a member by a non-contract provider at the request of a contract provider; • The payment shall not be less than 80% of the rate that would have been paid by the MCO if the member had received the services from a contract provider; and • The MCO shall only pay for covered long-term care services for which the member was eligible and that were authorized by the MCO in accordance with the requirements of this contract.
42 CFR § 438.206(b)(6) Credential all providers as required by 438.214

CRA § 2.11.10 Addresses credentialing of both contract and non-contract providers. CRA § 2.11.10.1.1 States except as provided in Sections A.2.11.10.3 and A.2.11.10.4 below, the CONTRACTOR shall utilize the current NCQA Standards and Guidelines for the Accreditation of MCOs for the credentialing and recredentialing of licensed independent providers and provider groups with whom it contracts or employs and who fall within its scope of authority and action.
CRA § 2.11.10.1.2 The CONTRACTOR shall completely process credentialing applications from all types of providers (physical health, behavioral health and long-term care providers) within thirty (30) calendar days of receipt of a completed credentialing application, including all necessary documentation and attachments, and a signed provider agreement. Completely process shall mean that the CONTRACTOR shall review, approve and load approved applicants to its provider files in its claims processing system or deny the application and ensure that the provider is not used by the CONTRACTOR.
CRA § 2.11.10.1.3 To the extent the CONTRACTOR has delegated credentialing agreements in place with any approved delegated credentialing agency, the CONTRACTOR shall ensure all providers submitted to the CONTRACTOR from the delegated credentialing agent is loaded to its provider files and into its claims processing system within thirty (30) calendar days of receipt.
CRA § 2.11.10.1.4 The CONTRACTOR shall notify TENNCARE when the CONTRACTOR denies a provider credentialing application for program integrity-related reasons or otherwise limits the ability of providers to participate in the program for program integrity reasons.

CRA § 2.11.10.2.1 States the MCCs must utilize the current NCQA Standards and Guidelines for the Accreditation of MCOs for the credentialing and recredentialing of licensed independent providers with whom it does not contract but with whom it has an independent relationship. An independent relationship exists when the CONTRACTOR selects and directs its members to see a specific provider or group of providers.

CRA § 2.11.10.2.2 States the CONTRACTOR shall completely process credentialing applications within thirty (30) calendar days of receipt of a completed credentialing application, including all necessary documentation and attachments, and a signed contract/agreement if applicable. Completely process shall mean that the CONTRACTOR shall review, approve and load approved applicants to its provider files in its claims processing system or deny the application and ensure that the provider is not used by the CONTRACTOR.

CRA § 2.11.10.2.3 The CONTRACTOR shall notify TENNCARE when the CONTRACTOR denies a provider credentialing application for program integrity-related reasons or otherwise limits the ability of providers to participate in the program for program integrity reasons.

42 CFR § 438.206(c)(1)(i) Providers meet state standards for timely access to care and services

CRA Attachment III states that, in general, MCOs shall provide available, accessible, and adequate numbers of institutional facilities, service locations, service sites, and professional, allied, and paramedical personnel for the provision of covered services, including all emergency services, on a 24 hour a day, seven day a week basis. At a minimum, this shall include:

Primary Care Physician or Extender

- Suburban/Rural/Frontier – <30 miles/<45 minutes.
- Urban – <20 miles/<30 minutes.
- Patient Load – 2,500 or less for physician; one-half this for a physician extender.
- Appointment/Waiting times – Not to exceed 3 weeks from date of a patient's request for regular appointments and 48 hours for urgent care. Waiting times shall not exceed 45 minutes.
- Documentation/Tracking requirements:
- Documentation – Plans must have a system in place to document appointment scheduling times.
- Tracking – Plans must have a system in place to document the exchange of member information if a provider, other than the primary care provider, (i.e., school-based clinic or health department clinic), provides health care.

Specialty Care and Emergency Care

- Referral appointments to specialists (e.g., specialty physician services, hospice care, home health care, substance abuse treatment, rehabilitation services, etc.) shall not exceed 30 days for routine care or 48 hours for urgent care. All emergency care is immediate, at the nearest facility available, regardless of contract. Waiting times shall not exceed 45 minutes.

Hospitals

- Transport access, <30 miles/<45 minutes, except in rural areas where access distance may be greater. If greater, the standard needs to be the community standard for accessing care, and exceptions must be justified and documented to the State on the basis of community standards.

Long-Term Care Services

- Long-Term Care Services: Transport access to licensed Adult Day Care providers, ≤ 20 miles travel distance and ≤ 30 minutes travel time for TennCare enrollees in urban areas, ≤ 30 miles travel distance and ≤ 45 minutes travel time for TennCare enrollees in suburban areas ≤ 60 miles travel distance and ≤ 90 minutes travel time for TennCare enrollees in rural/frontier areas, except where community standards and documentation shall apply.

General Optometry Services:

- Transport access <30 miles/<45 minutes, except in rural areas where community standards and documentation shall apply.
- Appointment/Waiting Times: Usual and customary, not to exceed 3 weeks for regular appointments and 48 hours for urgent care. Waiting times shall not exceed 45 minutes.

All Other Services

- Usual and customary for the community as defined by TennCare.

Access to Specialty Care (CRA Attachment IV)

- The MCO shall have provider agreements with providers practicing the following specialties: Allergy, Cardiology, Dermatology, Endocrinology, Otolaryngology, Gastroenterology, General Surgery, Nephrology, Neurology, Neurosurgery, Oncology/Hematology, Ophthalmology, Orthopedics, Psychiatry (adult, child, and adolescent), and Urology.
- Travel access must not exceed <60 miles/<90 minutes for at least 75% of non-dual members.
- Travel access must not exceed <90 miles/<120 minutes for all non-dual members.

Access to Opioid Use Disorder (OUD) treatment providers

- The MCO shall have provider agreements with DATA 2000 Waiver approved OUD treatment providers.
- Transport access <45 miles/<45 minutes for at least 75% of non-dual members.
- Travel access must not exceed 60 miles/60minutes for all non-dual member

Access for Behavioral Health Services (CRA Attachment V)

- *Psychiatric Inpatient Hospital Services* – Transport access <90 miles/<120 minutes for all Child and Adult members. Maximum time for admission/appointment is 4 hours (emergency involuntary), 24 hours (involuntary), and 24 hours (voluntary).
- *24 Hour Psychiatric Residential Treatment* – Not subject to geographic access standards. Maximum time for admission/appointment is within 30 calendar days.
- *Outpatient Non-MD Services* – Transport access <30 miles/<45 minutes for at least 75% of Child and Adult members, and <60 miles/<60 minutes for all Child and Adult members. Maximum time for admission/appointment is within 10 business days; if urgent, within 48 hours.
- *Intensive Outpatient [may include day treatment (adult), intensive day treatment (children/adolescents), or Partial Hospitalization]* – Transport access <90 miles/<90 minutes for at least 75% of Child and Adult members, and <120 miles/<120 minutes for all Child and Adult members. Maximum time for admission/appointment is within 10 business days; if urgent, within 48 hours.
- *Inpatient Facility Services (Substance Abuse)* – Transport access <90 miles/<120 minutes for all Child and Adult members. Maximum time for admission/appointment is within 2 calendar days; for detoxification-within 4 hours in an emergency and 24 hours for non-emergency.
- *24 Hour Residential Treatment Services (Substance Abuse)* – Not subject to geographic access standards. Timeframe: within 10 business days.
- *Outpatient Treatment Services (Substance Abuse)* – Travel access does not exceed 30 miles/30 minutes for 75% of Child and Adult members, and 45 miles/45 minutes for all Child and Adult members. Timeframe: within 10 business days; within 24 hours for detoxification.
- *Intensive Community Based Treatment Services*– Not subject to geographic access standards. Timeframe: within seven calendar days.
- *Tennessee Healthlink Services* – Not subject to geographic access standards. Timeframe: within 30 calendar days.
- *Psychosocial Rehabilitation (may include Supported Employment, Illness Management & Recovery, Peer Recovery services, or Family Support service)* – Not subject to geographic access standards. Timeframe: within ten business days.
- *Supported Housing* – Not subject to geographic access standards. Timeframe: within 30 calendar days.
- *Crisis Services (Mobile)* – Not subject to geographic access standards. Timeframe: face-to-face contact within 2 hours for emergency situations and 4 hours for urgent situations.
- *Crisis Stabilization* – Not subject to geographic access standards. Timeframe: within 4 hours of referral.

42 CFR § 438.206(c)(1)(ii) Network providers offer hours of operation that are no less than the hours of operation offered to commercial enrollees or comparable to Medicaid Fee For Service

CRA § 2.12.9.64 require that providers offer hours of operation that are no less than the hours of operation offered to commercial enrollees.

42 CFR § 438.206(c)(1)(iii) Services included in the contract are available 24 hours a day, 7 days a week

CRA § 2.7.1.1 requires that emergency services be available 24 hours a day, seven days a week.

42 CFR § 438.206(c)(1) (iv-v) Mechanisms/monitoring to ensure compliance by providers. Monitor network providers regularly to determine compliance.

Each MCO has a provider services unit that monitors the network for compliance with certain standards. TennCare has contracted with Qsource, TennCare's EQRO, to conduct a quarterly provider data validation (PDV) survey. The purpose of this activity is to determine the accuracy of the provider data files submitted by the TennCare MCCs and to use the results as a proxy to determine the extent to which providers are available and accessible to TennCare members. The survey is conducted using a hybrid methodology developed to maximize response rates. The survey consists of telephone calls and facsimile follow-up protocol as necessary. The validation tool was programmed into a Microsoft Access database and pre-populated with data elements from the MCC provider files. Qsource attempts to contact providers up to three times by telephone.

Providers were also notified of a toll-free number to allow the provider to call back if the time was not convenient. The following standards are monitored through this survey.

- Valid Telephone Number
- Contract Status with MCC
- Provider Address
- MCC Data Accuracy - Provider Credentialed Specialty/Behavioral Health Service Code.
- Provider Panel Status (Open/Closed)
- Routine and Urgent Care Services - Provider offices were questioned regarding whether they offered routine and/or urgent care during the time reported for validation. Accuracy was determined by comparing the responses to the thresholds specific to each provider.
- Services for Patients - Two questions were asked of the providers: 1) Do you provide services to patients less than 21 years of age? And 2) Do you provide services to patients 21 years of age and older?
- Primary Care Services
- Prenatal Care Services

42 CFR § 438.206(c)(2) Culturally competent services to all enrollees

CRA § 2.18.3 requires the CONTRACTOR and its Providers and Subcontractors that are providing services pursuant to this Contract shall participate in the State's efforts to promote the delivery of services in a culturally competent manner to all enrollees, including those with Limited English Proficiency, disabilities and diverse cultural and ethnic backgrounds regardless of an enrollee's sex. This includes the CONTRACTOR emphasizing the importance of network providers to have the capabilities to ensure physical access, accommodations, and accessible equipment for the furnishing of services to enrollees with physical or mental disabilities.

Additionally, CRA § 2.8.4.3.1 states that health coaching or other interventions for health risk management shall emphasize self-management strategies addressing self-management tools per PHM 4: Wellness and Prevention (Element H), as well as self-monitoring, co-morbidities, cultural beliefs, and appropriate communication with providers.

42 CFR § 438.207 ASSURANCES OF ADEQUATE CAPACITY AND SERVICES
42 CFR § 438.207(b)(1) Offer an appropriate range of preventive, primary care, and specialty services
CRA § 2.7.5.1 states, "The Contractor shall provide preventive services which include, but are not limited to, initial and periodic evaluations, family planning services, prenatal care, laboratory services, and immunizations in accordance with TennCare Rules and Regulations." CRA § 2.7.5.2.1 states, "The Contractor shall provide or arrange for the provision of medically necessary prenatal care to members beginning on the date of their enrollment in the MCO. This requirement includes pregnant women who are presumptively eligible for TennCare, enrollees who become pregnant, as well as enrollees who are pregnant on the effective date of enrollment in the MCO. The requirement to provide or arrange for the provision of medically necessary prenatal care shall include assistance in making a timely appointment for a woman who is presumptively eligible and shall be provided as soon as the Contractor becomes aware of the enrollment." For a woman in her second or third trimester, the appointment shall occur as required in Section A.2.11.5.2. In the event a member enrolling in the CONTRACTOR's MCO is receiving medically necessary prenatal care services the day before enrollment, the CONTRACTOR shall comply with the requirements in Sections A.2.9.2.2 and A.2.9.2.3 regarding prior authorization of prenatal care. CRA § 2.7.6.1.1 requires that the MCOs provide EPSDT services (TennCare Kids) to members under age 21. CRA § 2.7.6.3.1-2 further requires that the MCO provide periodic comprehensive child health assessments, meaning, "regularly scheduled examinations and evaluations of the general physical and mental health, growth, development, and nutritional status of infants, children, and youth." At a minimum, these screens must include periodic and interperiodic screens and be provided at intervals which meet reasonable standards set forth in the American Academy of Pediatrics Recommendations for Preventive Pediatric Health Care for medical practice and American Academy of Pediatric Dentistry (AAPD) guidelines for dental practice. See the response for 42 CFR § 438.207(b)(2) (below) for further standards of care.
42 CFR § 438.207(b)(2) Maintain network of providers sufficient in number, mix, and geographic distribution
CRA Attachments III, IV and V outline standards that the MCOs have to meet. (See Attachments I, II and III of this document to see the full set of standards.)
42 CFR § 438.208 COORDINATION AND CONTINUITY OF CARE
42 CFR § 438.208(b)(1) Each enrollee has an ongoing source of primary care appropriate to his or her needs

CRA Attachment III outlines standards for primary care providers that each MCO must meet. The requirements for Primary Care Physicians or Extenders are as follows:

- Access Suburban/Rural/ Frontier: 30 miles/45 minutes
- Access Urban: 20 miles/30 minutes
- Patient Load: 2,500 or less for physician; one-half this for a physician extender
- Appointment/Waiting Times: Usual and customary practice, not to exceed three weeks from date of a patient's request for regular appointments and 48 hours for urgent care. Waiting times shall not exceed 45 minutes.
- Documentation/Tracking requirements:
  - Health plans must have a system in place to document appointment scheduling times.
  - Tracking – Plans must have a system in place to document the exchange of member information if a provider other than the primary care provider (i.e., school-based clinic or health department clinic) provides health care.

42 CFR § 438.208(b)(2) All services that the enrollee receives are coordinated with the services the enrollee receives from any other MCO/PIHP

The MCOs are responsible for the management, coordination, and continuity of care for all their TennCare members and shall develop and maintain policies and procedures to address this responsibility. For CHOICES and ECF CHOICES members, these policies and procedures shall specify the role of the Care Coordinator/care coordination or Support Coordinator/support coordination team, or Support Coordinator/support coordination team, or the Integrated Support Coordination Team, as applicable, in conducting these functions (CRA § 2.9.1). Additionally, MCOs coordinate with other state and local departments and agencies to ensure that coordinated care is provided to members (CRA § 2.9.15).

42 CFR § 438.208(b)(3) Share with other MCOs, PIPHPs, and PAHPs serving the enrollee with special health care needs the results of its identification and assessment to prevent duplication of services

MCOs shall use their Population Health and CHOICES care coordination and ECF CHOICES support coordination programs to support the continuity and coordination of covered physical health, behavioral health, and long-term services and supports, and to support collaboration between physical health, behavioral health, and long-term services and supports providers (CRA § 2.9.8.8).

42 CFR § 438.208(b)(4) Protect enrollee privacy when providing care

The MCOs shall comply with all applicable HIPAA and HITECH requirements including, but not limited to, the following (CRA § 2.27.2.1-4):

- Compliance with the Privacy Rule, Security Rule, and Notification Rule
- The creation of and adherence to sufficient Privacy and Security Safeguards and Policies
- Timely reporting of violations in the access, use, and disclosure of PHI
- Timely reporting of privacy and/or security incidents

42 CFR § 438.208(c)(1) State mechanisms to identify persons with special health care needs
CRA § 2.9.15.1-7 requires MCOs to coordinate with other state and local departments and agencies to ensure that coordinated care is provided to members. This includes, but is not limited to, coordination with Tennessee Department of Mental Health & Substance Abuse Services (TDMHSAS) and DIDD for the purpose of interfacing with and assuring continuity of care and for coordination of specialized services in accordance with federal PASRR requirements; and for avoiding inappropriate admission of individuals with I/DD to an RMHI and/or coordinating timely discharge of individuals with I/DD from an RMHI, which shall include: 2.9.15.1.1 Ongoing tracking and coordination of members with I/DD experiencing a behavioral health crisis and referred for placement in an RMHI in order to divert the member from placement in an RMHI unless it is the most appropriate treatment setting; 2.9.15.1.2 Immediate engagement and coordinated post-discharge planning for any member with I/DD admitted to an RMHI to facilitate timely transition to the appropriate sub-acute or community placement, with follow-up as appropriate to ensure stabilization and avoid readmission; 2.9.15.1.3 Weekly case conferences between the CONTRACTOR's Behavioral Health Director, Behavior Supports Director, and other Behavioral Health leads, as appropriate, and each RMHI, TENNCARE and DIDD regarding the CONTRACTOR's members with I/DD referred to or receiving services in an RMHI; and 2.9.15.1.4 Monthly reporting to TENNCARE as described in Section A.2.30.6.10 regarding the CONTRACTOR's performance as it relates to avoiding inappropriate admission of individuals with I/DD to an RMHI and/or coordinating timely discharge of individuals with I/DD from an RMHI. 2.9.15.2 *Tennessee Department of Children's Services (DCS)* for the purpose of interfacing with and assuring continuity of care; 2.9.15.3 *Tennessee Department of Health (DOH)* for the purposes of establishing and maintaining relationships with member groups and health service providers; 2.9.15.4 *Tennessee Department of Human Services (DHS) and DCS Protective Services Section,* for the purposes of reporting and cooperating in the investigation of abuse and neglect; 2.9.15.5 *Tennessee Department of Intellectual Disabilities Services (DIDD),* for the purposes of coordinating physical and behavioral health services with HCBS available for members who are also enrolled in a Section 1915(c) HCBS waiver for persons with intellectual disabilities, and for purposes of ECF CHOICES, including intake, critical incident reporting and management, quality monitoring, and programmatic leadership, oversight, and statewide coordination of ECF Groups 7 and 8; and building the statewide capacity and continuum of the behavioral health system to meet the needs of individuals with I/DD who have co-occurring mental health conditions or behavioral support needs in a person-centered way. 2.9.15.5.1 Programmatic leadership, oversight and statewide coordination of Groups 7 and 8, and development of statewide behavioral health capacity shall include 2.9.15.5.1.1 Review and approval (or denial) of referrals for enrollment into Groups 7 and 8 as a part of the Interagency Review Committee; 2.9.15.5.1.2 Leadership, coordination and direction of Interagency Review Committee processes for Groups 7 and 8; 2.9.15.5.1.3 Review of MCO referrals for admission of any member with I/DD to an inpatient behavioral health setting, and consultation with MCO behavioral health and behavior supports staff regarding the most appropriate treatment setting;

2.9.15.5.1.4 Leadership, oversight, and support of the CONTRACTOR's coordination responsibilities between the CONTRACTOR and DMHSAS to facilitate timely discharge of individuals with I/DD from an RMHI, as described in 2.9.15.1.1 through 2.9.15.1.4;

2.9.15.5.1.5 Review, consultation, and approval of discharge plans for a member with I/DD from an RMHI or other inpatient behavioral health setting, including, but not limited to members enrolled in Groups 7 and 8;

2.9.15.5.1.6 Review, consultation, and approval of the CONTRACTOR's provider network for the provision of IBFCTSS in Group 7 and IBCTSS in Group 8, and broader network capacity for transition and ongoing support once stabilization is achieved, as well as direct assistance in developing the capacity of such networks;

2.9.15.5.1.7 Statewide support, technical assistance, coordination and oversight of the CONTRACTOR's development of statewide capacity for behavioral crisis and stabilization response specific to the needs of individuals with I/DD, leveraging telehealth with in-person backup as needed. To the extent service is provided directly by DIDD, the CONTRACTOR shall contract with DIDD for the provision of this service at a rate to be determined by TENNCARE;

2.9.15.5.1.8 Statewide support, technical assistance, coordination, and oversight of the CONTRACTOR's development of statewide capacity for rapid placement, intensive therapeutic behavioral stabilization, medication management (as applicable), and comprehensive person-centered assessment specifically targeted to the needs of individuals with I/DD, including person-centered transition planning with the HCBS provider and/or family caregiver (as applicable); program development and implementation (including training), and post-transition stabilization placement support (telehealth and in-person). To the extent this service is provided directly by DIDD, the CONTRACTOR shall contract with DIDD for the provision of this service at a rate to be determined by TENNCARE;

2.9.15.5.1.9 Ongoing monitoring, technical assistance, and support of the quality of services delivered by contracted providers to members enrolled in Group 7 or Group 8, with a primary focus on IBFCTSS and IBCTSS, Such activities shall include, but is not limited to: monthly review of data submitted by the MCO to TENNCARE, onsite review by a qualified I/DD professional with sufficient experience to adequately monitor the quality of care delivered by contracted providers to each of the CONTRACTOR's members enrolled in these Groups, and ongoing training, technical assistance and support of the CONTRACTOR and its contracted providers to help ensure quality and cost efficiency of services delivered to members in these Groups and to improve quality outcomes;

2.9.15.5.1.10 Review and approval of plans for transition of a Group 7 or Group 8 member to a different benefit group, and the support and oversight of the timely and effective implementation of such plans;

2.9.15.5.1.11 Post-transition stabilization review, monitoring, support and assistance as needed to ensure the adequacy of ongoing behavior supports;

2.9.15.5.1.12 Any other responsibility as defined in the Interagency Agreement between TENNCARE and DIDD and/or set forth by TENNCARE in policies or protocols.

2.9.15.5.6 *Area Agencies on Aging and Disability (AAADs)* regarding intake of members new to both TennCare and CHOICES, and assisting CHOICES members in Groups 2 and 3 with the TennCare eligibility redetermination process;

2.9.15.7 *Tennessee Department of Education (DOE)* and local education agencies for the purposes of coordinating educational services in compliance with the requirements of Individuals with Disabilities Education Act (IDEA) and to ensure school-based services for students with special needs are provided

MCOs are responsible for the delivery of medically necessary covered services to school-aged children. MCOs are encouraged to work with school-based providers to manage the care of students with special needs. The State has implemented a process, referred to as TennCare Kids Connection, to facilitate notification of MCOs when a school-aged child enrolled in TennCare has an Individualized Education Plan (IEP) that identifies a need for medical services. In such cases, the school is responsible for obtaining parental consent to share the IEP with the MCO and for subsequently sending a copy of the parental consent and IEP to the MCO. The school is also responsible for clearly delineating the services on the IEP that the MCOs are to consider for payment. If a school-aged member, needing medical services, is identified by the CONTRACTOR by another means, the CONTRACTOR shall request the IEP from the appropriate school system. (CRA § 2.9.15.7.1)
42 CFR § 438.208(c)(2) Mechanisms to assess enrollees with special health care needs by appropriate health care professionals

2.8.3 Member Assessment

2.8.3.1 The CONTRACTOR shall make a best effort to conduct an initial screening of each member's needs, within ninety (90) days of the effective date of enrollment for all new members to assess member's health risk utilizing a health risk assessment, also referred to as a health risk appraisal, that meets and/or exceeds the current National Committee for Quality Assurance (NCQA) Population Health Management standard, that has been approved by TENNCARE and Population Health staff, or a comprehensive health risk assessment that meets and/or exceeds the current National Committee for Quality Assurance (NCQA) Population Health Management standard. The CONTRACTOR shall make subsequent attempts to conduct an initial screening of each member's needs if the initial attempt to contact the member is unsuccessful, within thirty (30) days of the initial outreach attempt. These timelines may be shortened or contact methods specified for specific parts of the program in contract sections below. The information collected from these health assessments will be used to align individual members with appropriate intervention approaches and maximize the impact of the services provided.

2.8.3.2 At time of enrollment and annually thereafter, the CONTRACTOR shall make a reasonable attempt to assess the member's health. The comprehensive health risk assessment required by Level 2 Population Health programs, CHOICES, Dual Special Needs Program (D-SNP), Select Community, and Department of Children's Services (DCS) can be used in lieu of the approved health assessment required by the contract. Members exempt from the health assessment are those members that have completed an approved health assessment or a comprehensive health risk assessment in the prior twelve (12) months. The completed approved health assessment or comprehensive health risk assessment data may be shared among TennCare MCOs and used to meet the annual requirement. At the request of TENNCARE, the CONTRACTOR shall share with TENNCARE, or other MCCs serving the member, the results of any identification and assessment of that member's needs to assist in facilitating the administration of health related services and to prevent duplication of those activities.

2.8.3.3 The CONTRACTOR shall conduct a comprehensive Health Risk Assessment (HRA) for all members enrolled in the Chronic Care Management, Complex Case Management, and High-Risk Maternity Programs. The HRA should include screening for physical conditions, mental health, and substance abuse for all members.

2.8.3.4 For members considered high risk, the assessment shall include documenting the individual health history, determining each member's health literacy status, identifying substance abuse and behavioral issues/problems, identifying needs and gathering information, when appropriate, from other sources (e.g., family members, medical providers, and educators).

2.8.3.5 The CONTRACTOR shall conduct an assessment for the need of a face to face visit for members considered to have high health risks that are enrolled in the Chronic Care Management, Complex Case Management, or High-Risk Maternity programs. The CONTRACTOR shall assess the need for a face-to-face visit using the standard assessment criteria provided by TENNCARE. If needed, such a visit shall be conducted following consent of the member.

42 CFR § 438.208(c)(3) If applicable, treatment plans developed by the enrollee's primary care provider with enrollee participation, and in consultation with any specialists caring for the enrollee; approved in a timely manner; and in accord with applicable state standards

Not Applicable

42 CFR § 438.208(c)(4) Direct Access to specialists for enrollees with special health care needs
The MCOs shall establish and maintain a network of physician specialists that is adequate and reasonable in number, in specialty type, and in geographic distribution to meet the medical and behavioral health needs of its members (adults and children) without excessive travel requirements. (CRA § 2.11.3.2.1) TENNCARE will monitor CONTRACTOR compliance with specialty network standards on an ongoing basis. TENNCARE will use data from the monthly Provider Enrollment File required in CRA § A.2.30.8.1), to verify compliance with the specialty network requirements. TENNCARE will use these files to confirm the CONTRACTOR has a sufficient number and distribution of physician specialists and in conjunction with MCO enrollment data to calculate member to provider ratios. TENNCARE will also periodically phone providers listed on these reports to confirm that the provider is a contract provider as reported by the CONTRACTOR. TENNCARE shall also monitor appeals data for indications that problems exist with access to specialty providers. (CRA § 2.11.3.3.1)
42 CFR § 438.210 COVERAGE AND AUTHORIZATION OF SERVICES
42 CFR § 438.210(a)(1) Identify, define, and specify the amount, duration, and scope of each service.
See Attachment IV in this document for covered benefits.
42 CFR § 438.210(a)(2) Services are furnished in an amount, duration, and scope that is no less than those furnished to beneficiaries under fee-for-service Medicaid.
All covered benefits are provided if medically necessary through a capitated arrangement with the MCCs.
42 CFR § 438.210(a)(3)(i) Services are sufficient in amount, duration, or scope to reasonably be expected to achieve the purpose for which the services are furnished.
CRA § 2.6.3.1 relates to Medical Necessity Determinations. It states that the MCCs may establish procedures for the determination of medical necessity and for the use of medically appropriate cost-effective alternative benefits. The CONTRACTOR may also limit benefits for the purpose of utilization control in accordance with NCQA standards, as long as (1) the furnished benefits can reasonably achieve the purpose for which they are furnished, and as long as (2) the benefits furnished for enrollees with chronic conditions (or who require LTSS) are authorized in a manner that reflects the enrollee's ongoing need for such benefits. See 42 CFR § 438.3(e)(2) and 42 CFR § 438.210(a)(4).
42 CFR § 438.210(a)(3)(ii) No arbitrary denial or reduction in service solely because of diagnosis, type of illness or condition
CRA § 2.6.3.2 shall use written criteria based on sound clinical evidence to make utilization decisions. The written criteria shall specify procedures for appropriately applying the criteria. The criteria must satisfy NCQA standards. The CONTRACTOR shall apply objective and evidence-based criteria and take individual circumstances and the local delivery into account when determining the medical appropriateness of health care services and § 2.6.3.3 The CONTRACTOR shall ensure that the services are sufficient in amount, duration, or scope to reasonably achieve the purpose for which the services are furnished. The CONTRACTOR shall not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of the diagnosis, type of illness, or condition.
42 CFR § 438.210(a)(3)(iii) Each MCO/PIHP may place appropriate limits on a service, such as medical necessity.

CRA § 2.6.3.1 through 2.6.3.3 state the MCCs may not employ and shall not permit others acting on their behalf to employ, utilization control guidelines or other quantitative coverage limits, whether explicit or de facto, unless supported by an individualized determination of medical necessity based upon the needs of each TennCare enrollee and his/her medical history. The MCCs must not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of the diagnosis, type of illness, or condition.

42 CFR § 438.210(a)(5) Specify what constitutes "medically necessary services".

CRA § 2.6.3 relates to Medical Necessity Determinations. It states that the MCCs may establish procedures for the determination of medical necessity with the determination being made on a case- by-case basis and in accordance with the definition of medical necessity defined in TCA 71-5-1944 and TennCare rules and regulations governing medical necessity, which are delineated at 1200-13-16. Specifically, to be medically necessary, the benefit must meet each of the following criteria:

- It must be recommended by a licensed physician who is treating the enrollee or other licensed healthcare provider practicing within the scope of his or her license who is treating the enrollee;
- It must be required in order to diagnose or treat an enrollee's medical condition;
- It must be safe and effective;
- It must not be experimental or investigational; and
- It must be the least costly alternative course of diagnosis or treatment that is adequate for the enrollee's medical condition.

42 CFR § 438.210(b)(1) Each MCO/PIHP and its subcontractors must have written policies and procedures for authorization of services.

42 CFR § CFR § 438.210(b)(2)(i) Each MCO/PIHP must have mechanisms to ensure consistent application of review criteria for authorization decisions.

CRA § 2.14.1.8 states that MCOs shall use appropriately licensed professionals to supervise all medical necessity decisions and specify the type of personnel responsible for each level of UM, including prior authorization and decision making. They must also have written procedures documenting access to Board Certified Consultants to assist in making medical necessity determinations. Any amount, duration, or scope that is less than requested shall be made by a physical health or behavioral health care professional that has appropriate clinical expertise in treating the member's condition or disease or, in the case of long-term care services, a long-term care professional that has appropriate expertise in providing long-term care services.

CRA § 2.14.2.1 states that MCOs shall have in place, and follow, written policies and procedures for processing requests for initial and continuing prior authorizations of services and have in effect mechanisms to ensure consistent application of review criteria for prior authorization decisions. The policies and procedures shall provide for consultation with the requesting provider when appropriate. If prior authorization of a service is granted by the MCO and the service is provided, payment for the prior authorized service shall not be denied based on the lack of medical necessity, assuming that the member is eligible on the date of service, unless it is determined that the facts at the time of the denial of payment are significantly different than the circumstances which were described at the time the prior authorization was granted.

CRA § 2.14.5.1 states that MCOs shall have in place an authorization process for covered long-term services and cost-effective alternative services that is separate from but integrated with the prior authorization process for covered physical and behavioral health services.

42 CFR § 438.210(b)(3) Any decision to deny or reduce services is made by an appropriate health care professional.
CRA § 2.14.1.8 states that MCOs shall use appropriately licensed professionals to supervise all medical necessity decisions and specify the type of personnel responsible for each level of UM, including prior authorizations and decision making. They shall also have written procedures documenting access to Board Certified Consultants to assist in making medical necessity determinations. Any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested shall be made by a physical health or behavioral health care professional who has appropriate clinical expertise in treating the member's condition or disease or, in the case of long-term care services, a long-term care professional who has appropriate expertise in providing long-term care services.
42 CFR § 438.210(c) Each MCO/PIHP must notify the requesting provider, and give the enrollee written notice of any decision to deny or reduce a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. 42 CFR § 438.210(d) Provide for the authorization decisions and notices as set forth in CFR § 438.210(d). 42 CFR § 438.210(e) Compensation to individuals or entities that conduct utilization management activities does not provide incentives to deny, limit, or discontinue medically necessary services.
CRA § 2.14.7, Notice of Adverse Benefit Determination Requirements, require MCOs to: CRA § 2.14.7.1 In accordance with 42 CFR § 438.210(c), the CONTRACTOR must notify the requesting provider, and give the enrollee written notice of any decision to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. The Notice of Adverse Benefit Determination must meet the requirements set forth in CRA § A.2.19.2. CRA § 2.14.7.2 The CONTRACTOR shall comply with all member notice provisions in TennCare rules and regulations. CRA § 2.14.7.3 The CONTRACTOR shall issue appropriate notice prior to any CONTRACTOR-initiated decision to reduce or terminate CHOICES or non-CHOICES nursing facility services and shall comply with all federal court orders, and federal and state laws and regulations regarding members' transfer or discharge from nursing facilities.

Structure and Operations Standards

CMS Requirement: This section should include a discussion of the standards that the state has established in the MCO/PIHP contracts for structure and operations, as required by 42 CFR, § 438(D)D. These standards should relate to the overall goals and objectives listed in the quality strategy's introduction. States may either reference the structure and operations provisions from the state's managed care contracts, or provide a summary description of such provisions. CMS recommends states minimize reference to contract language in the quality strategy. However, if the state chooses the latter option, the summary description must be sufficiently detailed to offer a clear picture of the specific contract provisions and be written in language that may be understood by stakeholders who are interested in providing input as part of the public comment process.

STATE STRUCTURE & OPERATIONS STANDARDS AS REQUIRED BY 42 CFR, PART 438, SUBPART D
42 CFR § 438.214 Provider Selection
42 CFR § 438.214(a) Written Policies and procedures for Selection and Retention of Providers.
CRA § 2.11.1.3.3 states the MCO must have in place written policies and procedures for the selection and retention of providers. These policies and procedures must not discriminate against particular providers that service high risk populations or specialize in conditions that require costly treatment.
42 CFR § 438.214(b)(1) Uniform credentialing and recredentialing policy that each MCO/PIHP must follow.
CRA § 2.11.9.1 - Credentialing of Contract Providers: • The MCO must utilize the current NCQA Standards and Guidelines for the Accreditation of MCOs for the credentialing and recredentialing of licensed independent providers and provider groups with whom it contracts or employs and who fall within its scope of authority and action. • The MCO must completely process credentialing applications from all types of providers (physical health, behavioral health, and long-term care providers) within 30 calendar days of receipt of a completed credentialing application, including all necessary documentation and attachments, and a signed provider agreement. "Completely process" means that the MCO shall approve and load approved applicants to its provider files in its claims processing system or deny the application and ensure that the provider is not used by the MCO. • The MCO must ensure all providers submitted to it by the delegated credentialing agent are loaded to its provider files and into its claims processing system within 30 days of receipt. *CRA § 2.11.10.2 - Credentialing of Non-Contract Providers* • The MCO must utilize the current NCQA Standards and Guidelines for the Accreditation of MCOs for the credentialing of licensed independent providers with whom it does not contract but with whom it has an independent relationship. An independent relationship exists when the MCO selects and directs its members to see a specific provider or group of providers. • The MCO must completely process credentialing applications within 30 calendar days of receipt of a completed credentialing application, including all necessary documentation and attachments, and a signed contract/agreement if applicable. "Completely process" means that the MCO shall review, approve, and load approved applicants to its provider files in its claims processing system or deny the application and ensure that the provider is not used by the MCO. • The MCO must notify TennCare when it denies a provider credentialing application for program integrity-related reasons or otherwise limits the ability of providers to participate in the program for program integrity reasons.

CRA § 2.11.10.3 - Credentialing of Behavioral Health Entities

- The MCO must ensure each behavioral health provider's service delivery site meets all applicable requirements of law and has the necessary and current license/certification/accreditation/designation approval per state requirements.
- When individuals providing behavioral health treatment services are not required to be licensed or certified, it is the responsibility of the MCO to ensure, based on applicable state licensure rules and/or program standards, that they are appropriately educated, trained, qualified, and competent to perform their job responsibilities.

42 CFR § 438.214(d) MCOs/PIHPs may not employ or contract with providers excluded from Federal Health Care Programs.

CRA § 2.20.1.8 states, "The contractor, as well as its subcontractors and providers, whether contract or non-contract, shall comply with all federal requirements (42 CFR § 1002) on exclusion and debarment screening. The CONTRACTOR, its subcontractors and all tax-reporting provider entities that bill and/or receive TennCare funds as the result of this Contract shall screen their owners and employees against the General Services Administration (GSA) System for Award Management (SAM) and the HHS-OIG List of Excluded Individuals/Entities (LEIE). In addition, the CONTRACTOR and its subcontractors shall screen their owners and employees against the Social Security Master Death File. Any unallowable funds made to excluded individuals as full or partial wages and/or benefits shall be refunded to and/or obtained by the State and/or the CONTRACTOR dependent upon the entity that identifies the payment of unallowable funds to excluded individuals.

CRA § 2.20.3.6 states, "The contractor shall have provisions in its Compliance Plan regarding conducting monthly comparison of their provider files, including atypical providers, against the Social Security Master Death File, the General Services Administration (GSA) System for Award Management (SAM and the HHS-OIG List of Excluded Individuals/Entities (LEIE) and provide a report of the result of comparison to TENNCARE each month. The contractor shall establish an electronic database to capture identifiable information on the owners, agents and managing employees listed on providers' Disclosure forms."

CRA § 2.20.3.7 states, "The contractor shall have provisions in its Compliance Plan regarding performing a monthly check for exclusions of their owners, agents and managing employees. The contractor shall establish an electronic database to capture identifiable information on its owners, agents and managing employees and perform monthly exclusion checking. The contractor shall provide the State Agency with such database and a monthly report of the exclusion check."

42 CFR § 438.218 Enrollee Information
42 CFR § 438.218 Incorporate the requirements of 438.10
CRA § 2.17 incorporates the responses to 42 CFR § 438.10. Primary language is identified by the enrollment contractor at the time of each person's application for TennCare services. If the primary language is omitted from the enrollment files received by the MCO, the MCO staff then collects the information during new member calls. Requirements for the MCOs are as follows: • Must submit all materials that will be distributed to members to TennCare for prior approval. This includes, but is not limited to member handbooks, provider directories, member newsletters, identification cards, fact sheets, notices, brochures, form letters, mass mailings, and system generated letters. Modifications to existing materials must also receive prior approval. • All member materials must be worded at a sixth-grade reading level and must be clearly legible. They must also be available in alternative formats for persons with special needs at no expense to the member. Formats may include Braille, large print, and audio, depending on the needs of the member. • All vital documents must be translated and available in Spanish. Within 90 calendar days of notification from TennCare, all vital documents must be translated and available to each Limited English Proficiency (LEP) group identified by TennCare that constitutes 5% of the TennCare population or 1,000 enrollees, whichever is less. • All written member materials contain language and communication taglines and civil rights notices, which inform members that free oral interpretation is available for any language, free written translation and auxiliary aids or services are available upon request, and how to ask for help with their services. The language taglines are printed in the top 17 prevalent non-English languages in Tennessee. The taglines also comply with the 18-point font requirements. • Electronic information and services are readily accessible and incorporate the Section 508 guidelines and Web Content Accessibility Guidelines (WCAG) 2.0 AA. The MCOs may provide member materials electronically or on their websites as long as it meets the following requirements: (1) the material/information must be placed on the MCO's website in a location that is prominent and readily accessible for applicants and members to link to from the MCO's home page; (2) the material/information must be provided in a format that can be electronically saved and printed; and (3) if a member or applicant requests that the MCO mail them a copy of the material/information, the MCO must mail free of charge the material/information to them within five (5) days of that request. • The MCO must provide written notice to members of any changes in policies or procedures described in written materials previously sent to members. They must provide written notice at least 30 days before the effective date of a request. • The contractor must use the approved Glossary of Required Spanish Terms in the Spanish translation of all member materials. • All educational materials must be reviewed and updated concurrently with the update of the Clinical Practice Guidelines to ensure the materials reflect current evidence-based information.

- The MCO must develop a member handbook based on a template provided by TennCare and update it periodically (at least annually). It must be distributed within 30 calendar days of receipt of notice of enrollment in the MCO or prior to enrollees' enrollment effective date and at least annually thereafter. Members must receive a revised member handbook whenever material changes are made.

