2022 QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT STRATEGY

Available for Public Comment: October 3, 2022 – November 3, 2022

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Section I: Introduction

Background

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

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

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

In 2020, TennCare and the Department of Intellectual and Developmental Disabilities (DIDD) jointly announced that all Medicaid long-term services and supports (LTSS) programs for people with intellectual and developmental disabilities (I/DD), including the Section 1915(c) HCBS waivers, the Employment and Community First CHOICES Program, and Intermediate Care Facility services for Individuals with Intellectual Disabilities (ICF/IID) will, for the first time, be aligned in the managed care program under the direct operational leadership, management and oversight of DIDD. The primary goal of this integration will be to finally and fully achieve a single, seamless, person-centered system of service delivery system for people with I/DD that supports them to increase their independence, fully participate in their communities, and achieve their competitive, integrated employment goals. In early 2021, TennCare submitted waiver amendments to the 1115 waiver as well as the three 1915(c) waivers seeking to integrate I/DD services. The 1115 waiver amendment is still pending.[1]

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

[1] At the request of CMS, the 1915(c) waivers were temporarily withdrawn in order to align approval of IDD integration across Medicaid authorities. Once integrated, the 1915(c) data will affect LTSS metrics related to the I/DD population.

addresses the steps taken to improve quality in both programs.

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

Table 1. TennCare Managed Care Contract Information

Plan Name	MCC Type	Managed Care Authority	Populations Served
Amerigroup	MCO	1115; CHIP State Plan	Medicaid adults, children, and CHIP
Volunteer State Health Plan, Inc. dba BlueCare	MCO	1115; CHIP State Plan	Medicaid adults, children, and CHIP
UnitedHealthcare Plan of the River Valley, Inc. dba UnitedHealthcare Community Plan	MCO	1115; CHIP State Plan	Medicaid adults, children, and CHIP
TennCare Select	PIHP	1115	Selected populations as specified in the state's 1115 demonstration
DentaQuest	PAHP	1115	Medicaid adults and children with a dental benefit[2]
OptumRx	PAHP	1115	Medicaid adults and children with a pharmacy benefit (i.e., non-duals)

TennCare Quality Strategy Goals and Objectives

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

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

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

[2] Dental services are a covered benefit for children under age 21, pregnant and postpartum adults, and adult enrollees in some Home and Community-Based Services (HCBS) programs.

quality, cost-effective home and community-based services that allow members to meet their individualized goals and live the life of their choosing.

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

Table 2. TennCare Quality Strategy Goals and Objectives

Objective	Objective description	Quality measure	Statewide performance baseline (year)	Statewide performance target for objective (year)
Goal 1: Improve the health and wellness of new mothers and infants				
1.1	Increase the use of prenatal services	Timeliness of Prenatal Care (PPC-CH)	78.4% (2019)	82.4% (2025)
1.2	Increase the use of postpartum services	Postpartum Care (PPC-AD)	69.4% (2019)	73.4% (2025)
1.3	Increase the use of well-child visits in the first 15 months of life	Well-Child Visits in the 1st 30 Months of Life, 1st 15 Months (W30-CH)	53.7% (2020)	56.6% (2025)
Goal 2: Increase use of preventive care services for all members to reduce risk of chronic health conditions				
2.1	Increase child and adolescent well care visits	Child and Adolescent Well-Care Visits, Total Rate (WCV-CH)	51.1% (2020)	53.1% (2025)
2.2	Increase CMS-416 EPSDT screening rate	CMS-416 EPSDT Screening Rate	69.0% (2020)	80.0% (2025)
2.3	Increase child immunizations	Childhood Immunization Status – Combo10 (CIS-CH)	36.7% (2019)	39.7% (2025)
2.4	Improve high blood pressure control in adults	Controlling High Blood Pressure (CBP-AD)	64.2% (2019)	66.2% (2025)
2.5	Increase cervical cancer screening in adults	Cervical Cancer Screening (CCS-AD)	64.2% (2019)	66.2% (2025)
2.6	Increase dental sealant use in children	Sealant Recipient on Permanent First Molars, at least one sealant (SFM-CH)	60.7% (2020)	62.7% (2025)
2.7	Decrease emergency department utilization for children**	Ambulatory Care (AMB-CH), ED visits, Total Rate ages 0-19	49.0 (2019)	46.0 (2025)
2.8	Reduce rate of hospital readmissions	Plan All Cause Readmissions	1.07 (2019)	0.79 (2025)
Goal 3: Integrate patient-centered, holistic care including non-medical risk factors into population health coordination for all members				
3.1	Maintain high member satisfaction with TennCare	Percent of respondents indicating satisfaction with TennCare (UT survey)	94.0% (2019)	94.0% (2025)
3.2	Increase screening for non-medical risk factors	Percent of members screened by the MCO for non-medical risk factors (Custom)	3.2% (2021)	15.0% (2025)
3.3	Ensure CHOICES members receive person-centered care	Percent of members who report the long term services	80.0% (2018-2019)	82.0% (2025)

