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.

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. Department of Health Perinatal Advisory Committee: 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	Breast and Cervical Cancer Screening Program: 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	Quality of Care Concerns and Critical Incident Process: 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.

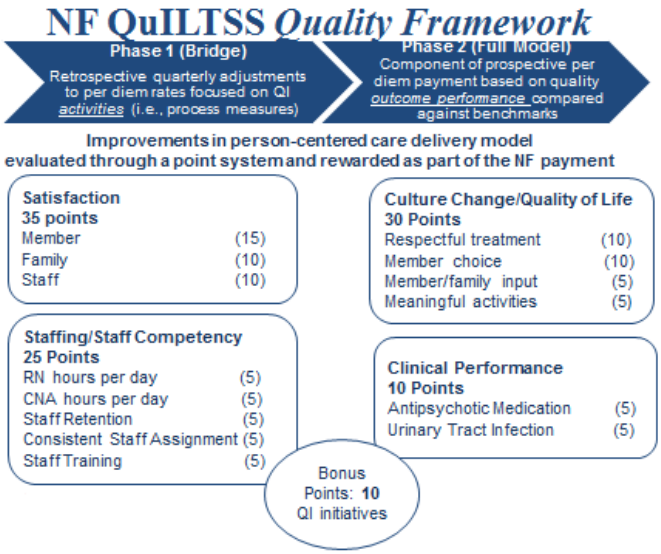
LTSS Value-Based Purchasing and Delivery System Transformation Initiatives

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 CONTRACTOR Physical Health Benefits Chart for TennCare Members (Excluding CoverKids)

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 <u>Long-Term Care Benefits for CHOICES Members</u>

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: o A current, valid license to practice o The past five years of malpractice claims or settlements from the malpractice carrier, or the results of the National Practitioner Data Bank (NPDB) query o A current and signed application with attestation o Does not hold practitioners in provisional status for longer than 60 calendar days. o 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. o 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. o 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