CRA § 2.17.4.6 requires that each member handbook include the following:

- Table of Contents.
- Explain how members will be notified of member-specific information such as effective date of enrollment, PCP assignment, and care coordinator assignment for CHOICES members or support coordinator assignment for ECF CHOICES members.
- Explain how members can request to change PCPs.
- Description of services provided including benefit limits, the consequences of reaching a benefit limit, non-covered services, and use of non-contract providers, including that members are not entitled to a fair hearing about non-covered services and that members shall use contract providers except in specified circumstances.
- Explain that prior authorization is required for some services, including non-emergency services provided by a non-contract provider, and that service authorization is required for all long-term care services; that such services will be covered and reimbursed only if such prior authorization/service authorization is received before the service is provided; that all prior authorizations/service authorizations are null and void upon expiration of a member's TennCare eligibility; and that the member shall be responsible for payment for any services provided after the member's eligibility has expired.
- Descriptions of the Medicaid Benefits, Standard Benefits, and the covered long-term care services for CHOICES and ECF CHOICES members, by CHOICES group and ECF CHOICES group. This shall include information about how transportation is provided, including transportation for any benefits carved out of the CRA and provided by the state;
- Provide information regarding ECF CHOICES as specified in a template provided by TennCare.
- Description of TennCare cost sharing or patient liability responsibilities including an explanation that providers and/or the CONTRACTOR may utilize whatever legal actions are available to collect these amounts. Further, the information shall specify the instances in which a member may be billed for services, and shall indicate that the member may not be billed for covered services except for the amounts of the specified TennCare cost sharing or patient liability responsibilities and explain the member's right to appeal in the event that they are billed for amounts other than their TennCare cost sharing or patient liability responsibilities. The information shall also identify the potential consequences if the member does not pay his/her patient liability, including loss of the member's current nursing facility provider, disenrollment from CHOICES or ECF CHOICES, and, to the extent the member's eligibility depends on receipt of long-term care services, loss of eligibility for TennCare.
- Information about preventive services for adults and children, including TennCare Kids; a listing of covered preventive services; and notice that preventive services are at no cost and without cost sharing responsibilities.
- Procedures for obtaining required services, including procedures for obtaining referrals to specialists as well as procedures for obtaining referrals to non-contract providers. The handbook shall advise members that if they need a service that is not available from a contract provider or MCO, for certain reasons, including, moral or religious reasons, they will be referred to a non-contract provider and any copayment requirements would be the same as if this provider were a contract provider.

- Information on the CHOICES program, including a description of the CHOICES groups; eligibility for CHOICES; enrollment in CHOICES, including whom to contact at the MCO regarding enrollment in CHOICES; enrollment targets for Group 2 and Group 3 (excluding Interim Group 3), including reserve capacity and administration of waiting lists; and CHOICES benefits, including benefit limits, the individual cost neutrality cap for Group 2, and the expenditure cap for Group 3.
- Information on care coordination for CHOICES members, including but not limited to the role of the care coordinator, level of care assessment and reassessment, comprehensive assessment and reassessment, and care planning, including the development of a plan of care for members in CHOICES Groups 2 and 3.
- Information on the right of CHOICES and ECF CHOICES members to request an objective review by the State of their need's assessment and/or care planning processes and how to request such a review.
- Information regarding consumer direction of eligible CHOICES HCBS, including but not limited to the roles and responsibilities of the member or the member's representative, the services that can be directed, the member's right to participate in or voluntarily withdraw from consumer direction at any time, the role of and services provided by the FEA, and a statement that voluntary or involuntary withdrawal from consumer direction will not affect a member's eligibility for CHOICES.
- Explanation of emergency services and procedures on how to obtain emergency services both in and out of the contractor's service area, including but not limited to an explanation of post-stabilization services, the use of 911, locations of emergency settings, and locations for post-stabilization services.
- Information on how to access the primary care provider on a 24-hour basis as well as the 24-hour nurse line. The handbook may encourage members to contact the PCP or 24-hour nurse line when they have questions as to whether they should go to the emergency room.
- Information on how to access a care coordinator, including the ability to access a care coordinator after regular business hours through the 24-hour nurse triage/advice line.
    - Information about the civil rights laws as directed by TENNCARE, which shall include, but is not limited to the notice of nondiscrimination, taglines, and the discrimination complaint forms;
    - Shall include information about the Long-Term Care Ombudsman Program;
    - Shall include information on the beneficiary support system, including but not limited to, help with choice counseling, filing complaints or appeals, finding the status of a complaint or appeal, and resolving related issues related to rights and responsibilities.
    - Shall include information about the CHOICES consumer advocate, including but not limited to the role of the consumer advocate in the CHOICES program and how to contact the consumer advocate for assistance;
    - Shall include information about how to report suspected abuse, neglect, and exploitation of members who are adults (see TCA 71-6-101 et seq.) and suspected brutality, abuse, or neglect of members who are children (see TCA 37-1-401 et seq. and TCA 37-1-601 et seq.), including the phone numbers to call to report suspected abuse/neglect;
    - Shall include Grievance and Appeal procedures as described in Section A.2.19 of the Contract
    - Shall include notice that the member shall have the right to request reassessment of eligibility related decisions directly to TENNCARE;
    - Shall include written policies on member rights and responsibilities, pursuant to 42 CFR 438.100 and NCQA's Standards and Guidelines for the Accreditation of MCOs;
    - Shall include written information concerning advance directives as described in 42 CFR 489 Subpart I and in accordance with 42 CFR 422.128;
    - Shall include notice that enrollment in the CONTRACTOR's MCO invalidates any prior authorization for services granted by another MCO but not utilized by the member prior to the member's enrollment into the CONTRACTOR's MCO and notice of continuation of care when entering the

CONTRACTOR's MCO as described in Section A.2.9.2 of this Contract;

- Shall include notice to the member that it is the member's responsibility to notify the CONTRACTOR, TENNCARE (or for SSI eligibles, SSA) each and every time the member moves to a new address and that failure to notify TENNCARE (or for SSI eligibles, SSA) could result in the member not receiving important eligibility and/or benefit information;
- Shall include notice that a new member may request to change MCOs at any time during the ninety (90) calendar day period immediately following their initial enrollment in an MCO, subject to the capacity of the selected MCO to accept additional members and any restrictions limiting enrollment levels established by TENNCARE. This notice shall include instructions on how to contact TENNCARE to request a change;
- Shall include notice that the member may change MCOs at the next choice period as described in Section A.2.4.7.2.2 of this Contract and shall have a ninety (90) calendar day period immediately following the enrollment, as requested during said choice period, in a new MCO to request to change MCOs, subject to the capacity of the selected MCO to accept additional enrollees and any restrictions limiting enrollment levels established by TENNCARE. This notice shall include instructions on how to contact TENNCARE to request a change;
- Shall include notice that the member has the right to ask TENNCARE to change MCOs based on hardship, the circumstances which constitute hardship, explanation of the member's right to file an appeal if such request is not granted, and how to do so;
- Shall include notice of the enrollee's right to terminate participation in the TennCare program at any time with instructions to contact TENNCARE for termination forms and additional information on termination;
- Shall include TENNCARE and MCO member services toll-free telephone numbers, including the TENNCARE hotline, the CONTRACTOR's member services information line, and the CONTRACTOR's 24/7 nurse triage/advice line with a statement that the member may contact the CONTRACTOR or TENNCARE regarding questions about the TennCare program, including CHOICES, as well as the service/information that may be obtained from each line;
- Shall include information on how to obtain information in alternative formats or how to access interpretation services as well as a statement that interpretation and translation services are free;
- Shall include information educating members of their rights and necessary steps to amend their data in accordance with HIPAA regulations and state law;
- Shall include directions on how to request and obtain information regarding the "structure and operation of the MCO" and "physician incentive plans" (see Section A.2.17.9.2);
- Shall include information that the member has the right to receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand;
- Shall include information that the member has the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation;
- Shall include notice that member has the right to participate in decisions regarding his or her health care, including the right to refuse treatment;
- Shall include notice that the member has the right to request and receive a copy of their medical records and request that they be amended or corrected;
- Shall include information on appropriate prescription drug usage (see Section A.2.9.10);
- Shall include state-developed definitions as required in 42 CFR 438.10(c)(4)(i) which the CONTRACTOR shall use when communicating with enrollees; and
- Shall include any additional information required in accordance with NCQA's Standards and Guidelines for the Accreditation of MCOs

- Information about the CHOICES and ECF CHOICES consumer advocate, including but not limited to the role of the consumer advocate in the CHOICES and ECF CHOICES program and how to contact the consumer advocate for assistance.
- Information about how to report suspected abuse, neglect, and exploitation of members who are adults (see TCA 71-6-101 et seq.) and suspected brutality, abuse, or neglect of members who are children (see TCA 37-1-401 et seq. and TCA 37-1-601 et seq.), including the phone numbers to call to report suspected abuse/neglect.
- Complaint and appeal procedures.
- Notice that in addition to the member's right to file an appeal directly to TennCare for adverse actions taken by the MCO, the member shall have the right to request reassessment of eligibility related decisions directly to TennCare.
- Written policies on member rights and responsibilities, pursuant to 42 CFR § 438.100 and NCQA's Standards and Guidelines for the Accreditation of MCOs.
- Written information concerning advance directives as described in 42 CFR § 489 Subpart I and in accordance with 42 CFR § 422.128.
- Notice that enrollment in the contractor's MCO invalidates any prior authorization for services granted by another MCO but not utilized by the member prior to the member's enrollment into the contractor's MCO and notice of continuation of care when entering the contractor's MCO as described in § 2.9.2 of this Agreement.
- Notice to the member that it is his or her responsibility to notify the MCO, TennCare, and Department of Human Services (DHS) (or for SSI eligibles, SSA) each and every time the member moves to a new address and that failure to notify DHS (or for SSI eligibles, SSA) could result in the member not receiving important eligibility and/or benefit information.
- Notice that a new member may request to change MCOs at any time during the 45-calendar day period immediately following their initial enrollment in an MCO, subject to the capacity of the selected MCO to accept additional members and any restrictions limiting enrollment levels established by TennCare. This notice must include instructions on how to contact TennCare to request a change.
- Notice that the member may change MCOs at the next choice period and shall have a 45-calendar day period immediately following the enrollment, as requested during said choice period, in a new MCO to request to change MCOs, subject to the capacity of the selected MCO to accept additional enrollees and any restrictions limiting enrollment levels established by TennCare. This notice shall include instructions on how to contact TennCare to request a change.
- Notice that the member has the right to ask TennCare to change MCOs based on hardship, the circumstances which constitute hardship, explanation of the member's right to file an appeal if such request is not granted, and how to do so.
- Notice of the enrollee's right to terminate participation in the TennCare program at any time with instructions to contact TennCare for termination forms and additional information on termination.
- TennCare and MCO member services toll-free telephone numbers, including the TennCare hotline, the MCO's member services information line, and the MCO's 24/7 nurse triage/advice line with a statement that the member may contact the MCO or TennCare regarding questions about the TennCare program, including CHOICES and ECF CHOICES, as well as the service/information that may be obtained from each line.
- Information educating members of their rights and necessary steps to amend their data in accordance with HIPAA regulations and state law.
- Directions on how to request and obtain information regarding the "structure and operation of the MCO" and "physician incentive plans."

- Information that the member has the right to receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand.
- Information that the member has the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
- Information on appropriate prescription drug usage.
- Any additional information required in accordance with NCQA's Standards and Guidelines for the Accreditation of MCOs.

Provider Directory requirements, listed in CRA § 2.17.8, are as follows:

- The MCO must distribute information regarding general provider directories to new members within 30 calendar days of receipt of notification of enrollment in the MCO or prior to the member's enrollment effective date. Such information must include how to access the provider directory, including the right to request a hard copy and to contact the member services line to inquire regarding a provider's participation in the network. Members receiving a hard copy of the provider directory must be advised that the network may have changed since the directory was printed and told how to access current information regarding participating providers.
- The MCO must provide information regarding the CHOICES or ECF CHOICES provider directory to each CHOICES or ECF CHOICES member as part of the face-to-face visit (for members enrolled through the SPOE) or face-to-face intake visit (for current members) as applicable, but not more than 30 days from notice of CHOICES enrollment. Such information shall include how to access the CHOICES or ECF CHOICES provider directory, including the right to request a hard copy and to contact the member services line to inquire regarding a provider's participation in the network. Members receiving a hard copy of the CHOICES or ECF CHOICES provider directory shall be advised that the network may have changed since the directory was printed, and how to access current information regarding the MCO's participating providers.
- The MCO is also responsible for maintaining updated provider information in an online searchable electronic general provider directory and an online searchable electronic CHOICES and ECF CHOICES provider directory. A PDF copy of the hard copy version will not meet this requirement. The online searchable version of the general provider directory and the CHOICES or ECF CHOICES provider directory shall be updated on a daily basis during the business week. In addition, the MCO must make available upon request, in hard copy format, a complete and updated general provider directory to all members and an updated CHOICES or ECF CHOICES provider directory to CHOICES or ECF CHOICES members. The hard copy of the general provider directory and the CHOICES or ECF CHOICES provider directory shall be updated at least on an annual basis. Members receiving a hard copy and/or accessing a PDF version of the hard copy on the MCO's website of the general provider directory or the CHOICES provider directory must be advised that the network may have changed since the directory was printed and told how to access current information regarding participating providers, including the searchable electronic version of the general provider directory and the CHOICES or ECF CHOICES provider directory as well as the member services line.
- Provider directories (including the general provider directory, the CHOICES provider directory and the ECF CHOICES provider directory) and any revisions thereto, must be submitted to TennCare for written approval prior to distribution to enrollees. The text of the directory must be in the format prescribed by TennCare. In addition, the provider information used to populate the provider directory must be submitted as a TXT file or such format as otherwise approved in writing by TennCare and be produced using the same extract process as the actual provider directory.

- The MCO must develop and maintain a general provider directory, which shall be made available to all members. The provider directory must be posted on the MCC website and provided in hard copy upon request of the member. Members must be advised in writing regarding how to access the provider directory, including the right to request a hard copy and to contact the member services line to inquire regarding a provider's participation in the network. Members receiving a hard copy of the provider directory must be advised that the network may have changed since the directory was printed and told how to access current information regarding participating providers. The online version of the provider directory shall be updated on a daily basis. The general provider directory must include the following: names, locations, telephone numbers, web site; office hours, and non-English languages spoken and cultural capabilities by contract PCPs and specialists; whether the provider's office/facility has accommodations for people with physical disabilities, including offices, exam room(s) and equipment; identification of providers accepting new patients; identification of whether or not a provider performs TennCare Kids screens; Specialty, as appropriate; hospital listings, including locations of emergency settings and post-stabilization services, with the name, location, and telephone number of each facility/setting; and a prominent notice that CHOICES or ECF CHOICES members should refer to the CHOICES or ECF CHOICES provider directory for information on long-term services and supports providers.
- The MCO shall develop and maintain a CHOICES and ECF CHOICES provider directory that includes long-term care providers. The CHOICES and ECF CHOICES provider directory, shall be made available to all CHOICES or ECF CHOICES members and applicants, as applicable, shall include the following: nursing facility listings with the name, location, and telephone number of each facility; community-based residential alternatives, by type, with the name, location, and telephone number of each facility; and a listing of other (non-residential) CHOICES and ECF CHOICES HCBS providers with the name, location, telephone number, and type of services by county of each provider. The CHOICES and ECF CHOICES provider directory shall be posted on the MCO's website and provided in hard copy upon request of the member. Members shall be advised in writing regarding how to access the CHOICES and ECF CHOICES provider directory, including the right to request a hard copy and to contact the MCO's member services line to inquire regarding a provider's participation in the MCO's network. Members receiving a hard copy of the CHOICES or ECF CHOICES provider directory shall be advised that the MCO's network may have changed since the directory was printed, and how to access current information regarding the MCO's participating providers. The online version of the CHOICES and ECF CHOICES provider directory shall be updated a minimum of three (3) days a week.

42 CFR § 438.224 Confidentiality
42 CFR § 438.224 Individually identifiable health information is closed in accordance with Federal privacy requirements.
Individually identifiable health information is used and disclosed in accordance with HIPAA privacy requirements (CRA § 2.23.2.1).
42 CFR § 438. 226 Enrollment and Disenrollment
42 CFR § 438.226 Each MCO/PIHP complies with the enrollment and disenrollment requirements and limitations in § 438.56

CRA § 2.5.3 states that the MCO must not request disenrollment of an enrollee for any reason, and TennCare shall not disenroll members for any of the following reasons:

- Adverse changes in the enrollee's health;
- Pre-existing medical or behavioral health conditions;
- High cost medical or behavioral health bills;
- Failure or refusal to pay applicable TennCare cost sharing responsibilities, except when this results in loss of eligibility for TennCare;
- Enrollee's utilization of medical or behavioral health services;
- Enrollee's diminished mental capacity; or
- Enrollee's uncooperative or disruptive behavior resulting from his or her special needs (except when his or her continued enrollment in the MCO seriously impairs the entity's ability to furnish services to either this particular enrollee or other enrollees).

42 CFR § 438.228 Grievance Systems
42 CFR § 438.228(a) Grievance system meets the requirements of § 438 (F)
42 CFR § 438.228(b) If applicable, random State reviews of notice of action designation to ensure notification of enrollees in a timely manner
CRA § 2.19.3 outlines all requirements related to appeals as stated below: • The MCO must have a contact person who is knowledgeable of appeal procedures and shall direct all appeals, whether the appeal is verbal, or the member chooses to file in writing, to TennCare. Should a member choose to appeal in writing, the member shall be instructed to file via mail or fax to the designated TennCare P.O. Box or fax number for medical appeals. • The MCO must have sufficient support staff (clerical and professional) available to process appeals in accordance with TennCare requirements related to the appeal of adverse actions affecting a TennCare member. The MCO must notify TennCare of the names of appointed staff members and their phone numbers. Staff must be knowledgeable about applicable state and federal law, TennCare rules and regulations, and all court orders and consent decrees governing appeal procedures, as they become effective. • The MCO must educate its staff concerning the importance of the appeals procedure, the rights of the member, and the time frames in which action must be taken by the MCO regarding the handling and disposition of an appeal. • The MCO must identify the appropriate internal individual or body having decision-making authority as part of the appeal procedure. • The MCO must have the ability to take telephone appeals and accommodate persons with disabilities during the appeals process. Appeal forms shall be available at each service site and by contacting the MCO. However, members shall not be required to use a TennCare-approved appeal form in order to file an appeal. • Upon request, the MCO must provide members a TennCare approved appeal form(s). • The MCO must provide reasonable assistance to all appellants during the appeal process. • At any point in the appeal process, TennCare has the authority to remove a member from the MCO when it is determined that such removal is in the best interest of the member and TennCare. • The MCO must require providers to display notices of members' right to appeal adverse actions affecting services in public areas of each facility in accordance with TennCare rules and regulations. The MCO must ensure that providers have correct and adequate supply of public notices. • Neither the MCO nor TennCare shall prohibit or discourage any individual from testifying on behalf of a member. • The MCO must ensure compliance with all notice requirements and notice content requirements specified in applicable state and federal law, TennCare rules and regulations, and all court orders and consent decrees governing notice and appeal procedures, as they become effective. • TennCare may develop additional appeal process guidelines or rules, including requirements as to content and timing of notices to members, which must be followed by the MCO. However, the MCO must not be precluded from challenging any judicial requirements, and to the extent judicial requirements that are the basis of such additional guidelines or rules are stayed, reversed, or otherwise rendered inapplicable, the MCO must not be required to comply with such guidelines or rules during any period of such inapplicability. • The MCO must provide general and targeted education to providers regarding expedited appeals (described in TennCare rules and regulations), including when an expedited appeal is appropriate, and procedures for providing written certification thereof.

• The MCO must require providers to provide written certification regarding whether a member's appeal is an emergency upon request by a member prior to filing such appeal, or upon reconsideration of such appeal by the MCO when requested by TennCare. • The MCO must provide notice to contract providers regarding provider responsibility in the appeal process, including but not limited to, the provision of medical records and/or documentation. • The MCO must urge providers who feel they cannot order a drug on the TennCare Preferred Drug List to seek prior authorization in advance, as well as to take the initiative to seek prior authorization or change or cancel the prescription when contacted by a member or pharmacy regarding denial of a pharmacy service due to system edits (e.g., therapeutic duplication, etc.). • Member eligibility and eligibility-related grievances and appeals (including but not limited to long-term care eligibility and enrollment), including termination of eligibility, effective dates of coverage, and the determination of premium, copayment, and patient liability responsibilities shall be directed to TennCare.
42 CFR § 438.230 Sub-contractual Relationships and Delegation
42 CFR § 438.230(c)(1i) Each MCO/PIHP must oversee and be accountable for any delegated functions and responsibilities
In accordance with contractual requirements, MCOs must monitor all delegated functions to ensure that they are in compliance with all regulations (CRA § 2.26.1).
42 CFR § 438.230(b)(1) Before any delegation, each MCO/PIHP must evaluate prospective subcontractor's ability to perform.
All MCOs must evaluate prospective subcontractors' ability to perform the activities to be delegated in accordance with contractual requirements (CRA§ 2.26.1.1).
42 CFR § 438.230(b)(2)(i)(ii) Written agreement that specifies the activities and report responsibilities delegated to the subcontractor; and provides for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate.
MCOs must require that all delegated agreements be in writing and specify the activities and report responsibilities delegated to the subcontractor. Contracts require that delegation may be revoked, or sanctions applied if the subcontractor's performance is inadequate (CRA § 2.26.1.2).
42 CFR § 438.230(b)(3) Monitoring of subcontractor performance on an ongoing basis
MCOs must monitor all subcontractors on an ongoing basis and subject them to formal review, on at least an annual basis, consistent with NCQA standards and state MCO laws and regulations (CRA § 2.26.1.4).
42 CFR § 438.230(b)(4) Corrective action for identified deficiencies or areas for improvement
MCOs must identify deficiencies or areas for improvement and require subcontractors to take corrective action as necessary (CRA § 2.26.1.5).

Measurement and Improvement Standards

CMS requirement: This section should include a discussion of the standards that the state has established in the MCO/PIHP contracts for measurement and improvement, as required by 42 CFR § 438(D). These standards should relate to the overall objectives listed in the quality strategy's introduction. States may either reference the measurement and improvement provisions from the state's managed care contracts or provide a summary description of such provisions. CMS recommends states minimize reference to contract language in the quality strategy. However, if the state chooses the latter option, the summary description must be sufficiently detailed to offer a clear picture of the specific contract provisions and be written in language that may be understood by stakeholders who are interested in providing input as part of the public comment process.

STATE MEASUREMENT & IMPROVEMENT STANDARDS AS REQUIRED BY 42 CFR, PART 438, SUBPART D
42 CFR § 438.236 Practice Guidelines
438.236(b) Practice guidelines: 1) are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field; 2) consider the needs of enrollees; 3) are adopted in consultation with contracting health care professionals; and 4) are reviewed and updated periodically, as appropriate.
CRA § 2.15.4 states that the MCO must utilize evidence-based clinical practice guidelines required by 42 CFR 438.236 in its Population Health Programs. Wherever possible, MCOs utilize nationally recognized clinical practice guidelines. On occasion, tools for standardized specifications for care to assist practitioners and patient decisions about appropriate care for specific clinical circumstances are developed through a formal process and are based on authoritative sources that include clinical literature and expert consensus. The guidelines must be reviewed and revised whenever the guidelines change and at least every two years. The MCO is required to maintain an archive of its clinical practice guidelines for a period of five years. Such archive must contain each clinical guideline as originally issued so that the actual guidelines for prior years are retained for program integrity purposes. All MCOs are required to be NCQA accredited. As part of the accreditation survey, files are reviewed to ensure that the NCQA requirements for clinical practice guidelines are met. It should be noted that TennCare defines evidenced-based practice as a clinical intervention that has demonstrated positive outcomes in several research studies to assist consumers in achieving their desired goals of health and wellness. Implied in that definition is that the evidence-based guidelines will incorporate the enrollee's needs and interests as part of the development of evidence-based guidelines.
438.236(c) Dissemination of practice guidelines to all providers, and upon request, to enrollees
All MCOs are required to be NCQA accredited. As part of the accreditation survey, files are reviewed to ensure that the NCQA requirements for clinical practice guidelines are met.

42 CFR 438.330 Quality Assessment and Performance Improvement Program
438.330(a) Each MCO and PIHP must have an ongoing quality assessment and performance improvement program.
CRA § 2.15.1 and § 2.15.2 addresses the Quality Assessment and Performance Improvement standards for the MCOs. They must: • Receive and maintain accreditation from NCQA. • Have a written program that clearly defines its quality structures and processes and assigns responsibility to appropriate individuals. • Use NCQA standards as a guide and include a plan for improving patient safety. • Address physical health, behavioral health, and long-term care services. • Be accountable to the MCC Board of Directors and executive management team. • Have substantial involvement of a designated physician and designated behavioral health practitioner. • Have a Quality Improvement (QI) Committee that oversees the QI functions. • Have an annual work plan. • Have dedicated staff as well as data and analytical resources. • Evaluate the program annually and update as appropriate. • Make all information available to providers and members. • Make performance data available to providers and members. • Use results of activities to improve the quality of physical health, behavioral health, and long-term care service delivery with appropriate input from providers and members. • Take appropriate action to address service delivery, provider, and other QI issues as they are identified. • Participate in workgroups hosted by TennCare and agree to establish and implement policies and procedures, including billing and reimbursement, in order to address specific quality concerns. • Collect data on race and ethnicity. • Include QM/QI activities to improve healthcare disparities identified through data collection. • Have a QM/QI committee which must include medical, behavioral health, and long-term care staff as well as contract providers, including medical, behavioral, and long-term care. This committee analyzes and evaluates results, recommends policy decisions, and ensures participation of providers. It must also review and approve the QM/QI program description, annual evaluation, and associated work plan prior to submission to TennCare.
438.330(b)(1) and 438.330(d) Each MCO, PIHP, and PAHP must conduct PIPs and measure and report to the state its performance.
CRA § 2.15.3 – Performance Improvement Projects (PIPs) – requires that each MCO must perform and report on at least two clinical and three non-clinical PIPs. The two clinical PIPs must include one in the area of behavioral health that is relevant to bipolar disorder, major depression, or schizophrenia and one in the area of either child health or perinatal (prenatal/postpartum) health. One of the three non-clinical PIPs must be in the area of long-term services and supports. The MCOs must use existing processes, methodologies, and protocols, including the CMS protocols. Beginning in 2017, a PIP in the area of EPSDT is also required. CMS protocols must be followed for all PIPs. Based on the State's CMS-416 MCO report, if an MCO has an overall EPSDT rate below eighty percent (80%) the MCO shall submit a PIP on EPSDT Screening and Community outreach plans in addition to the above required PIPs. MCOs are

required to submit PIP topics annually for TennCare approval. MCOs must also submit an annual report on PIPs with specific data and information, including improvement strategies. (CRA § 2.30.12.1) The PBM and DBM are also required to perform on two PIPs. TennCare provides s summary of its PIP validation in the Annual EQRO Technical Report.

438.330(b)(2) and 438.233(c) Each MCO and PIHP must measure and report performance measurement data as specified by the State.

CRA § 2.15.6 states that MCOs must complete all HEDIS measures designated by NCQA as relevant to Medicaid. Due to a Dental carve-out, the dental measures are excluded. Measure results are reported separately for each Grand Region of the state. MCOs must use the Hybrid methodology (i.e., gathered from administrative and medical record data) as the data collection method for any Medicaid HEDIS measure containing Hybrid specifications as identified by NCQA. The MCOs must contract with an NCQA certified HEDIS auditor to validate the processes of the MCO in accordance with NCQA requirements. Audited HEDIS results are submitted both to TennCare and to the EQRO, who then provides a written report to TennCare. TennCare provides a list of the validated measures in its Annual EQRO Technical Report.

438.330(b)(3) Each MCO and PIHP must have mechanisms to detect both underutilization and overutilization of services.

CRA § 2.14, Utilization Management (UM), requires MCOs to provide for methods of assuring the appropriateness of inpatient care. Such methodologies must be based on individualized determinations of medical necessity in accordance with UM policies and procedures and, at a minimum, must include:

- Pre-admission certification process for non-emergency admissions;
- A concurrent review program to monitor and review continued inpatient hospitalization, length of stay, or diagnostic ancillary services regarding their appropriateness and medical necessity.
- Admission review for urgent and/or emergency admissions, on a retroactive basis when necessary, in order to determine if the admission is medically necessary and if the requested length of stay for the admission is reasonable based upon an individualized determination of medical necessity. Such reviews must not result in delays in the provision of medically necessary urgent or emergency care.
- Restrictions against requiring pre-admission certification for admissions for the normal delivery of children; and
- Prospective review of same day surgery procedures.
- The UM Program, including the UM Program description, associated work plan and annual evaluation shall address Emergency Department (ED) utilization and ED diversion efforts. (CRA § 2.14.1.3).

MCOs must have in place, and follow, written policies and procedures for processing requests for initial and continuing prior authorizations of services and have in effect mechanisms to ensure consistent application of review criteria for prior authorization decisions (CRA § 2.14.2.1).

Any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested shall be made by a physical health or behavioral health care professional who has appropriate clinical expertise in treating the member's condition or disease or, in the case of long-term care services, a long-term care professional who has appropriate expertise in providing long-term care services (CRA § 2.14.1.8).

MCOs must not place maximum limits on the length of stay for members requiring hospitalization and/or surgery. MCOs may not employ and shall not permit others acting on their behalf to employ, utilization control guidelines or other quantitative coverage limits, unless supported by an individualized determination of medical necessity based upon the needs of each member and his/her medical history (CRA § 2.14.1).

MCOs must have mechanisms in place to ensure that required services are not arbitrarily denied or reduced in amount, duration, or scope solely because of the diagnosis, type of illness, or condition (CRA § 2.14.1.10).

438.330(b) (4) and 438.330 (b) (8) Each MCO and PIHP must have mechanisms to assess the quality and appropriateness of care furnished to enrollees with special health care needs. The State must identify mechanisms implemented to comply with §438.208(c)(1) (relating to the identification of persons who need long-term services and supports or persons with special health care needs).

MCOs are contractually required to have in place a written Quality Management/Quality Improvement program that describes all of the mechanisms that they have in place for assessing the quality and appropriateness of care for all enrollees, including those with special health care needs (CRA§ 2.15).

Additionally, CRA § 2.8.3, Member Assessment, MCO's must make a best effort to conduct an initial screening of each member's needs, within ninety (90) days of the effective date of enrollment for all new members to assess member's health risk utilizing a health risk assessment, or a comprehensive health risk assessment. The MCO must make subsequent attempts to conduct an initial screening of each member's needs if the initial attempt to contact the member is unsuccessful. The information collected from these health assessments will be used to align individual members with appropriate intervention approaches and maximize the impact of the services provided.

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

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

438.340(b)(5) and 457.1240(e) The state must include a description of its transition of care policy required under 42 CFR 438.62(b) (3).
The state maintains a transition of care policy that addresses transfers between managed care contractors and that ensures continue access to services during any transition between managed care contractors. This transition of care policy specifies that transferring enrollees continue to have access to services consistent with their prior access, including the ability to retain their current provider for a period of time if that provider is not in the new MCO's network. In addition, the transition of care policy ensures that the enrollee is referred to appropriate providers of services that are in the new MCO's network. Under the state's transition of care policy, the enrollee's old MCO must fully and timely comply with appropriate information requests from the enrollee's new MCO, including requests for historical utilization data. In addition, the enrollee's new providers are able to obtain copies of the enrollee's medical records, consistent with federal and state law. The transition of care policy also includes a process for the electronic exchange of specified data classes and elements.
438.330(e) Annual review by the State of each quality assessment and improvement program. If the state requires that an MCO or PIHP have in effect a process for its own evaluation of the impact and effectiveness of its quality assessment and performance improvement program, indicate this in the quality strategy.

The MCO quality assessment and improvement programs are reviewed in multiple ways. The first is the NCQA Accreditation Review that occurs for all health plans every three years. The second review is done annually by the EQRO and includes the following:

- Policies and procedures ensuring coordination between physical, behavioral health, and long-term care (LTC) services by including the following key elements:
  - Screening for behavioral health needs
  - Referral to physical health, behavioral health, and LTC providers
  - Screening for LTC needs
  - Confidentiality
  - Exchange of information
  - Assessment
  - Treatment plan development
  - Collaboration
  - Case management (CM) and Population Health (PH)
  - Provider training
  - Monitoring implementation and outcomes
  - Encourages PCPs and other providers to use state-approved behavioral health screening tool
- Processes in place to ensure that members discharged from psychiatric inpatient hospitals and psychiatric residential treatment facilities are evaluated for mental health CM services and provided with appropriate behavioral health follow-up services.
- Process in place to identify and enroll eligible members in each PH program including CHOICES and Employment and Community First CHOICES members, through the same process used or identification of non-CHOICES and Employment and Community First CHOICES members and the CHOICES non-Employment and Community First CHOICES care coordination process or Employment and Community First CHOICES support coordination process.
- Processes to ensure that each Population Health program includes the development of program descriptions that serve as the outline for all activities and interventions in the program. Condition monitoring, patient adherence to the program, consideration of other co-morbidities and condition related lifestyle issues are addressed.

- Processes to ensure that PH program descriptions address how the CHOICES care-coordinator or Employment and Community First support coordinator will receive notification of the member's participation, information collected about the member, and educational materials given to the member.
- Processes to identify CHOICES and Employment and Community First CHOICES member needs when they are in transition between MCOs. Must ensure that a comprehensive assessment is immediately conducted, the plan of care is updated, and the changes in services are implemented within 10 days of the MCO becoming aware of the change in needs.
- Processes for ensuring that members transitioning from a nursing facility to a community based residential alternative or to live with a relative or other caretaker, the care coordinator or support coordinator, as applicable, makes contact with the member within the first 24 hours of transition and visits the member in his/her new residence within seven days of transition.
- Processes to ensure the MCO conducts a CHOICES or Employment and Community First CHOICES level of care assessment at least annually and within five business days of awareness of a change in a member's functional or medical status that could potentially affect eligibility.

Quality Improvement staff receives many different reports from the health plans that are due at various times of the year. These include, but are not limited to:

- EPSDT Annual Community Outreach Plan and subsequent quarterly reports.
- Annual Quality Survey that outlines major initiatives conducted by the health plan.
- Population Health Program reports – both bi-annually and annually.

Additionally, there are collaborative workgroups that address specific topics and includes individuals from all health plans; monthly meetings with the MCO Quality Director's; and site visits with the health plans at least annually.

42 CFR 438.242 Health Information Systems

438.242(a) Each MCO and PIHP must maintain a health information system that can collect, analyze, integrate, and report data and provide information on areas including, but not limited to, utilization, claims, grievances and appeals, and disenrollments for other than loss of Medicaid eligibility.

By contract, each MCO must maintain all information related to interactions with enrollees and providers, including complaints and appeals. Each MCO is also required by contract to maintain all information and/or encounter information for providers with whom the MCO has a capitated arrangement both current and historical. Each MCO is also required to maintain all records and information related to member health status and outcomes.

438.242(b) (1) Each MCO and PIHP must collect data on enrollee and provider characteristics and on services furnished to enrollees.

By contract, each MCO is required to maintain all member enrollment and other information, both current and historical. By contract, each MCO is required to maintain all claims information and/or encounter information and all authorization and care coordination both current and historical.

438.242(b) (2) Each MCO and PIHP must ensure data received is accurate and complete.

By contract, each MCO is responsible for ensuring that the level of care is accurate and complete and reflects the member's current medical and functional status based on information gathered and/or claims and encounters submitted.

SECTION IV: IMPROVEMENT AND INTERVENTIONS

Interventions with Goals

CMS Requirement: Describe, based on the results of assessment activities, how the state will attempt to improve the quality of care delivered by MCOs and PIHPs through interventions such as, but not limited to:

- ***Cross state agency collaborative***
- ***Pay-for-performance or value-based purchasing initiatives***
- ***Accreditation requirements***
- ***Grants***
- ***Disease management programs***
- ***Changes in benefits for enrollees***
- ***Provider network expansion, etc.***

Describe how the state's planned interventions tie to each specific goal and objective of the quality strategy.

PLANNED INTERVENTIONS' ALIGNMENT WITH QUALITY STRATEGY GOALS AND OBJECTIVES	
GOAL: ENSURE APPROPRIATE ACCESS TO CARE	
OBJECTIVE	**INTERVENTION**
Adult's access to preventive/ ambulatory health services	Distribution of Member Materials: MCOs distribute a large number of educational and informational materials to their membership, including but not limited to member handbooks, newsletters, social media postings, fact sheets, and brochures. Each MCO is required to receive prior written approval from TennCare of all materials that are distributed to members, whether developed by the MCOs or their contractors. TennCare staff reviews the submitted materials for both clinical and programmatic content and either approves or denies them within 15 calendar days from the date of submission. QI staff works closely with the MCOs regarding continual quality improvement of materials developed.
Children & adolescents' access to primary care	TennCare Kids Collaborative: The Division of Quality Improvement will continue to quarterly TennCare Kids Collaborative meetings that include representatives from all MCOs, the Dental Benefits Manager, the Department of Health, and the TN Chapter of the AAP. This group addresses ways of reaching out to TennCare enrollees who are under the age of 21 as well as to their families.

GOAL: PROVIDE HIGH-QUALITY, COST-EFFECTIVE CARE	
Timeliness of Prenatal Care (Objective 2.1)	TennCare has included the HEDIS Timeliness of Prenatal Care Measure in the list of measures with which the MCOs can receive a pay for performance incentive. Likewise, the MCOs have included this measure in their Provider Pay for Performance program. <u>Department of Health Perinatal Advisory Committee</u>: Staff from TennCare's Chief Medical Office participates on the Department of Health's Perinatal Advisory Committee. The committee continues to meet on a semi-annual basis to address Neonatal Abstinence Syndrome, Post-neonatal Follow-up, Baby and Me Tobacco Free, Safe Sleep, Breastfeeding, the Tennessee Infant Mortality Reduction Strategic Plan, Certificate of Need Changes, Mothers' Milk Bank of Tennessee, and issues identified by the Regional Perinatal Centers. A new workgroup is reviewing and revising the Educational Objectives for Nurses.
Breast and Cervical Cancer Screening	<u>Breast and Cervical Cancer Screening Program</u>: This program provides breast and cervical cancer screening to eligible women and diagnostic follow-up tests for those with suspicious results. Women diagnosed with breast or cervical cancer or pre-cancerous conditions for these cancers are enrolled for treatment coverage through TennCare. The mission of the program is to reach and serve lower income uninsured or underinsured women for these basic preventive health screening exams.
Quality of Care Concerns	<u>Quality of Care Concerns and Critical Incident Process:</u> The Division of Quality Improvement receives notification of Quality of Care Concerns regarding members that are sent directly to TennCare. These concerns are addressed in a variety of ways – through calls to the person submitting the concern, correspondence with the MCOs, or referrals to other agencies. Quality of Care Concerns may also be received from other Divisions within TennCare. Home Health Agency (HHA) critical incidents are also sent directly to TennCare from the MCOs. These incidents are investigated and addressed through action taken by the agency involved or through other State agencies, action taken by the MCOs, corrective action as indicated, and follow-up actions. Quality of Care Concerns and Critical incidents and or related to the LTSS population are forwarded to the TennCare LTSS Division, for notification purposes.

Child Health (Objective 2.1)	The *"Taking Care of Baby and Me"* program provides pregnant members prenatal packets offering healthcare information, MCO contact information for assistance in scheduling appointments or transportation, and an incentive (gift card) to members when their doctor sends written verification to the MCOs indicating the member has been seen.
GOAL: ENSURE SATISFACTION WITH SERVICES	
Consumer Satisfaction (Objective 3.2)	CAHPS Survey: Annually, each MCO must conduct CAHPS surveys (adult survey, child survey, and children with chronic conditions survey) using a NCQA-certified CAHPS survey vendor. Survey results must be reported to TennCare separately for each required CAHPS survey and must be reported by grand region.
GOAL: IMPROVE HEALTH CARE	

Comprehensive Diabetes Care	As part of TennCare's Population Health Program all members are stratified, according to associated risks, into levels of care that have specific interventions associated with them. Diabetes is one of the diagnoses that are categorized into either the Health Risk Management (HRM) group or the Chronic Care Management Group (CCM). Pregnant women who have diabetes are placed into a High-Risk Maternity Program. If the member is in the HRM group they will receive one to four non-interactive contacts, offer of individual support for self-management, 24/7 nurse line, offer of health coaching, and offer of weight management and/or tobacco cessation assistance. If the member is in the CCM group, they receive monthly coaching calls with a face to face visit as appropriate, clinical reminders, development of a plan of care, and after hours' assistance if needed. The following are other interventions conducted by TennCare Managed Care Organizations. • Diabetic self-management care plans for topics such as foot care, signs and symptoms of hyper/hypoglycemia, management of co-morbidities, management of diabetes when they are ill. • Members who are identified with health risk behaviors are directed to local community resources. • Members identified with psychosocial issues receive education on their condition and treatment plan. They are provided access to transportation and receive assistance with any identified barriers. • Depression screening • Diabetes classes • Nutritional support from a dietician • Telemonitoring • Education on types of questions to ask their Primary Care Physician (PCP) • Interactive web-based health tools that members may use to track, chart, and respond to clinical and wellness parameters, such as blood glucose. • Availability of home monitoring services. • Member outreach calls to diabetic members that are non-compliant to discuss and encourage recommended screenings. • Mobile Diabetic Retinal Eye Exams, • Member mailings. • Member incentives

EPSDT (TennCare Kids) screening (Objective 1.1 and 2.4)	<u>Community Outreach</u>: All federal requirements will continue to be met. Each MCO must submit to TennCare Kids Annual Outreach Plan by August 15 for the Federal Fiscal Year. The following information must be included in each plan: • MCO goals related to screening rates, participant ratio, outreach, partnerships, program improvements, etc. • Outreach strategies for state identified priority areas based on previous screening rates, barriers, etc. Each MCO will submit a quarterly update on the above information, as well as a Year-End update. While the MCOs are expected to develop a comprehensive outreach plan, other outreach criteria also remain as contractual requirements. They are as follows: • Ability to conduct EPSDT outreach in formats appropriate to members who are blind, deaf, illiterate or have Limited English Proficiency (LEP). • New member calls if screening rate is below 90% • Minimum of six (6) outreach contacts per member per calendar year; • Method for notifying families when screenings are due

	• Follow-up for members who do not receive their screenings timely; • Two attempts to re-notify families if no services were used within a year; • Must have outreach activities informing pregnant women, prior to their expected delivery date, about the availability of EPSDT services for their children and to offer these services for the children when they are borne. Currently, all of the MCOs hire Spanish-speaking bilingual outreach staff, if available, for community outreach events targeting the Hispanic TennCare population. These events promote the importance of preventive health care and educate members about how to access their benefits and improve their health outcomes by properly utilizing available health care resources.
Collaborative Workgroup	<u>Collaborative Workgroup with TennCare Select for Children in State Custody</u>: The TennCare Division of Behavioral Health Operations leads quarterly workgroup meetings with the Department of Children's Services addressing the issues and initiatives affecting children in foster care. This workgroup includes representatives from the Division of TennCare and TennCare Select/ BlueCare. These meetings focus on issues such as immediate eligibility, using out of state providers, safety admissions to hospitals, and the Resource Parent Mailing List. The group also discusses initiatives such as behavioral health training for pediatricians; Adverse Childhood experiences (ACEs) trainings, new intensive in-home services for children in state custody and programs to help close gaps in care.

Other Interventions Affecting All Goals and Objectives

TennCare also attempts to improve the quality of care delivered by MCOs through interventions such as, but not limited to:

- Health Information Technology
- LTSS Value-Based Purchasing and Delivery System Transformation Initiatives
- Enhanced Respiratory Care
- Patient Centered Dental Home
- Prescription for Success
- Population Health
- MCO Provider Agreements
- Grants
- Directed Payments

A description of each of the interventions are described below.

Health Information Technology

TennCare continues to work to enhance accurate and timely data collection, analysis, and distribution. TennCare's comprehensive information management strategy affects every aspect of Tennessee's "Medicaid Enterprise," from medical and eligibility policy to budget and financial accountability. The process of transforming from a traditional transaction-driven medical program to a health care monitoring and management organization recognizes the advantages of Tennessee's unique, fully managed care framework and builds on the TennCare's commitment to be a wise and efficient contractor of services, steward of public funds, and advocate for quality healthcare with a goal to improve quality outcomes of TennCare's constituents. With guidance from TennCare's Health Care Informatics and Office of eHealth Initiatives groups, the State is revamping its data strategy to take into account changes in the Health Information Exchange (HIE) landscape. This includes taking steps to critically examine current data assets and design options to collect and analyze data, make better use of currently available encounter data via the State's Medicaid Management Information System (MMIS), and target methods to distribute the resulting information in ways that are most streamlined and effective for providers through enhanced dashboards, web portals, and outcomes based reporting. Examples of these efforts are outlined through the following ongoing projects:

- ***Quality Applications:*** The Quality Applications solution implemented by Edifecs allows TennCare to collect clinical quality data that cannot be acquired from processed medical billing claims and encounters. Initially, Quality Applications was designed on a contractor-provided service to support two innovation strategies: 1) Episodes of Care and 2) Long-Term Services and Supports (LTSS). As part of payment reform efforts within the Tennessee Health Care Innovation Initiative (HCII), these two strategies aimed to increase the quality of care, reduce health care costs, and improve the health of Tennessee's population. The LTSS Enhanced Respiratory Care Initiative is supported by Quality Applications, including payment calculations, data aggregation, quality measures, and reporting. Ultimately, the goal of the Quality Apps was to provide payers, beginning with the State's Medicaid participating MCOs, with the necessary information to reimburse providers for high quality health outcomes. The LTSS ERC Quality Application is in

production and continues to add value to TennCare Leadership and the MCOs in improving health outcomes.

- ***Identify Access Management:*** This project will implement enterprise-wide Identify Access Management (IAM) for TennCare. This functionally is needed to ensure the privacy and security of patient clinical data and will be the standard for future TennCare applications. This is a security tool that automates user's provisioning based upon roles-based access.
- ***Master Patient Index and Master Provider Directory:*** TennCare has contracted with Audacious Inquiry (AI) to implement a Master Data Management (MDM) module. This project will provide a data management tool that will enable TennCare to uniquely identify patients and providers through the use of MPI and Master Provider Directory.
- ***Care Coordination Tool (CCT):*** Tennessee has developed a shared Care Coordination Tool (CCT) that allows providers participating in the Patient Centered Medical Home (PCMH) and Tennessee Health Link (THL) programs to be more successful in improving quality outcomes of their attributed members. The tool identifies and tracks the closure of Gaps in Care linked to NCQA's Healthcare Effectiveness Data and Information Set® (HEDIS) and TennCare Medicaid quality measures. It also allows providers to view their member panel and members' risk scores, which facilitates provider outreach to members with a higher likelihood of adverse health events. The Tool also enables users to see when one of their attributed members has had an ADT from a hospital, such as a visit to the emergency room, and track follow-up actions. The initial Care Coordination Tool was rolled out to PCMH and Tennessee Health Link providers in February 2017 and continues to be available to participating PCMH and THL providers. In November 2020, TennCare launched CCT 2.0, a secure, cloud-based solution which is a new and improved tool with HL7-integrated and standardized key data sets, robust dashboard and analytical capabilities for providers, care coordinators, TennCare leadership, and the MCOs to view TennCare member metrics in real-time.
    - ***Admission, Discharge, and Transfer (ADT) and Immunization Registry feeds in the CCT:*** The TennCare HIE collects and standardizes the Tennessee hospitals' ADT feeds as well as Tennessee's Department of Health (TDH) Immunization Registry or the Tennessee Immunization Information System (TennIIS) using Health International Level Seven (HL7). The ADT feeds contains data about emergency room visits, inpatient admissions, and discharge information to allow providers' access to valuable information to improve quality outcomes of TennCare members. The new CCT will allow providers to also view immunization information and coordinate their MCO's attributed patients' care across primary care and behavioral health providers. Subsequently, claims data will be populated with the HIE supplied data to allow for a common risk score calculations, identify gaps in care and present a patient register to providers (history, medications, etc.).
- ***Integration of HIT and HIE:*** As an early leader in the work to develop digital health information capacity, Tennessee has built a comprehensive set of HIT and HIE assets. One of these is the collective level of experience and lessons learned among stakeholders about fostering HIT and HIE innovation amidst evolving health systems, technology environments, and data priorities.

Both TennCare and the OeHI within the TennCare Division play integral leadership roles in the promotion of statewide HIT/HIE. Given the interdependencies between Health Information Technology adoption and Health Information Exchange, efforts to administer the Health Information Technology for Economic and Clinical Health (HITECH) Act programs in Tennessee are a highly integrated collaboration. These programs include the State HIE Cooperative agreement Program and the CMS Medicaid EHR Provider Incentive Payment Program. Strategies and activities are guided with input and active participation by an array of other state partners and stakeholders such as state government agencies, TennCare MCOs, health information organizations throughout the state, and provider associations. For example, to disseminate information about specific EHR Provider Incentive Payment Program features and policies, TennCare has conducted dedicated outreach to entities such as the Tennessee Medical Association, Tennessee Hospital Association, Tennessee Primary Care Association, the Children's Hospital Alliance of Tennessee, and TennCare's MCOs other health information organizations throughout the state, and provider associations.

Additional examples of the evolution of integrated Information Technology include the continued modularization of the MMIS and the Tennessee Eligibility Determination System (TEDS).

- ***Medicaid Management Information System (MMIS):*** Tennessee currently has a contract with DXC Technology [formerly Hewlett Packard Enterprise (HPE)] to provide Legacy MMIS services and Facility Management services. Direction from the Centers for Medicare and Medicaid Services (CMS) has encouraged states to pivot from large single vendor systems and contracts to a modular environment with multiple contracts. TennCare has implemented one (1) core module for the Pharmacy Benefits Management (PBM) with OptumRx and is in the process of implementing another core module for the Provider Services Module (PSM) with OptumInsight. Both the PBM and PSM are cloud-based, efficient solutions. TennCare will determine additional functionality that can be uncoupled and modularized for future modernization over the next several years. Examples of future modules could include Program Integrity, Fee-For-Service (FFS) Claims, and Electronic Data Interchange (EDI). This approach allows an already highly modular Medicaid Enterprise to meet the objectives of CMS with the lowest amount of risk and greatest potential for success while continuing to be good stewards of state and federal funding.
- ***Tennessee Eligibility Determination System (TEDS):*** The goal of the TEDS project is to modernize and enhance the State's Medicaid and CHIP program eligibility determination system and processes through updated technology, as well as the eligibility appeals functions that protect and support the interests of the State's citizens while complying with the requirements of federal law and regulations. TennCare envisions a client service model that is customer-centric, efficient, and effective and provides a customer friendly experience. Within this vision TennCare enrollees, excluding applicants for Supplement Security Income (SSI) benefits, who must continue to file applications through the Social Security Administration (SSA), will be able to file applications for services or benefits, as well as report changes through an online process. Most required materials and verification documents will be scanned and stored electronically within the electronic case record. Whenever possible, verification of required information will be captured

electronically through a web-based service and updated automatically in the electronic case record. Workers or automated processes will review applications and send additional questions or request additional documentation electronically or through print media to communicate with customers.

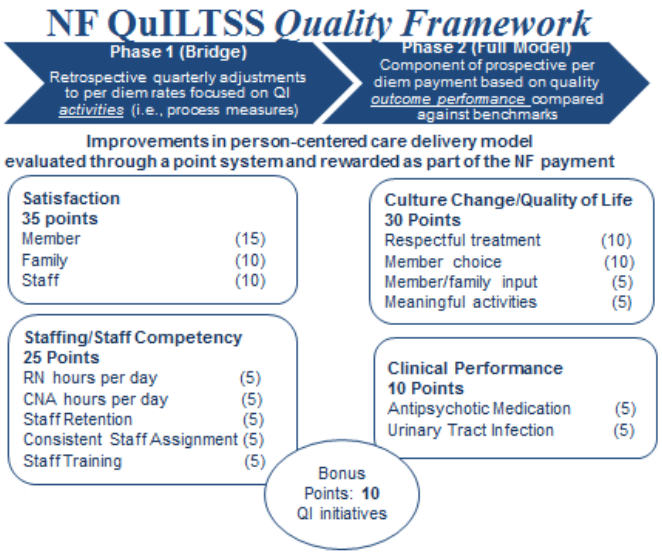
LTSS Value-Based Purchasing and Delivery System Transformation Initiatives

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

Nursing Facility (NF) QuILTSS

VBP/DST for NFs launched in 2014, with retrospective quality- and acuity-based adjustments to NFs' per diem payments, using a Quality Framework (see Figure 1, below) developed in partnership with stakeholders. Legislation brought by the NF industry during the 2013-14 legislative session and passed by the General Assembly modified a longstanding nursing home bed tax into a nursing home assessment fee, effective July 1, 2014, generating additional revenues to support changes to the NF reimbursement structure.[2]

Figure 1



While the NF QuILTSS *Quality Framework* was developed at the program's outset and has remained unchanged throughout the program's more than six year history, TennCare learned that success in delivering these person-centered outcomes would require an iterative, developmental DST and quality improvement process—focused first on supporting providers to develop the quality infrastructure, processes and capacity that would ultimately position them for success in delivering expected outcomes, and then raising expectations and providing ongoing feedback over time to deliver and ultimately improve quality performance outcomes.

Implementation of NF QuILTSS occurred in two phases: phase one - the "bridge" payment process, with

[2] As a result, NF expenditures have increased substantially, even though the volume of Medicaid days has continued to decline.

quarterly retroactive adjustments to facilities' per diem rates based largely on facilities' quality improvement *activities* (i.e. process measures); and phase two - transition to quality as a component of the prospective per diem rate based on NF *performance* on specified quality measures compared against state and national benchmarks. Effective July 1, 2018, TennCare transitioned fully to the new prospective payment system. The prospective value-based NF reimbursement structure includes both a quality incentive pool and additional "quality-informed" adjustments (or "levers") based on a facility's quality performance.

Quality Incentive Pool

A specified amount of the funding for NF services is set aside during each fiscal year for purposes of calculating a quality-based component of each NF provider's per diem payment (i.e., a quality incentive component). The pool is divided among facilities during the rate-setting process, with each NF's portion incorporated as a component of their per diem rate, based on their performance on measures in the *Quality Framework*, taking into account their volume of Medicaid bed days. Under the law, at implementation, the amount of funding set aside for the quality-based component was no less than forty million dollars ($40 million) or four percent (4%) of the total projected fiscal year expenditures for NF services, whichever was greater. In each subsequent year, the amount of funding set aside for the quality-based component will increase at two (2) times the rate of inflation, and will then increase or decrease at a rate necessary to ensure that the quality-based component of the reimbursement methodology remains at ten percent (10%). For FY 19, the quality incentive pool was valued at $55 million.

Quality-Informed Rate Components

In addition to the quality incentive pool, each NF's quality performance score is used to "inform" the setting of multiple other components of the rate, based on tiers of quality incentive scores, including:

- Direct care (the largest rate component), encompassing both:
    - Case-mix adjusted (based on resident acuity)—Nurse/CNA staffing; and
    - Non case-mix-adjusted (raw food, recreation and social services); and
- Fair rental value.

Additionally, there is an incentive in the fair rental value rate component to use excess bed capacity in NFs (resulting from lower Medicaid utilization) to make private rooms (typically available only to private pay residents) available to Medicaid residents. The incentive is based on the percentage of Medicaid private room resident days to total base year bed days available. While more difficult to quantify, in total, quality-informed adjustments amount to about another 3.5% of the reimbursement structure.

HCBS QuILTSS

HCBS QuILTSS encompasses several different VBP/DST initiatives across TennCare's HCBS programs and authorities.

Systems of Support (SOS)

In early 2016, TennCare implemented a new model of support for the delivery of behavioral crisis prevention, intervention, and stabilization services for individuals with intellectual and developmental disabilities (I/DD). Delivered under the managed care program, the service focuses on crisis prevention, in-

home stabilization, sustained community living, and improved quality of life for individuals with challenging behaviors that place themselves and others at risk. The VBP approach utilizes a monthly case rate aligned to support improvement and increased independence over time as the provider is successful in helping paid or unpaid caregivers increase their capacity to provide needed support in order to prevent and/or manage crises. A second VBP component introduced in 2019 adds outcome-based deliverables in order to receive monthly payments. Multiple analyses of claims-based data for program participants have consistently found substantial reductions in three broad categories: Crisis Respite, Emergency Department, and Psychiatric, including a 64% reduction across all claim types, and a 73% reduction in psychiatric inpatient specifically. Learnings from this initiative helped to inform the design of new Groups 7 and 8 in Employment and Community First CHOICES (described below).

Employment and Community First CHOICES

Employment and Community First CHOICES is designed to promote integrated employment and community living as the first and preferred outcome for individuals with I/DD. Employment benefits designed in consultation with experts from the federal Office of Disability Employment Policy create a pathway to employment, even for people with severe disabilities. Reimbursement for employment benefits reflects a variety of value-based approaches including outcome-based reimbursement for up-front services leading to employment, tiered outcome-based reimbursement for Job Development and Self-Employment Start-Up based on the member's "acuity" level and paid in phases to support tenure, and tiered reimbursement for Job Coaching also based on the member's acuity, but taking into account the length of time the person has held the job and the amount of paid support required as a percentage of hours worked (which helps to incentivize greater independence in the workplace, the development of natural supports, and the fading of paid supports over time). As of December 2019, 27.4% of working age adults enrolled in the program are employed (50% higher than the national average).

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

1915(c) waivers

Also building on lessons learned from Employment and Community First CHOICES, TennCare and DIDD worked with providers and stakeholders to implement changes in each of the State's three Section 1915(c) waivers operated by DIDD that restructure current service definitions, service unit measurements, and rates of reimbursement for employment and day services. These amendments are designed to help move individuals towards competitive, integrated employment, increased community integration, and provide more flexibility for individuals served. The amendments introduce new pre-employment services with outcome-based reimbursement approaches and incentivize and reward best practice job coaching through a tiered and phased payment structure, similar to that used in Employment and Community First CHOICES. The goal is to realign existing waiver funds with desired outcomes by investing substantially more resources in higher rates for services that achieve competitive, integrated employment and reducing reimbursement for services that do not support desired outcomes, including facility-based programs.

Waiver amendments were approved in September 2018. After multiple delays (due to the implementation of new computer systems at DIDD and a 90-day moratorium on new administrative rules issued by the incoming Administration), the changes were effective January 1, 2020.

Workforce Development

Workforce development was originally envisioned as a foundational component of both NF and HCBS QuILTSS--to elevate the competency and quality of the LTSS direct support workforce (DSW) and the capacity of LTSS providers to deliver quality outcomes. As the QuILTSS initiative has proceeded and workforce challenges have increased, reflecting a national shortage in the supply of Direct Support Workers (DSWs) to deliver needed LTSS, TennCare's comprehensive evidence-based workforce development strategy has evolved to encompass three primary components:

Workforce Development Education and Training

TennCare has leveraged federal SIM grant funding to create a competency-based workforce development education program for DSWs who deliver LTSS across services and settings. While clearly targeted to impact individuals receiving Medicaid reimbursed LTSS, the program will in fact have much broader impact across payer sources. The program combines modular web-based training with work-based learning components, with opportunity to both learn and earn while acquiring shorter term, stackable credentials with clear labor market value that are recognized and portable across service settings. The program is poised to launch in the fall 2020 through Tennessee's Community Colleges and Colleges of Applied Technology, leveraging *Tennessee Promise* and *Tennessee Reconnect* funding to cover tuition costs, offering 18 hours of college credit and a post-secondary certificate, which will contribute to the *Drive to 55* Initiative and can be applied toward a variety of degree paths. In addition to providing an education path for DSWs, it will also provide a career path, as participants build competencies to access more advanced jobs and higher wages. The program will be administered on behalf of TennCare by The QuILTSS Institute, a 501(c)(3) launched to enter into contracts with the Tennessee Board of Regents, Tennessee's Community Colleges, and Tennessee Colleges of Applied Technology whereby each interested institution will be granted a license to teach the content according to the Institute's standards; train faculty delivering the content and assessors determining the competencies of the DSW learners; maintain the technology needed to implement the WFD program; oversee assessment operations in Tennessee, requiring providers to demonstrate competence before earning LTSS credentials; and continuously review and update the curriculum as needed.

Data Collection and Capacity-Building Investments

TennCare has engaged national Subject Matter Experts (SMEs) at the University of Minnesota's Institute on Community Integration to assist in establishing processes for the collection and use of workforce-related data at provider and system levels to target and measure improvement efforts over time, and to provide training and technical assistance to providers to support adoption of evidence-based and best practices that have been shown to result in more effective recruitment, increased retention, and better outcomes for people served. Two years of data have now been collected targeting providers in Employment and Community First CHOICES, although many also participate in other HCBS programs. Effective in 2020, MCOs are charged with establishing data collection processes across MLTSS programs (as well as home health and private duty nursing), which should lead to ongoing collection of data to measure and drive improvement efforts.

Workforce Incentives

An essential component of the comprehensive strategy is the alignment of incentives for workers to both enroll and especially to complete the education program. As part of the FY 21 budget, TennCare requested, the Governor recommended, and the General Assembly approved funding to launch direct wage incentives to workers delivering Medicaid services in TennCare's CHOICES (including NF and HCBS), Employment and Community First CHOICES, and Section 1915(c) HCBS waivers operated by DIDD. Under this unique VBP approach targeting front-line staff, workers would receive (via a wage increase pass-thru to the provider) a $.50/hr wage increase for Medicaid LTSS they provide upon completion of the first 4 training modules, an additional $1.00/hr upon completion of the next 4 training modules, and an additional $1.50/hr increase in hourly wages upon completion of the last 4 training modules and the post-secondary certificate.

Unfortunately, the significant impact of the COVID public health emergency on the State's budget, including the Medicaid program budget, resulted in the loss of these funds before the program could be launched. While workforce development continues as a priority focus and one of TennCare's strategic goals and we are hopeful that the funds will be restored in future budget years, TennCare is now seeking alternative approaches to test the efficacy of the three-pronged approach to support future funding requests.

Enhanced Respiratory Care

Enhanced Respiratory Care (ERC) reimbursement is higher levels of Medicaid payment made by MCOs for certain types of specialized care in NFs for individuals who are ventilator dependent and/or have a tracheostomy. On July 1, 2016, TennCare launched a new VBP/DST initiative focused on aligning payment for ERC services with higher quality of care and improved outcomes, including primarily liberation (or weaning) from the ventilator and de-cannulation (or removal of the tracheostomy tube), which have the greatest potential impact on the person, resulting in many cases in the opportunity to leave the nursing facility and resume normal life in the community. Facilities providing higher quality care and achieving better outcomes receive a higher level of reimbursement for the services they provide, thus incentivizing higher quality performance.

The initiative has improved quality and outcomes **and** reduced cost, leading to a win-win for the State, providers, and especially for people with enhanced respiratory care needs.

Patient Centered Dental Home

DentaQuest, TennCare's contracted Dental Benefits Manager (DBM), has established a patient-centered dental home (PCDH) for all TennCare members. A PCDH is defined as a place where a child's oral health care is delivered in a comprehensive, continuously accessible, coordinated and family centered way by a dentist participating in the TennCare program. TennCare members can either choose their dental home dentist or be assigned a dentist. Individual primary care dentists must be able to access their roster of dental home assignments through their provider web portal established by the DBM. One of the primary reasons for establishing a PCDH is to ensure that all enrollees truly have access to a participating primary care dentist who is identified through member assignment. Provider acceptance and engagement of member assignments is essential to the success of the program for TennCare beneficiaries. Key to

evaluating success is the development of reports that track patient engagement, quality of care and provider performance. The Provider Performance Report (PPR) is an individual confidential report card sent to participating primary care dentists on a quarterly basis. The PPR is a provider educational tool to afford providers in the network the opportunity to see how their practice compares with their peers and the overall network average in cost, access, and preventive care. Confidential feedback has been shared with providers through the PPR with the goal of encouraging those performing under the network benchmark or mean to modify their practice pattern to meet or exceed network benchmarks. It has further encouraged movement of the needle in a positive direction on quality and cost. Additional member assignments to a dental home will be based upon the PPR as well as other provider utilization reports. Going forward, members will be assigned or reassigned to participating dentists providing high quality care (grounded in performance metrics from data, Dental Home scoring, and PPR) that are accessible (e.g. close to home) and promote the provision of preventive care, including sealants and fluoride treatments and utilize innovative treatments like Silver Diamine Fluoride to arrest dental caries. This will ensure that TennCare members have access to dental home providers demonstrating a commitment to providing the highest quality care. The dental home model is key component of TennCare's overall vision to transform the TennCare dental program from a surgical/dental restorative program to a more balanced program that emphasizes prevention and control of oral diseases through minimally invasive treatment resulting in improved oral health and quality of life for members.

Prescription for Success

Response to the Opioid Epidemic: TennCare has long worked to confront the impacts of opioid misuse and abuse; by re-examining the complex nature of the crisis in our state. Early in 2014, TennCare refined it's strategy by working closely with our Managed Care Organizations, Pharmacy Benefits Manager, and Dental Benefits Manager. There are three priority areas of focus include:

- Reducing the risk of TennCare members becoming newly dependent or addicted to opioids;
- Increasing patient engagement, early detection of dependence, and evidence-based pain treatment for TennCare members chronically using opioids;
- Increasing outreach to women of childbearing age chronically using opioids to provide education and treatment options;
- Further remove barriers to access for Voluntary Reversible Long-Acting Contraceptives (IUD's and implants) for women; and
- Supporting high-quality addiction and recovery treatment services for TennCare members who are dependent, misusing, or abusing opioids and other substances

In January 2018, TennCare implemented policies to increase access to nonopioid analgesics and strengthen existing opioid prescription coverage limits for first-time and non-chronic opioid users. Simultaneously, we took action to educate and engage our members who use opioids chronically in safe and effective pain management. By connecting members to TennCare's strong primary care and mental health providers, increasing access to appropriate voluntary reversible long-acting contraception (VRLAC),

and safely tapering chronic opioid therapy, the unintended consequences from chronic opioid use, such as neonatal abstinence syndrome (NAS) and opioid use disorder can be reduced. Further, TennCare has increased member access to high-quality substance and opioid use disorder treatment by working with our Managed Care Organizations to strengthen their treatment networks for opioid use disorder in order to provide high quality, evidence-based treatment across the continuum of care, thereby reducing opioid related overdoses and deaths.

TennCare, along with the contracted Managed Care Organizations (MCOs) – Amerigroup, BlueCare Tennessee and UnitedHealthcare – have determined the need for a comprehensive network of providers who offer specific enhanced services for members with opioid use disorder (OUD). A dedicated provider network for medication assisted treatment (MAT), known as the *Buprenorphine Enhanced and Supportive Medication Assisted Recovery and Treatment (BESMART) Program* was officially launched in January 2019 to ensure TennCare members are receiving high-quality and coordinated treatment of OUD. To provide buprenorphine MAT and recovery services within the BESMART Network, a provider must meet all federal and Tennessee state requirements to prescribe buprenorphine. Additionally, providers must also comply with all requirements in this document, including: 1) meeting the network provider eligibility criteria and complying with the TennCare pharmacy benefit, 2) providing necessary behavioral health supports, 4) coordinating care with other providers, and 3) participating in required Quality of Care activities. By participating in the network, providers receive enhanced resources and support from the MCOs.

Population Health

Beginning in January 2013, a phased in implementation of the conversion from a traditional disease management/case management model to the Population Health model began. Full implementation occurred in July 2013. In 2020, TennCare QI staff redesigned the Population Health program guidelines and reporting structure in a way that provides more actionable data to TennCare and more closely aligns with the NCQA Population Health Management standards. The newly designed Population Health model was a collaborative effort across all MCOs and reflects a consensus of all participants.

Advantages of the Population Health model include:

- Targeting all members' needs across the entire health care continuum, with all eligible populations being included;
- Providing both proactive and reactive interventions;
- Targeting interventions based on risk and lifestyle, not just disease;
- Addressing multiple risks and co-morbidities in a whole-person approach; and
- Addressing upstream causes of poor health (e.g., nutrition, physical inactivity, substance abuse, social determinants of health)

Under the Population Health model, the entire TennCare population for each MCO is identified/stratified into at least the following seven programs and most programs require specific minimum interventions:

1. Wellness - To include behavioral and physical health promotion, and preventive services
2. Low Risk Maternity - To engage pregnant women into timely prenatal care and to deliver a

healthy, term infant without complications

3. Health Risk Management - Includes members in the low or moderate risk categories, designed to empower members to be proactive in their health and support the provider-patient relationship. The interventions provided in this program shall address the program's goal of preventing, reducing or delaying exacerbation and complications of a condition or health risk behavior.
4. Care Coordination - Helps members navigate and coordinate health care services to ensure members get the services they need to prevent or reduce an adverse health outcome
5. Chronic Care Management - To improve the quality of life, health status and utilization of services, of members with multiple chronic conditions, by providing intense self-management education and support.
6. High Risk Maternity – To engage members having high risk pregnancy needs into timely prenatal care and to deliver a healthy, term infant without complications
7. Complex Case Management - To move members with complex needs to optimal levels of health and well-being by providing timely coordination of quality services and self-management support.

As part of the evaluation process, all Managed Care Organizations annually report utilization, maternal health, and chronic/complex outcome metrics. They also report semi-annual Population Health program updates that detail updates to models of care, member engagement strategies, care management practices, as well as social determinants of health assessment and trends.

MCO Provider Agreements

The Tennessee Department of Commerce and Insurance (TDCI) operates under an inter-agency agreement with TennCare to review all MCOs' provider agreements to ensure the provider agreements meet the uniform requirements set forth in the CRA. When TDCI receives a provider agreement that contains clinical information or other information outside their area of expertise, a copy is sent to TennCare for review and comments. As a means of quality assurance, the Tennessee Comptroller's office is responsible for auditing the activities of TDCI.

Grants

Money Follows the Person (MFP) was a federally funded grant awarded to TennCare with the purpose of assisting the state to transition people from nursing homes and institutions to home and community based care, and to also assist the state to rebalance their long term care expenditures, however grant funding ended in December 2018. A project funded by MFP that is expected to continue through 2020 pertains to a contract with five non-profit home developers, all of which are Neighborworks America Alliance members. The State contracted with these nonprofit home developers to support the expansion of accessible and affordable housing in Tennessee's five metropolitan areas to assist in the transition of individuals who receive LTSS to the community. As a result of this contract, 10 homes in total, will be completed in 2020. The homes are in Memphis, Nashville, Knoxville, Johnson City, and Chattanooga. Upon completion of all the homes, 25 CHOICES and Employment and Community First CHOICES members, who would either be placed in an institutional setting or would be at risk of placement in an institutional

setting, will have the opportunity to live and be supported in an accessible and affordable home in the community.

Overview of Directed Payments

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

Directed Payment 1: Fee Schedules

Goal: Ensure positive patient experience for CHOICES members
Objective: Ensure positive patient experience by measuring survey scores on meaningful activities, patient satisfaction, and respectful treatment

TennCare established various fee schedules in order to control costs, maintain exemplary access to care, and positive patient experience. Consistent with Goal 3, the goal of the directed payments in the fee schedules submission is to ensure that patients report a positive experience when encountering a TennCare provider. To account for this, TennCare measures patient opinion of meaningful activities, member satisfaction, and respectful treatment via the QuiLTSS Satisfaction Survey so as to maintain the highest quality care and quality of life for the program's CHOICES population. The member satisfaction score measures the likelihood of a member recommending the provider. Meaningful activities seeks to gage whether the facility offers activities that are meaningful and enjoyable. The respectful treatment metric measures members' perception of staff showing genuine respect and treating the member with dignity. For more information on this survey please see page 43.

Directed Payment 2: Hospital Uniform Percentage Increase

Goal: Provide high-quality cost-effective care & improve overall health of TennCare members
Objective: Reduce the rate of observed to expected hospital readmissions

TennCare has implemented a uniform percentage increase in hospital payments in order to ensure members not only have access to high-quality and cost-effective care, but also as a means of seeking improved overall health outcomes of members. This program advances those goals by keying into the CMS Adult Core Set Measure "Plan All-Cause Readmission." This measure reflects the rate of observed to expected hospital readmissions. These payments are designed to motivate the identified class of hospitals to work towards reducing (thus improving) the state's most recent score.

Directed Payment 3: Hospital Rate Variation

Goal: Provide high-quality cost-effective care & improve overall health of TennCare members
Objective: Reduce the rate of observed to expected hospital readmissions
Reduce the rate of ambulatory care for members between the ages of 0-19

TennCare has implemented a specified corridor for hospital payments in order to provide high-quality,

cost-effective care to enrollees and improve members over-all health. MCOs must contract within the corridors. The goal of the directed payments in the hospital rate variation submission is to ensure a high level of hospital quality of care and improve enrollees' overall health by monitoring select CMS Core Set Measures. This directed payment is aligned with producing a lower rate (better performance) of observed to expected hospital readmissions and reducing the rate (better performance) of ambulatory care for members between the ages of 0-19.

Directed Payment 4: Emergency Medical Services (ground ambulance) Uniform Dollar Increase

Goal: Ensure appropriate access to care
Objective: Ensure that access to care is maintained by measuring ground ambulance fleet size and age, and usage of 12-lead technology and hydraulic stretchers.

TennCare has implemented a uniform dollar increase on ground ambulance transportations in order to maintain exemplary access to care. The goal of the directed payments in the EMS uniform dollar increase submission is to ensure that access to care is maintained by measuring ground ambulance fleet size and age, and usage of 12-lead technology and hydraulic stretchers. On an annual basis, TennCare uses a survey instrument to collect data on the size and age of the statewide ambulance fleet, as well as the usage of 12-lead technology and hydraulic stretchers within the fleet. The goal of this directed payment is to expand the number of vehicles in service over time, as well as to help prevent decay of the fleet by allowing replacements to be purchased when vehicles age too much. Another goal is to see expanded use of 12-lead technology in the ground fleet. This lifesaving technology should result in better quality of care for TennCare recipients. Additionally, the program seeks to increase the use of hydraulic stretchers in order to improve the safety of TennCare recipients who utilize ground ambulance transport services.

Directed Payment 5: Patient Centered Medical Homes

For more information on the quality objectives of the PCMH directed payment, please see pg 117-118 of the Quality Strategy.

Directed Payment 6: Academic Physicians' Upper Payment Limit (UPL)

Goals:

- Ensure Appropriate Access to care
- Provide quality care to enrollees
- Improve health care for program enrollees

Objectives:

- The two academic physician practices in this payment will:
    - leverage population health strategies to support increased care coordination and care management for attributed TennCare members across primary care, specialty care, and behavioral health care.
    - be key partners with TennCare in addressing the opioid crisis by integrating early detection, prevention, and treatment of opioid addition into their primary and specialty care services. They will take a leading role in supporting models of care to address the different clinical pathways of patients who use opioids.

- be key partners with TennCare in addressing early prevention and screening for the pediatric and maternity populations. They will take a lead in developing clinical pathways and engagement opportunities to increase use of preventive services for the attributed maternity and pediatric populations. Additionally, they will identify opportunities for collaboration to focus on high-risk clinical conditions such as neonatal abstinence syndrome and high-risk OB patients to provide early engagement and treatment to minimize the poor health outcomes associated with these conditions.

TennCare has implemented a value based directed payment arrangement with two academic physician groups in order to pay them potentially up to the UPL depending on their ability to achieve certain outcomes. TennCare has engaged in an initiative with academic medical centers multispecialty medical groups: University of Tennessee – University Clinical Health (UCH) and East Tennessee State University (ETSU). This upper payment limit initiative will leverage the combination of primary and specialist physicians in the groups and their academic affiliations to improve the effectiveness and quality of care for TennCare members especially in population health and care coordination, prevention, misuse and treatment for opioid addiction, and focused engagement for maternity and pediatric care.

The provider groups will be engaged in activities aimed at achieving the objectives above.

In consideration of the need to retain and train additional staff, the level of coordination of care necessary to achieve the underlying goals, and the multi-faceted approach required to make quality improvements, a multi-year payment arrangement is required. The first year 12 months of the arrangement (January 2019 – December 2019) focused on implementation of quality initiatives, baseline evaluation, and necessary data reporting. Years 2-5 introduce additional quality initiatives and requisite data reporting, with baseline evaluation and year over year incremental improvement.

The following table provides the list of twenty quality metrics and two reporting measures for CY 2020. Given the timing of the HEDIS specifications release for MY2020, information for the EPSDT metrics is not yet available.

Metric ID	Quality Metrics	Threshold
QM 1	Antidepressant Medication Management (AMM)	≥40%
QM 2	Asthma Medication Ratio (AMR)	≥81%
QM 3	Childhood Immunization – Combination 10 (CIS)	≥42%
QM 4	Comprehensive Diabetes Care: BP Control (<140/90 mmHg) (CDC)	≥56%
QM 5	Comprehensive Diabetes Care: Eye Exam (Retinal) Performed (CDC)	≥51%
QM 6	Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%) (CDC)	≤47%
QM 7	EPDST: Child and Adolescent Well-Care Visits (WVC) Ages 3-11	TBD
QM 8	EPSDT: Child and Adolescent Well-Care Visits (WVC) Ages 12-17	TBD
QM 9	EPSDT: Child and Adolescent Well-Care Visits (WVC) Ages 18-21	TBD
QM 10	EPSDT: Well-Child Visits in the First 30 Months of Life (W30) First 15 Months	TBD
QM 11	EPSDT: Well-Child Visits in the First 30 Months of Life (W30) 15 Months – 30 Months	TBD
QM 12	Immunizations for Adolescents – Combination 2 (IMA)	≥26%
QM 13	Chronic Opioid Users with Decreased Usage (Custom)	≥34%

QM 14	Concurrent Use of Opioids and Benzodiazepines (COB)	≤9%
QM 15	Initiation of Opioid Abuse or Dependence Treatment (IET-AD Modified)	≥39%
QM 16	Follow up After ED Visit for Alcohol and Other Drug Abuse or Dependence (FUA)	≥18%
QM 17	Prenatal and Postpartum Care: Postpartum Care (PPC)	≥66%
QM 18	Prenatal and Postpartum Care: Postpartum Care for Women with OUD (PPC Modified)	≥66%
QM 19	Prenatal and Postpartum Care: Timeliness of Prenatal Care (PPC)	≥84%
QM 20	Plan All-Cause Readmissions: 30 Day Rate (PCR)	≤17%
QM 21	ED Utilization (Custom)	≤44
	Reporting Metrics	
RM 1	Contraceptive Care: Postpartum Women 60 Day Rate (CCP-AD Modified)	-
RM 2	Contraceptive Care: Postpartum Women with OUD 60 Day Rate (CCP-AD Modified)	-

Directed Payment 7: Medication Management Therapy

Goals:

- Ensure Appropriate Access to Care
- Provide Quality Care to Enrollees
- Improve Health Care for Program Enrollees

Objectives:

- **Objective 1.3:** By 2023, at least forty-five percent of TennCare members will be cared for through a Patient Centered Medical Home (PCMH) model. All participating sites provide care delivery services that ensure appropriate access to care for members as evidenced by achieving or renewing NCQA PCMH recognition.
- **Objective 2.3:** Through 2019, the number of TennCare members enrolled in the Tennessee Health Link program for members with the highest behavioral health needs will remain at least 60,000 members each month. By 2019, Health Link practices will be measured on 19 quality metrics, and providers will be given quarterly updates on how their performance compares to their peers statewide.
- **Objective 2.4:** By 2020, statewide HEDIS rates for the following child and adolescent immunization measures will improve to the national medians: • MMR: from 86.49% to 88.99% • Combo 1 (Meningococcal and Tdap/Td): from 68.87% to 75.12% • Influenza: from 37.56% to 43.92%
- **Objective 4.2:** TennCare members will show improvement across the following Population Health outcome measures: • Emergency department visits per 1000 members: improve from 543 in CY 2017 to 610 in CY 2019. • Readmissions (within 30 days) per 100 members: improve from 62.2 in CY 2017 to 13 in CY 2019 • End stage renal disease per 100 members with diabetes: improve from 7.4 in CY 2017 to 7.8 in CY 2019.

TennCare has implemented a minimum fee schedule for medication therapy management (MTM) payments in order to maintain exemplary access to care and improve patient outcomes for patients associated with PCMHs and the Tennessee Health Link program. The goal of the directed payments in the MTM submission is to meet the objectives listed above. TennCare tracks metrics for the above criteria on a routine basis in order to determine whether the MTM program is effective in achieving its goals.

Directed Payment 8: Tennessee Health Link

For more information on the quality objectives of the Tennessee Health Link directed payment program, please see pages 119-120 of the quality strategy.

Directed Payment 9: Emergency Medical Service (ground ambulance) Fee Schedule

Goal: Ensure appropriate access to care
Objective: Ensure that access to care is maintained by measuring average ground ambulance response times

TennCare has implemented a 67.5% Medicare fee schedule on ground ambulance transportations in compliance with state law that was codified in 2020 in order to maintain exemplary access to care. The goal of the directed payments in the EMS fee schedule submission is to ensure that access to care is maintained by measuring ground ambulance response times for both emergent and non-emergent transports. Response time of EMS resources to a request for service is a direct reflection on the timeliness to treat and ultimately reduce the exacerbation of an injury or illness.

Directed Payment 10: Methadone Medication Assistance Treatment

Goal: Ensure appropriate access to care
Objective: Ensure that access to care for members with opioid use disorder is maintained through an established provider network

TennCare now covers methadone as a treatment for opioid use disorder. For the 6 months prior to the coverage starting, the Managed Care Organizations were directed to meet with each licensed Opioid Treatment Program in Tennessee and offer the facility a contract for Methadone Medication Assisted Treatment, unless there were quality of care concerns.

The Managed Care Organizations will provide to each Opioid Treatment Provider in their network information about their utilization and quality of care. This Quality Monitoring process is a focused assessment of treatment patterns and patient health outcomes for members with Opioid and Substance Use Disorders. The MCO will provide analysis using nationally available measures, claims-based metrics, and through medical record assessment of treatment practices and patterns at the Facility level. The quality review may include, but is not limited to, measures in the following treatment areas:

- Length of MAT treatment with methadone
- Facility drop-out rate
- Health care utilization patterns of attributed OTP recipients (e.g. emergency room visits, hospitalizations, primary care visits, etc.)
- Concurrent use of benzodiazepines while on MAT

COVID Directed Payments: COVID-19 Public Health Crisis Response

On March 13, 2020, President Trump issued a proclamation declaring a national emergency concerning the novel coronavirus disease (COVID-19) outbreak. With the ongoing threat to communities across the state of Tennessee as well as the strain on the state's healthcare system, TennCare is making a concerted effort

to mitigate the impact of COVID-19 on TennCare enrollees while maintaining our four primary Quality Strategy goals (page *10*). TennCare anticipates the effects of COVID-19 may have a longer duration than the initial wave of infection. As a result, TennCare is implementing a robust and long-lasting COVID-19 response strategy until there are effective treatment and mitigation options available.
With the increased levels of COVID-19 activity and the current COVID-19 emergency declaration, TennCare is working toward a singular goal.

COVID-19 Response Goal: **Mitigate the impact of the novel coronavirus, COVID-19, while maintaining the four primary goals of the Quality Strategy for TennCare enrollees.**

Objective 1: Prevent provider network erosion
Ensuring appropriate access to care is critical to maintaining quality care for enrollees. TennCare is dedicated to finding meaningful ways to support providers that routinely see TennCare enrollees as part of their regular practice during this ongoing state of emergency. Moreover, as part of a continued effort to ensure appropriate access of care for enrollees, TennCare routinely monitors changes in MCO network capacity. This is part of the state's ongoing monitoring of network adequacy. In addition, the state's contracted External Quality Review Organization also monitors network adequacy on an ongoing basis and produces reports to the state. If any deficiencies in network adequacy are uncovered through this work, MCOs are required to submit corrective action plans to bring network adequacy back to an acceptable level.

Objective 2: Contribute to flattening the curve and controlling the spread of COVID-19
TennCare is prioritizing efforts to help control the spread of COVID-19. TennCare continues to the monitor COVID-19 trends globally, nationally, statewide, and within the TennCare enrollee population in order to better understand and address the ongoing demands of the current public health crisis. In order to ensure the health and safety of our enrollees, TennCare is actively communicating with our MCOs and providers on how to best serve our enrollees during this time. These communications include but are not limited to: recommendations on COVID-19 preparedness, guidance for TennCare required face-to-face contacts, how to best facilitate treatment and containment, testing and telehealth policies for TennCare enrollees, and COVID-19 infection control.

Objective 3: Reduce morbidity rates by maintaining high levels of prevention and treatment
TennCare is dedicated to supporting providers in delivering the highest quality of treatment and care to our enrollees during and after the COVID-19 public health crisis. TennCare will review a range of metrics to ensure this objective is met. These efforts include monitoring bed capacity, access of personal protective equipment (PPE), potential pharmaceuticals, innovative lifesaving technologies, and other treatments.

Intermediate Sanctions

CFR § 438.204(e) For MCOs, detail how the state will appropriately use intermediate sanctions that meet the requirements of 42 CFR Part 428, Subpart I.
CRA § E.29.1 Addresses Intermediate Sanctions: • TennCare may impose any or all sanctions upon reasonable determination that the contractor failed to comply with any Corrective Action Plan (CAP) or is otherwise deficient in the performance of its obligations under the Agreement, which shall include, but may not be limited to the following: o Fails substantially to provide medically necessary covered services; o Imposes on members cost sharing responsibilities that are in excess of the cost sharing permitted by TennCare; o Acts to discriminate among enrollees on the basis of health status or need for health care services; o Misrepresents or falsifies information that it furnishes to CMS or to the State; o Misrepresents or falsifies information furnished to a member, potential member, or provider; o Fails to comply with the requirements for physician incentive plans as listed in 42 CFR 438.6(h); o Has distributed directly, or indirectly through any agent or independent contractor, marketing or member materials that have not been approved by the State or that contain false or materially misleading information; and o Has violated any of the other applicable requirements of Sections 1903(m) or 1932 of the Social Security Act and any implementing regulations. • TennCare shall only impose those sanctions it determines to be appropriate for the deficiencies identified. However, TennCare may impose intermediate sanctions on the contractor simultaneously with the development and implementation of a Corrective Action Plan if the deficiencies are severe and/or numerous. Intermediate sanctions may include: o Liquidated damages; o Suspension of enrollment in the contractor's MCO; o Disenrollment of members; o Limitation of contractor's service area; o Civil money penalties as described in 42 CFR 438.704; o Appointment of temporary management for an MCO as provided 42 CFR § 438.706 o Suspension of all new enrollment, including default enrollment, after the sanction's effective date; o Suspension of payment for members enrolled after the sanction's effective date and until CMS or the State is satisfied that the reason for the sanction no longer exists and is not likely to recur; or o Additional sanctions allowed under federal law or state statue or regulation that address areas of non-compliance; o Suspension of payment for members enrolled after the effective date of the sanction and until CMS or the State is satisfied that the reason for the sanction no longer exists and is not likely to recur; or o Additional sanctions under federal law or state statute or regulation that address areas of non-compliance.

Specify the state's methodology for using intermediate sanctions as a vehicle for addressing identified quality of care problems.
Each Division of TennCare is responsible for recommending sanctions on an MCO if any of the following are identified. The Division of Managed Care Operations reviews all recommendations for sanctions and has the final responsibility for either approving or disapproving them. Once sanctions are approved, the MCO involved is notified that the sanctions will be imposed. Liquidated damages may be assessed for a variety of quality of care issues, including: • Failure to perform specific responsibilities or requirements that result in a significant threat to patient care or to the continued viability of the TennCare program; • Failure to perform specific responsibilities or requirements that pose threats to TennCare integrity, but which do not necessarily imperil patient care; • Failure to perform specific responsibilities or requirements that result in threats to the smooth and efficient operation of the TennCare Program • Failure to meet performance standards Deficiencies may be identified through review of MCO reports, audits, or failure to meet other contractual obligations.

42 CFR § 438.204(f) Detail how the state's information system supports initial and ongoing operation and review of the state's quality strategy. Describe any innovative health information technology (HIT) initiatives that will support the objectives of the state's quality strategy and ensure the state is progressing toward its stated goals.
Tennessee's Quality Strategy represents a different route for meeting the goals and priorities of HIE outlined by ONC for expanding statewide internet and broadband use, expansion e-Prescribing, sharing electronic structured data (e.g., lab results from labs, and supporting patient care transitions with electronic care summaries). These basic HIE building blocks will support numerous care improvements for patients, including better treatment and diagnosis, improved chronic care coordination, and reductions in medication errors and unnecessary repeat testing, as well as protecting enrollee privacy by utilizing electronic health records. In addition to promoting Electronic Health Records, and in accordance with the HITECH Act of 2009, a Business Associate's (BA) disclosure, handling, and use of PHI must comply with HIPAA Security Rule and HIPAA Privacy Rule mandates. Under the HITECH Act, any HIPAA business associate that serves a health care provider or institution is now subject to audits by the Office for Civil Rights (OCR) within the Department of Health and Human Services and can be held accountable for a data breach and penalized for noncompliance. With these new regulations in mind, TennCare's HIPAA business associate agreement explicitly spells out how a BA will report and respond to a data breach, including data breaches that are caused by a business associate's subcontractors. In addition, TennCare's HIPAA business associate agreement requires a BA to demonstrate how it will respond to an OCR investigation. CRA § 2.12.9.55 requires that the provider safeguard enrollee information according to applicable state and federal laws and regulations including, but not limited, to HIPAA and Medicaid laws, rules and regulations.

SECTION V: Delivery System Reforms

CMS requirement: This section should be completed by states that have recently implemented or are planning to implement delivery system reforms. Examples of such delivery system reforms include, but are not limited to, the incorporation of the following services and/or populations into a managed care delivery system: aged, blind, and disabled population; long-term services and supports; dental services, behavioral health; substance abuse services; children with special health care needs; foster care children; or dual eligibles.

Describe the reasons for incorporating this population/service into managed care. Include a definition of this population and methods of identifying enrollees in this population.
Please see below
List any performance measures applicable to this population/service, as well as the reasons for collecting these performance measures.
Please see below
List any performance improvement projects that are tailored to this population/service. This should include a description of the interventions associated with the performance improvement projects.
Please see below
Address any assurances required in the state's Special Terms and Conditions (STCs), if applicable.
Please see below

LTSS Delivery System Reforms

TennCare is partnering with the Tennessee Department of Intellectual and Developmental Disabilities (DIDD) to integrate all Medicaid LTSS programs and services for individuals with I/DD—including Intermediate Care Facility Services for Individuals with Intellectual Disabilities (ICF/IID), the Section 1915(c) home- and community- based services (HCBS) waivers, and Employment and Community First CHOICES[3] into the managed care program, under the direct operational leadership, management, and oversight of DIDD.

This is part of a shared multi-year strategic plan goal to transform the service delivery system for people with I/DD in order to accomplish the following strategic objectives:

- Eliminate the waiting list of persons with I/DD who are actively seeking to enroll in Medicaid services.
- Embed person-centered thinking, planning and practices and align key requirements and process across Medicaid programs and authorities in order to create a single, seamless person-centered system of service delivery for people with I/DD, including:
    - Critical incident management;
    - Quality assurance and improvement;
    - Direct support workforce training and qualifications;
    - Provider qualifications and enrollment/credentialing processes;

  Providers have long sought not just alignment, but *person-centered* alignment, that minimizes some of the restrictive and burdensome expectations that have resulted from the impact of longstanding litigation.

[3] Employment and Community First CHOICES is already part of the managed care program, but not under the direct operational leadership, management and oversight of DIDD.

• Design and implement value-based reimbursement approaches aligned with system values and outcomes. These value-based approaches will be specifically designed to support the independence, integration, and competitive, integrated employment of individuals with I/DD through the use of effective person-centered planning, technology first approach, and the development of natural supports as evidenced by an increase in the number of working age adults participating in competitive, integrated employment, and the transition of persons supported to less intensive support arrangements based on individualized needs and preferences. This will be beneficial in multiple ways:

- Most importantly, it will help persons supported live better lives in the community with as much independence as possible.
- It will utilize limited staffing resources much more efficiently, addressing critical workforce shortages and creating additional workforce capacity to serve additional people.
- It will allow for a much more efficient and effective use of state and federal Medicaid resources to serve the I/DD population.

• Increase the capacity, competency and consistency of the direct support workforce.

• Support the independence, integration, and competitive, integrated employment of individuals with I/DD through the use of effective person-centered planning, enabling technology, and the development of natural supports as evidenced by an increase in the number of working age adults participating in competitive, integrated employment, and the transition of persons supported to less intensive support arrangements based on individualized needs and preferences.

• Integrate the budgeting process for programs and services for people with I/DD in order to best meet the needs of all Tennesseans with I/DD and their families. By integrating the budget process for programs and services for people with I/DD and providing services more efficiently, we will be able to utilize existing program resources to serve additional people with I/DD from the current waiting list.

Proposed New System Structure

Under the transformed service delivery system for people with I/DD, all LTSS for individuals with I/DD will be part of the managed care program. They will be administered through the managed care program under the direct operational leadership, management, and oversight of DIDD.

TennCare will contract with DIDD to serve as the operational lead agency for all I/DD programs and services.

TennCare will continue to contract with Managed Care Organizations, with DIDD leading the day-to-day management and oversight of the MCO contracts for I/DD benefits, and TennCare continuing to lead management and oversight of other integrated benefit components for the I/DD population—physical and behavioral health, pharmacy, and dental services, in consultation and partnership with DIDD.

Amendments to the 1115 demonstration and to the 1915(c) waivers to implement this delivery system transformation are in development. Upon approval, the Quality Strategy will be revised to reflect these new system components.

Importantly, the State intends to continue operation of the three (3) Section 1915(c) Waivers, each of which has an effective Quality Improvement Strategy.

The Quality, Accountability, and Innovation unit within the TennCare Division of Long-Term Services and Supports is charged with day-to-day management and oversight of 1915(c) waiver programs for persons with intellectual disabilities (ID), including contracted functions of the Operating Agency for this waiver, the Department of Intellectual and Developmental Disabilities (DIDD). The Quality, Accountability, and Innovation unit also helps to carry out quality oversight activities through data collection and analysis, and utilization and other focused reviews of waiver providers.

DIDD is contracted as the Operating Agency for Tennessee's 1915(c) HCBS waiver programs through an interdepartmental contract (Interagency Agreement) with the Division of TennCare, Department of Finance and Administration. The Interagency Agreement sets out the duties and responsibilities delegated to DIDD by the Division of TennCare for the operation of Tennessee's Comprehensive Aggregate Cap (CAC) Waiver. It also sets out duties and responsibilities of the Division of TennCare, including oversight of all contracted functions.

The Interagency Agreement contains a provision for 'the parties' (TennCare and DIDD) to meet on a regularly scheduled basis to review the performance of the activities under the agreement and the CMS approved waiver.

DIDD and TennCare staff convene monthly during the Statewide Continuous Quality Improvement (SCQI) meeting to review performance measure data, as well as findings resulting from TennCare Quality Assurance activities (e.g., targeted reviews, utilization reviews, and fiscal audits) and discuss appropriate corrective actions. The SCQI is operated by TennCare, and its mission is to promote the health and safety of waiver participants as well as program integrity by maintaining a system that continually identifies opportunities for improvement through measured outcomes of quality. SCQI responsibilities include oversight of quality monitoring processes, i.e., discovery, remediation, and improvement, and ongoing quality monitoring. Specific SCQI activities include promoting understanding and fidelity of the quality monitoring process; requesting evaluation of specific topics as necessary; reviewing significant quality monitoring findings to identify patterns and trends; and recommending improvements to enhance program effectiveness and quality.

This section outlines the process for monitoring the safeguards and standards under the waiver ("performance") and the process for remediation of substandard performance ("findings") when applicable.

Monitoring performance. The State maintains a quality management system, including processes for discovery, remediation, improvement, and data analysis and reporting. The State conducts individual record reviews and qualified provider reviews on an ongoing basis. The State also conducts ongoing People Talking to People Surveys. In addition, the State reports waiver-specific data across financial accountability and additional health and welfare measures, including incidents and complaints. Each of these activities is described in the following pages. Since May 2009, the State has been gathering, analyzing, and reporting comprehensive waiver-specific data, including investigations and qualified provider reviews across all waiver assurances and sub-assurances for the CAC Waiver program, including: Administrative Authority, Level of Care, Qualified Providers, Service Plans, Health and Welfare, and Financial Accountability. DIDD is responsible for collecting most of the compliance data and generating the Quality Management Report (QMR) summarizing that information.

TennCare is responsible for collection of data pertaining to three assurance areas, Administrative Authority, Level of Care, and two of the three Financial Accountability measures. TennCare is responsible for collection of data pertaining to two of the Financial Accountability performance measures and DIDD is responsible for one Financial Accountability measure related to verifying that claims have the proper approval and supporting documentation (FAa.i.3).

TennCare has primary responsibility for ensuring the integrity of all data and of the implementation of the quality monitoring strategy. Specifically, TennCare reviews and analyzes all data submitted by DIDD, reviews and approves corrective actions (e.g. remediation) completed by DIDD as necessary, and maintains a comprehensive summary report of all monthly activity related to performance in the CMS assurance areas, the "Aggregated Quality Report." This summary assists TennCare in monitoring compliance and addressing remediation, as applicable, at both the individual and systemic level. In accordance with CMS expectations, Tennessee has established a minimum compliance standard of 100%. On a statewide basis, all instances of non-compliance are required to be remediated (i.e., corrected) within 30 days of discovery. Further, performance measures demonstrating a compliance percentage below 85.5% are flagged and targeted for further review and/or systemic improvement. Intervention may take a variety of forms including clarifications or revisions of policies, targeted training and technical assistance, and assessment of sanctions and/or recoupment of payments to providers.

Details about Tennessee's ongoing monitoring strategies are below:

I. **Individual Record Reviews** are conducted annually by designated Quality Assurance surveyors and then compiled and reviewed by DIDD Quality Management staff in the Central Office. The Individual Record Reviews cover performance measures within the following assurance areas: Service Plans and Health and Welfare. The reviews target a random sample of waiver

participants which is generated at the beginning of each waiver year. The CAC waiver census in December of 2018 was 1,594, the universe from which the random sample for individual record reviews was generated for the 2019 program year. Note: The random sample is generated using CMS approved methodology. After the sample is identified, the reviews are scheduled throughout the following 12 months of the calendar year so that the data reflects performance over the entire year, rather than a concentrated period of a few months. For each waiver participant included in the sample, the individual's records are reviewed by DIDD staff who verify documentation on file to demonstrate compliance with each performance measure reviewed.

II. **Provider Reviews** are conducted annually by designated DIDD Quality Assurance surveyors and then compiled and reviewed by DIDD Quality Management staff in the Central Office. The Qualified Provider reviews cover performance measures within the Qualified Provider assurance area as well as compliance with other DIDD policies and guidelines. The reviews target 100% of provider agencies who employ two or more staff. Additionally, a representative sample of independent providers (e.g., physical therapists, occupational therapists, speech language pathologists, audiologists, nurses, nutritionists, and behavior service providers) who do not employ any additional staff (i.e., the provider consists of one person) are reviewed annually. During the reviews, the DIDD Quality Assurance staff verify compliance with the applicable performance measures during an on-site survey with each provider, which may include interviewing staff and obtaining documentation which demonstrates required compliance.

III. "People Talking to People" Survey

Complaint resolution and participant feedback is facilitated through "People Talking to People" (PTP) Surveys. The CAC waiver census in December of 2018 was 1,594, the universe from which the random sample for People Talking to People Surveys was generated for the 2019 program year. Surveys are conducted using a modified version of the Participant Experience Survey (PES) developed by CMS. The DIDD contracts with the Arc Tennessee to survey people with disabilities served by DIDD and TennCare, and who are enrolled in one of the state's three 1915(c) waivers. These face-to-face interviews are conducted by an interview team, which includes an individual with intellectual disabilities and an assistant, with the waiver participant and a person who knows them well such as a family member. The survey questions focus on four primary areas of a person's experiences: choice and control; respect and dignity; access to care; and community integration and inclusion, as detailed below.

- **Choice and Control:** Do people have input into the services they receive? Do they make choices about their living situations and daily activities?
- **Respect/Dignity:** Are people being treated with respect by others?
- **Access to Care:** Are people's needs such as personal assistance, equipment, and community access being met?

- **Community Inclusion:** Do people receiving services participate in activities and events outside their homes when and where they want?

Furthermore, after each interview, People Talking to People interviewers distribute a copy of DIDD pamphlets on "Protection from Harm" and "Equal Opportunity is the Law in Tennessee."

Complaint resolution. The survey process also offers an opportunity for the interviewee to identify and report any complaints or issues (if applicable). Every individual who provides a negative response or direct complaint on the PTP survey receives either a response or an in-person consultation by the DIDD Customer Focused Services Unit, depending on the nature of the response or complaint. DIDD's self-imposed timeframe for identifying a resolution is within 30 calendar days. Follow-up contacts to the complainant are made to determine if the problem has been adequately resolved. Outstanding complaint cases are to be discussed at the TennCare/DIDD monthly meetings. However, for the past several years, there have been no complaints resulting from PTP surveys that have not been resolved by the process outlined above.

ii. **Data describing investigations** is entered on an ongoing basis into the DIDD Incident and Investigation (I&I) Database. Monthly reports are generated by DIDD and submitted to TennCare. They include data describing substantiated investigations concluded during the month and investigations for which an extension beyond 30 days was granted, including the type of allegation, the reason for the extension, and the date the investigation was completed.

iii. **Financial Accountability Reviews** (FAR) are conducted annually by DIDD Quality Management staff for 100% of providers who billed over $500,000 during the previous state fiscal year. TennCare's Quality, Accountability, and Innovation Unit conducts similar reviews targeting providers who billed less than $500,000. FAR is conducted on a 15% sample of individuals served by the provider agency over a three-month period of time. Note: A random sample generator is used to determine the sample. The minimum number of individuals to be reviewed is 5; the maximum is 30. The FAR auditors review the services billed by the provider for the service recipients in the sample, checking for documentation to support billing for the service. Further information about the FAR is detailed in Appendix I of the CAC Waiver.

As previously described, an aggregation of the above performance data is compiled by DIDD and submitted to TennCare on a monthly basis, along with aggregated remediation data corresponding to each of the findings identified. TennCare reviews and analyzes data in monthly, quarterly, and annual (e.g. year to date) formats as appropriate. Additionally, DIDD reviews all performance measures with compliance percentages below the minimum compliance threshold of 85.5% to determine whether or not the issue is systemic in nature, and to identify and implement systemic remediation as appropriate. Systemic Remediation activity is detailed in a different report, the Systemic Remediation Report, which is also submitted to TennCare on a monthly basis. TennCare staff meet each month with a team of DIDD staff, who gather and submit data monthly for an in-depth review of identified issues. Note: the DIDD representatives include Compliance, Operations, Policy, Protection from Harm, and Quality

Management. Others may be included as well, depending on agenda item/issues to discuss. This regular meeting allows constant communication and sharing to occur between the two agencies. Further details about the remediation strategy are below.

Remediation of Findings, as Applicable

Tennessee has established a minimum compliance standard of 100%. Although instances of non- compliance occur, Tennessee identifies such instances and requires 100% remediation of all instances of non-compliance within 30 days of discovery. Instances of non-compliance and corrective actions are identified in the ***Aggregated Remediation Data and Analysis*** report, prepared by TennCare and informed by DIDD. The state deploys strategies to address both individual and systemic remediation, detailed below.

Individual issues are remediated by the responsible party, generally the Independent Support Coordinator or waiver services provider. DIDD validates that each finding has been remediated, and TennCare monitors and maintains oversight for assuring that all findings have been remediated within 30 days.

In addition to remediating individual issues, Tennessee continually evaluates the scope of each issue so that broader improvements can be implemented to prevent future occurrences. The mechanisms for identifying and addressing systemic issues are two committees, the Statewide Continuous Quality Improvement Committee (SCQI) and the Statewide Quality Management Committee (SQMC). Note: More details about the SQMC can be found in Appendix A.2.b section of the waiver. Systemic issues are addressed through in-depth analysis of the data (understanding what it means), identification of root causes and/or contributing factors, and strategic interventions including policy clarifications and/or revisions, training and technical assistance, and where appropriate, provider sanctions and/or recoupment of funds. Systemic findings will typically require longer time periods to determine the root cause and develop system-wide remediation strategies. Systemic improvement strategies are proposed by DIDD and discussed with TennCare during monthly SCQI meetings and documented in the Systemic Remediation Report. TennCare monitors the implementation of DIDD systemic improvement strategies via review of supporting documentation and data, status updates during interagency meetings, and/or focused surveys.

TennCare plans to establish a baseline data plan for the new program component, encompassing many of the same measures established for Employment and Community First CHOICES, but also additional measures related to IDD integration goals.

We further expect that requirements pertaining to MCO PIPs will be revised to focus attention on key opportunities related to these newly integrated program components.

As it relates to assurances in the STCs, these amendments have not yet been submitted. However, as it relates specifically to STC. 46. Quality Improvement Strategy for 1915(c) or 1915(i)-approvable HCBS Services, for services that could have been authorized to individuals under a 1915(c) waiver or under 1915(i) authority, the 1915(c) waivers will continue to operate concurrently with the TennCare II demonstration and reflect a comprehensive Quality Improvement Strategy that demonstrates compliance with applicable federal waiver assurances set forth in 42 CFR 441.301 and 441.302.

TennCare Patient Centered Medical Homes (PCMH)

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.

Tennessee has built on the existing PCMH efforts by providers and payers in the state to create a robust PCMH program that features alignment across payers on critical elements. To date, approximately 37% of TennCare members (over 591,000) are attributed to one of the 81 PCMH-participating provider organizations at nearly 500 locations 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, access to the Care Coordination Tool and full financial sponsorship for NCQA PCMH recognition and renewal for all sites. To date, 100% of hospitals and licensed hospital beds statewide are submitting admissions, discharge, and transfer data. These providers are compensated with ongoing financial support and an opportunity for an annual outcome payment based on quality and efficiency performance.

2020 Patient Centered Medical Home
Quality Metrics

Core Metric	Description	Threshold
1. Antidepressant medication management (adults only)- Effective continuation phase	Percentage of members 18 and older who were treated with antidepressant medication, had a diagnosis of major depression, and who remained on an antidepressant medication for at least 180 days (6 months)	≥40%
2. Asthma medication ratio	The percentage of members 5–64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year	≥81%
3. Controlling high blood pressure	Percentage of members 18-85 years of age who had a diagnosis of hypertension (HTN) and whose BP was adequately controlled (<140/90 mm Hg) during the measurement year.	>49%
4. Childhood immunizations-Combination 10	Percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); three Hemophilus influenza type B (HiB); three hepatitis B (HepB), one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday.	≥42%
5. Comprehensive Diabetes Care: BP control (<140/90 mmHg)	Percentage of members 18-75 years of age with diabetes (type 1 and type 2) whose most recent blood pressure reading is less than 140/90 mm Hg	≥56%

	(controlled)	
6. Comprehensive Diabetes Care: eye exam (retinal) performed	Percentage of members 18-75 years of age with diabetes (type 1 and type 2) who had an eye exam (retinal) performed	≥51%
7. Comprehensive Diabetes Care: HbA1c poor control (>9.0%)	Percentage of members 18-75 years of age with diabetes (type 1 and type 2) with most recent HbA1c level during the measurement year greater than 9.0%	≤47%
8. Child and Adolescent Well-Care Visits	-	-
• Ages 3-11 years	Percentage 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.	TBD*
• Ages 12-17 years	Percentage 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.	TBD*
• Ages 18- 21 years	Percentage 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.	TBD*
9. Well-Child Visits in the First 30 Months of Life	-	-
• Well-child visits in the first 15 months	Percentage 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.	TBD*
• Well-child for age 15 months – 30 months	The percentage 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.	TBD*
10. Immunizations for adolescents-Combination 2	Percentage of adolescents 13 years of age who had one dose of meningococcal conjugate vaccine, one tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine, and have completed the human papillomavirus (HPV) vaccine by their 13th birthday Efficiency measures for TennCare's PCMH program are as follows. Thresholds are set by MCOs with guidance from TennCare: • Ambulatory care – ED visits • Inpatient admissions	≥26%

* Thresholds are not yet available for these well child metrics due to the timing of the specifications being released from NCQA/HEDIS

Tennessee Health Link

The primary objective of Tennessee Health Link is to coordinate health care services for TennCare members with the highest behavioral health needs.

TennCare has worked closely with providers and TennCare's three health plans to create a program to address the diverse needs of these members. A Health Link Technical Advisory Group of Tennessee clinicians and practice administrators was convened in 2015 to develop recommendations in several areas of program design including, quality measures, sources of value, and provider activity requirements. The design of Health Link was also influenced by federal Health Home requirements.

Through better coordinated behavioral and physical health services, the Health Link program is meant to produce improved member outcomes, greater provider accountability and flexibility when it comes to the delivery of appropriate care for each individual and improved cost control for the state. Health Link providers are encouraged to ensure the best care setting for each member, offer expanded access to care, improve treatment adherence, and reduce hospital admissions. In addition, the program is built to encourage the integration of physical and behavioral health, as well as, mental health recovery, giving every member a chance to reach his or her full potential for living a rewarding and increasingly independent life in the community.

Health Link providers commit to providing comprehensive care management, care coordination, referrals to social supports, member and family support, transitional care, health promotion, and Population Health management. Participating providers receive training and technical assistance, quarterly reports with actionable data, and access to the Care Coordination Tool. These providers are compensated with financial support in the form of activity payments and an opportunity for an annual outcome payment based on quality and efficiency performance.

The Health Link program began statewide on December 1, 2016.

Health Link Quality Metrics

1	**7- and 30-day psychiatric hospital / RTF readmission rate** 7-day 30-day
2	**Antidepressant medication management** Acute phase treatment Continuation phase treatment
3	**Follow-up after hospitalization for mental illness within 7 and 30 days** 7-days 30-days
4	**Initiation/engagement of alcohol and drug dependence treatment** Initiation Engagement
5	**Use of multiple concurrent antipsychotics in children/adolescents**
6	**BMI and weight composite metric** Adult BMI screening BMI percentile (children and adolescents only) Counseling for nutrition (children and adolescents only)
7	**Comprehensive diabetes care (Composite 1)** Diabetes eye exam Diabetes BP < 140/90 Diabetes nephropathy
8	**Comprehensive diabetes care (Composite 2)** Diabetes HbA1c testing Diabetes HbA1c poor control (> 9%)
9	**EPSDT: Well-child visits ages 7-11 years**
10	**EPSDT: Adolescent well-care visits age 12-21**

Efficiency measures for Tennessee Health Link are as follows:

- Ambulatory care – ED visits
- Inpatient admissions – total inpatient

SECTION VI: CONCLUSIONS AND OPPORTUNITIES

Identify any successes that the state considers to be best or promising practices

Population Health

The TennCare MCOs successfully transitioned from Disease Management to Population Health (PH). All TennCare enrollees are now stratified into three PH levels across the care continuum based on their health risk rather than disease. This approach allows for both proactive and reactive interventions and supports staying healthy as well as managing a chronic illness. 2018 and 2019 evaluation data showed positive results for a number of the measures. These are listed in a previous section of this document.

Telehealth and other behavioral health adaptations in the era of a pandemic

The COVID-19 health crisis and pandemic has accelerated and expanded adaptation of telehealth. These initiatives have been supported by licensure exemptions and waivers promulgated by the Governor's office and professional licensing boards in Tennessee in order to increase access to services. While this has had less of an impact on behavioral services reimbursed by managed care programs due to credentialing and network requirements for reimbursement, the MCOs have re-evaluated their policies, procedures and requirements for reimbursement and adopted more flexible policies to enable telehealth services. Qualified telehealth services have expanded beyond individual services to other service areas such as Intensive Outpatient and Partial Hospitalization. TennCare also submitted a proposal for additional, supplemental funds from CMS and some providers used these funds to adapt their service delivery systems. An example of this is acquisition of additional equipment such as laptops and tablets that could be made available in centralized, secure locations so that members could access remote services while physically distancing in a safe manner. TennCare staff have also initiated discussion with various behavioral providers to identify promising emerging practices and adaptations, as well as barriers and challenges that are encountered during the pandemic.

Tennessee Health Link

Tennessee Health Link continues to improve the quality of life and health outcome for TennCare members with highest behavioral health needs. Tennessee Health Link is a care coordination service designed based on CMS' Health Home model. This service launched on December 1, 2016.
In October 2019, TennCare published an Advanced Analytics Report which reviewed the data from Performance Years 2017 and 2018.

THL findings are as follows:

- Quality has improved across 9 out of 18 of measures, particularly those for physical health
- Across two different comparison methods, there was a reduction in the total cost of care relative to the control group
- The rate of both inpatient hospital admissions and emergency department visits declined relative to the control group
- Primary care follow-up visits have improved in the two years since program launch
- Providers report being better able to improve care for their patients

EPSDT Services

The MCOs were commended for demonstrating strength in their dedication to Early and Periodic Screening, Diagnostic, and Treatment standard. MCOs were praised for their innovative ways to outreach members.

In addition, each MCO continued to participate in the statewide collaborative work groups with TennCare and other MCOs. These collaborations remain important strengths and have improved how the MCOs educate and conduct outreach to members and providers by presenting a unified message on topics such as adolescent outreach and increasing the number of adolescent well-child visits.

EQRO Activities

Innovation has always been a priority throughout TennCare. Consistent with its mission "to continuously improve the health and satisfaction of TennCare enrollees," the Division of Quality Improvement works closely with health plan representatives to foster such innovation and encourage adoption of evidence-based practices statewide. Each MCC demonstrates a strong commitment to quality improvement and best practices across a range of programs. During the various activities monitored by the EQRO, the following activities were identified as promising practices:

Performance Measure Validations

- Continual use of standard and nonstandard supplemental data sources for HEDIS reporting.
- Ongoing efforts to increase electronic claims submissions from providers
- Excellent processes for tracking and trending all sources of HEDIS data
- Commitment to achieving a more sophisticated internal body of knowledge of the HEDIS reporting process
- Robust audit procedures in place to ensure accuracy

Performance Improvement Projects

- Dedication to ensuring compliance across all PIPs
- Detailed analyses of PIPs maturing to subsequent re-measurement years
- Ongoing multidisciplinary barrier analyses to determine the effectiveness of implemented interventions
- Thorough, comprehensive results covering all required criteria
- Complete measurement descriptions & corresponding documentation of results and significance of findings
- Extensive interpretation of results that illustrated the effectiveness of the improvement activities

Annual Network Adequacy and Benefit Delivery Review

- Improvements to the overall credentialing and re-credentialing process
- Staff training to improve knowledge of documentation requirements
- High compliance with provider to member ratios and geographical-across standards
- Ongoing provider education to improve member outcomes
- Excellent scores related to provider & member benefit notification

Annual Quality Survey

- Continued commitment to participating in the statewide collaborative workgroups with TennCare and other MCCs
- Continued commitment to monitoring EPSDT services
- High ratings on Quality Performance standards and Performance Activity Standards
- Ongoing and improved outreach to members and providers

Include a discussion of the ongoing challenges the state faces in improving the quality of care for beneficiaries.

Lack of member engagement in chronic condition programs, wellness programs, and even complex case management programs continues to be a barrier to positive outcomes, both nationally and the TennCare population. Proven programs can be implemented but fail if members cannot be engaged. TennCare MCOs, as well as national research, have identified several reasons for lack of engagement by the Medicaid population. Lack of correct or current phone numbers is always the first barrier listed. Medicaid members are very mobile; they change phone numbers and discontinue use of cell phones frequently. Health plans have found this to be true even when the attempt is made one day after receiving the number. When using traditional identification methodologies, there is often a significant lag time between diagnosis and engagement attempts. Members are much more receptive to help at the time of diagnosis.

Psychosocial issues also affect engagement rates. If a member has a behavioral health problem, lack of housing and food, or low self-worth, engaging them in health issues is difficult. Another concern for those attempting to engage Medicaid members, is the fact that many want their immediate needs met and are not receptive to addressing long-term issues. Often initial engagement occurs but retention in a program does not. The last barrier identified is discovering the right message for the targeted audience. This is extremely difficult and varies tremendously among subpopulations. All TennCare health plans use motivational interviewing techniques in an attempt to engage their members. They are also testing engagement techniques such as social media, face-to-face engagement, focus group approaches, and telephonic strategies.

For dual eligible beneficiaries, one of the greatest challenges remains the coordination of benefits across two complex health insurance programs (Medicare and Medicaid) for individuals who are more likely to have multiple chronic health conditions as well as functional limitations requiring the provision of LTSS. Hospital Admission Discharge and Transfer (ADT) feeds now allow TennCare to be informed when a dual eligible beneficiary is admitted to or leaves a hospital, and TennCare is now piloting sharing full ADT feeds with health plans to facilitiate transition to the most integrated setting appropriate, and with the right post discharge care and supports to help sustain community tenure and avoid readmission.

With respect to individuals receiving LTSS more broadly, the greatest challenge lies in addressing what has become a national workforce shortage in direct care staff to provided needed care—especially in home and community based settings. Without an adequate supply of well-trained staff, it is impossible to deliver high quality LTSS to individuals who need them to ensure their health and safety and their quality of life on a day-to-day basis. Escalating workforce challenges across HCBS programs led to the development of an alternative value-based payment approach in HCBS to directly address the direct service workforce crisis (in addition to the development and implementation of a comprehensive, competency-based workforce development program). The new comprehensive approach to workforce development encompasses an array of provider capacity-building investments a competency-based

training program and aligned financial incentives. Investments include engaging national Subject Matter Experts (SMEs) at the University of Minnesota's Institute on Community Integration to assist in establishing processes for the collection and use of workforce-related data at provider and system levels to target and measure improvement efforts over time, and to provide training and technical assistance to providers to support adoption of evidence-based and best practices that have been shown to result in more effective recruitment, increased retention, and better outcomes for people served. Value-based payment strategies will then be implemented to incentivize the provider adoption of ***practices*** that will lead to desired ***outcomes***, including data collection, reporting, and use at the provider level and adoption of evidence-based and best practice approaches to workforce recruitment/retention as well as organization culture/business model changes. Incentives will also be aligned at the worker level by implementing pass-through incentive payments to ensure wages are increased as DSWs increase their level of training and competency and upon completing the certification program. VBP approaches will transition to financial incentives for specific workforce and quality of life *outcomes* once practices expected to result in the outcomes have been effectively adopted. We plan to implement workforce incentives across LTSS programs, services, populations and settings, and ultimately, to expand the comprehensive approach across HCBS programs and authorities.

Include a discussion of challenges or opportunities with data collection systems, such as registries, claims or enrollment reporting systems, pay-for-performance tracking or profiling systems, electronic health record (EHR) information exchange, regional health information technology collaborative, telemedicine initiatives, grants that support state HIT/EHR development or enhancement, etc.

Although some information systems present challenges to data collection for Quality Improvement and analysis, the State of Tennessee has multiple opportunities for the collection of data to track a variety of quality metrics. Tennessee is constantly seeking ways to upgrade data analytic capabilities across state systems as well as its Medicaid Management Information System (MMIS)-related investments.

With the implementation of the Care Coordination Tool, Tennessee is able to provide the ability for health care providers, case managers, and care coordinators to coordinate patients' care across multiple payers and plan types (i.e., Medicaid, Medicare and Commercial plans). The solution, produces risk scores; prioritize patients and activities based on their risk scores; track gaps in care; allow for view of prescription fill information; produce care plans; allow users to track completion of tasks attributed to the care plans and the patient's needs; utilize eCommunication to foster greater coordination across the Care Team; and support the work of both Patient Centered Medical Home (PCMH) and Health Link care models. Opportunities also include the ability to provide a greater quality of care to patients in a more timely manner.

The implementation of a Clinical Knowledge Module, that includes hospital admission, discharge information and transfer information (ADT), standardizes the clinical information loaded from the ADT feeds. Once hospitals are on-boarded, Tennessee collects and co-locates ADT feeds to begin building a clinical database for the TennCare (HIE) that assists in identifying gaps in care and reducing hospital admissions.

EHR Information Exchange and Regional Health Information Collaborative

In Tennessee, HIE development/use has experienced many challenges. Taking advantage of a national initiative, the State has launched Office of eHealth to create the set of standards and services that, with a policy framework, can enable simple, directed, routed and scalable transport over the Internet to be

used for secure and meaningful exchange between known participants in support of meaningful use. Direct technology offers providers a simple and secure way to communicate protected health information (e.g., clinical summaries, continuity of care documents, and laboratory results) between care settings, as well as directly with the patient who also owns a Direct address. Patients are able to communicate via Direct in a secure fashion by using personal health records that are Direct enabled. The most basic implementation of the Direct Project is secure email via an email client or web portal, which works just like regular email but with an added level of security required for point-to point exchange of sensitive health information. Direct is advantageous for those with an EHR because it helps in meeting the meaningful use requirements for electronic exchange/transport/transfer of electronic health information. As many as six Meaningful Use Modified Stage 2 measures could be met with various implementations of Direct. The state currently has nearly 5,000 DIRECT secure messaging users.

Since the beginning of the EHR Incentive Program in 2011, the TennCare Program has paid EHR Incentive Payments to 5,435 unique Eligible Professionals and 109 unique Eligible Hospitals. As of January 2021, the TennCare EHR Incentive Program has made 11,851 EHR Incentive Payments totaling $296,981,920.

EHR and Meaningful Use

TennCare's Provider Services Division EHR Incentive Unit assumed responsibility for the meaningful use aspect of the EHR Incentive Program in 2019. As such, the Division has three responsibilities:

- Evaluating meaningful use attestations (pre-payment verification)
- Facilitating successful meaningful use
- Collecting MU data

The prepayment verification procedures have been structured to encourage and enable providers' continued participation in the program even if an attestation is at first incorrect or incomplete. The robust verification procedures also contribute to the success of that participation by correcting mistakes when they are first available for note and identifying areas of common challenge. The attestation review and prepayment verification process are done through the TennCare Provider Incentive Payment Program (PIPP) portal. This portal receives attestations and allows TennCare staff to approve or return the attestations as they progress through various stages of the portal. Additional functionality in the portal to support administration of the program is constantly being planned and implemented, and such improvements will continue to affect the process, though not the content, of verification procedures. The goal of these improvements is to support electronic submission of Clinical Quality Measures and other measures as technology advances. These improvements will result in greater reliability of submissions, reducing clerical errors. TennCare continually monitors CMS notices and publications in order to update the program as necessary to maintain current CMS criteria for the EHR Incentive Program.

In accordance with CMS Rules and Regulations, TennCare has established the following for attestations submitted for Program Years 2020 and 2021:

Program Year 2020

- Submission of PY 2020 attestations begin November 1, 2020 and continues through March 31, 2021.
- The MU data collection period, including CQMs, is any consecutive 90-day period in Calendar Year 2020. Providers have been informed that while CMS would prefer an entire year of CQM data, the

shorter period is permissible to allow earlier attestation submission.

- A Security Risk Analysis (SRA) must be performed prior to submitting a PY 2020 attestation.
- Review and prepayment verification will begin immediately upon receipt of attestations and continue through June 30, 2021. Attestations determined to be in error will be returned immediately to the provider with instructions and offers of assistance to correct noted errors.

Program Year 2021

- Submission of PY 2021 attestations will begin July 1, 2021 and continues through September 30, 2021.
- Providers cannot access and complete their PY 2021 attestation until their PY 2020 attestation has been adjudicated, if appropriate.
- The MU data collection period, including CQMs, is any consecutive 90-day period beginning January 1, 2021 through July 31, 2021.
- An SRA may be done at any point during 2021, provided the SRA has not been used with a previously submitted attestation. If an SRA is not done prior to submission of the PY 2021 attestation, the provider must attest to the fact that an SRA will be done prior to December 31, 2021; must complete the SRA by that time; and may be required to submit proof to TennCare of the SRA having been timely completed.
- Review and prepayment verification will begin immediately upon receipt of attestations and continue through November 30, 2021. Attestations determined to be in error will be returned immediately to the provider with instructions and offers of assistance to correct noted errors.
- The Provider Services EHR Incentive Unit will work with the Office of Fiscal Budget to ensure that all EHR Incentive Payments, except for adjustments and audits, are made no later than December 31, 2021.

Following the completion of attestation submissions and incentive payments made, the Provider Services EHR Incentive Unit will work with other TennCare units to complete the final SMHP and Annual Report in accordance with CMS requirements and time frames.

Grants that support State HIT/EHR development or enhancement

The state of Tennessee has received grants from the Office of the National Coordinator (ONC), CMS, and SAMSHSA/MITRE to further HIT and HIE across the state. ONC granted $11.7 million for HIE advancement over a four-year period (February 2010 to February 2014). These funds have assisted in upgrading the state's immunization system, electronic lab reporting, a state DIRECT HISP implementation, the statewide roll-out to providers of DIRECT technology, and ePrescribing adoption, as well as operations and improvement of the program. CMS has granted the state a HIT/HIE IAPD grant of $25,551,041. $12,184,496 of these funds is intended to fund administration of the CMS Provider Incentive Program and HIE program in Tennessee as well as updates to the State's incentive program registration system. $13,366,543 of these funds is intended to fund HIE projects, including providing State HIE Core services, allowing access to clinical data contained in Medicaid claims to both providers and Medicaid recipients, development of regional HIE organizations, and assisting provider practices in attainment of meaningful use.

Include recommendations that the State has for ongoing Medicaid and CHIP quality improvement activities in the state. Highlight any grants received that support improvement of the quality of care received by managed care enrollees, if applicable.
MoM Grant The Division of TennCare, in partnership with Vanderbilt University Medical Center is a current recipient of Maternal Opioid Misuse (MOM) Model grant through the Centers for Medicare and Medicaid Services. Tennessee's MOM program focuses on the coordination of clinical care at a single site of care and the integration of individualized non-clinical services critical for health, well-being, and recovery facilitated by a team of Peer Recovery Specialists. The goal of the program is to improve the quality of care and reduce the costs for mothers and infants impacted by opioid use.

Attachment I: CRA Access Standards

GENERAL ACCESS STANDARDS

In general, contractors shall provide available, accessible, and adequate numbers of institutional facilities, service locations, service sites, professional, allied, and paramedical personnel for the provision of covered services, including all emergency services, on a 24-hour-a-day, 7-day-a-week basis. At a minimum, this shall include:

- Primary Care Physician or Extender:

  (a) Distance/Time Suburban/ Rural/Frontier: ≤ 30 miles/≤45 minutes

  (b) Distance/Time Urban: ≤20 miles/≤30 minutes

  (c) Patient Load: 2,500 or less for physician; one-half this for a physician extender.

  (d) Appointment/Waiting Times: Usual and customary practice (see definition below), not to exceed 3 weeks from date of a patient's request for regular appointments and 48 hours for urgent care. Waiting times shall not exceed 45 minutes.

  (e) Documentation/Tracking requirements:

  + Documentation - Plans must have a system in place to document appointment scheduling times.

  + Tracking - Plans must have a system in place to document the exchange of member information if a provider, other than the primary care provider (i.e., school-based clinic or health department clinic), provides health care.

- Specialty Care and Emergency Care: Referral appointments to specialists (e.g., specialty physician services, hospice care, home health care, substance abuse treatment, rehabilitation services, etc.) shall not exceed 30 days for routine care or 48 hours for urgent care. All emergency care is immediate, at the nearest facility available, regardless of contract. Waiting times shall not exceed 45 minutes.
- Hospitals
  (a) Transport access <30 miles/<45 minutes, except in rural areas where distance may be greater. If greater, the standard needs to be the community standard for accessing care, and exceptions must be justified and documented to the State on the basis of community standards.

In addition, pursuant to 42 CFR 438.68(2), TennCare has established the following standards regarding network adequacy for MLTSS providers:

- Time and distance standards for LTSS provider types in which an enrollee must travel to the provider to receive services
- Adult Day Care: Transport access to licensed Adult Day Care providers, ≤ 20 miles travel distance and ≤ 30 minutes travel time for TennCare enrollees in urban areas, ≤ 30 miles travel distance and ≤ 45 minutes travel time for TennCare enrollees in suburban areas ≤ 60 miles travel distance and ≤ 90 minutes travel time for TennCare enrollees in rural areas, except where community standards and documentation shall apply.

Network adequacy standards other than time and distance standards for LTSS provider types that travel to the enrollee to deliver services

For services provided in the member's home, MCOs must ensure the following:

- **Choice of providers for every HCBS.** In general, this means a minimum of 2 contracted providers for each HCBS in every county. MCO provider files must identify MLTSS providers separately by the service(s) they are contracted to provide, and the counties in which they are contracted to provide the service. For services provided in the member's home, it does not mean that the provider has to be located in the county, but rather, have staff to serve people who live in the county, providing those services to members in their homes.
- **A sufficient number of providers to initiate services as specified in the person-centered support plan in accordance with the timeframes specified in A.2.9.6 and to ensure continuity of such services without gaps in care.** In general, the contract prescribes the specific number of days that an MCO has from the date a member is enrolled in MLTSS to complete an initial assessment, develop an initial plan of care, and initiate HCBS (in the case of ECF CHOICES, "immediately needed HCBS"). For most services, this is 10 business days. This is monitored through ongoing reporting and audit processes to ensure that each MCOs' network is adequate. In addition, TennCare monitors gaps in care through the mandated use of an electronic visit verification system and monthly appeals data.
- **For special populations--specifically individuals with I/DD, a network of providers with appropriate experience and expertise in serving people with I/DD and in achieving important program outcomes, such as employment.** Quality assurance is accomplished through monitoring of preferred contracting standards which are tracked on the provider file in order for us to ensure that the MCO's network is adequate in terms of the experience and expertise of its providers.

In the future, we also intend to incorporate quality performance as part of the network adequacy structure for LTSS. At this juncture, we are implementing quality monitoring and quality measurement processes that will allow us to identify high performing providers and to prepare us to be able to establish a process for taking quality performance into consideration as part of the review of network adequacy for LTSS providers.

General Optometry Services:

(a) Transport access < 30 minutes/<45 minutes, except in rural areas where community standards and documentation shall apply.

(b) Appointment/Waiting Times: Usual and customary not to exceed 3 weeks for regular appointments and 48 hours for urgent care. Waiting times shall not exceed 45 minutes.

- All other services not specified here shall meet the usual and customary standards for the community as determined by TENNCARE.

TENNCARE will evaluate the need for further action when the above standards are not met. At its sole discretion TENNCARE may elect one of three options: (1) TENNCARE may request a Corrective Action Plan (CAP), (2) a Request for Information (RFI), (3) or an On-Request Report (ORR) depending on the severity of the deficiency.

The requested CAP, RFI or ORR response shall detail the CONTRACTOR's network adequacy considering any alternate measures, documentation of unique market conditions and/or its plan for correction. If TENNCARE determines the CONTRACTOR's response demonstrates existence of alternate measures or unique market conditions, TENNCARE may elect to request periodic updates from the CONTRACTOR regarding efforts to address such conditions.

SPECIALTY NETWORK STANDARDS

The CONTRACTOR shall adhere to the following specialty network requirements to ensure access and availability to specialists for all members (adults and children) who are not dually eligible for Medicare and TennCare (non-dual members). For the purpose of assessing specialty provider network adequacy, TENNCARE will evaluate the CONTRACTOR's provider network relative to the requirements described below. A provider is considered a "specialist" if he/she has a provider agreement with the CONTRACTOR to provide specialty services to members.

Access to Specialty Care

The CONTRACTOR shall ensure access to specialty providers (specialists) for the provision of covered services. At a minimum, this means that:

- The CONTRACTOR shall have provider agreements with providers practicing the following specialties: Allergy, Cardiology, Dermatology, Endocrinology, Otolaryngology, Gastroenterology, General Surgery, Nephrology, Neurology, Neurosurgery, Oncology/Hematology, Ophthalmology, Orthopedics, Psychiatry (adult), Psychiatry (child and adolescent), and Urology; and

- The following access standards are met:
    - Transport access <60 miles/<90 minutes for at least 75% of non-dual members and
    - Travel access <90 miles/<120 minutes miles for ALL non-dual members

Availability of Specialty Care

The CONTRACTOR shall provide adequate numbers of specialists for the provision of covered services to ensure adequate provider availability for its non-dual members. To account for variances in MCO enrollment size, the guidelines described in this Attachment have been established for determining the number of specialists with whom the CONTRACTOR must have a provider agreement. These are aggregate guidelines and are not age specific. To determine these guidelines the number of providers within each Grand Region was compared to the size of the population in each Grand Region. The CONTRACTOR shall have a sufficient number of provider agreements with each type of specialist in each Grand Region served to ensure that the number of non-dual members per provider does not exceed the following:

Maximum Number of Non-Dual Members per Provider by Specialty

Specialty	Number of Non-Dual Members
Allergy & Immunology	100,000
Cardiology	20,000
Dermatology	40,000
Endocrinology	25,000
Gastroenterology	30,000
General Surgery	15,000

Nephrology	50,000
Neurology	35,000
Neurosurgery	45,000
Oncology/Hematology	80,000
Ophthalmology	20,000
Orthopedic Surgery	15,000
Otolaryngology	30,000
Psychiatry (adult)	25,000
Psychiatry (child & adolescent)	150,000
Urology	30,000

Access to Opioid Use Disorder (OUD) treatment providers

The CONTRACTOR shall ensure access to OUD treatment providers for the provision of covered services. At a minimum, this means that:

(1) The CONTRACTOR shall have provider agreements with DATA 2000 Waiver approved OUD treatment providers only for the provision of covered services with buprenorphine and

(2) The following access standards are met:

- Transport access ≤ 45 miles travel distance and ≤ 45 minutes travel time for at least 75% of non-dual members and
- Transport access ≤ 60 miles travel distance and ≤ 60 minutes travel time for ALL nondual members

Availability of OUD Treatment Care

The CONTRACTOR shall provide adequate numbers of OUD treatment providers for the provision of covered services to ensure adequate provider availability for its non-dual members. To account for variances in MCO enrollment size, the guidelines described in this Attachment have been established for determining the number of OUD treatment providers with whom the CONTRACTOR must have a provider agreement. These are aggregate guidelines and are not age specific. The CONTRACTOR shall have a sufficient number of provider agreements with each type of specialist in each Grand Region served to ensure that the number of non-dual members per provider does not exceed the following:

Maximum Number of Non-Dual Members per Provider by Specialty

Specialty	Number of Non-Dual Members
OUD Treatment Provider contracted to treat with buprenorphine	10,000
OUD Treatment Provider contracted to treat with Methadone	50,000

(Provider Enrollment File service type coding options for OUD treatment providers are identified in Attachment V.)

Capacity of OUD Treatment Providers

All Contracted MAT Providers are required to have a DATA 2000 Waiver to provide Buprenorphine Medication Assisted Treatment (MAT). The DATA 2000 Waiver, as outlined by Substance Abuse and Mental Health Services Administration (SAMSHA), restricts the number of members a provider can treat across all payer types. The number of members a provider can treat is now on referred to as "slots."

To ensure access to OUD treatment across the state, TennCare will calculate the number of slots and/or providers needed for each MCO's contracted MAT network by Tennessee Grand Region (West, Middle, East) on an annual basis. The calculation will be based on prevalence of opioid use disorder (OUD) by Grand Region and MCO enrollment. The Capacity Standards will be in addition to the geographic and time standards outlined previously.

The updated adequacy standards will be provided July 1st of every year.

TENNCARE will evaluate the need for further action when the above standards are not met. At its sole discretion TENNCARE may elect one of three options: (1) TENNCARE may request a Corrective Action Plan (CAP), (2) a Request for Information (RFI), (3) or an On-Request Report (ORR) depending on the severity of the deficiency.

The requested CAP, RFI or ORR response shall detail the CONTRACTOR's network adequacy considering any alternate measures, documentation of unique market conditions and/or its plan for correction. If TENNCARE determines the CONTRACTOR's response demonstrates existence of alternate measures or unique market conditions, TENNCARE may elect to request periodic updates from the CONTRACTOR regarding efforts to address such conditions.

ACCESS & AVAILABILITY FOR BEHAVIORAL HEALTH SERVICES

The CONTRACTOR shall adhere to the following behavioral health network requirements to ensure access and availability to behavioral health services for all members (adults and children). For the purpose of assessing behavioral health provider network adequacy, TENNCARE will evaluate the CONTRACTOR's provider network relative to the requirements described below. Providers serving adults will be evaluated separately from those serving children.

Access to Behavioral Health Services

The CONTRACTOR shall ensure access to behavioral health providers for the provision of covered services. At a minimum, this means that:

The CONTRACTOR shall have provider agreements with providers of the services listed in the table below and meet the geographic and time for admission/appointment requirements.

Service Type	Geographic Access Requirement	Maximum Time for Admission/Appointment
Psychiatric Inpatient Hospital Services	Transport access ≤90 miles travel distance and ≤120 minutes travel time for all Child and Adult members.	4 hours (emergency involuntary)/24 hours (involuntary)/ 24 hours (voluntary)
24 Hour Psychiatric Residential Treatment	Not subject to geographic access standards	Within 30 calendar days
Outpatient Non-MD Services	Transport access ≤ 30 miles travel distance and ≤ 45 minutes travel time for at least 75% of CHILD and ADULT members and ≤ 60 miles travel distance and ≤ 60 minutes travel time for all CHILD and ADULT members	Within 10 business days; if urgent, within 48 hours

Intensive Outpatient (may include Day Treatment (adult), Intensive Day Treatment (Children & Adolescent) or Partial Hospitalization	Transport access ≤ 90 miles travel distance and ≤ 90 minutes travel time for 75% of CHILD and ADULT members and ≤ 120 miles travel distance and ≤ 120 minutes travel time for all CHILD and ADULT members	Within 10 business days; if urgent, within 48 hours
Inpatient Facility Services (Substance Abuse)	Transport access ≤ 90 miles travel distance and ≤ 120 minutes travel time for all CHILD and ADULT members	Within 2 calendar days; for detoxification - within 4 hours in an emergency and 24 hours for non-emergency
24 Hour Residential Treatment Services (Substance Abuse)	Not subject to geographic access standards	Within 10 business days
Outpatient Treatment Services (Substance Abuse)	Transport access ≤ 30 miles travel distance and ≤ 30 minutes travel time for 75% of CHILD and ADULT members and ≤ 45 miles travel distance and ≤ 45 minutes travel time for all CHILD and ADULT members	Within 10 business days; for detoxification – within 24 hours
Tennessee Health Link	Not subject to geographic access standards	Within 30 calendar days
Intensive Community Based Treatment Services	Not subject to geographic access standards	Within 7 calendar days
Supported Housing	Not subject to geographic access standards	Within 30 calendar days

Crisis Services (Mobile)	Not subject to geographic access standards	Face-to-face contact within 2 hours for emergency situations and 4 hours for urgent situations
Crisis Stabilization	Not subject to geographic access standards	Within 4 hours of referral
Psychosocial Rehabilitation (may include Supported Employment, Illness Management & Recovery, Peer Recovery services or Family Support service	Not subject to geographic access standards	Within 10 business days

TENNCARE will evaluate the need for further action when the above standards are not met. At its sole discretion TENNCARE may elect one of three options: (1) TENNCARE may request a Corrective Action Plan (CAP), (2) a Request for Information (RFI), (3) or an On-Request Report (ORR) depending on the severity of the deficiency.

The requested CAP, RFI or ORR response shall detail the CONTRACTOR's network adequacy considering any alternate measures, documentation of unique market conditions and/or its plan for correction. If TENNCARE determines the CONTRACTOR's response demonstrates the existence of alternate measures or unique market conditions, TENNCARE may elect to request periodic updates from the CONTRACTOR regarding efforts to address such conditions

At a minimum, providers for the following service types shall be reported on the Provider Enrollment File:

Service Type	Service Code(s) for use in position 330-331 of the Provider Enrollment
Psychiatric Inpatient Hospital Services	Adult - 11, 79, 85 Child – A1 or H9
24 Hour Psychiatric Residential Treatment	Adult - 13, 81, 82 Child – A9, H1, or H2
Outpatient MD Services (Psychiatry)	Adult – 19 Child – B5
Outpatient Non-MD Services	Adult – 20 Child – B6
Intensive Outpatient/ Partial Hospitalization	Adult – 21, 23, 62 Child - B7, C2, C3
Inpatient Facility Services (Substance Abuse)	Adult – 15, 17 Child – A3, A5
24 Hour Residential Treatment Services (Substance Abuse)	Adult - 56 Child - F6

Outpatient Treatment Services (Substance Abuse)	Adult – 27 or 28 Child – D3 or D4
Tennessee Health Link Services	Adult – 31 Child –D7
Intensive Community Based Treatment Services	Adult 66 or 83 Child C7, G2, G6, or K1
Psychiatric Rehabilitation Services:	
Psychosocial Rehabilitation	42
Supported Employment	44
Peer Recover Service	88
Family Support Services	49
Illness Management & Recovery	91
Supported Housing	32 and 33
Crisis Services (Mobile)	Adult - 37, 38, 39 Child - D8, D9, E1
Crisis Respite	Adult – 40 Child – E2
Crisis Stabilization	Adult 41
Opioid Use Disorder – Treatment with buprenorphine	P1
Opioid Use Disorder – Treatment with buprenorphine or naltrexone	P2
Opioid Use Disorder- Treatment with naltrexone only	P3
Opioid Use Disorder- Treatment with methadone	P4
Opioid Use Disorder- [NP and PA only] Buprenorphine at OBOT	P5
Opioid Use Disorder- [NP and PA only Buprenorphine at CMHC	P6
Opioid Use Disorder- [NP and PA only] Buprenorphine at FQHC	P7

A.2.6 BENEFITS/SERVICE REQUIREMENTS AND LIMITS

A.2.6.1 CONTRACTOR Covered Benefits

2.6.1.1 The CONTRACTOR shall cover the physical health, behavioral health and long-term care services/benefits outlined below. Additional requirements for behavioral health services are included in Section A.2.7.2 and Attachment I.

2.6.1.2 The CONTRACTOR shall integrate the delivery of physical health, behavioral health and long-term care services. This shall include but not be limited to the following:

2.6.1.2.1 The CONTRACTOR shall operate a member services toll-free phone line (see Section A.2.18.1) that is used by all members, regardless of whether they are calling about physical health, behavioral health and/or long-term care services. The CONTRACTOR shall not have a separate number for members to call regarding behavioral health and/or long-term care services. The CONTRACTOR may either route the call to another entity or conduct a "warm transfer" to another entity, but the CONTRACTOR shall not require an enrollee to call a separate number regarding behavioral health and/or long-term care services.

2.6.1.2.2 If the CONTRACTOR's nurse triage/nurse advice line is separate from its member services line, the CONTRACTOR shall comply with the requirements in Section A.2.6.1.2.2 as applied to the nurse triage/nurse advice line. The number for the nurse triage/nurse advice line shall be the same for all members, regardless of whether they are calling about physical health, behavioral health and/or long-term services, and the CONTRACTOR may either route calls to another entity or conduct "warm transfers," but the CONTRACTOR shall not require an enrollee to call a separate number.

2.6.1.2.3 As required in Section A.2.9.6, the CONTRACTOR shall ensure continuity and coordination among physical health, behavioral health, and long-term services and supports and ensure collaboration among physical health, behavioral health, and long-term services and supports providers. For CHOICES members and ECF CHOICES members, the member's Care Coordinator, Support Coordinator, or Integrated Support Coordination Team, as applicable, shall ensure continuity and coordination of physical health, behavioral health, and long-term services and supports, and facilitate communication and ensure collaboration among physical health, behavioral health, and long-term services and supports providers.

2.6.1.2.4 Each of the CONTRACTOR's Population Health programs (see Section A.2.8) shall address the needs of members who have co-morbid physical health and behavioral health conditions.

2.6.1.2.5 The CONTRACTOR shall provide the appropriate level of Population Health services (see Section A.2.8.4 of this Contract) to non-CHOICES and non-ECF CHOICES members with co-morbid physical health and behavioral health conditions. These members should have a single

case manager that is trained to provide Population Health services to enrollees with co-morbid physical and behavioral health conditions. If a member with co-morbid physical and behavioral conditions does not have a single case manager, the CONTRACTOR shall ensure, at a minimum, that the member's Population Health Care Manager collaborates on an ongoing basis with both the member and other individuals involved in the member's care. As required in Section A.2.9.6.1.9 of this Contract, the CONTRACTOR shall ensure that upon enrollment into CHOICES or ECF CHOICES, the appropriate level of Population Health activities are integrated with CHOICES care coordination or ECF CHOICES support coordination processes and functions, and that the member's assigned Care Coordinator, Support Coordinator, or Integrated Support Coordination Team, as applicable, has primary responsibility for coordination of all the member's physical health, behavioral health and long-term services and supports needs. The member's Care Coordinator or Support Coordinator may use resources and staff from the CONTRACTOR's Population Health program, including persons with specialized expertise in areas such as behavioral health, to supplement but not supplant the role and responsibilities of the member's Care Coordinator/care coordination or Support Coordinator/support coordination team. The CONTRACTOR shall report on its Population Health activities per requirements in Section A.2.30.5.

2.6.1.2.6 If the CONTRACTOR uses different Systems for physical health services, behavioral health and/or long-term care services, these systems shall be interoperable. In addition, the CONTRACTOR shall have the capability to integrate data from the different systems.

2.6.1.2.7 The CONTRACTOR's administrator/project director (see Section A.2.29.1.3.1) shall be the primary contact for TENNCARE regarding all issues, regardless of the type of service, and shall not direct TENNCARE to other entities. The CONTRACTOR's administrator/project director shall coordinate with the CONTRACTOR's Behavioral Health Director who oversees behavioral health activities (see Section A.2.29.1.3.5 of this Contract) for all behavioral health issues and the senior executive responsible for CHOICES activities (see Sections A.2.29.1.3.7 of this Contract) for all issues pertaining to the CHOICES and ECF CHOICES programs.

2.6.1.3 <u>CONTRACTOR Physical Health Benefits Chart for TennCare Members (Excluding CoverKids)</u>

SERVICE		BENEFIT LIMIT
Inpatient Hospital Services		**Medicaid/Standard Eligible, Age 21 and older:** As medically necessary. Inpatient rehabilitation hospital facility services are not covered for adults unless determined by the CONTRACTOR to be a cost effective alternative (see Section A.2.6.5). **Medicaid/Standard Eligible, Under age 21:** As medically necessary, including rehabilitation hospital facility.
Outpatient Hospital Services		As medically necessary.
Physician Inpatient Services		As medically necessary.

SERVICE		BENEFIT LIMIT
Physician Outpatient Services/Community Health Clinic Services/Other Clinic Services		As medically necessary.
TennCare Kids Services		**Medicaid/Standard Eligible, Age 21 and older:** Not covered. **Medicaid/Standard Eligible, Under age 21:** Covered as medically necessary, except that the screenings do not have to be medically necessary. Children may also receive screenings in-between regular checkups if a parent or caregiver believes there is a problem. Screening, interperiodic screening, diagnostic and follow-up treatment services as medically necessary in accordance with federal and state requirements. See Section A.2.7.6.
Preventive Care Services		As described in Section A.2.7.5.
Lab and X-ray Services		As medically necessary.
Hospice Care		As medically necessary. Shall be provided by a Medicare-certified hospice.
Dental Services		**Dental Services shall be provided by the Dental Benefits Manager or in some cases, through an HCBS waiver program for persons with intellectual disabilities.** However, the facility, medical and anesthesia services related to the dental service that are not provided by a dentist or in a dentist's office shall be covered services provided by the CONTRACTOR when the dental service is covered by the DBM or though an HCBS waiver program for persons with intellectual disabilities.

SERVICE		BENEFIT LIMIT
Vision Services		**Medicaid/Standard Eligible, Age 21 and older:** Medical eye care, meaning evaluation and management of abnormal conditions, diseases, and disorders of the eye (not including evaluation and treatment of refractive state), shall be covered as medically necessary. Routine periodic assessment, evaluation, or screening of normal eyes and examinations for the purpose of prescribing fitting or changing eyeglass and/or contact lenses are not covered. One pair of cataract glasses or lenses is covered for adults following cataract surgery. **Medicaid/Standard Eligible, Under age 21:** Preventive, diagnostic, and treatments services (including eyeglasses) are covered as medically necessary in accordance with TennCare Kids requirements.
Home Health Care		**Medicaid /Standard Eligible, Age 21 and older:** Covered as medically necessary and in accordance with the definition of Home Health Care at Rule 1200-13-13-.01 (for TennCare Medicaid) and Rule 1200-13-14-.01 (for TennCare Standard). Prior authorization required for home health nurse and home health aide services, as described in Rule 1200-13-13-.04 (for TennCare Medicaid) and 1200-13-14-.04 (for TennCare Standard). **Medicaid/Standard Eligible, Under age 21:** Covered as medically necessary in accordance with the definition of Home Health Care at Rule 1200-13-13-.01 (for TennCare Medicaid) and Rule 1200-13-14-.01 (for TennCare Standard). Prior authorization required for home health nurse and home health aide services, as described in Rule 1200-13-13-.04 (for TennCare Medicaid) and 1200-13-14-.04 (for TennCare Standard).
Pharmacy Services		**Pharmacy services shall be provided by the Pharmacy Benefits Manager (PBM), unless otherwise described below.** The CONTRACTOR shall be responsible for reimbursement of injectable drugs obtained in an office/clinic setting and to providers providing both home infusion services and the drugs and biologics. The CONTRACTOR shall require that all home infusion claims contain National Drug Code (NDC) coding and unit information to be paid. Services reimbursed by the CONTRACTOR shall not be included in any pharmacy benefit limits established by TENNCARE for pharmacy services (see Section A.2.6.2.2).

SERVICE		BENEFIT LIMIT
Durable Medical Equipment (DME)		As medically necessary. Specified DME services shall be covered/non-covered in accordance with TennCare rules and regulations.
Medical Supplies		As medically necessary. Specified medical supplies shall be covered/non-covered in accordance with TennCare rules and regulations.
Emergency Air And Ground Ambulance Transportation		As medically necessary.
Non-emergency Medical Transportation (including Non-Emergency Ambulance Transportation)		Covered non-emergency medical transportation (NEMT) services are necessary non-emergency transportation services provided to convey members to and from TennCare covered services (see definition in Exhibit A to Attachment XI). Non emergency transportation services shall be provided in accordance with federal law and the Division of TennCare's rules and policies and procedures. TennCare covered services (see definition in Exhibit A to Attachment XI) include services provided to a member by a non-contract or non-TennCare provider if (a) the service is covered by Tennessee's Medicaid State Plan or Section 1115 demonstration waiver, (b) the provider could be a TennCare provider for that service, and (c) the service is covered by a third party resource (see definition in Section A.1 of the Contract). If a member requires assistance, an escort (as defined in TennCare rules and regulations) may accompany the member; however, only one (1) escort is allowed per member (see TennCare rules and regulations). Except for fixed route and commercial carrier transport, the CONTRACTOR shall not make separate or additional payment to a NEMT provider for an escort. Covered NEMT services include having an accompanying adult ride with a member if the member is under age eighteen (18). Except for fixed route and commercial carrier transport, the CONTRACTOR shall not make separate or additional payment to a NEMT provider for an adult accompanying a member under age eighteen (18). The CONTRACTOR is not responsible for providing NEMT to HCBS provided through a 1915(c) waiver program for persons with intellectual disabilities and

SERVICE		BENEFIT LIMIT
		HCBS provided through the CHOICES program. However, as specified in Section A.2.11.1.8 in the event the CONTRACTOR is unable to meet the access standard for adult day care (see Attachment III), the CONTRACTOR shall provide and pay for the cost of transportation for the member to the adult day care facility until such time the CONTRACTOR has sufficient provider capacity. The CONTRACTOR shall be responsible for providing NEMT to dental services for ECF CHOICES members, including medical and dental services related to such dental services. Mileage reimbursement, car rental fees, or other reimbursement for use of a private automobile (as defined in Exhibit A to Attachment XI) is not a covered NEMT service, unless otherwise allowed or required by TENNCARE as a pilot project or a cost effective alternative service. If the member is a child, transportation shall be provided in accordance with TennCare Kids requirements (see Section A.2.7.6.4.6). Failure to comply with the provisions of this Section may result in liquidated damages.
Renal Dialysis Services		As medically necessary.

SERVICE		BENEFIT LIMIT
Private Duty Nursing		**Medicaid/Standard Eligible, Age 21 and older:** Covered as medically necessary in accordance with the definition of Private Duty Nursing at Rule 1200-13-13-.01 (for TennCare Medicaid) and Rule 1200-13-14-.01 (for TennCare Standard), when prescribed by an attending physician for treatment and services rendered by a Registered Nurse (R.N.) or a licensed practical nurse (L.P.N.) who is not an immediate relative. Private duty nursing services are limited to services that support the use of ventilator equipment or other life sustaining technology when constant nursing supervision, visual assessment, and monitoring of both equipment and patient are required. Prior authorization required, as described Rule 1200-13-13-.04 (for TennCare Medicaid) and 1200-13-14-.04 (for TennCare Standard). **Medicaid/Standard Eligible, Under age 21:** Covered as medically necessary in accordance with the definition of Private Duty Nursing at Rule 1200-13-13-.01 (for TennCare Medicaid) and 1200-13-14-.01 (for TennCare Standard) when prescribed by an attending physician for treatment and services rendered by a registered nurse (R.N.) or a licensed practical nurse (L.P.N.), who is not an immediate relative. Prior authorization required as described in Rule 1200-13-13-.04 (for TennCare Medicaid) and 1200-13-14-.04 (for TennCare Standard).
Speech Therapy		**Medicaid/Standard Eligible, Age 21 and older:** Covered as medically necessary by a Licensed Speech Therapist to restore speech (as long as there is continued medical progress) after a loss or impairment. The loss or impairment must not be caused by a mental, psychoneurotic or personality disorder. **Medicaid/Standard Eligible, Under age 21:** Covered as medically necessary in accordance with TennCare Kids requirements.
Occupational Therapy		**Medicaid/Standard Eligible, Age 21 and older:** Covered as medically necessary when provided by a Licensed Occupational Therapist to restore, improve, or stabilize impaired functions. **Medicaid/Standard Eligible, Under age 21:** Covered as medically necessary in accordance with TennCare Kids requirements.

SERVICE		BENEFIT LIMIT
Physical Therapy		**Medicaid/Standard Eligible, Age 21 and older:** Covered as medically necessary when provided by a Licensed Physical Therapist to restore, improve, or stabilize impaired functions. **Medicaid/Standard Eligible, Under age 21:** Covered as medically necessary in accordance with TennCare Kids requirements.
Organ and Tissue Transplant And Donor Organ Procurement		**Medicaid/Standard Eligible, Age 21 and older:** All medically necessary and non-investigational/experimental organ and tissue transplants, as covered by Medicare, are covered. These include, but may not be limited to: Bone marrow/Stem cell; Cornea; Heart; Heart/Lung; Kidney; Kidney/Pancreas; Liver; Lung; Pancreas; and Small bowel/Multi-visceral. **Medicaid/Standard Eligible, Under age 21:** Covered as medically necessary in accordance with TennCare Kids requirements. Experimental or investigational transplants are not covered.
Reconstructive Breast Surgery		Covered in accordance with TCA 56-7-2507, which requires coverage of all stages of reconstructive breast surgery on a diseased breast as a result of a mastectomy, as well as surgical procedures on the non-diseased breast to establish symmetry between the two breasts in the manner chosen by the physician. The surgical procedure performed on a non-diseased breast to establish symmetry with the diseased breast shall only be covered if the surgical procedure performed on a non-diseased breast occurs within five (5) years of the date the reconstructive breast surgery was performed on a diseased breast.
Chiropractic Services		**Medicaid/Standard Eligible, Age 21 and older:** Not covered unless determined by the CONTRACTOR to be a cost-effective alternative (see Section A.2.6.5). **Medicaid/Standard Eligible, Under age 21:** Covered as medically necessary in accordance with TennCare Kids requirements.

2.6.1.4 CONTRACTOR Behavioral Health Benefits Chart

SERVICE		BENEFIT LIMIT
Psychiatric Inpatient Hospital Services (including physician services)		As medically necessary.
24-hour Psychiatric Residential Treatment		**Medicaid/Standard Eligible, Age 21 and older:** As medically necessary. **Medicaid/Standard Eligible, Under age 21:** Covered as medically necessary.
Outpatient Mental Health Services (including physician services)		As medically necessary.
Inpatient, Residential & Outpatient Substance Abuse Benefits[1]		**Medicaid/Standard Eligible, Age 21 and older:** Covered as medically necessary. **Medicaid/Standard Eligible, Under age 21:** Covered as medically necessary.
Behavioral Health Intensive Community Based Treatment		As medically necessary.
Psychiatric-Rehabilitation Services		As medically necessary.
Behavioral Health Crisis Services		As necessary.
Lab and X-ray Services		As medically necessary.
Non-emergency Medical Transportation (including Non-Emergency Ambulance Transportation)		Same as for physical health (see Section A.2.6.1.3 above).

[1]When medically appropriate, services in a licensed substance abuse residential treatment facility may be substituted for inpatient substance abuse services.

2.6.1.4.1 The CMS Managed Care Rules specify that an MCO may cover, in addition to services covered under the state plan, any services necessary for compliance with the requirements for parity in mental health and substance use disorder benefits in 42 CFR part 438, subpart K. In accordance with this requirement, this Contract identifies the types and amount, duration and scope of services consistent with the analysis of parity compliance conducted by TENNCARE.

2.6.1.4.1.1 In accordance with 42 CFR 438.905(a), the CONTRACTOR must comply with 42 CFR Subpart K—Parity in Mental Health and Substance Use Disorder Benefits requirements for all enrollees of a MCO in states that cover both medical/surgical benefits and mental health or substance use disorder benefits under the state plan.

2.6.1.4.1.2 TENNCARE does not impose an annual dollar limit on any medical/surgical benefits or includes an aggregate lifetime or annual dollar limit that applies to medical/surgical benefits provided to enrollees through a contract with the state, therefore, the CONTRACTOR shall not impose an aggregate lifetime or annual dollar limit on mental health or substance use disorder benefits, in accordance with 42 CFR 438.905(b), 42 CFR 438.905(c), and 42 CFR 438.905(e).

2.6.1.4.1.3 In accordance with 42 CFR 438.910(b)(1), the CONTRACTOR shall not apply any financial requirement or treatment limitation to mental health or substance use disorder benefits in any classification that is more restrictive than the predominant financial requirement or treatment limitation of that type applied to substantially all medical/surgical benefits in the same classification furnished to enrollees (whether or not the benefits are furnished by the same managed care contractor).

2.6.1.4.1.4 In accordance with 42 CFR 438.910(b)(2) and as specified in the benefit charts of Section A.2.6.1.3 and A.2.6.1.4, if an enrollee is provided mental health or substance use disorder benefits in any classification of benefits (inpatient, outpatient, emergency care, or prescription drugs), mental health or substance use disorder benefits must be provided to the MCO enrollee in every classification in which medical/surgical benefits are provided.

2.6.1.4.1.5 In accordance with 42 CFR 438.910(c)(3), the CONTRATOR shall not apply any cumulative financial requirements for mental health or substance use disorder benefits in a classification (inpatient, outpatient, emergency care, prescription drugs) that accumulates separately from any established for medical/surgical benefits in the same classification.

2.6.1.5 Long-Term Care Benefits for CHOICES Members

2.6.1.5.1 In addition to physical health benefits (see Section A.2.6.1.3) and behavioral health benefits (see Section A.2.6.1.4), the CONTRACTOR shall provide long-term care services (including CHOICES HCBS and nursing facility care) as described in this Section A.2.6.1.5 to members who have been enrolled into CHOICES by TENNCARE, as shown in the outbound 834 enrollment file furnished by TENNCARE to the CONTRACTOR.

2.6.1.5.2 TennCare enrollees will be enrolled by TENNCARE into CHOICES if the following conditions, at a minimum, are met:

2.6.1.5.2.1 TENNCARE or its designee determines the enrollee meets the categorical and financial eligibility criteria for Group 1, 2 or 3;

2.6.1.5.2.2 For Groups 1 and 2, TENNCARE determines that the enrollee meets nursing facility level of care including for Group 2, that the enrollee needs ongoing CHOICES HCBS in order to live safely in the home or community setting and to delay or prevent nursing facility placement;

2.6.1.5.2.3 For Group 2, the CONTRACTOR or, for new TennCare applicants, TENNCARE or its designee, determines that the enrollee's combined CHOICES HCBS, private duty nursing and home health care can be safely provided at a cost less than the cost of nursing facility care for the member;

2.6.1.5.2.4 For Group 3, TENNCARE determines that the enrollee meets the at-risk level of care; and

2.6.1.5.2.5 For Groups 2 and 3, but excluding Interim Group 3, if there is an enrollment target, TENNCARE determines that the enrollment target has not been met or, for Group 2, approves the CONTRACTOR's request to provide CHOICES HCBS as a cost effective alternative (see Section A.2.6.5). Enrollees transitioning from a nursing facility to the community will not be subject to the enrollment target for Group 2 but must meet categorical and financial eligibility for Group 2.

2.6.1.5.3 The following long-term care services are available to CHOICES members, per Group, when the services have been determined medically necessary by the CONTRACTOR.

Service and Benefit Limit	Group 1	Group 2	Group 3
Nursing facility care	X	Short-term only (up to 90 days)	Short-term only (up to 90 days)
Community-based residential alternatives		X	(Specified CBRA services and levels of reimbursement only. See below)[4]
Personal care visits (up to 2 visits per day at intervals of no less than 4 hours between visits)		X	X
Attendant care (up to 1080 hours per calendar year; up to 1400 hours per full calendar year only for		X	X

[4] CBRAs for which Group 3 members are eligible include only: Assisted Care Living Facility services, Community Living Supports 1 (CLS1), and Community Living Supports-Family Model 1 (CLS-FM1)

Service and Benefit Limit	Group 1	Group 2	Group 3
persons who require covered assistance with household chores or errands in addition to hands-on assistance with self-care tasks)			
Home-delivered meals (up to 1 meal per day)		X	X
Personal Emergency Response Systems (PERS)		X	X
Adult day care (up to 2080 hours per calendar year)		X	X
In-home respite care (up to 216 hours per calendar year)		X	X
In-patient respite care (up to 9 days per calendar year)		X	X
Assistive technology (up to $900 per calendar year)		X	X
Minor home modifications (up to $6,000 per project; $10,000 per calendar year; and $20,000 per lifetime)		X	X
Pest control (up to 9 units per calendar year)		X	X

2.6.1.5.3.1 The CONTRACTOR shall review all requests for short-term NF stays and shall authorize and/or reimburse short-term NF stays for Group 2 and Group 3 members only when (1) the member is enrolled in CHOICES Group 2 or 3, as applicable, and receiving HCBS upon admission; (2) the member meets the nursing facility level of care in place at the time of admission; (3) the member's stay in the facility is expected to be less than ninety (90) days; and (4) the member is expected to return to the community upon its conclusion. The CONTRACTOR shall monitor all short-term NF stays for Group 2 and Group 3 members and shall ensure that the member is transitioned from Group 2 or Group 3, as applicable, to Group 1 at any time a) it is determined that the stay will not be short-term or the member will not transition back to the community; and b) prior to exhausting the ninety (90)-day short-term NF benefit covered for CHOICES Group 2 and Group 3 members.

2.6.1.5.3.1.1 The ninety (90) day limit shall be applied on a per admission (and not a per year) basis. A member may receive more than one short-term stay during the year; however, the visits shall not be consecutive. Further, the CONTRACTOR shall be responsible for carefully reviewing any instance in which a member receives multiple short-term stays during the year or across multiple years, including a review of the circumstances which resulted in each nursing facility admission, and shall evaluate whether the services and supports provided to the member are sufficient to safely meet his needs in the community such that transition back to CHOICES Group 2 or Group 3 (as applicable) is appropriate.

2.6.1.5.3.1.2 The CONTRACTOR shall monitor, on an ongoing basis, members utilizing the short-term NF benefit, and shall submit to TENNCARE on a monthly basis a member-by-member status for each Group 2 and Group 3 member utilizing the short-term NF stay benefit, including but not limited to the name of each Group 2 and Group 3 member receiving short-term NF services, the NF in which s/he currently resides, the date of admission for short-term stay, the number of days of short-term NF stay utilized for this admission, and the anticipated date of discharge back to the community. For any member exceeding the ninety (90)-day limit on short-term NF stay, the CONTRACTOR shall include explanation regarding why the benefit limit has been exceeded, and specific actions the CONTRACTOR is taking to facilitate discharge to the community or transition to Group 1, as applicable, including the anticipated timeline.

2.6.1.5.4 In addition to the benefit limits described above, in no case shall the CONTRACTOR exceed the member's individual cost neutrality cap (as defined in Section A.1 of this Contract) for CHOICES Group 2 or the expenditure cap for Group 3.

2.6.1.5.4.1 For CHOICES members in Group 2, the services that shall be compared against the member's individual cost neutrality cap include the total cost of CHOICES HCBS and Medicaid reimbursed home health care and private duty nursing. The total cost of CHOICES HCBS includes all covered CHOICES HCBS and other non-covered services that the CONTRACTOR elects to offer as a cost effective alternative to nursing facility care pursuant to Section A.2.6.5.2 of this Contract including, as applicable: CHOICES HCBS in excess of specified CHOICES benefit limits, the one-time transition allowance for Group 2 and NEMT for Groups 2 and 3.

2.6.1.5.4.2 For CHOICES members in Group 3, the total cost of CHOICES HCBS, excluding minor home modifications, shall not exceed the expenditure cap (as defined in Section A.1 of this Contract).

2.6.1.5.5 CHOICES members may, pursuant to Section A.2.9.7, choose to participate in consumer direction of eligible CHOICES HCBS and, at a minimum, hire, fire and supervise workers of eligible CHOICES HCBS.

2.6.1.5.6 The CONTRACTOR shall, on an ongoing basis, monitor CHOICES members' receipt and utilization of long-term care services and identify CHOICES members who are not receiving long-term care services. Pursuant to Section A.2.30.11.4, the CONTRACTOR shall, on a monthly basis, notify TENNCARE regarding members that have not received long-term care services for a thirty (30) day period of time. The CONTRACTOR shall be responsible for immediately initiating disenrollment of any member who is not receiving TennCare-reimbursed long-term care services and is not expected to resume receiving long-term care services within the next thirty (30) days, except under extenuating circumstances which must be reported to TennCare on the CHOICES Utilization Report. Acceptable circumstances may include, but are not limited to, a member's temporary hospitalization or temporary receipt of Medicare-reimbursed skilled nursing facility care. Such notification and/or disenrollment shall be based not only on receipt and/or payment of claims for long-term care services, but also upon review and investigation by the CONTRACTOR as needed to determine whether the member has received long-term care services, regardless of whether claims for such services have been submitted or paid.

2.6.1.5.7 The CONTRACTOR may submit to TENNCARE a request to no longer provide long-term care services to a member due to concerns regarding the ability to safely and effectively care for the member in the community and/or to ensure the member's health, safety and welfare. Acceptable reasons for this request include but are not limited to the following:

2.6.1.5.7.1 A member in Group 2 for whom the CONTRACTOR has determined that it cannot safely and effectively meet the member's needs at a cost that is less than the member' cost neutrality cap, and the member declines to transition to a nursing facility;

2.6.1.5.7.2 A member in Group 2 or 3 who repeatedly refuses to allow a Care Coordinator entrance into his/her place of residence (Section A.2.9.6);

2.6.1.5.7.3 A member in Group 2 or 3 who refuses to receive critical HCBS as identified through a comprehensive assessment and documented in the member's PCSP; and

2.6.1.5.7.4 A member in Group 1 who fails to pay his/her patient liability and the CONTRACTOR is unable to find a nursing facility willing to provide services to the member (Section A.2.6.7.2).

2.6.1.5.7.5 A member in Group 2 or 3 who refuses to pay his/her patient liability and for whom the CONTRACTOR is either: 1) in the case of persons receiving CBRA services, unable to identify another provider willing to provide services to the member; or 2) in the case of persons receiving non-residential HCBS or companion care, the CONTRACTOR is unwilling to continue to serve the member, and the Division of TennCare has determined that no other MCO is willing to serve the member.

2.6.1.5.7.6 The CONTRACTOR's request to no longer provide long-term care services to a member shall include documentation regarding specific reason for which disenrollment is requested (for example, documentation of repeated attempts to visit a member or repeated refusal of services, including dates, times, and reasons given, as applicable) and other documentation to support the request as specified by TENNCARE. It must be evident from the documentation that the CONTRACTOR has made diligent and repeated attempts to address the issue and maintain continuity of the member's enrollment and services. The State shall make any and all determinations regarding whether the CONTRACTOR may discontinue providing long-term care services to a member, disenrollment from CHOICES, and, as applicable, termination from TENNCARE.

2.6.1.5.8 The CONTRACTOR may submit to TENNCARE a request to disenroll from CHOICES a member who is not receiving any Medicaid-reimbursed LTC services based on the CONTRACTOR's inability to reach the member only when the CONTRACTOR has exhausted all reasonable efforts to contact the member, and has documented such efforts in writing, which must be submitted with the disenrollment request. Efforts to contact the member shall include, at a minimum:

2.6.1.5.8.1 Multiple attempts to contact the member, his/her representative or designee (as applicable) by phone. Such attempts must occur over a period of at least two (2) weeks and at different times of the day and evening, including after business hours. The CONTRACTOR shall attempt to contact the member at the phone number provided in the outbound 834 enrollment file, any additional phone numbers the CONTRACTOR has on file, including referral records and case management notes; and phone numbers that may be provided in TENNCARE's PAE Tracking System. The CONTRACTOR shall also contact the member's Primary Care Provider and any contracted LTSS providers that have delivered services to the member during the previous six (6) months in order to obtain contact information that can be used to reach the member;

2.6.1.5.8.2 At least one (1) visit to the member's most recently reported place of residence except in circumstances where significant safety concerns prevent the CONTRACTOR from completing the visit, which shall be documented in writing; and

2.6.1.5.8.3 An attempt to contact the member by mail at the member's most recently reported place of residence at least two (2) weeks prior to the request to disenroll.

2.6.1.6 Long-Term Services and Supports Benefits for ECF CHOICES Members

2.6.1.6.1 In addition to physical health benefits (see Section A.2.6.1.3) and behavioral health benefits (see Section A.2.6.1.4), the CONTRACTOR shall provide long-term services and supports as described in this Section A.2.6.1.6 to members who have been enrolled into ECF CHOICES by TENNCARE, as shown in the outbound 834 enrollment file furnished by TENNCARE to the CONTRACTOR.

2.6.1.6.2 TennCare enrollees will be enrolled by TENNCARE into ECF CHOICES in accordance with criteria set forth in the approved 1115 waiver and TennCare rule.

2.6.1.6.3 The following long-term services and supports are available to ECF CHOICES members, per Group and subject to all applicable service definitions, benefit limits, and Expenditure Caps, when the services have been determined medically necessary by the CONTRACTOR.

Benefit	Group 4	Group 5	Group 6	Group 7	Group 8
Respite (up to 30 days per calendar year **or** up to 216 hours per calendar year only for persons living with unpaid family caregivers)	X	X	X		
Supportive home care (SHC)	X				
Family caregiver stipend in lieu of SHC (up to $500 per month for children under age 18; up to $1,000 per month for adults age 18 and older)	X				
Community integration support services (subject to limitations specified in the approved 1115 waiver and TennCare Rule)	X	X	X	X	
Community transportation	X	X	X	X	
Independent living skills training (subject to limitations specified in the approved 1115 waiver and TennCare Rule)	X	X	X	X	
Assistive technology, adaptive equipment and supplies (up to $5,000 per calendar year)	X	X	X	X	X
Minor home modifications (up to $6,000 per project; $10,000 per calendar year; and $20,000 per lifetime)	X	X	X	X	X
Community support development, organization and navigation	X			X	
Family caregiver education and training (up to $500 per calendar year)	X			X	
Family-to-family support	X			X	

Benefit	Group 4	Group 5	Group 6	Group 7	Group 8
Decision-making supports (up to $500 per lifetime)	X	X	X	X	X
Health insurance counseling/forms assistance (up to 15 hours per calendar year)	X			X	
Personal assistance (up to 215 hours per month)		X	X		
Community living supports (CLS)		X	X		
Community living supports—family model (CLS-FM)		X	X		
Individual education and training (up to $500 per calendar year)		X	X		X
Peer-to-Peer Support and Navigation for Person-Centered Planning, Self-Direction, Integrated Employment/Self-Employment and Independent Community Living (up to $1,500 per lifetime)		X	X		X
Specialized consultation and training (up to $5,000 per calendar year[5])		X	X		X
Adult dental services (up to $5,000 per calendar year; up to $7,500 across three consecutive calendar years)	X[6]	X	X		X
Employment services/supports as specified below (subject to limitations specified in the approved 1115 waiver and in TennCare Rule)	X	X	X	X	X
– Supported employment—individual employment support – Exploration – Benefits counseling – Discovery – Situational observation and assessment – Job development plan or self-employment plan – Job development or self-employment start up – Job coaching for individualized, integrated employment or self-employment	X	X	X	X	X

[5] For adults in the Group 6 benefit group determined to have exceptional medical and/or behavioral support needs, and for adults in Group 8, specialized consultation services are limited to $10,000 per person per calendar year.
[6] Limited to adults age 21 and older.

Benefit	Group 4	Group 5	Group 6	Group 7	Group 8
– Co-worker supports – Career advancement					
Intensive Behavioral Family-Centered Treatment, Stabilization and Supports (IBFCTSS)				X	
Intensive Behavioral Community Transition and Stabilization Services					X

2.6.1.6.4 In addition to the benefits specified above which shall be delivered in accordance with the definitions, including limitations set forth in the approved 1115 waiver and in TennCare rule, a person enrolled in ECF CHOICES Groups 4, 5, and 6 may receive short-term nursing facility care, without being required to disenroll from their ECF CHOICES group until such time that it is determined that transition back to HCBS in ECF CHOICES will not occur within ninety (90) days from admission. A person enrolled in ECF CHOICES Groups 7 and 8 shall not be eligible to receive short-term nursing facility care.

2.6.1.6.5 The CONTRACTOR shall review all requests for short-term NF stays and shall authorize and/or reimburse short-term NF stays for Groups, 4, 5 and 6 members only when (1) the member is enrolled in ECF CHOICES Group 4, 5, or 6 and receiving HCBS upon admission; (2) the member meets the nursing facility level of care in place at the time of admission; (3) the member's stay in the facility is expected to be less than ninety (90) days; and (4) the member is expected to return to the community upon its conclusion. The CONTRACTOR shall monitor all short-term NF stays for Group 4, 5, and 6 members and shall ensure that the member is disenrolled from ECF CHOICES if a) it is determined that the stay will not be short-term or the member will not transition back to the community; and b) prior to exhausting the ninety (90)-day short-term NF benefit covered for ECF CHOICES Group 4, 5, and 6. A person enrolled in ECF CHOICES Groups 7 or 8 is not eligible for a short-term NF stay and must be disenrolled from ECF CHOICES in order to receive Medicaid-reimbursed NF services.

2.6.1.6.6 The ninety (90) day limit shall be applied on a per admission (and not a per year) basis. A member may receive more than one short-term stay during the year; however, the visits shall not be consecutive. Further, the CONTRACTOR shall be responsible for carefully reviewing any instance in which a member receives multiple short-term stays during the year or across multiple years, including a review of the circumstances which resulted in each nursing facility admission, and shall evaluate whether the services and supports provided to the member are sufficient to safely meet his needs in the community such that transition back to ECF CHOICES Group 4, 5 or 6 (as applicable) is appropriate.

2.6.1.6.7 The CONTRACTOR shall monitor, on an ongoing basis, members utilizing the short-term NF benefit, and shall submit to TENNCARE on a monthly basis a member-by-member status for each Group 4, 5, or 6 member utilizing the short-term NF stay benefit, including but not limited to the name of each Group 4, 5, or 6 member receiving short-term NF services, the NF in which s/he currently resides, the date of admission for short-term stay, the number of days of short-term NF stay utilized for this admission, and the anticipated date of discharge back to the community. For any member exceeding the ninety (90)-day limit on short-term NF stay, the CONTRACTOR shall include explanation regarding why the benefit limit has been

exceeded, and specific actions the CONTRACTOR is taking to facilitate discharge to the community including the anticipated timeline.

2.6.1.6.8 The cost of such services shall not be counted toward the person's expenditure cap. During the short-term stay, the person's patient liability amount will continue to be calculated based on the community personal needs allowance in order to allow the person to maintain his/her community residence. Additional tracking, reporting and monitoring processes will be put in place for these services.

2.6.1.6.9 ECF CHOICES benefits will be subject to an annual per member expenditure cap. Specifically:

2.6.1.6.9.1 Individuals receiving Group 4 benefits will be subject to a $15,000 cap, not counting the cost of minor home modifications;

2.6.1.6.9.2 Individuals receiving Group 5 benefits will be subject to a $30,000 cap. The State may grant an exception for emergency needs up to $6,000 in additional services per year, but shall not permit expenditures to exceed a hard cap of $36,000 per calendar year, except that, for purposes of compliance with the federal HCBS Settings Rule, a member receiving Community Living Supports may be permitted to exceed the cap when necessary to permit access to Supported Employment and/or Individual Employment Support benefits.

2.6.1.6.9.2.1 The exception applies only to newly requested Individual Employment Support benefits; previously approved Individual Employment Support benefits that have been provided within a member's Expenditure Cap shall not be shifted above the Expenditure Cap by adding other HCBS which are not eligible for this exception.

2.6.1.6.9.2.2 For a Group 5 member requiring a Community Stabilization and Transition rate of reimbursement for Community Living Supports (CLS), the higher cost of transitional CLS shall be excluded from the Group 5 member's Expenditure Cap for the year in which the transitional CLS are required, when a member is expected to be safely and appropriately served within the Group 5 Expenditure Cap, once transition to the appropriate ongoing CLS level occurs and the transitional rate ends.

2.6.1.6.9.3 Individuals receiving Group 6 benefits will be subject to an annual expenditure cap as follows:

2.6.1.6.9.3.1 Individuals in Group 6 with low need as determined by the State shall be subject to a $45,000 expenditure cap. The State may, on a case-by-case basis, grant an exception for emergency or one-time (including transitional CLS) needs up to seven thousand five hundred dollars ($7,500) per calendar year. Except as provided below, the CONTRACTOR shall not permit HCBS expenditures to exceed a hard cap of $52,500 per calendar year.

2.6.1.6.9.3.2 Individuals in Group 6 with moderate need as determined by the State shall be subject to a $67,500 expenditure cap. The State may, on a case-by-case basis, grant an exception for emergency or one-time (including transitional CLS) needs up to seven thousand five hundred dollars ($7,500) per calendar year. Except as provided below, the CONTRACTOR shall not permit HCBS expenditures to exceed a hard cap of $75,000 per calendar year.

2.6.1.6.9.3.2.1 Any exception for emergency or one-time needs that may be granted shall apply only for the calendar year in which the exception is approved.

2.6.1.6.9.3.2.2 For purposes of compliance with the federal HCBS Settings Rule, a member receiving Community Living Supports may be permitted to exceed the $75,000 hard cap when necessary to permit access to Supported Employment and/or Individual Employment Support benefits.

2.6.1.6.9.3.2.3 This exception shall apply *only* to newly requested Individual Employment Support benefits. Previously approved Individual Employment Support benefits that have been provided within a member's Expenditure Cap shall not be shifted above the Expenditure Cap by adding other HCBS which are not eligible for this exception.

2.6.1.6.9.3.3 Individuals with high need as determined by the State shall be subject to a $88,250 expenditure cap. The State may, on a case-by-case basis, grant an exception for emergency or one-time (including transitional CLS) needs up to seven thousand five hundred dollars ($7,500) per calendar year. Except as provided below, the CONTRACTOR shall not permit HCBS expenditures to exceed a hard cap of $95,750 per calendar year.

2.6.1.6.9.3.4 The State may grant an exception as follows: for individuals with DD and exceptional medical/behavioral needs as determined by the State, up to the average cost of NF plus specialized services that would be needed for persons with such needs determined appropriate for NF placement; or for individuals with ID and exceptional medical/behavioral needs as determined by the State, up to the average cost of private ICF/IID services.

2.6.1.6.9.3.4.1 No exceptions to the Expenditure Cap shall be permitted for individuals with exceptional medical/behavioral needs as determined by the State. When a member's Expenditure Cap is based on the comparable cost of institutional care (an individual cost neutrality cap), the member's Expenditure Cap shall not be exceeded.

2.6.1.6.9.4 Individuals receiving Group 7 benefits shall be subject to an expenditure cap based on the comparable cost of institutional care as determined by TENNCARE.

2.6.1.6.9.4.1 Any home health or PDN services the member receives shall be counted against the expenditure cap.

2.6.1.6.9.4.2 While integrated in the delivery system, behavioral health services (other than IBFCTSS) shall not be counted against the expenditure cap.

2.6.1.6.9.4.3 No exceptions to the expenditure cap shall be permitted for individuals in ECF CHOICES Group 7.

2.6.1.6.9.5 Individuals receiving Group 8 benefits shall be subject to an expenditure cap based on the comparable cost of institutional care, as determined by TENNCARE, which may as determined appropriate, take into account the cost of short-term inpatient psychiatric hospitalization or other restrictive treatment setting for which the CONTRACTOR would otherwise be responsible for payment.

2.6.1.6.9.5.1 Any home health or PDN services the member receives shall be counted against the expenditure cap.

2.6.1.6.9.5.2 While integrated in the delivery system, behavioral health services (other than IBCTSS) will not be counted against the expenditure cap.

2.6.1.6.9.5.3 No exceptions to the expenditure cap shall be permitted for individuals in ECF CHOICES Group 8

2.6.1.6.10 ECF CHOICES members may, pursuant to Section A.2.9.7, choose to participate in consumer direction of eligible ECF CHOICES HCBS and, at a minimum, hire, fire and supervise workers of eligible ECF CHOICES HCBS.

2.6.1.6.11 The CONTRACTOR shall, on an ongoing basis, monitor ECF CHOICES members' receipt and utilization of long-term services and supports and identify ECF CHOICES members who are not receiving long-term services and supports. Pursuant to Section A.2.30.11.4, the CONTRACTOR shall, on a monthly basis, notify TENNCARE regarding members that have not received long-term services and supports for a thirty (30) day period of time. The CONTRACTOR shall be responsible for immediately initiating disenrollment of any member who is not receiving TennCare-reimbursed long-term services and supports and is not expected to resume receiving long-term services and supports within the next thirty (30) days, except under extenuating circumstances which must be reported to TennCare on the CHOICES and ECF CHOICES Utilization Report. Acceptable circumstances may include, but are not limited to, a member's temporary hospitalization or temporary receipt of Medicare-reimbursed skilled nursing facility care. Such notification and/or disenrollment shall be based not only on receipt and/or payment of claims for long-term services and supports, but also upon review and investigation by the CONTRACTOR as needed to determine whether the member has received long-term services and supports, regardless of whether claims for such services have been submitted or paid.

2.6.1.6.12 The CONTRACTOR may submit to TENNCARE a request to no longer provide long-term services and supports to a member due to concerns regarding the ability to safely and effectively care for the member in the community and/or to ensure the member's health, safety and welfare. Acceptable reasons for this request include but are not limited to the following:

2.6.1.6.12.1 A member in any ECF CHOICES Group for whom the CONTRACTOR has determined that it cannot safely and effectively meet the member's needs at a cost that is less than the member' expenditure cap when the member is unable or unwilling to transition to a different ECF CHOICES Group in which the member's needs could be safely and effectively met within the expenditure cap that would be applied in that Group;

2.6.1.6.12.2 A member in any ECF CHOICES Group who repeatedly refuses to allow a Support Coordinator entrance into his/her place of residence (Section A.2.9.6);

2.6.1.6.12.3 A member in any ECF CHOICES Group who refuses to receive critical HCBS as identified through a comprehensive assessment and documented in the member's PCSP; and

2.6.1.6.12.4 A member in any ECF CHOICES Group who refuses to pay his/her patient liability and for whom the CONTRACTOR is either: 1) in the case of persons receiving CBRA services, unable to identify another provider willing to provide services to the member; or 2) in the case of persons receiving non-residential HCBS or companion care, the CONTRACTOR is unwilling to continue to serve the member, and the Division of TennCare has determined that no other MCO is willing to serve the member.

2.6.1.6.13 The CONTRACTOR's request to no longer provide long-term services and supports to a member shall include documentation as specified by TENNCARE. The State shall make any and all determinations regarding whether the CONTRACTOR may discontinue providing long-term services and supports to a member, disenrollment from ECF CHOICES, and, as applicable, termination from TennCare.

2.6.1.6.14 The CONTRACTOR may submit to TENNCARE a request to disenroll from ECF CHOICES a member who is not receiving any Medicaid-reimbursed long-term services and supports based on the CONTRACTOR's inability to reach the member only when the CONTRACTOR has exhausted all reasonable efforts to contact the member, and has documented such efforts in writing, which must be submitted with the disenrollment request. Efforts to contact the member shall include, at a minimum:

2.6.1.6.14.1 Multiple attempts to contact the member, his/her representative or designee (as applicable) by phone. Such attempts must occur over a period of at least two (2) weeks and at different times of the day and evening, including after business hours. The CONTRACTOR shall attempt to contact the member at the phone number provided in the outbound 834 enrollment file, any additional phone numbers the CONTRACTOR has on file, including referral records and case management or support coordination notes; and phone numbers that may be provided in TENNCARE's PAE Tracking System. The CONTRACTOR shall also contact the member's Primary Care Provider and any contracted providers of long-term services and supports that have delivered services to the member during the previous six (6) months in order to obtain contact information that can be used to reach the member;

2.6.1.6.14.2 At least one (1) visit to the member's most recently reported place of residence except in circumstances where significant safety concerns prevent the CONTRACTOR from completing the visit, which shall be documented in writing; and

2.6.1.6.14.3 An attempt to contact the member by mail at the member's most recently reported place of residence at least two (2) weeks prior to the request to disenroll.

2.6.1.7 CoverKids Benefits (Effective January 1, 2021)

SERVICE		BENEFIT LIMIT
Ambulance Services, Air and Ground		As medically necessary.
Chiropractic care		**Children Under Age 19:** Maintenance visits not covered when no additional progress is apparent or expected to occur. **Mothers (Age 19 and over) of Eligible Unborn Children:** Not Covered
Clinic Services and other Ambulatory Health Care Services		As medically necessary
Dental Services		**Dental Services shall be provided by the Dental Benefits Manager** However, the facility, medical and anesthesia services related to the dental service that are not provided by a dentist or in a dentist's office shall be covered services provided by the CONTRACTOR when the dental service is covered by the DBM
Disposable Medical Supplies		As medically necessary. Specified medical supplies shall be covered/non-covered in accordance with TennCare Division rules and regulations.
Durable Medical Equipment (DME)		Must be medically necessary. Durable medical equipment and other medically-related or remedial devices: Limited to the most basic equipment that will provide the needed care. Hearing aids are limited to one per ear per calendar year up to age 5, and limited to one per ear every two years thereafter. Specified DME services shall be covered/non-covered in accordance with TennCare Division rules and regulations.
Home Health Services		Prior approval required. Limited to 125 visits per enrollee per calendar year.
Hospice Care		As medically necessary. Shall be provided by a Medicare-certified hospice.

SERVICE		BENEFIT LIMIT
Inpatient Hospital Services		As medically necessary, including rehabilitation hospital facility.
Inpatient Mental Health and Substance Abuse Services		As medically necessary.
Lab and X-ray Services		As medically necessary.
Outpatient Mental Health and Substance Abuse Services		As medically necessary.
Outpatient Hospital Services		As medically necessary.
Pharmacy Services		**Pharmacy services shall be provided by the Pharmacy Benefits Manager (PBM), unless otherwise described below.** The CONTRACTOR shall be responsible for reimbursement of injectable drugs obtained in an office/clinic setting and to providers providing both home infusion services and the drugs and biologics. The CONTRACTOR shall require that all home infusion claims contain National Drug Code (NDC) coding and unit information to be paid. Services reimbursed by the CONTRACTOR shall not be included in any pharmacy benefit limits established by TENNCARE for pharmacy services (see Section A.2.6.2.2).
Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders.		Limited to 52 visits per calendar year per type of therapy.
Physician Inpatient Services		As medically necessary.
Physician Outpatient Services/Community Health Clinic Services/Other Clinic Services		As medically necessary.

SERVICE		BENEFIT LIMIT
Prenatal care and pre-pregnancy family services and supplies		As medically necessary.
Preventive Care Services		As described in Section A.2.7.5.
Skilled Nursing Facility services		Limited to 100 days per calendar year following an approved hospitalization.
Surgical Services		As medically necessary.
Vision Services		**Children Under Age 19:** 1. Annual vision exam including refractive exam and glaucoma screening. 2. Prescription eyeglass lenses. Limited to one pair per calendar year. $85 maximum benefit per pair. 3. Eyeglass frames. Coverage for replacement frames limited to once every two calendar years. $100 maximum benefit per pair. 4. Prescription contact lenses in lieu of eyeglasses. Limited to one pair per calendar year. $150 maximum benefit per pair. **Mothers (Age 19 and over) of Eligible Unborn Children:** Medical eye care, meaning evaluation and management of abnormal conditions, diseases, and disorders of the eye (not including evaluation and treatment of refractive state), shall be covered as medically necessary. Routine periodic assessment, evaluation, or screening of normal eyes and examinations for the purpose of prescribing fitting or changing eyeglass and/or contact lenses are not covered. One pair of cataract glasses or lenses is covered for adults following cataract surgery.

Attachment V: 2019 CARE Social and Health Needs Action Plan

CARE Social and Health Needs Plan
https://www.tn.gov/content/dam/tn/tenncare/documents/CAREActionPlan.pdf

Attachment VI: Additional Information on LTSS Objectives and Measurement

As LTSS programs and the Quality Strategy have continued to evolve, while we recognize our obligation to continue measuring compliance with federal waiver assurances and sub-assurances and with the Medicaid Managed Care rule, we seek to refocus our quality improvement efforts on the core objectives for which each MLTSS program was established and for which annual performance is measured and reported to CMS.

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

The CHOICES program was designed to demonstrate the following:

- We can provide HCBS for elderly and/or physically disabled persons who would otherwise require Nursing Facility services, and we can provide these services for individuals at a cost that does not exceed the individual cost neutrality test used in a Section 1915(c) waiver; and

- Through improved coordination of care and use of more cost-effective home and community-based alternatives, we can expand access to home and community-based services for persons who do not yet meet a NF level of care, but who are "at risk" of needing NF services (similar to the new State plan option under Section 1915(i)), thereby delaying or preventing the need for more expensive institutional care.

The Employment and Community First CHOICES program was designed to demonstrate the following:

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

In order to identify baseline performance (i.e. prior to implementation of each MLTSS program component) and to measure performance improvement, TennCare created a baseline data plan for each program. The baseline data plan for each program identifies the key metrics that will be tracked over time for each program in order to determine whether program goals are being achieved.

Baseline Data Plan Approach: CHOICES Program

The CHOICES baseline data plan is organized around five key program objectives, all of which relate to access. In LTSS programs, access is a multi-faceted concept. The primary outcome is expanding access to HCBS for older adults and adults with physical disabilities, as compared to the fee-for-service Section 1915(c) waiver that existed prior to the implementation of CHOICES. Secondarily, is helping to ensure that improvements can be sustained over time, including as the demand for LTSS increases.

At the most basic level, outcome data should support that a larger number of older adults and adults with physical disabilities have been able to access HCBS since implementation of the CHOICES program. At the

program's inception, there was a waiting list for HCBS among these populations, with expanded capacity for enrollment contingent each year on new funding to support waiver program expansion. If the program, including the global budget approach in which money follows each person into the setting of their choice, is successful, the number of persons receiving HCBS should increase.

At the same time, however, when controlling for overall growth in the aging population, the number of people receiving services in a nursing facility should decline. This means that more people are choosing HCBS and are able to access those HCBS in order to divert or transition from institutional settings into HCBS. Additional baseline measures help to track success in diversion and transition from institutional care.

A final facet of access in LTSS programs is cost. As a practical matter, states have a limited amount of Medicaid funding to support LTSS. Higher utilization of more expensive institutional services reduces the amount of program funding available to provide for increased access to HCBS. Because the ability to expand HCBS hinges on a rebalancing of long-term care expenditures, it is critical not just to track the number and percentage of people receiving HCBS versus institutional care, but also to track expenditures for HCBS relative to institutional care and to understand the relative average annualized cost of services in the two settings over time.

Specific Baseline Quality Outcome Measures for CHOICES are as follows:

CHOICES Program Objective #1: Expand access to HCBS for older adults and adults with physical disabilities.

CHOICES Program Objective 1.1

Increase the number and percentage of older adults and adults with physical disabilities actively receiving HCBS at a point in time and over the course of each demonstration year compared to the year prior to implementation.

CHOICES Program Objective 1.2

Decrease the number and percentage of persons receiving nursing facility services at a point in time and over the course of each demonstration year compared to the year prior to implementation.

Baseline data elements:

- Number of older adults and adults with physical disabilities actively receiving HCBS as the time of CHOICES implementation and annually thereafter
- Unduplicated number of older adults and adults with physical disabilities receiving HCBS during the 12 months prior to CHOICES implementation and annually thereafter
- Number of persons receiving NF services at the time of CHOICES implementation and annually thereafter
- Unduplicated number of persons receiving NF services during the twelve months prior to CHOICES implementation and annually thereafter

CHOICES Data Elements:

- Number of older adults and adults with physical disabilities actively receiving HCBS one year after CHOICES implementation and annually thereafter
- Unduplicated number of older adults and adults with physical disabilities receiving HCBS during the first year after CHOICES implementation and annually thereafter

- Number of persons receiving NF services one year after CHOICES implementation and annually thereafter
- Unduplicated number of persons receiving NF services during the first year after CHOICES implementation and annually thereafter

CHOICES Program Objective #2: [Re]balance TennCare spending on long-term services and supports for older adults and adults with physical disabilities to increase the proportion that goes to HCBS.

CHOICES Program Objective 2.1

Increase HCBS expenditures for older adults and adults with physical disabilities (based on encounters, not capitation payments) as a percentage of total long-term care expenditures for older adults and adults with physical disabilities during each demonstration year compared to the year prior to implementation.

CHOICES Program Objective 2.2

Decrease nursing facility expenditures for older adults and adults with physical disabilities (based on encounters, not capitation payments) as a percentage of total long-term care expenditures for older adults and adults with physical disabilities during each demonstration year compared to the year prior to implementation.

Baseline Data Elements:

- HCBS expenditures for older adults and adults with physical disabilities during the 12 months prior to CHOICES implementation
- HCBS expenditures for older adults and adults with physical disabilities during the 12 months prior to CHOICES implementation as a percentage of total long-term services and supports expenditures (excluding expenditures on LTSS for individuals with I/DD)

  Numerator: HCBS expenditures for older adults and adults with physical disabilities during the 12 months prior to CHOICES implementation
  Denominator: Total LTSS expenditures (NF and HCBS for older adults and adults with physical disabilities) during the 12 months prior to CHOICES implementation

- NF expenditures during the 12 months prior to CHOICES implementation
- NF expenditures during the 12 months prior to CHOICES implementation as a percentage of total long-term care expenditures (excluding expenditures on LTSS for individuals with I/DD)

  Numerator: NF expenditures during the 12 months prior to CHOICES implementation
  Denominator: Total LTSS expenditures (nursing facility and HCBS for older adults and adults with physical disabilities) during the 12 months prior to CHOICES implementation

CHOICES Data Elements:

- HCBS expenditures for older adults and adults with physical disabilities (based on encounters, not cap payments) during the first year following CHOICES implementation and annually thereafter
- NF expenditures (based on encounters, not cap payments) during the first year following CHOICES implementation and annually thereafter
- HCBS expenditures for older adults and adults with physical disabilities (based on encounters, not cap payments) during the first year following CHOICES implementation and annually thereafter as a

percentage of total long-term care expenditures (excluding expenditures for the population of persons with I/DD)

Numerator: HCBS expenditures for older adults and adults with physical disabilities (based on encounters, not cap payments) during the first year following CHOICES implementation and annually thereafter
Denominator: Total LTSS expenditures (NF and HCBS for older adults and adults with physical disabilities based on encounters, not cap payments) during the first year following CHOICES implementation and annually thereafter

- NF expenditures (based on encounters, not cap payments) during the first year following CHOICES implementation and annually thereafter as a percentage of total long-term care expenditures (excluding expenditures for the population of persons with I/DD)

  Numerator: NF expenditures (based on encounters, not cap payments) during the first year following CHOICES implementation and annually thereafter
  Denominator: Total LTSS expenditures (NF and HCBS for older adults and adults with physical disabilities based on encounters, not cap payments) during the first year following CHOICES implementation and annually thereafter

CHOICES Program Objective #3: Provide cost effective care in the community for older adults and adults with physical disabilities who would otherwise require NF care.

CHOICES Program Objective 3.1

Per person HCBS expenditures on older adults and adults with physical disabilities (based on encounters, not capitation payments) remain lower than per person NF expenditures on older adults with physical disabilities (based on encounters, not capitation payments payments) for each demonstration year.

Baseline Data Elements:

- Average per person HCBS expenditures for older adults and adults with physical disabilities during the 12 months prior to CHOICES implementation
- Average per person NF expenditures during the 12 months prior to CHOICES implementation

CHOICES data elements:

- Average per person HCBS expenditures for older adults and adults with physical disabilities (based on encounters, not cap payments) during the first year following CHOICES implementation and annually thereafter
- Average per person NF expenditures (based on encounters, not cap payments) during the first year following CHOICES implementation and annually thereafter

CHOICES Program Objective #4: Provide HCBS that will enable older adults and adults with physical disabilities who would otherwise be required to enter NFs to be diverted to the community.

CHOICES Program Objective 4.1

Increase the average length of stay in HCBS for each demonstration year compared to the year prior to implementation.

CHOICES Program Objective 4.2

Increase the percentage of new LTSS recipients admitted to HCBS during each demonstration year compared to the year prior to implementation

CHOICES Program Objective 4.3

Decrease the percentage of new LTSS recipients admitted to NFs during each demonstration year compared to the year prior to implementation.

Baseline data elements:

- Average length of stay in HCBS during the 12 months prior to CHOICES implementation
- Percent of new LTSS recipients admitted to NFs during the 12 months prior to CHOICES implementation

CHOICES Data Elements:

- Average length of stay in HCBS during the first year after CHOICES implementation and annually thereafter
- Percent of new LTSS recipients admitted to NFs during the first year after CHOICES implementation and annually thereafter

CHOICES Program Objective #5: Provide HCBS that will enable older adults and adults with physical disabilities receiving services in NFs to be able to transition back to the community.

CHOICES Program Objective 5.1

Decrease the average length of stay in NFs for each demonstration year compared to the year prior to implementation.

CHOICES Program Objective 5.2

Increase the number of persons who transitioned from NFs to HCBS during each demonstration year compared to the year prior to implementation.

Baseline data elements:

- Average length of stay in NFs during the 12 months prior to CHOICES implementation
- Number of persons transitioned from NFs to HCBS during the 12 months prior to CHOICES implementation

CHOICES data elements:

- Average length of stay in NFs during the first year after CHOICES implementation and annually thereafter
- Number of persons who transitioned from NFs to HCBS during the first year following CHOICES implementation and annually thereafter

Baseline Data Plan Approach: Employment and Community First CHOICES Program

Like the CHOICES baseline data plan, the baseline data plan for Employment and Community First CHOICES is also organized around five key program objectives. However, in the case of Employment and Community First

CHOICES, objectives and measures relate to each of the program goals set forth in the STCs, including access to MLTSS, improved health outcomes and beneficiary satisfaction.

The first goal is expanding access to HCBS for individuals with intellectual disabilities, for individuals with developmental disabilities, and across the I/DD population broadly, as compared to the fee-for-service Section 1915(c) waivers that existed prior to the implementation of Employment and Community First CHOICES. Secondarily, is helping to ensure that improvements can be sustained over time, including as the demand for LTSS increases.

As with CHOICES, the program goals and measures take into account the multi-faceted nature of access, but do not include measures related to diversion and transition since ICF/IID services remain outside the demonstration program. Data should support that a larger number of individuals with intellectual disabilities, a larger number of people with developmental disabilities, and a larger number of people across the I/DD population have been able to access HCBS since implementation of the Employment and Community First CHOICES program.

Also, as with CHOICES, a critical facet of access in Employment and Community First CHOICES is cost. The higher average cost of services in the state's fee-for-service programs (ICF/IID and 1915(c) waiver) have made it difficult to provide services to all of the people who need them, and left no resources to provide services to people with developmental disabilities. It is thus critical to understand the relative average annualized cost of services in each program, in order to demonstrate that we are able to provide services more cost-effectively, thereby expanding access for more of the people in the population who need LTSS. And even though institutional services are carved out of the demonstration, it is important to track expenditures for HCBS relative to institutional care and to ensure that we are continuing to focus investment in community-based, rather than institutional settings.

A second goal for the Employment and Community First CHOICES program is increasing participation in integrated employment, earning at or above the minimum wage, as compared to the fee-for-service Section 1915(c) waivers that existed prior to the implementation of Employment and Community First CHOICES. This is the most critical health-related program goal. Employment status may have implications for an individual's health status. A study funded by CMS through a Medicaid Infrastructure Grant which included a review of the literature on the relationship between employment and health found "a consistent association between employment and better health and unemployment and poorer health," including for people with disabilities. The study suggested that, "One possible cost-effective way to increase the health of members of Managed Long Term Care Systems is to promote and support the competitive employment of members, and that "[W]hen evaluating quality of Managed Long Term Care Systems, members' employment status may become an important outcome that cannot be ignored.[7]"

The final goal for the Employment and Community First CHOICES program is improving the overall quality of life of persons with I/DD who enroll in the program and receive HCBS.

Specific Baseline Quality Outcome Measures for Employment and Community First CHOICES are as follows:

ECF CHOICES Program Objective #1: Expand access to HCBS for individuals with intellectual and developmental disabilities.

[7] Hartman, E. A literature review on the relationship between employment and health: How this relationship may influence managed long term care. Available at https://www.uwstout.edu/svri/upload/The-relationship-between-employment-and-health-A-literature-review.pdf.

ECF CHOICES Program Objective 1.1

Increase the number of individuals with ID actively receiving HCBS at a point in time and over the course of each demonstration year compared to the year prior to implementation.

ECF CHOICES Program Objective 1.2

Increase the number of individuals with DD actively receiving HCBS at a point in time and over the course of each demonstration year compared to the year prior to implementation.

ECF CHOICES Program Objective 1.3

Increase the number of individuals with I/DD actively receiving HCBS at a point in time and over the course of each demonstration year compared to the year prior to implementation.

Baseline data elements:

- Number of individuals with ID actively receiving HCBS at the time of Employment and Community First CHOICES implementation
- Unduplicated individuals with ID receiving HCBS during the 12 months prior to Employment and Community First CHOICES implementation

Employment and Community First baseline data elements:

- Number of individuals with ID actively receiving HCBS one year after Employment and Community First CHOICES implementation and annually thereafter
- Unduplicated number of individuals with ID receiving HCBS during the first year after Employment and Community First CHOICES implementation and annually thereafter

Data shall be reported for Employment and Community First CHOICES and across Medicaid HCBS programs including Section 1915 (c) waivers

Baseline data elements – Individuals with developmental disabilities (other than intellectual disabilities):

- Number of individuals with DD actively receiving HCBS at the time of Employment and Community First CHOICES implementation
- Unduplicated individuals with DD receiving HCBS during the 12 months prior to Employment and Community First CHOICES implementation

Employment and Community First CHOICES data elements – individuals with developmental disabilities (other than intellectual disabilities):

- Number of individuals with DD actively receiving HCBS one year after Employment and Community First CHOICES implementation and annually thereafter
- Unduplicated number of individuals with DD receiving HCBS during the first year after Employment and Community First CHOICES implementation and annually thereafter

Data shall be reported only for Employment and Community First CHOICES.

Baseline data elements – individuals with intellectual and developmental disabilities:

- Number of individuals with I/DD actively receiving HCBS at the time of Employment and Community First CHOICES implementation
- Unduplicated individuals with I/DD receiving HCBS during the 12 months prior to Employment and Community First CHOICES implementation

Employment and Community First CHOICES data elements – individuals with intellectual and developmental disabilities:

- Number of individuals with I/DD actively receiving HCBS one year after Employment and Community First CHOICES implementation and annually thereafter
- Unduplicated individuals with I/DD receiving HCBS during the first year after Employment and Community First CHOICES implementation and annually thereafter

Data shall be reported for Employment and Community First CHOICES and across Medicaid HCBS programs, including Section 1915(c) waivers.

ECF CHOICES Program Objective #2: Provide more cost-effective services and supports persons with intellectual and developmental disabilities.

ECF CHOICES Program Objective 2.1:

Decrease average per person LTSS expenditures on individuals with I/DD (based on encounters, not capitation payments, and fee-for-service expenditures) compared to the year prior to implementation.

Baseline data element:

- Average per person LTSS expenditures for individuals with I/DD during the 12 months prior to Employment and Community First CHOICES implementation

Employment and Community First CHOICES data element:

- Average per person LTSS expenditures on individuals with I/DD (based on fee-for-service payments and encounters, not cap payments) during the first year following Employment and Community First CHOICES implementation and annually thereafter

Data shall be reported for Employment and Community First CHOICES, Section 1915(c) waivers, ICF/IID services, and across Medicaid HCBS (including Section 1915(c) waivers and LTSS, including ICF/IID.

ECF CHOICES Program Objective #3: Continue balancing TennCare spending on long-term services and supports for individuals with intellectual and developmental disabilities to increase the proportion spent on HCBS.

ECF CHOICES Program Objective 3.1

Increase HCBS expenditures for individuals with I/DD (based on encounters, not capitation payments, and fee-for-service expenditures) as a percentage of total LTSS expenditures for individuals with I/DD during each demonstration year compared to the year prior to implementation.

ECF CHOICES Program Objective 3.2

Decrease ICF/IID expenditures as a percentage of total LTSS expenditures for individuals with I/DD (based on encounters, not capitation payments, and fee-for-service expenditures) during each demonstration year compared to the year prior to implementation.

Baseline data elements:

- HCBS expenditures for individuals with I/DD during the 12 months prior to Employment and Community First CHOICES implementation
- HCBS expenditures for individuals with I/DD during the 12 months prior to Employment and Community First CHOICES implementation as a percentage of total LTSS expenditures for individuals with I/DD

  Numerator: HCBS expenditures for individuals with I/DD during the 12 months prior to Employment and Community First CHOICES implementation
  Denominator: Total LTSS expenditures (ICF/IID and HCBS) for individuals with I/DD (based on fee-for-service payments and encounters, not cap payments) during the 12 months prior to Employment and Community First CHOICES implementation

- ICF/IID expenditures during the 12 months prior to Employment and Community First CHOICES implementation
- ICF/IID expenditures during the 12 months prior to Employment and Community First CHOICES implementation as a percentage of total LTSS expenditures for individuals with I/DD

  Numerator: ICF/IID expenditures during the 12 months prior to Employment and Community First CHOICES implementation
  Denominator: Total LTSS expenditures (ICF/IID and HCBS) for individuals with I/DD (based on fee-for-service payments and encounters, not cap payments) during the 12 months prior to Employment and Community First CHOICES implementation

Employment and Community First CHOICES data elements:

- HCBS expenditures for individuals with I/DD (based on fee-for-service payments and encounters, not cap payments) during the first year following Employment and Community First CHOICES implementation and annually thereafter
- ICF/IID expenditures during the first year following Employment and Community First CHOICES implementation and annually thereafter
- HCBS expenditures on individuals with I/DD (based on fee-for-service payments and encounters, not cap payments) during the first year following Employment and Community First CHOICES implementation, and annually thereafter, as a percentage of total LSS expenditures for individuals with I/DD

  Numerator: HCBS expenditures on individuals with I/DD (based on encounters, not cap payments) during the first year following Employment and Community First CHOICES implementation, and annually thereafter
  Denominator: Total LTSS expenditures (ICF/IID and HCBS) for individuals with I/DD (based on FFS payments and encounters, not cap payments) during the first year following Employment and Community First CHOICES implementation, and annually thereafter

- ICF/IID expenditures during the first year following Employment and Community First CHOICES implementation, and annually thereafter, as a percentage of total LTSS expenditures for individuals with I/DD

  Numerator: ICF/IID expenditures on individuals with I/DD during the first year following Employment and Community First CHOICES implementation, and annually thereafter
  Denominator: Total LTSS expenditures (ICF/IID and HCBS) for individuals with I/DD (based on FFS payments and encounters, not cap payments) during the first year following Employment and Community First CHOICES implementation, and annually thereafter

ECF CHOICES Program Objective #4: Increase the number and percentage of working age adults with intellectual and development disabilities enrolled in HCBS programs who are employed in an integrated setting earning at or above the minimum wage.

ECF CHOICES Program Objective 4.1

Increase the number and percentage of working age adults with I/DD enrolled in HCBS programs who are employed in an integrated setting earning at or above the minimum wage during each demonstration year compared to the baseline year.

Baseline data elements:

- Number of individuals with I/DD enrolled in HCBS programs who are employed in an integrated setting earning at or above the minimum wage at the time of Employment and Community First CHOICES implementation.
- Percent of individuals with I/DD enrolled in HCBS programs who are employed in an integrated setting earning at or above the minimum wage at the time of Employment and Community First CHOICES implementation.

  Numerator: Number of individuals with I/DD enrolled in HCBS programs employed in an integrated setting earning at or above the minimum wage at the time of Employment and Community First CHOICES implementation
  Denominator: Total number of individuals with I/DD enrolled in HCBS programs at the time of Employment and Community First CHOICES implementation

Employment and Community First CHOICES data elements:

- Number of individuals with I/DD enrolled in HCBS programs who are employed in an integrated setting earning at or above the minimum wage one year after Employment and Community First CHOICES implementation and annually thereafter
- Percent of individuals with I/DD enrolled in HCBS programs who are employed in an integrated setting earning at or above the minimum wage during the first year following Employment and Community First CHOICES implementation and annually thereafter

Numerator: Number of individuals with I/DD enrolled in HCBS programs employed in an integrated setting earning at or above the minimum wage one year after Employment and Community First CHOICES implementation and annually thereafter
Denominator: Total number of individuals with I/DD enrolled in HCBS programs one year after Employment and Community First CHOICES implementation and annually thereafter

Data shall be reported for Employment and Community First CHOICES and across Medicaid HCBS programs including Section 1915(c) waivers.

ECF CHOICES Program Objective #5: Improve the quality of life of individuals with intellectual and developmental disabilities enrolled in HCBS programs.

ECF CHOICES Program Objective 5.1

Improve quality of life of individuals with I/DD during each demonstration year compared to the baseline year.

Baseline data element:

- Perceived quality of life of individuals with I/DD upon enrollment into Employment and Community First CHOICES as measured by the *National Core Indicators™* Survey

Employment and Community First CHOICES data element:

- Perceived quality of life of individuals with I/DD one year after enrollment into Employment and Community First CHOICES as measured by the *National Core Indicators™* Survey

Medicaid Management Information Systems (MMIS) Enrollment Reports- LTSS uses MMIS Enrollment Reports to provide CHOICES and Employment and Community First CHOICES enrollment statistics, in point-in-time counts monthly.

CHOICES and Employment and Community First CHOICES Annual Baseline Data Reports

The Annual CHOICES and ECF CHOICES Data Reports are submitted to CMS in June of each year pursuant to STC47

Point in time CHOICES data is derived from monthly Medicaid MMIS Enrollment Reports for the program. Point in time ECF CHOICES and annual aggregate CHOICES and ECF CHOICES enrollment and expenditures are derived from an analysis of MCO encounter data submissions as reflected in the MMIS by the Health Care Informatics (HCI) group in the TennCare Fiscal Division.

Enrollment of individuals with I/DD in other (i.e., non-MLTSS) LTSS programs and services and expenditures for other (i.e., non-MLTSS) LTSS programs and services for individuals with I/DD is derived from an analysis of MMIS fee-for-service claims by HCI.

Employment Data Surveys- Employment data is derived from TennCare's analysis of aggregated data collected through individual conducted with each working age adult receiving LTSS on an annual basis by the entity responsible for support coordination in each LTSS program.

National Core Indicators (NCI)- Quality of life data is derived from an analysis of data collected through the administration of the in-person survey with Employment and Community First CHOICES members.

Attachment VII: Quality Strategy Effectiveness Evaluation

TennCare Quality Strategy Evaluation Summary

This report provides an evaluation of the progress TennCare made in 2020 toward achieving the goals set forth in its Quality Strategy, which is required by 42 *Code of Federal Regulations* (CFR) 438.340(c)(2)(i), 438.340(c)(2)(ii), and 457.1240(e) to be reviewed and updated at least every three years.
According to 42 CFR § 438.340, all states with managed care are required to submit to the Centers for Medicaid & Medicare Services (CMS) a written strategy for assessing and improving the quality of managed care services provided to Medicaid members. TennCare's Quality Strategy outlines the State's quality improvement activities, which are consistent with the Three Aims of the National Quality Strategy: better care, healthy people/healthy communities, and affordable care. TennCare's Quality Strategy is shaped by four primary physical and behavioral health goals:

1. Ensure appropriate access to care;
2. Provide high-quality, cost-effective care;
3. Ensure enrollees' satisfaction with services; and
4. Improve healthcare for program enrollees.

In addition, TennCare has established performance measures specific to populations enrolled in TennCare's two long-term services and supports (LTSS) programs, CHOICES and Employment and Community First (ECF) CHOICES. The first CHOICES program provides home- and community-based services (HCBS) for older adults and adults with physical disabilities, while ECF CHOICES provides employment opportunities and HCBS for individuals with intellectual and developmental disabilities. As these programs and the Quality Strategy have evolved, TennCare has continued to focus quality improvement efforts on the core objectives for which both CHOICES programs were established. Due to changes in the goals for the CHOICES programs, this report does not evaluate the LTSS goals for 2020.

Methodology/Data Sources

This report provides a progress update on statewide managed care organization (MCO) performance in meeting the Quality Strategy's four physical and behavioral health goals. A variety of data sources were used to measure the effectiveness of these goals and objectives, including statewide average Healthcare Effectiveness Data and Information Set (HEDIS) and Consumer Assessment of Healthcare Providers and Systems (CAHPS) rates; patient-centered medical home (PCMH) data provided by the National Committee for Quality Assurance (NCQA); and TennCare enrollment and claims data.

Results

Overall, the Quality Strategy represents an effective tool for measuring and improving the quality of TennCare's managed care services. Of the 11 objectives that make up the Quality Strategy's physical and behavioral health goals, six met or exceeded the goals set forth for 2020, one was partially met, and data for one objective were unavailable due to the COVID-19 pandemic. Several objectives significantly exceeded the targets, and trending with previous years reveals that many measures have steadily improved over time, including the following:

- **Objective 2.1:** The Postpartum Care rate for the Prenatal and Postpartum Care (PPC) HEDIS measure exceeded the goal by 6.61 percentage points at 70.20% (goal: 63.59%).

Objective 3.2: For CAHPS 2020, the percentage of TennCare members who responded "Always" or "Usually" to the Getting Needed Care composite measure was 85.77% for the adult Medicaid population (goal: 82.48%) and 88.84% for the child Medicaid population (goal: 86.82%). These rates exceeded the target, and trending reveals steady increases in the measure since CAHPS 2018.

Objective 4.1: These three Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC) rates surpassed the goals by 6.24, 3.36, and 4.35 percentage points, respectively:

- BMI Percentile Documentation: 80.51% (goal: 74.27%)
- Counseling for Nutrition: 70.68% (goal: 67.32%)
- Counseling for Physical Activity: 66.74% (goal: 62.39%)

Three objectives and one partial objective did not fully achieve the 2020 aims. The results for these objectives are listed below:

- **Objective 1.1:** The statewide EPSDT screening rate fell slightly short of the 80% goal at 79% in FFY 2019. Of the 16 counties with screening rates between 60% and 69%, only five improved by 5% or more; however, a total of seven brought their screening rates to 70% or higher.
- **Objective 2.1:** The Timeliness of Prenatal Care rate for the PPC measure fell slightly short of the target at 83.68% (goal: 83.76%). The other PPC rate exceeded the goal. However, while both rates are improvements over previous years, NCQA indicated a break in trending for PPC due to changes in measure specifications for HEDIS 2020.
- **Objective 2.4:** The statewide rates for HEDIS 2020 (measurement year 2019) were as follows: CIS—MMR: 88.90% (goal: 90.1%); IMA—Combination 1: 78.02% (goal: 79.19%); CIS—Influenza: 44.68% (goal: 46.91%). Although these rates fell slightly short of the goals, trending with previous years reveals steady improvements in all three rates.
- **Objective 4.2:** The statewide rates for these population health outcome measures, in which lower rates indicate better performance, were as follows: ED visits per 1000 members—593 (goal: 582); 30-day readmissions per 100 members—13.6 (goal: 10.7); ESRD per 100 members with diabetes—7.8 (goal: 7.0). Although these rates did not meet the goals, trending shows steady improvement in the ED visit rate over the previous three years.

2021 AQS MCO Deemed CRA References

Every year, Qsource updates compliance assessment tools based on current Protocol 3: Review of Compliance with Medicaid and CHIP Managed Care Regulations, titled Annual Quality Survey (AQS), for the TennCare program, and based on the most recent contractual obligations between the State and managed care organizations (MCOs). After the AQS tools are updated, Qsource compares the evaluation elements with elements in the applicable NCQA accreditation standards. AQS elements with the same requirements as NCQA elements are deemed to prevent duplication. All Tennessee MCOs are required to have NCQA accreditation. These processes prevent duplication of activities for the MCO TennCare program participants. The table below includes fully deemable CRA references.

#	Contract/CFR Reference Language*	2020 NCQA Reference/Language**
1	CRA and TSA § 2.11.11.1.2 If a PCP ceases participation in the CONTRACTOR's MCO, the CONTRACTOR shall provide written notice as soon as possible, but no less than thirty (30) calendar days prior to the effective date of the termination and no more than fifteen (15) calendar days after receipt or issuance of the termination notice, to each member who has chosen or been assigned to that provider as their PCP. The requirement to provide notice thirty (30) calendar days prior to the effective date of termination shall be waived in instances where a provider becomes physically unable to care for members due to illness, a provider dies, the provider fails to provide thirty (30) calendar days advance notice to the CONTRACTOR, the provider moves from the service area and fails to notify the CONTRACTOR or a provider fails credentialing, and instead shall be made immediately upon the CONTRACTOR becoming aware of the circumstances.	MED1, Element H: The organization provides written notification to affected members of termination of a practitioner or practice group within 15 calendar days after receipt or issuance of the termination notice.
2	CFR 438.206.b.3 The State must ensure, through its contracts, that each MCO, PIHP and PAHP, consistent with the scope of its contracted services, meets the following requirements: Provides for a second opinion from a network provider, or arranges for the enrollee to obtain one outside the network, at no cost to the enrollee.	MED1, Element C: The organization provides for a second opinion from an in-network provider or arranges for the member to obtain a second opinion outside the network.

* Contract language from CRA with Amendment 12 and TSA with Amendments 1–48.
** Reference language was pulled from the 2020 NCQA standards.

#	Contract/CFR Reference Language*	2020 NCQA Reference/Language**
3	CFR 438.610.a An MCO, PIHP, PAHP, PCCM, or PCCM entity may not knowingly have a relationship of the type described in paragraph (c) of this section with the following: 1. An individual or entity that is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in nonprocurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549. 2. An individual or entity who is an affiliate, as defined in the Federal Acquisition Regulation at 48 CFR 2.101, of a person described in paragraph (a)(1) of this section. CFR 438.610.b An MCO, PIHP, PAHP, PCCM, or PCCM entity may not have a relationship with an individual or entity that is excluded from participation in any Federal health care program under section 1128 or 1128A of the Act.	CR5, Element A: The organization implements ongoing monitoring and makes appropriate interventions by: 1. Collecting and reviewing Medicare and Medicaid sanctions. 2. Collecting and reviewing sanctions and limitations on licensure. 3. Collecting and reviewing complaints. 4. Collecting and reviewing information from identified adverse events. 5. Implementing appropriate interventions when it identifies instances of poor quality in factors 1-4. CR7, Element A: The organization's policy for assessing a health care delivery provider specifies that before it contracts with a provider, and for at least every 36 months thereafter, it: 1. Confirms that the provider is in good standing with state and federal regulatory bodies. 2. Confirms that the provider has been reviewed and approved by an accrediting body. 3. Conducts an onsite quality assessment if the provider is not accredited.
4	CRA and TSA § 2.8.3.1 The CONTRACTOR shall make a best effort to conduct an initial screening of each member's needs, within ninety (90) days of the effective date of enrollment for all new members to assess member's health risk utilizing a health risk assessment, also referred to as a health risk appraisal, that meets and/or exceeds the current National Committee for Quality Assurance (NCQA) Population Health Management standard, that has been approved by TENNCARE and Population Health staff, or a comprehensive health risk assessment that meets and/or exceeds the current National Committee for Quality Assurance (NCQA) Population Health Management standard. The CONTRACTOR shall make subsequent attempts to conduct an initial screening of each member's needs if the initial attempt to contact the member is unsuccessful, within thirty (30) days of the initial outreach attempt. These timelines may be shortened or contact methods specified for specific parts of the program in contract sections below. The information collected from these health assessments will be used to align individual members with appropriate intervention approaches and maximize the impact of the services provided.	MED6, Element A: The organization conducts an initial screening of the health care needs of all new members within 90 calendar days of enrollment.
5	CRA and TSA § 2.8.8.1 The CONTRACTOR's Population Health Program Strategy shall include a CHOICES/ECF CHOICES section that describes how the organization integrates a CHOICES or ECF CHOICES member's information with other CONTRACTOR activities, including but not limited to, Utilization Management (UM), Health Risk assessment information, Health Risk Management and Chronic Care Management programs to assure programs are linked and enrollees receive appropriate and timely care.	PHM1, Element A, Factor 4: The organization coordinates programs or services it directs and those facilitated by providers, external management programs and other entities. The PHM strategy describes how the organization coordinates programs across settings, providers and levels of care to minimize the confusion for members being contacted from multiple sources. Coordination activities are not required to be exclusive to one area of focus and may apply across the continuum of care and to other organization initiatives.

#	Contract/CFR Reference Language*	2020 NCQA Reference/Language**
6	CRA and TSA § 2.15.1.1 The CONTRACTOR shall have a written Quality Management/Quality Improvement (QM/QI) program that clearly defines its quality improvement structures and processes and assigns responsibility to appropriate individuals. Program documents must include all of the elements listed below and shall include a separate section on CHOICES care coordination. This QM/QI program shall use as a guideline the current NCQA Standards and Guidelines for the Accreditation of MCOs and shall include the CONTRACTOR's plan for improving patient safety. This means at a minimum that the QM/QI program shall: CRA and TSA § 2.15.1.1.5 Have an annual work plan CRA and TSA § 2.15.2.1 The CONTRACTOR shall have a QM/QI committee which shall include medical, behavioral health, and long-term care staff and contract providers (including medical, behavioral health, and long-term care providers). This committee shall analyze and evaluate the results of QM/QI activities, recommend policy decisions, ensure that providers are involved in the QM/QI program, institute needed action, and ensure that appropriate follow-up occurs. CRA and TSA § 2.15.2.2 The QM/QI committee shall keep written minutes of all meetings. A copy of the signed and dated written minutes for each meeting shall be available on-file after the completion of the following committee meeting in which the minutes are approved and shall be available for review upon request and during the annual on-site EQRO review and/or NCQA accreditation review.	QI1, Element A: The organization's QI program description specifies: 1. The QI program structure. 2. The behavioral healthcare aspects of the program. 3. Involvement of a designated physician in the QI program. 4. Involvement of a behavioral healthcare practitioner in the behavioral aspects of the program. 5. Oversight of QI functions of the organization by the QI Committee. 6. An annual work plan. 7. Objectives for serving a culturally and linguistically diverse membership. QI1, Element B: The organization conducts an annual written evaluation of the QI program that includes the following information: 1. A description of completed and ongoing QI activities that address quality and safety of clinical care and quality of service. 2. Trending of measures to assess performance in the quality and safety of clinical care and quality of service. 3. Analysis and evaluation of the overall effectiveness of the QI program and of its progress toward influencing networkwide safe clinical practices. QI1, Element C: he organization conducts an annual written evaluation of the QI program that includes the following information: 1. A description of completed and ongoing QI activities that address quality and safety of clinical care and quality of service. 2. Trending of measures to assess performance in the quality and safety of clinical care and quality of service. 3. Analysis and evaluation of the overall effectiveness of the QI program and of its progress toward influencing networkwide safe clinical practices. QI1, Element D: The organization's QI Committee: 1. Recommends policy decisions. 2. Analyzes and evaluates the results of QI activities. 3. Ensures practitioner participation in the QI program through planning, design, implementation or review. 4. Identifies needed actions. 5. Ensures follow-up, as appropriate.
7	CRA and TSA § 2.15.4 The CONTRACTOR shall utilize evidence-based clinical practice guidelines in its Population Health Programs (see Section A.2.8.6 of this Contract). The guidelines shall be reviewed and revised whenever the guidelines change and at least every two (2) years. The CONTRACTOR shall provide copies of clinical practice guidelines to enrollees upon request. The CONTRACTOR is required to maintain an archive of its	MED2, Practice Guidelines, Element A: The organization adopts at least four evidence-based clinical practice guidelines, approved by its QI committee, that: 1. Are based on valid and reliable clinical evidence or a consensus of practitioners in the particular field. 2. Consider the needs of the organization's members. 3. Are adopted in consultation with contracted health care

#	Contract/CFR Reference Language*	2020 NCQA Reference/Language**
	clinical practice guidelines for a period of five (5) years. Such archive shall contain each clinical guideline as originally issued so that the actual guidelines for prior years are retained for Program Integrity purposes. CFR 438.236.b-.c b. Adoption of practice guidelines. Each MCO and, when applicable, each PIHP and PAHP adopts practice guidelines that meet the following requirements: 1. Are based on valid and reliable clinical evidence or a consensus of providers in the particular field. 2. Consider the needs of the MCO's, PIHP's, or PAHP's enrollees. 3. Are adopted in consultation with contracting health care professionals. 4. Are reviewed and updated periodically as appropriate. c. Dissemination of guidelines. Each MCO, PIHP, and PAHP disseminates the guidelines to all affected providers and, upon request, to enrollees and potential enrollees.	professionals. 4. Are reviewed and updated at least every two years, as applicable. MED 2, Element B: The organization distributes the evidence-based guidelines it adopted in MED 2, Element A, to the appropriate practitioners and to members and potential members, upon request.
8	CRA and TSA § 2.14.1.8 The CONTRACTOR shall use appropriately licensed professionals to supervise all medical necessity decisions and specify the type of personnel responsible for each level of UM, including prior authorization and decision making. The CONTRACTOR shall have written procedures documenting access to Board Certified Consultants to assist in making medical necessity determinations. Any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested shall be made by a physical health or behavioral health care professional who has appropriate clinical expertise in treating the member's condition or disease or, in the case of long-term care services, a long-term care professional who has appropriate expertise in providing long-term care services.	UM4, Element A: The organization has written procedures: 1. Requiring appropriately licensed professionals to supervise all medical necessity decisions. 2. Specifying the type of personnel responsible for each level of UM decision making. UM 4, Element B: The organization has a written job description with qualifications for practitioners who review denials of care based on medical necessity. Practitioners are required to have: 1. Education, training or professional experience in medical or clinical practice. 2. A current clinical license to practice or an administrative license to review UM cases. UM 4, Element C: The organization uses a physician or other health care professional, as appropriate, to review any nonbehavioral healthcare denial based on medical necessity. UM 4, Element D: The organization uses a physician or appropriate behavioral healthcare practitioner, as appropriate, to review any behavioral healthcare denial of care based on medical necessity. UM 4, Element E: The organization uses a physician or a pharmacist to review pharmacy denials based on medical necessity. UM 4, Element F: The organization: 1. Has written procedures for using board-certified consultants to assist in making medical necessity determinations. 2. Provides evidence that it uses board-certified

#	Contract/CFR Reference Language*	2020 NCQA Reference/Language**
		consultants for medical necessity determinations.
9	CRA § 2.17.4.6; 2.17.4.6.35/TSA § 2.17.4.7; 2.17.4.7.33 Each member handbook shall, at a minimum, be in accordance with the following guidelines: Shall include information on how to obtain information in alternative formats or how to access interpretation services as well as a statement that interpretation and translation services are free	MED12, Element C: The organization's member handbook: 1. Informs members how to access auxiliary aids and services. 2. Is available upon request. 3. Is available free of charge. MED12, Element E: The organization's member handbook is available to existing and potential members: 1. In regular and large print. 2. In alternative formats, upon request, free of charge. 3. In the prevalent non-English languages in its service area. 4. With taglines in the prevalent non-English languages in the state.

2021 ANA Deemed MCO Credentialing Tool Elements

CRA Reference	Element in 2021 ANA Review Tool	NCQA Language*
Credentialing/Recredentialing: Element #1-Written P&Ps for Credentialing CRA §A.2.11.10.1.1 Except as provided in Sections A.2.11.10.3 and A.2.11.10.4 below, the CONTRACTOR shall utilize the current NCQA Standards and Guidelines for the Accreditation of MCOs for the credentialing and recredentialing of licensed independent providers and provider groups with whom it contracts or employs and who fall within its scope of authority and action.	The MCO has written credentialing P&Ps that include the MCO's initial credentialing for all providers with whom the MCO contracts or employs and who fall within its scope of authority and action.	CR1, Element A Factor 4: The organization specifies the process for making credentialing and recredentialing decisions.
Credentialing/Recredentialing: Element #2-Written P&Ps for Recredentialing CRA §A.2.11.10.1.1 Except as provided in Sections A.2.11.10.3 and A.2.11.10.4 below, the CONTRACTOR shall utilize the current NCQA Standards and Guidelines for the Accreditation of MCOs for the credentialing and recredentialing of licensed independent providers and provider groups with whom it contracts or employs and who fall within its scope of authority and action.	The MCO has written recredentialing P&Ps that include the MCO's recredentialing of all providers with whom the MCO contracts or employs and who fall within its scope of authority and action.	CR1, Element A Factor 4: The organization specifies the process for making credentialing and recredentialing decisions.
Credentialing/Recredentialing: Element 3-Credentialing Committee CRA §A.2.11.10.1.1 Except as provided in Sections A.2.11.10.3 and A.2.11.10.4 below, the CONTRACTOR shall utilize the current	There is written documentation that the MCO submits all practitioner files to the Credentialing Committee for review or has a process for medical director or qualified physician to review and approve clean files.	CR2, Element A: The organization's Credentialing Committee: 1) Uses participating practitioners to provide advice and expertise for credentialing decisions 2) Reviews credentials for practitioners who

CRA Reference	Element in 2021 ANA Review Tool	NCQA Language*
NCQA Standards and Guidelines for the Accreditation of MCOs for the credentialing and recredentialing of licensed independent providers and provider groups with whom it contracts or employs and who fall within its scope of authority and action.		do not meet established thresholds 3) Ensures that files that meet established criteria are reviewed and approved by a medical director or designated physician
Credentialing/Recredentialing: Element #4- Credentialing Prior to Providing Services CRA §A.2.11.10.1.1 Except as provided in Sections A.2.11.10.3 and A.2.11.10.4 below, the CONTRACTOR shall utilize the current NCQA Standards and Guidelines for the Accreditation of MCOs for the credentialing and recredentialing of licensed independent providers and provider groups with whom it contracts or employs and who fall within its scope of authority and action.	Credentialing documents include the statement that practitioners are credentialed prior to providing care to TennCare MCO members.	CR2, Element A, *Providing Care to Members:* The organization does not permit practitioners who are not credentialed to provide care to members.
Credentialing/Recredentialing: Element #5- Recredentialing Timeline CRA §A.2.11.10.1.1 Except as provided in Sections A.2.11.10.3 and A.2.11.10.4 below, the CONTRACTOR shall utilize the current NCQA Standards and Guidelines for the Accreditation of MCOs for the credentialing and recredentialing of licensed independent providers and provider groups with whom it contracts or employs and who fall within its scope of authority and action.	Written recredentialing P&Ps include the statement that practitioners are recredentialed at least every 36 months.	CR4, Element A: The length of the recredentialing cycle is within the required 36-month time frame.
Credentialing/Recredentialing: Element #6- Provisional Credentialing CRA §A.2.11.10.1.1 Except as provided in Sections A.2.11.10.3 and A.2.11.10.4 below, the CONTRACTOR shall utilize the current NCQA Standards and Guidelines for the Accreditation of MCOs for the credentialing and recredentialing of licensed independent providers and provider groups with whom it contracts or employs and who fall within its scope of authority and action.	The organization has a process for one-time provisional credentialing for practitioners applying to the organization for the first time.	CR1, Element A, *Related Information*: If the organization decides to provisionally credential practitioners, it: • Has a process for one-time provisional credentialing of practitioners applying to its network for the first time • Verifies the following within the required time limits: ○ A current, valid license to practice ○ The past five years of malpractice claims or settlements from the malpractice carrier, or the results of the National Practitioner Data Bank (NPDB) query ○ A current and signed application with attestation ○ Does not hold practitioners in provisional status for longer than 60 calendar days. ○ Follows the same process for presenting provisional
Credentialing/Recredentialing: Element #7- Length of Provisional Credentialing CRA §A.2.11.10.1.1 Except as provided in Sections A.2.11.10.3 and A.2.11.10.4 below, the CONTRACTOR shall utilize the current NCQA Standards and Guidelines for the Accreditation of MCOs for the credentialing and recredentialing of licensed independent providers and provider groups with whom it contracts or employs and who fall within its scope of authority and action.	If the organization uses provisional credentialing, a practitioner may not be in provisional status for more than 60 calendar days.	
Credentialing/Recredentialing: Element #8- Documents Required for Provisional	If the MCO uses provisional credentialing, the following documents are obtained prior to the	

CRA Reference	Element in 2021 ANA Review Tool	NCQA Language*
Credentialing CRA §A.2.11.10.1.1 Except as provided in Sections A.2.11.10.3 and A.2.11.10.4 below, the CONTRACTOR shall utilize the current NCQA Standards and Guidelines for the Accreditation of MCOs for the credentialing and recredentialing of licensed independent providers and provider groups with whom it contracts or employs and who fall within its scope of authority and action.	MCO granting provisional credentialing privileges: a) Primary-source verification of a current, valid license to practice b) Primary-source verification of the past five years of malpractice claims or settlements from the malpractice carrier, or the results of the National Practitioner Data Bank (NPDB) query c) Current, signed application with the attestation The MCO follows the same process for presenting provisionally credentialed files to the credentialing committee or medical director as it does for its regular credentialing process.	credentialing files to the Credentialing Committee or medical director as it does for its regular credentialing process.
Credentialing/Recredentialing: Element #9-Evaluation of Complaints and Adverse Events CRA §A.2.11.10.1.1 Except as provided in Sections A.2.11.10.3 and A.2.11.10.4 below, the CONTRACTOR shall utilize the current NCQA Standards and Guidelines for the Accreditation of MCOs for the credentialing and recredentialing of licensed independent providers and provider groups with whom it contracts or employs and who fall within its scope of authority and action.	The organization monitors for adverse events at least every six months and may limit monitoring of adverse events to PCPs and high-volume behavioral healthcare practitioners.	CR5, Element A: The organization implements ongoing monitoring and makes appropriate interventions by: • Collecting and reviewing Medicare and Medicaid sanctions • Collecting and reviewing sanctions and limitations on licensure • Collecting and reviewing complaints • Collecting and reviewing information from identified adverse events • Implementing appropriate interventions when it identifies instances of poor quality • From Factor 4: Adverse Events: The organization may limit monitoring of adverse events to primary care practitioners and high-volume behavioral healthcare practitioners.
Credentialing/Recredentialing: Element #10-Delegated Credentialing P&Ps CRA §A.2.11.10.1.1 Except as provided in Sections A.2.11.10.3 and A.2.11.10.4 below, the CONTRACTOR shall utilize the current NCQA Standards and Guidelines for the Accreditation of MCOs for the credentialing and recredentialing of licensed independent providers and provider groups with whom it contracts or employs and who fall within its scope of authority and action.	If credentialing and recredentialing activities are delegated, the MCO has a delegation agreement describing the delegated credentialing activities.	CR8, Element A: The written delegation agreement: • Is mutually agreed upon • Describes the delegated activities and the responsibilities of the organization and the delegated entity • Requires at least semiannual reporting by the delegated entity to the organization • Describes the process by which the organization evaluates the delegated entity's performance • Specifies that the organization retains the right to approve, suspend and terminate individual practitioners, providers and sites, even if the organization delegated decision making • Describes the remedies available to the organization if the delegated entity does not fulfill its obligations,
Credentialing/Recredentialing: Element #11-Delegated Credentialing Accountability CRA §A.2.11.10.1.1 Except as provided in Sections A.2.11.10.3 and A.2.11.10.4 below, the CONTRACTOR shall utilize the current NCQA Standards and Guidelines for the Accreditation of MCOs for the credentialing and recredentialing of licensed	If credentialing and recredentialing activities are delegated, the agreement specifies that reporting is at least semi-annual, and the information to be reported by the delegate about the delegated activities.	

CRA Reference	Element in 2021 ANA Review Tool	NCQA Language*
independent providers and provider groups with whom it contracts or employs and who fall within its scope of authority and action.		including revocation of the delegation agreement
Credentialing/Recredentialing: Element #13: Non-discrimination in Credentialing and Recredentialing CRA §A.2.11.10.1.1 Except as provided in Sections A.2.11.10.3 and A.2.11.10.4 below, the CONTRACTOR shall utilize the current NCQA Standards and Guidelines for the Accreditation of MCOs for the credentialing and recredentialing of licensed independent providers and provider groups with whom it contracts or employs and who fall within its scope of authority and action.	Credentialing P&Ps concerning nondiscrimination explicitly specify that the organization does not base credentialing decisions based on an applicant's race, ethnic/national identity, gender, age, sexual orientation or patient type (e.g., Medicaid) in which the practitioner specializes.	CR1, Element A, Factor 6: The organization specifies the process for requiring that credentialing and recredentialing are conducted in a non-discriminatory manner. From "Examples": Monitoring includes, but is not limited to: • Maintaining a heterogeneous credentialing committee membership and the requirement for those responsible for credentialing decisions to sign a statement affirming that they do not discriminate; • Periodic audits of credentialing files (in-process, denied and approved files) that suggest potential discriminatory practice in selecting practitioners; and • Annual audits of practitioner complaints for evidence of alleged discrimination. Credentialing policies and procedures: • State that the organization does not base credentialing decisions on an applicant's race, ethnic/national identity, gender, age, sexual orientation or patient type (e.g., Medicaid) in which the practitioner specializes. • Specify the process for preventing discriminatory practices. ○ Preventing involves taking proactive steps to protect against discrimination occurring in the credentialing and recredentialing processes. • Specify how the organization monitors the credentialing and recredentialing processes for discriminatory practices, at least annually. ○ Monitoring involves tracking and identifying discrimination in credentialing and recredentialing processes.
Credentialing/Recredentialing: Element 14-Monitor to Prevent Discrimination in Credentialing and Recredentialing CRA §A.2.11.10.1.1 Except as provided in Sections A.2.11.10.3 and A.2.11.10.4 below, the CONTRACTOR shall utilize the current NCQA Standards and Guidelines for the Accreditation of MCOs for the credentialing and recredentialing of licensed independent providers and provider groups with whom it contracts or employs and who fall within its scope of authority and action.	Credentialing P&Ps concerning nondiscrimination explicitly specify the steps that the organization takes to periodically monitor for and prevent discriminatory practices during the credentialing and recredentialing process, and annually audit practitioner complaints for evidence of alleged discrimination.	
Credentialing/Recredentialing: Element 15-Interventions for Providers Concerning Poor Quality Care CRA §A.2.11.10.1.1 Except as provided in Sections A.2.11.10.3 and A.2.11.10.4 below, the CONTRACTOR shall utilize the current	The organization implements interventions based on its P&Ps if there is evidence of poor quality that could affect the health and safety of its members.	CR5, Element A, Factor 5: The organization implements interventions based on its policies and procedures if there is evidence of poor quality that could affect the health and safety of its members.

CRA Reference	Element in 2021 ANA Review Tool	NCQA Language*
NCQA Standards and Guidelines for the Accreditation of MCOs for the credentialing and recredentialing of licensed independent providers and provider groups with whom it contracts or employs and who fall within its scope of authority and action.		
Credentialing/Recredentialing: Element 18-Confidentiality CRA §A.2.11.10.1.1 Except as provided in Sections A.2.11.10.3 and A.2.11.10.4 below, the CONTRACTOR shall utilize the current NCQA Standards and Guidelines for the Accreditation of MCOs for the credentialing and recredentialing of licensed independent providers and provider groups with whom it contracts or employs and who fall within its scope of authority and action.	The MCO's credentialing P&Ps describe the organization's process for securing the confidentiality of all information obtained in the credentialing process, except as otherwise provided by law.	CR1, Element A 10: The organization specifies the process for securing the confidentiality of all information obtained in the credentialing process, except as otherwise provided by law. CR1, Element A, Factor 10: Credentialing policies and procedures describe the organization's process for ensuring confidentiality of the information collected during the credentialing process and the procedures it uses to keep this information confidential.
Credentialing/Recredentialing: Element 19-Provider Appeals Processes CRA §A.2.11.10.1.1 Except as provided in Sections A.2.11.10.3 and A.2.11.10.4 below, the CONTRACTOR shall utilize the current NCQA Standards and Guidelines for the Accreditation of MCOs for the credentialing and recredentialing of licensed independent providers and provider groups with whom it contracts or employs and who fall within its scope of authority and action.	The MCO has written P&Ps for providers to appeal determinations that suspend or terminate a provider's privileges.	CR6, Element A: Credentialing policies and procedures describe the organization's process for notifying practitioners when credentialing information obtained from other sources varies substantially from that provided by the practitioner. The organization has policies and procedures specifying: • The range of actions available to the organization. • Making the appeal process known to practitioners • From Factor 1: That the organization reviews participation of practitioners whose conduct could adversely affect members' health or welfare. • The range of actions that may be taken to improve practitioner performance before termination.
Credentialing/Recredentialing: Element #20-Provider Notification CRA §A.2.11.10.1.1 Except as provided in Sections A.2.11.10.3 and A.2.11.10.4 below, the CONTRACTOR shall utilize the current NCQA Standards and Guidelines for the Accreditation of MCOs for the credentialing and recredentialing of licensed independent providers and provider groups with whom it contracts or employs and who fall within its scope of authority and action.	When provider privileges are suspended or terminated, there is evidence of written notification to the provider that includes the reasons for the action (see letter to provider).	
Credentialing/Recredentialing: Element #21-Provider Appeal Rights CRA §A.2.11.10.1.1 Except as provided in Sections A.2.11.10.3 and A.2.11.10.4 below, the CONTRACTOR shall utilize the current NCQA Standards and Guidelines for the Accreditation of MCOs for the credentialing and recredentialing of licensed independent providers and provider groups with whom it contracts or employs and who fall within its scope of authority and action.	When provider privileges are suspended or terminated, there is evidence of written notification to the provider that includes the appeal rights and process (see letter to provider).	

Acronyms

AAAD	Area Agency on Aging and Disability
AAP	American Academy of Pediatrics
ACE	Adverse Childhood Experiences
ACS	Affiliated Computer Services Inc.
ADHD	Attention Deficit Hyperactivity Disorder
ADT	Admission, Discharge, Transfer
AI	Audacious Inquiry
AIU	Adopt, Implement, Upgrade
ANA	Provider Network Adequacy Benefit Delivery Review
AQS	Annual Quality Survey
ASH	Abortion, Sterilization, Hysterectomy
ASO	Administrative Services Only
BA	Business Associate
BCBST	BlueCross BlueShield of Tennessee
BHO	Behavioral Health Organization
BMI	Body Mass Index
BSS	Beneficiary Support System
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CAP	Corrective Action Plan
CCM	Chronic Care Management Group
CCT	Care Coordination Tool
CD	Consumer Direction
CDC	Centers for Disease Control and Prevention
CFR	Code of Federal Regulations
CHAT	Children's Hospital Alliance of Tennessee
CHCS	Center for Health Care Strategies
CIR	Critical Incident Report
CIM	Critical Incident Management
CKM	Clinical Knowledge Management

CLAS	Culturally and linguistically appropriate services
CLS	Community Living Supports
CLS-FM	Community Living Supports-Family Model
CM	Case Management
CMS	Centers for Medicare & Medicaid Services
COPD	Chronic Obstructive Pulmonary Disease
CRA	Contractor Risk Agreement
DBM	Dental Benefits Manager
DD	Developmental Disabilities
DIDD	Department of Intellectual and Developmental Disabilities
D-SNPs	Dual Eligible Special Needs Plans
DHS	Department of Human Services
DM	Disease Management
DME	Durable Medical Equipment
DSW	Direct Support Worker
ECF CHOICES	Employment and Community First CHOICES
ED	Emergency Department
EDI	Electronic Data Interchange
EDS	Employment Data Survey
EHR	Electronic Health Record
EP	Eligible Professional
EPLS	Excluded Parties List System
EPSDT	Early and Periodic Screening, Diagnostic and Treatment
EQR	External Quality Review
EQRO	External Quality Review Organization
ERC	Enhanced Respiratory Care
EVV	Electronic Visit Verification
FEA	Fiscal Employer Agent
FBDE	Full Benefit Dual Eligible
FHSC	First Health Services Corporation
FIDE SNP	Fully Integrated Dual Eligible Special Needs Population
FFM	Federally Facilitated Market

FFS	Fee-For-Service
HCBS	Home and Community-Based Services
HCFA	Health Care Finance and Administration
HCI	Health Care Informatics, TennCare
HEDIS	Healthcare Effectiveness Data and Information Set
HHA	Home Health Agency
HIE	Health Information Exchange
HIPAA	Health Insurance Portability and Accountability Act
HIT	Health Information Technology
HITECH	Health Information Technology for Economic and Clinical Health
HHS	Health and Human Services
HMO	Health Maintenance Organization
HPE	Hewlett Packard Enterprise
HRM	Health Risk Management
IAM	Identify Access Management
I/DD	Intellectual and/or Developmental Disabilities
ICF/IID	Immediate Care Facility for Individuals with Intellectual Disabilities
IDEA	Individuals with Disabilities Education Act
IEA	Individual Experience Assessment
IEP	Individualized Education Plan
ISP	Individual Support Plan
IUD	Intrauterine Contraceptive Device
LARC	Long Acting Removable Contraceptives
LEIE	List of Excluded Individuals and Entities
LEP	Limited English Proficiency
LOC	Level of Care
LTC	Long Term Care
LTSS	Long Term Services and Supports
MCC	Managed Care Contractor
MCO	Managed Care Organization
MDM	Master Data Management
MDS	Minimum Data Set

MFP	Money Follows the Person
MH	Mental Health
MIPPA	Medicare Improvements for Patients and Providers Act
MLTSS	Medicaid Managed Long Term Services and Supports
MMA	Medicare Prescription Drug Improvement and Modernization Act
MMIS	Medicaid Management Information System
MRR	Medical Record Review
MU	Meaningful Use
NAS	Neonatal Abstinence Syndrome
NASDDDS	National Association of State Directors of Developmental Disabilities Services
NASUAD	National Association of States United for Aging and Disabilities
NCI	National Core Indicators
NCI-AD	National Core Indicators – Aging and Disabilities
NCQA	National Committee for Quality Assurance
NDC	National Drug Code
NEMT	Non-Emergency Medical Transportation
NF	Nursing Facility
NMRR	New Member Record Review
NPI	National Provider Identifier
OCR	Office for Civil Rights
OeHI	Office of eHealth Initiatives
OIG	Office of Inspector General
ONC	Office of the National Coordinator for Health Information Technology
ORR	On Request Report
PA	Performance Activity or Prior Authorization
PAE	Pre-Admission Evaluation
PAHP	Prepaid Ambulatory Health Plan
PASRR	Preadmission Screening and Resident Review
PBM	Pharmacy Benefits Manager
PCMH	Patient Centered Medical Home
PCP	Primary Care Provider
PCP	Person-Centered Planning

PCSP	Person-Centered Support Plan
PDV	Provider Data Validation
PERS	Personal Emergency Response Systems
PH	Population Health
PHI	Protected Health Information
PHIT	Pediatric Healthcare Improvement Initiative for Tennessee
PIHP	Prepaid Inpatient Health Plan
PIP	Performance Improvement Project
PIPP	Provider Incentive Payment Portal
PLHSO	Prepaid Limited Health Services Organization
PMV	Performance Measure Validation
POC	Plan of Care
PPC	Prenatal and Postpartum Care
QA	Quality Assurance
QI	Quality Improvement
QIA	Quality Improvement Activity
QI/UM	Quality Improvement/Utilization Management
QM/QI	Quality Management/Quality Improvement
QMP	Quality Management Program
QOC	Quality of Care Concern
QOL	Quality of Life
QuILTSS	Quality Improvement in Long Term Services and Supports
RCI	Rapid Cycle Improvement
RFI	Request for Information
RFP	Request for Proposal
RMHI	Regional Mental Health Institute
REM	Reportable Event Management
RRU	Relative Resource Use
SDOH	Social Determinants of Health
SED	Serious Emotional Disturbance
SIM	State Innovation Model (grant)
SME	Subject Matter Expert

SOS	System of Support
SPMI	Serious and Persistent Mental Illness
SPOE	Single Point of Entry
SSA	Social Security Administration
SSI	Supplemental Security Income
STLG	Systems Transformation Leadership Group
STORC	Standard Obstetric Record Charting System
STC	Special Terms and Conditions
STS	Short-Term Stay
TAMHO	Tennessee Association of Mental Health Organizations
TCS	TennCare Select
TDCI	Tennessee Department of Commerce and Insurance
TDMHSAS	Tennessee Department of Mental Health and Substance Abuse Services
TEDS	Tennessee Eligibility Determination System
TNAAP	Tennessee Chapter of the American Academy of Pediatrics
TSPN	Tennessee Suicide Prevention Network
UM	Utilization Management
VBP	Value Based Purchasing
VLARC	Long Acting Removable Contraceptives
WCAG	Web Content Accessibility Guidelines
WCC	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents
WFD	Workforce Development

Attachment M:
TennCare II Report for July – December 2020

TennCare II Report: July 1 – December 31, 2020

The last Annual Report that the State submitted to CMS for the TennCare II Demonstration covered the period of July 1, 2019, through June 30, 2020. The first Annual Monitoring Report for the TennCare III Demonstration (to which this document is an attachment) covers the period of January through December 2021. The six-month period between those two reports—July 1 – December 31, 2020—was addressed extensively in Quarterly Progress Reports submitted by the State to CMS on November 25, 2020, and March 1, 2021. At CMS' request, however, the State revisits that six-month period by presenting the following summary of events and data. All STC references in this report refer to those that were in effect as of December 31, 2020.

Key Dates of the Reporting Period

Key dates of approval/operation for the TennCare II Demonstration during Quarters 3 and 4 of Calendar Year 2020, together with the corresponding Special Terms and Conditions (STCs), if applicable, are presented in Table 1.

Table 1
Key Dates of Approval/Operation in the Reporting Period

Date	Action	STC #
7/7/20	CMS issued written approval of Demonstration Amendment 41, which would increase the amount of money that TennCare can distribute to qualifying hospitals for providing uncompensated care. (CMS did not approve the request contained in Amendment 41 to increase the amount of funding for graduate medical education in Tennessee.)	
7/23/20	The Monthly Call for July 2020 was held.	53
8/27/20	The Monthly Call for August 2020 was held.	53
8/28/20	The State submitted the Quarterly Progress Report for the January – March 2020 quarter to CMS.	54
9/24/20	The Monthly Call for September 2020 was cancelled.	53
10/22/20	The Monthly Call for October 2020 was held.	53
10/22/20	The State submitted the Draft Annual Report for Demonstration Year 18 to CMS.	55
11/2/20	CMS issued written approval of Demonstration Amendment 40, which established the State's Katie Beckett/Medicaid Diversion program to provide services and supports to certain children with disabilities and/or complex medical needs.	
11/9/20	The State notified the public of its intent to submit to CMS an application to extend the TennCare II Demonstration. (The extension application was	15

Date	Action	STC #
	subsequently rendered moot in January 2021, when CMS approved the TennCare III Demonstration.)	
11/16/20	The State published the details (including date, time, and internet location) of a public forum at which comments on the progress of the TennCare Demonstration would be accepted.	10
11/18/20	The State submitted finalized point-in-time and annual aggregate data about the ECF CHOICES program to CMS.	52.d.
11/23/20	The State implemented a new Katie Beckett/Medicaid Diversion component of the Demonstration, providing services and supports to certain children with disabilities and/or complex medical needs.	
11/25/20	The State submitted the Quarterly Progress Report for the July – September 2020 quarter to CMS.	54
11/26/20	The Monthly Call for November, which would have been held on this date, was cancelled.	53
12/10/20	The State requested CMS approval of Statewide MCO Contract Amendment 13 and TennCare Select Contract Amendment 49.	44
12/17/20	The State held a public forum to accept comments on the progress of the TennCare Demonstration.	10
12/24/20	The Monthly Call for December, which would have been held on this date, was cancelled.	53

I. Operational Updates

Program Developments During the Reporting Period

During the July-September and October-December 2020 quarters, a number of proposals were in various stages of development. These included the following:

Katie Beckett/Medicaid Diversion Program. On November 23, 2020, the State launched a new Katie Beckett/Medicaid Diversion program as part of the TennCare II Demonstration. The program provides services and supports for children under age 18 with disabilities and/or complex medical needs who are not eligible for traditional Medicaid because of their parents' income or assets. The implementation of the new program is discussed in more detail below.

Demonstration Amendment 35. In May 2018, the State submitted Demonstration Amendment 35 to CMS. Amendment 35 proposed to modify the TennCare benefits package to cover residential substance use disorder (SUD) treatment services in facilities that meet the definition of an institution for mental diseases (IMD). Historically, TennCare's MCOs were permitted to cover residential treatment services in IMDs, if the MCO determined that such care was medically

appropriate and cost-effective as compared to other treatment options. However, CMS regulations limit this option to treatment stays of no more than 15 days per calendar month. The State was seeking authority with Amendment 35 to allow enrollees to receive short-term services in IMDs beyond the 15-day limit in federal regulation, up to 30 days per admission. As of the end of the reporting period, CMS's review of Amendment 35 was ongoing. (Amendment 35 was ultimately withdrawn by the State in July 2021, following CMS approval of State Plan authority under Section 1915(I) for Tennessee to cover SUD treatment services in IMDs.)

Demonstration Amendment 36. Amendment 36 was submitted to CMS in August 2018. Amendment 36 grew out of legislation passed by the Tennessee General Assembly in 2018 establishing that it is the policy of the state of Tennessee to favor childbirth and family planning services that do not include elective abortions within the continuum of care or services, and to avoid the direct or indirect use of state funds to promote or support elective abortions.

Amendment 36 requested authority for TennCare to establish state-specific criteria for providers of family planning services, and to exclude any providers that did not meet these criteria from participation in the TennCare program. The State proposed to exclude any entity that performed, or operated or maintained a facility that performed, more than 50 abortions in the previous year, including any affiliate of such an entity. At the conclusion of the reporting period, CMS's review of Amendment 36 was ongoing.

Demonstration Amendment 38. The State submitted Amendment 38 to CMS in December 2018. Like Amendment 36, Demonstration Amendment 38 was the result of legislation passed during Tennessee's 2018 legislative session. The legislation in question directed the State to submit a demonstration amendment to authorize the creation of reasonable work and community engagement requirements for non-pregnant, non-elderly, non-disabled adults enrolled in the TennCare program who do not have dependent children under the age of six. The legislation also required the State to seek approval from the U.S. Department of Health and Human Services (HHS) to use funds from the state's Temporary Assistance for Needy Families (TANF) program to support implementation of the community engagement program. As of the end of the reporting period, discussions between the State and CMS on Amendment 38, as well as conversations between the State and federal TANF officials, were ongoing.

Policy or Administrative Difficulties in Operating the Demonstration

There were no significant administrative difficulties in operating the TennCare II Demonstration during the reporting period.

Key Challenges During the Reporting Period

During the July-September and October-December 2020 quarters, the State continued to address the threat to public health and safety posed by the novel coronavirus disease 2019 (or "COVID-19"). As the agency in Tennessee state government responsible for providing health insurance to more than 1.5 million individuals (as of the end of the reporting period), the Division of TennCare deployed a multilayered response to the COVID-19 emergency. Working in tandem

with partners and stakeholders at the federal and state levels, TennCare designed and deployed a strategy consisting of such elements as—

- Coordinating with the provider community and TennCare's health plans to ensure access to care for TennCare members in need of testing or treatment for COVID-19;
- Assisting providers in offering covered services to TennCare members via telehealth when medically appropriate;
- Increasing care coordination services for members impacted by COVID-19 who are self-isolated, so that they can receive additional supports as needed;
- Pausing nearly all terminations of eligibility for TennCare and CoverKids (the State's separate CHIP program) members during the COVID-19 emergency;
- Working with TennCare's health plans to streamline or temporarily lift authorization requirements to ensure services are delivered promptly and claims paid quickly;
- Expediting access to home-based care for former nursing facility patients being discharged from hospitals and electing to transition home;
- Enhancing access to prescription drugs by allowing early refills of prescriptions and by allowing 90-day supplies to be prescribed for most medications;
- Obtaining multiple Section 1135 waivers from CMS that provide flexibilities to help ensure that TennCare members receive necessary services;
- Submitting emergency amendments to the TennCare Demonstration to make retainer payments to providers of HCBS in the Employment and Community First CHOICES program; to obtain additional flexibilities to support TennCare HCBS providers during the public health emergency; and to furnish Enabling Technologies to recipients of HCBS;
- Assisting providers of long-term services and supports in reducing the spread of COVID-19 among individuals who are residents of nursing facilities; and
- Implementing targeted, state-directed managed care payments to provide enhanced financial support for providers disproportionately affected by the COVID-19 emergency, including primary care providers, nursing facilities, dentists, and community mental health centers and other providers of behavioral health services.

Additional resources concerning the State's response to the COVID-19 pandemic were available on a dedicated page of the TennCare website throughout the reporting period (and remain accessible today).

Key Achievements During the Reporting Period

During the July-September and October-December 2020 quarters, the State obtained CMS approval of two significant initiatives: the Katie Beckett/Medicaid Diversion program and the TennCare III Demonstration. Furthermore, the State achieved notable results in its Medication Therapy Management and Electronic Health Records programs.

Katie Beckett/Medicaid Diversion Program. On November 23, 2020, the State launched a new Katie Beckett/Medicaid Diversion program as part of the TennCare II Demonstration. The program provides services and supports for children under age 18 with disabilities and/or

complex medical needs who are not eligible for traditional Medicaid because of their parents' income or assets.

The State's program consists of three parts:

- **Katie Beckett (Part A)** – Children with the most severe needs receive the full TennCare benefits package, as well as essential wraparound home and community based services. These individuals are subject to monthly premiums, which are determined on a sliding scale based on the member's household income.
- **Medicaid Diversion (Part B)** – Individuals in this group receive a specified package of essential wraparound services and supports, including premium assistance. These services are intended to prevent or delay the need for traditional Medicaid supports.
- **Continued Eligibility (Part C)** – Children in this group are enrolled in TennCare, have been determined no longer to meet the eligibility requirements for a Medicaid category, meet the criteria for enrollment in Katie Beckett (Part A), but do not have available slots in which to enroll. These individuals receive the full TennCare benefits package.

The new Katie Beckett/Medicaid Diversion program began accepting self-referral forms from interested families on November 23, 2020. As of the last day of Calendar Year 2020, a total of 101 children were enrolled, all of whom were placed in Medicaid Diversion program (Part B).

Approval of TennCare III Demonstration. On November 20, 2019, the State submitted Demonstration Amendment 42 to CMS with the aim of converting the bulk of the TennCare program's federal funding to a block grant. Amendment 42 was developed and submitted in accordance with legislation passed by the General Assembly during the 2019 legislative session.

On January 8, 2021, CMS approved Amendment 42. CMS' approval took the form of a new TennCare demonstration referred to as "TennCare III." Under the terms of the new demonstration, the budget neutrality model applied to TennCare was to be calculated in an aggregate basis (subject to certain adjustments). In addition, the State was granted the opportunity to access additional federal funds (referred to in the demonstration as "shared savings") by not exceeding the federal budget neutrality cap applied to the program, as well as by maintaining or improving performance on key quality metrics. The TennCare III Demonstration also provided certain new administrative flexibilities to the State. CMS approved the TennCare III Demonstration for a period of ten years.

Medication Therapy Management. During the concluding quarters of the TennCare II Demonstration, the State's Medication Therapy Management (MTM) benefit continued to be delivered by licensed pharmacists, with the aim of optimizing drug therapy and improving therapeutic outcomes for patients. MTM services during the reporting period included medication therapy reviews, pharmacotherapy consults, monitoring efficacy and safety of medication therapy, and other clinical services.

TennCare's MTM benefit was implemented in July 2018 for TennCare members affected by the State's patient-centered medical home program and health home program (known as "Health Link") who met specified clinical risk criteria. The State originally proposed to operate the MTM benefit on a two-year pilot basis in order to evaluate the impact of MTM services on health outcomes, as well as the cost and quality of care for affected members. The pilot project was then extended an additional year to allow additional information to be gathered on the effectiveness of the MTM program and to inform future decision-making about the benefit.

During the July-September and October-December 2020 quarters, the MTM program yielded 4,531 paid claims and 3,638 date-of-service claims; disbursed $255,029 for paid claims; and had a network of 47 claims-ready providers. These achievements were the result of a number of actions taken by the State, including raising reimbursement rates, streamlining documentation requirements for providers, and enabling MTM to be delivered via telehealth services.

Electronic Health Record Incentive Program. The Electronic Health Records (EHR) Incentive Program was a partnership between federal and state governments that grew out of the Health Information Technology for Economic and Clinical Health (HITECH) Act of 2009. The purpose of the program was to provide financial incentives to Medicaid providers to replace outdated, often paper-based approaches to medical record-keeping with Certified Electronic Health Record Technology (as defined by CMS) that met rigorous criteria and that could improve health care delivery and quality. The federal government provided 100 percent of the funding for the incentive payments and 90 percent of the funding for administrative costs. During the July-September and October-December 2020 quarters, Tennessee's EHR program distributed $204,000 to a total of 24 providers, bringing the total amount of EHR funds distributed to Tennessee providers as of the end of Calendar Year 2020 to $296,981,920.

Issues or Complaints Identified by Beneficiaries

Eligibility Appeals. Table 2 presents a summary of eligibility appeal activity during the reporting period. It should be noted that appeals (whether related to eligibility, medical services, or LTSS) may be resolved or taken to hearing in a quarter other than the one in which they are initially received by TennCare.

Table 2
Eligibility Appeals for the Reporting Period

	Jul – Sep 2020	Oct – Dec 2020
No. of appeals received	5,061	4,827
No. of appeals resolved or withdrawn	8,882	6,929
No. of appeals taken to hearing	3,915	3,074
No. of hearings resolved in favor of appellant	140	87

Medical Service Appeals. Table 3 below presents a summary of the medical service appeals handled during the reporting period.

Table 3
Medical Service Appeals for the Reporting Period

	Jul – Sep 2020	Oct – Dec 2020
No. of appeals received	2,674	2,555
No. of appeals resolved	1,128	1,436
• Resolved at the MCC level	336	359
• Resolved at the TSU level	121	141
• Resolved at the LSU level	671	936
No. of appeals that did not involve a valid factual dispute	1,078	1,111
No. of directives issued	273	268
No. of appeals resolved by fair hearing	671	936
No. of appeals that were withdrawn by the enrollee at or prior to the hearing	245	284
Appeals that went to hearing and were decided in the State's favor	394	605
Appeals that went to hearing and were decided in the appellant's favor	32	47

By way of explanation:

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

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

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

LTSS Appeals. The following table provides information regarding certain appeals administered by TennCare's Long-Term Services and Supports Division during the reporting period (e.g., appeals of PreAdmission Evaluation denials, appeals of PreAdmission Screening and Resident Review determinations, etc.).

Table 4
Long-Term Services and Supports Appeals for the Reporting Period

	Jul – Sep 2020	Oct – Dec 2020
No. of appeals received	79	68
No. of appeals resolved or withdrawn	62	40
No. of appeals set for hearing	14	24
No. of hearings resolved in favor of appellant	1	0

Audits, Investigations, or Lawsuits that Impact the Demonstration

During the July-September and October-December 2020 quarters, there were no audits or investigations that affected the TennCare II Demonstration. There were, however, updates to two of the lawsuits in which the Division of TennCare was involved. Details of the suits with relevant updates from the reporting period are as follows:

Dyersburg Family Walk-In Clinic, Inc. v. Tennessee Department of Finance and Administration, et al. Lawsuit. On December 22, 2020, Dyersburg Family Walk-In Clinic, Inc., which does business under the registered assumed name Reelfoot Family Walk-In Clinic, filed a federal lawsuit against TennCare in the District Court for the Western District of Tennessee. Reelfoot operates three Rural Health Clinics that receive supplemental payments from TennCare. The lawsuit challenges TennCare requirements related to these supplemental payments and seeks injunctive and declaratory relief. As of the conclusion of the reporting period, the State was preparing a motion to dismiss.

EMCF v. TennCare Lawsuit. In September 2018, Emergency Medical Care Facilities, P.C., filed a complaint for declaratory judgment and injunctive relief against the Division of TennCare in Davidson County Chancery Court. The suit relates to a $50 cap imposed by the agency on payment for emergency room physician services determined to be non-emergent. EMCF alleges that the State implemented this cap through its contractual relationship with its MCOs and not through the administrative rulemaking process. The parties filed cross-motions for summary judgment, and, on September 1, 2020, the Chancellor granted summary judgment to EMCF on their claim that the $50 cap was void. EMCF then voluntarily dismissed their remaining claims pertaining to the determination of payment for the services in question. During the July-September 2020 quarter, the State filed a timely appeal of the Chancery Court's ruling.

Unusual or Unanticipated Trends

Throughout the reporting period, the State claimed the enhanced FMAP authorized under Section 6008 of the Families First Coronavirus Response Act (FFCRA). As a condition of receiving this federal funding, the State generally maintained eligibility for all persons enrolled in TennCare. As a result, TennCare enrollment increased by 2.3 percent from the July-September 2020 quarter to the October-December 2020 quarter.

Legislative Updates

The Tennessee General Assembly passed certain pieces of legislation with implications for TennCare during Calendar Year 2020. Among the more notable examples were one-year extensions of annual assessments on hospitals, nursing homes, and ground ambulance providers, as well as changes to the law concerning the electronic delivery of healthcare and its coverage under TennCare.

Public Forums

In compliance with the federal regulation at 42 CFR § 431.420(c) and the Special Terms and Conditions of the TennCare II Demonstration, the State hosted a public forum on December 17, 2020. The purpose of the forum was to provide members of the public an opportunity to comment on the progress of the TennCare Demonstration project, which has delivered Medicaid services to eligible Tennesseans under a managed care model since 1994.

The December 17 open meeting was not the only avenue through which feedback could be offered. Notice of the forum, which appeared on the TennCare website, included an email address and a physical address at which comments would be accepted. No comments were received through any of these outlets (in contrast to the forum subsequently hosted by the State during DY 1 of the TennCare III Demonstration, at which the State received stakeholder feedback.

Enrollment Data

Information about TennCare enrollment by category during the concluding quarters of Calendar Year 2020 is presented in Table 5.

Table 5
Enrollment Counts for the Reporting Period

Demonstration Populations	Jul – Sep 2020	Oct – Dec 2020
EG1 Disabled	131,711	133,024
EG9 H-Disabled	634	671
EG2 Over 65	264	283
EG10 H-Over 65	38	42
EG3 Children	787,834	802,039
EG4 Adults	416,712	434,966
EG5 Duals and EG11 H-Duals 65	152,448	154,230

Demonstration Populations	Jul – Sep 2020	Oct – Dec 2020
EG6E Expan Adult	10	8
EG7E Expan Child	13	12
EG8, Med Exp Child	0	0
Med Exp Child, Title XXI Demonstration Population	11,761	11,338
EG12E Carryover	1,836	1,710
TOTAL*	1,503,261	1,538,323

*** Unique member counts for reporting quarter, with at least one day of eligibility. To avoid duplication, the member counts are based on the last eligibility group (EG) of the quarter.**

Eighty percent of TennCare's enrollment at the conclusion of the reporting period fell within the categories of EG3 children and EG4 adults. The number of individuals enrolled in TennCare increased by 2.3 percent from the July-September 2020 quarter to the October-December 2020 quarter. This rise in enrollment was primarily the result of the continuous coverage requirement contained in the Families First Coronavirus Response Act.

Information and Data about the CHOICES Program

CHOICES is TennCare's program of managed long-term services and supports for individuals who are elderly and/or have physical disabilities. Implemented in 2010, CHOICES offers nursing facility services (CHOICES 1) and home and community-based services (CHOICES 2 and 3) to eligible individuals via the State's managed care program.

As required by STC 34.d., the State offers the following table delineating CHOICES enrollment in the last two quarters of Calendar Year 2020, as well as information about the number of available reserve slots.

Table 6
CHOICES Enrollment and Reserve Slots
for the Reporting Period

	Statewide Enrollment Targets and Reserve Capacity[1]	Enrollment and Reserve Slots Being Held as of the End of the Jul – Sep 2020 Quarter	Enrollment and Reserve Slots Being Held as of the End of the Oct – Dec 2020 Quarter
CHOICES 1	Not applicable	15,729	14,654
CHOICES 2	11,000	10,094	10,206

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

	Statewide Enrollment Targets and Reserve Capacity[1]	Enrollment and Reserve Slots Being Held as of the End of the Jul – Sep 2020 Quarter	Enrollment and Reserve Slots Being Held as of the End of the Oct – Dec 2020 Quarter
CHOICES 3 (including Interim CHOICES 3)	To be determined	2,256	2,179
Total CHOICES	Not applicable	28,079	27,039
Reserve Capacity	300	300	300

The CMS letter approving CHOICES implementation in Middle Tennessee dated February 26, 2010, and STC 52 required specific monitoring and reporting activities that include:

Data and trends of the designated CHOICES data elements: STC 52.d. of the TennCare II Demonstration required the State to submit to CMS periodic statistical reports about the use of LTSS by TennCare enrollees. Seventeen separate reports of data pertaining to the CHOICES program were submitted between August 2011 and June 2020.

Taken together, the reports depict a program evolving according to the characteristics of LTSS recipients, with institutional care available to individuals with the highest acuity of need, and Home and Community-Based Services (HCBS) available to individuals whose needs can be safely and effectively met at home or in other non-institutional settings. Point-in-time data revealed declining use of Nursing Facility (NF) services over time, with placement in institutional settings decreasing from 21,530 individuals on June 30, 2011, to 16,609 individuals on June 30, 2019. According to annual aggregate data contained in the reports, this downward trend was even more pronounced for new LTSS recipients, 81 percent of whom had been admitted to NFs in the year prior to implementation of the CHOICES program, as compared with 63 percent admitted to NFs in the ninth year of CHOICES. Furthermore, nursing facility expenditures in the year prior to CHOICES implementation accounted for more than 90 percent of total LTSS expenditures, whereas the percentage was approximately 79 percent ten years later.

By contrast, appropriate use of HCBS by TennCare enrollees grew significantly during these years. The aggregate number of members accessing HCBS increased from 6,226 in the twelve-month period preceding CHOICES implementation in Middle Tennessee to 15,281 after CHOICES had been in place for nine full fiscal years. This trend was mirrored in point-in-time data as well: on the day prior to CHOICES implementation, 4,861 individuals were using HCBS, but the number had grown to 12,484 by June 30, 2019. The percentage of LTSS expenditures devoted to HCBS grew as well, rising from 9.75 percent in the year prior to CHOICES, to 21.01 percent after the CHOICES program had been in place for nine years.

Selected elements of the aforementioned CHOICES data are summarized in Table 7.

Table 7
Changes in Use of HCBS by Persons Who Are Elderly or Disabled (E/D) Before and After CHOICES Implementation

Annual Aggregate Data			Point-in-Time Data		
No. of TennCare enrollees accessing HCBS (E/D), 3/1/09 – 2/28/10	No. of TennCare enrollees accessing HCBS (E/D), 7/1/19 – 6/30/20	Percent increase over a nine-year period	No. of TennCare enrollees accessing HCBS (E/D) on the day prior to CHOICES implementa-tion	No. of TennCare enrollees accessing HCBS (E/D) on 6/30/19	Percent increase from the day prior to CHOICES implementa-tion to 6/30/19
6,226	15,281	145%	4,861[2]	12,484	157%

Frequency and use of MCO-distributed transition allowances (CHOICES approval letter dated February 26, 2010): The allocation of CHOICES transition allowance funds by Grand Region during the reporting period is detailed in Table 8.

Table 8
CHOICES Transition Allowances for the Reporting Period

	Jul – Sep 2020		Oct – Dec 2020	
Grand Region	# Distributed	Total Amount	# Distributed	Total Amount
East	9	$4,492	19	$10,171
Middle	41	$19,201	20	$11,257
West	30	$14,567	17	$9,731
Statewide Total	80	$38,260	56	$31,159

Information and Data about the Employment and Community First CHOICES Program

Designed and implemented in partnership with people with intellectual and developmental disabilities, their families, advocates, providers, and other stakeholders, Employment and Community First CHOICES is the first managed LTSS program in the nation that is focused on promoting and supporting integrated, competitive employment and independent community living as the first and preferred option for people with intellectual and other types of developmental disabilities.

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

As required by STC 35.d. of the TennCare II Demonstration, the State offers the following table delineating ECF CHOICES enrollment throughout the reporting period, as well as information about enrollment targets and the number of available reserve slots. It should be noted that the number of filled reserve slots does not include slots in a "held" status that have been assigned to a person but for whom actual enrollment is pending an eligibility determination.

Table 9
ECF CHOICES Enrollment, Enrollment Targets, and Reserve Slots for the Reporting Period

	Statewide Enrollment Targets and Reserve Capacity	Enrollment and Reserve Slots Filled as of the End of the Jul – Sep 2020 Quarter	Enrollment and Reserve Slots Filled as of the End of the Oct – Dec 2020 Quarter
ECF CHOICES 4	928	882	881
ECF CHOICES 5	1,679	1,536	1,554
ECF CHOICES 6	954	890	939
ECF CHOICES 7	32	31	32
ECF CHOICES 8	44	37	44
Total ECF CHOICES	3,637[3]	3,376	3,450
Reserve Capacity	1,262	1,015	1,056
Waiver Transitions[4]	Not applicable	53	58

Data and trends of the designated ECF CHOICES data elements: STC 52.d. of the TennCare II Demonstration required the State to provide CMS periodic statistical reports about the ECF CHOICES program. As of the end of the reporting period, the State had submitted baseline data for the year-long period preceding implementation of ECF CHOICES, as well as three years' worth of post-implementation data. In comparing the baseline data with the post-implementation data, several notable trends emerged:

[3] As provided in the revised enrollment targets submitted to CMS in July 2020, while the combined total of all upper limits was 3,700, there would never have been a scenario in which all benefit groups were set at the upper limit, since program funding would have been insufficient to cover the cost. These upper limits provided flexibility to move slots as required to meet the needs of program applicants.

[4] Waiver transitions are instances in which an individual enrolled in a 1915(c) HCBS waiver program is transferred into the ECF CHOICES program. Since these individuals have an independent funding source (i.e., the money that would have been spent on their care in the 1915(c) program), their enrollment in ECF CHOICES does not count against the enrollment target. Waiver transition numbers are cumulative since the program began. Group 6 enrollment included some of these transitions that did not count against the enrollment target.

- The number of individuals with intellectual disabilities receiving HCBS through the TennCare program grew from 8,295 in the year preceding implementation of ECF CHOICES to 8,637 after ECF CHOICES had been in place for three years.
- The number of individuals with developmental disabilities other than intellectual disabilities who received HCBS through the TennCare program grew from 0 to 1,492.
- Average LTSS expenditures for individuals with intellectual or developmental disabilities fell from $94,327 per person to $85,790 per person.
- The percentage of working age adults with intellectual or developmental disabilities who were enrolled in HCBS programs, employed in an integrated setting, and earning at or above the minimum wage grew from 14.32 percent to 21.07 percent.

These trends toward individuals with intellectual and developmental disabilities living independently in the community continued to accelerate after the reporting period, as data submissions from subsequent quarters have demonstrated.

Information and Data about the Katie Beckett and Medicaid Diversion Groups

The State's Katie Beckett and Medicaid Diversion groups provide services and supports for children under age 18 with disabilities and/or complex medical needs who are not eligible for traditional Medicaid because of their parents' income or assets. Although the State has long provided Katie Beckett program services to certain TennCare members via its three section 1915(c) HCBS waivers and the ECF CHOICES program, the availability of these services expanded significantly with CMS approval of the new Katie Beckett/Medicaid Diversion program on November 2, 2020.

During the reporting period, the State offered services to eligible children through a traditional Katie Beckett program, in which members received the full TennCare benefits package plus essential wraparound HCBS. In addition, the TennCare II Demonstration included an innovative Medicaid Diversion component, which furnished a specified package of essential wraparound services and supports, including premium assistance. (Both of these programs have carried over to the TennCare III Demonstration.)

As required by STC 36.c. of the TennCare II Demonstration, the following table delineates Katie Beckett and Medicaid Diversion enrollment as of the conclusion of the reporting period, as well as information about enrollment targets and the number of available reserve slots. Since approval of the programs did not occur until November 2, 2020, with program launch following on November 23, 2020, the data in the table is not representative of a full quarter of implementation.

Table 10
Katie Beckett, Medicaid Diversion, and Continued Eligibility Enrollment and Reserve Slots for the Reporting Period

	Statewide Enrollment Targets and Reserve Capacity	Enrollment and Reserve Slots Filled as of the End of the October-December 2020 Quarter
Katie Beckett	50	0
Medicaid Diversion	2,700	101
Reserve Capacity	50	0

Data and trends of the designated Katie Beckett/Medicaid Diversion data elements: STC 52.d. of the TennCare II Demonstration required the State to provide CMS periodic statistical reports about the Katie Beckett and Medicaid Diversion groups. As of the end of the reporting period, the State anticipated submitting baseline data for these groups one year after full program implementation, with trend data to follow on an annual basis thereafter.

Steps Taken to Ensure Compliance with Regulations Governing HCBS Settings

The State's Transition Plan—delineating the State's process for assuring compliance with the HCBS settings rule—has been fully implemented. The State submitted its final Statewide Transition Plan Quarterly Status Report to CMS on April 11, 2019, affirming that all identified settings had achieved full compliance by March 17, 2019. The State continues to monitor ongoing compliance with the HCBS Settings Rule, as described in each Annual Report.

Beginning in March 2020, certain aspects of compliance with the HCBS Settings Rule have been affected by stay-at-home orders and social distancing expectations resulting from the COVID-19 public health emergency. On April 30, 2020, an amendment to the State's 1115 demonstration was submitted to CMS. One component of the amendment was a request to temporarily provide services in alternative settings, including settings that do not comply with the HCBS settings requirement at 42 CFR § 441.301(c)(4)(vi)(D) that individuals are able to have visitors of their choosing at any time. The purpose of the request was to minimize the spread of infection during the COVID-19 pandemic. This amendment was approved and incorporated into the STCs as Attachment K to the TennCare Demonstration on June 19, 2020. A request to extend the approved Attachment K was subsequently submitted as the public health emergency continued. The extension of Attachment K was approved by CMS for six months after the public emergency ends.

II. Performance Metrics

Impact of the Demonstration in Providing Insurance Coverage

As noted in Section I of this report, the TennCare II Demonstration was furnishing health care coverage to 1,538,323 Tennesseans as of the end of the reporting period. This total represented approximately 22 percent of the 6.9 million persons living in Tennessee at that time.

Impact of the Demonstration in Ensuring Access to Care

Ensuring Access Through Contractual Means

TennCare's managed care contractors (MCCs) are contractually required to furnish available, accessible, and adequate numbers of contracted providers for the delivery of TennCare-covered services (including medical, behavioral, long-term services and supports, dental, and pharmacy). The State uses specialized software to monitor enrollee access to care and to ensure that access requirements contained in the MCCs' contracts are fulfilled. If a deficiency in an MCC's provider network were to be identified, the MCC would be notified and a Corrective Action Plan would be required to address the deficiency. Financial penalties would then be assessed by the State if the Corrective Action Plan were determined to be inadequate.

Measuring Access Through Provider Data Validation

TennCare's External Quality Review Organization (EQRO), Qsource, conducted—and published the results of—provider data validation surveys for the July-September and October-December 2020 quarters. The EQRO took samples of provider data files from TennCare's MCCs[5] and reviewed each for accuracy in the following categories:

- Active contract status
- Provider address
- Provider specialty / behavioral health service code
- Provider panel status
- Services for children
- Services for adults (MCO only)
- Primary care services (MCO only)
- Prenatal care services (MCO only)
- Availability of routine care services
- Availability of urgent care services

The validity of such information is one measure of providers' availability and accessibility to TennCare enrollees. The EQRO's reports demonstrated generally strong performance by the MCCs, especially in the categories of "active contract status," "provider specialty / behavioral health service code," "services for children," and "prenatal care services." For all of these categories, accuracy rates exceeded 95 percent during both of the quarters in question.

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

Qsource's report concluded that the MCCs "maintained high accuracy rates" for the third and fourth quarters of Calendar Year 2020.

Impact of the Demonstration in Improving Health Outcomes and Ensuring Quality of Care

HEDIS/CAHPS Report

The annual report of HEDIS/CAHPS data—titled "Comparative Analysis of Audited Results from TennCare MCOs Following the 2020 National Benchmark Release"—was released in November 2020. The full name for HEDIS is "Healthcare Effectiveness Data Information Set," and the full name for CAHPS is "Consumer Assessment of Health Plans Surveys." This report, which is available on the TennCare website, provides data that enables the State to compare the performance of its MCOs against national norms and benchmarks and to compare performance among MCOs.

Improved statewide performance was noted for certain child health measures during the evaluation period, with higher success rates achieved in all of the following categories:

- Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents
- Immunizations for Adolescents
- Medication Management for People with Asthma (both 5-11 years and 12-18 years)
- Asthma Medical Ratio (both 5-11 years and 12-18 years)
- Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life

Improvement was also evident in a variety of health categories applicable to adults, including Adult BMI Assessment; Pharmacotherapy Management of COPD Exacerbation; Medication Management for People with Asthma; Asthma Medical Ratio; Persistence of Beta-Blocker Treatment After a Heart Attack; Comprehensive Diabetes Care; Statin Therapy for Patients with Diabetes; Use of Opioids from Multiple Providers; and Risk of Continued Opioid Use.

Categories related to women's health showed higher outcomes as well, with improved results in the areas of Breast Cancer Screening, Cervical Cancer Screening, Chlamydia Screening in Women, Statin Therapy for Patients with Cardiovascular Disease ("Females 40-75 Years"), and Non-Recommended Cervical Cancer Screening in Adolescent Females.

HEDIS 2020 was the eleventh year of statewide reporting of behavioral health measures following the integration of medical and behavioral health services among TennCare's health plans. Results superior to those in the preceding measurement period were achieved in the behavioral health categories of Antidepressant Medication Management; Follow-Up Care for Children Prescribed ADHD Medication; Follow-Up After Hospitalization for Mental Illness; Follow-Up After Emergency Department Visit for Mental Illness; Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications; Diabetes Monitoring for People With Diabetes and Schizophrenia; Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia; and Adherence to Antipsychotic Medications for Individuals With Schizophrenia.

With regard to the CAHPS portion of the 2020 report, the performance of the MCOs was generally strong, and was comparable to the results achieved in 2019. CAHPS data in the report was organized into three major areas: Adult Medicaid Survey Results, Child Medicaid Survey Results (General Population), and Child Medicaid Survey Results (Children with Chronic Conditions). Each of these three major categories contained several subcategories (e.g., "Getting Needed Care," "Getting Care Quickly," "How Well Doctors Communicate," etc.) in which the health plans were rated. The number of subcategories in 2020 was 23, as compared with 38 subcategories in 2019. Of the 23 subcategories common to both years, statewide averages could not be calculated for three subcategories in 2020. Therefore, of the 20 subcategories that were common to both years and for which statewide averages could be calculated in both years, the 2020 ratings of the MCOs were higher than the 2019 ratings in 12 subcategories. In the subcategories in which performance did not improve, the 2020 ratings were generally within one to two percentage points of the 2019 ratings.

Beneficiary Survey

Every year since 1993, the Boyd Center for Business and Economic Research (BCBER) at the University of Tennessee in Knoxville has conducted a survey of Tennessee citizens—TennCare enrollees, individuals with private insurance, and uninsured individuals alike—to assess their opinions about health care. Respondents provide feedback on a range of topics, including demographics (age, household income, family size, etc.), perceptions of quality of care received, and behavior relevant to health care (the type of provider from whom an individual is most likely to seek initial care, the frequency with which care is sought, etc.).

BCBER conducted another survey during 2020 and published a summary of the results in a report titled "The Impact of TennCare: A Survey of Recipients, 2020". Although the findings of a single survey must be viewed in context of long-term trends, several results from the report are noteworthy:

- Satisfaction with TennCare remained high. Ninety-four percent of respondents covered by TennCare expressed satisfaction with the quality of care they had received. This level of satisfaction tied for the second highest in the program's history and was the fourth time in a row that a satisfaction level of at least 94 percent had been attained. In addition, 2020 was the twelfth straight year in which survey respondents had reported satisfaction levels exceeding 90 percent.
- The uninsured rate in Tennessee rose for adults but remained the same for children. The reported percentage of uninsured adults rose from 8.1 percent in 2019 to 9.9 percent in 2020. This result was not entirely unexpected, as the pandemic was predicted to cause a loss of employment—and therefore health insurance—for a significant number of Tennesseans. Nonetheless, the reported percentage of uninsured children did not increase in 2020, remaining at the 2019 level of 2.8 percent.
- TennCare members were less likely to use the emergency room for initial medical care. While heads of households with TennCare continued to seek initial medical care for

themselves at hospitals six percent of the time, the likelihood of seeking such care for their children fell from six percent in 2019 to three percent in 2020.

In summary, the report notes, "TennCare continues to receive positive feedback from its recipients, with 94 percent reporting satisfaction with the program. This positive feedback is a strong indication that TennCare is providing satisfactory medical care and meeting the expectations of those it serves."

III. Budget Neutrality and Financial Reporting Requirements

Budget neutrality was successfully maintained by the State during the reporting period. The State's budget neutrality workbooks for the July-September and October-December 2020 quarters were submitted to CMS on November 25, 2020, and March 1, 2021, respectively. (A corrected budget neutrality workbook for the October-December 2020 quarter was submitted to CMS on March 19, 2021.)

IV. Evaluation Activities and Interim Findings

On April 2, 2019, CMS approved the State's evaluation design for the TennCare II Demonstration. According to the terms and conditions of the Demonstration, the focus of the evaluation design was to be the State's two managed long-term services and supports (MLTSS) programs: CHOICES and Employment and Community First CHOICES.

The five objectives related to the CHOICES program as described in the State's approved evaluation design for the TennCare II Demonstration were as follows:

1. Expand access to HCBS for older adults and adults with physical disabilities.
2. Rebalance TennCare spending on long-term services and supports to increase the proportion that goes to HCBS.
3. Provide cost-effective care in the community for persons who would otherwise require nursing facility care.
4. Provide HCBS that will enable persons who would otherwise be required to enter nursing facilities to be diverted to the community.
5. Provide HCBS that will enable persons receiving services in nursing facilities to be able to transition back to the community.

The five objectives related to the Employment and Community First CHOICES program as described in the State's draft evaluation design for the TennCare II Demonstration were as follows:

1. Expand access to HCBS for individuals with intellectual and developmental disabilities.

2. Provide more cost-effective services and supports in the community for persons with intellectual and developmental disabilities.
3. Continue balancing TennCare spending on long-term services and supports for individuals with intellectual and developmental disabilities to increase the proportion spent on HCBS.
4. Increase the number and percentage of persons with intellectual and developmental disabilities enrolled in HCBS programs who are employed in an integrated setting earning at or above the minimum wage.
5. Improve the quality of life of individuals with intellectual and developmental disabilities enrolled in HCBS programs.

On November 9, 2020, as part of its application to extend the TennCare II Demonstration, the State published an interim evaluation report produced jointly by the Division of TennCare and its external evaluation partner, Qsource. The report described progress on the ten objectives contained in the State's evaluation design. Among the findings of the report was that nine of the ten objectives had been achieved, and that data collection for the tenth objective was still occurring. The report also concluded that this progress could be sustained over time. This report from the time of the TennCare II Demonstration remains available on the TennCare website.