		and supports they are getting meet their current needs and goals (NCI-AD, Q 86)		
3.4	Ensure ECF CHOICES members receive person-centered care	Percent of members who report their service plan includes things that are important to them (NCI-IPS, Q 49)	N/A *	N/A
3.5	Ensure Katie Beckett members receive person-centered care	Percent of members/families who report feeling that supports and services have made a positive difference in the life of their child (NCI-CFS, Q 62)	N/A *	N/A
Goal 4: Improve positive outcomes for members with LTSS needs				
4.1	Maintain or improve quality of life for CHOICES members	Percent of members who report their paid service and supports help them live the life they want (NCI-AD, Q 85)	88.0% (2018-2019)	90.0% (2025)
4.2	Maintain or improve quality of life for individuals with I/DD	Percent of members who report services and supports are helping to live a good life (NCI-IPS, Q 57)	N/A *	N/A
4.3	Maintain or improve quality of life for eligible children in the Katie Beckett program	Percent of members who report they are satisfied with the services and supports their child currently receives (NCI-CFS, Q 68)	N/A *	N/A
4.4	Increase percentage of older adults and adults with physical disabilities receiving LTSS in the community (HCBS) as compared to those receiving LTSS in an institution	CHOICES baseline data	39.3% (2021)	41.3% (2025)
4.5	Increase percentage of individuals with I/DD receiving LTSS in the community (HCBS) as compared to those receiving LTSS in an institution	ECF CHOICES baseline data	70.0% (2021)[3]	72.0% (2025)
Goal 5: Provide additional support and follow-up for patients with behavioral health care needs				
5.1	Improve follow-up after hospitalization for mental illness in adults	Follow-up After Hospitalization for Mental Illness (FUH-AD), 30-Day Follow-up	55.4% (2019)	57.4% (2025)
5.2	Improve follow-up after hospitalization for mental illness in children	Follow-up After Hospitalization for Mental Illness (FUH-CH), 30-Day Follow-up	73.3% (2019)	75.3% (2025)

[3] This includes only individuals enrolled in the Employment and Community First CHOICES program until CMS approves the pending waiver amendments to integrate the 1915(c) waiver programs into the 1115 Waiver. If 1915(c) waiver programs were included, this would be 91.0%.

5.3	Increase the use of medication assisted treatment of opioid dependance and addiction	Use of Pharmacotherapy for OUD, Total Rate (OUD-AD)	32.4% (2019)	34.4% (2025)
Goal 6: Maintain robust member access to health care services				
6.1	Ensure all members can access care according to time and distance standards	TennCare custom measure	100% (2021)	100% (2022)
6.2	Ensure adult members can access care, tests, or treatments timely	"Getting Needed Care" (CAHPS)	85.6% (2020)	87.6% (2025)
6.3	Ensure child members can access care, tests, or treatments timely	"Getting Needed Care" (CAHPS)	89.6% (2020)	90.6% (2025)
6.4	Maintain high compliance scores for access and availability (MCO)	EQRO Annual Technical Report, Annual Network Adequacy, MCO Access/Availability	97.0% (2020)	99.0% (2025)
6.5	Maintain high compliance scores for access and availability (DBM)	EQRO Annual Technical Report, Annual Network Adequacy, DBM Access/Availability	99.0% (2020)	100% (2025)
Goal 7: Maintain financial stewardship through increasing value-based payments and cost-effective care				
7.1	Maintain the percentage of TennCare members attributed to PCMH organizations	TennCare custom measure	40.7% (2019)	40.0% (2025)
7.2	Increase the percentage of TennCare members eligible for Tennessee Health Link (THL) who are active in THL	TennCare custom measure	49.0% (2019)	51.0% (2025)
7.3	Increase the percentage of nursing facilities showing quality improvement	QuILTSS for NF	45.61% (2020 QuILTSS 13 cycle)	47.61% (2025)
7.4	Increase the average Tier Score for facilities supporting members with ventilators or tracheostomies (Enhanced Respiratory Care)	TennCare custom measure	1.44 (October 2020-March 2021)***	1.3 (2025)

* Baseline data not available at this time

**Lower rates are better.

*** Closer to 1 is better

Selecting measures and determining performance targets

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

To set statewide performance targets, TennCare statewide performance was compared to NCQA HEDIS Quality Compass data, where available. Statewide rates were compared to the national benchmarks (50th, 75th, 90th, etc. percentiles) and targets were set based on the statewide performance. If there was no NCQA HEDIS Quality Compass data, the TennCare statewide performance was compared to CMS Chart Packs data for the Adult and Child Core Sets, where available. CMS Chart Packs data provides national information on all CMS Core Measures where at least 25 states reported quality data. If there was no national data available for a measure, the performance target was set to show two percent improvement.

LTSS quality is measured in many areas using data from the National Core Indicators (NCI) Aging and Disabilities Surveys (NCI-AD), In Person Surveys (NCI-IPS), Child and Family Surveys (NCI-CFS). Tennessee has participated in the NCI-AD survey for many years, however, due to the COVID-19 pandemic, no data for NCI-AD was collected for the 2019-2020 survey year. For that reason, the most recent data available for NCI-AD-related measures is 2018-2019. Tennessee implemented the NCI-IPS surveys with our Employment and Community First CHOICES population for the 2019-2020 survey year. However, this data is not recommended for use due to the impact of the COVID-19 pandemic. In addition, Tennessee will be utilizing the NCI-CFS tool starting in 2022 for the Katie Beckett member population and does not yet have baseline data. For these reasons, TennCare plans to update the measures reliant upon NCI-IPS and NCI-CFS data with baseline and target data in the annual Quality Strategy update, which will also include further updates and alignment with the recently issued state Medicaid Director Letter 22-003.

Updating the Quality Strategy

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

Every three years, TennCare will coordinate a comprehensive review and update to the Quality Strategy.[4] The state's EQRO conducted an evaluation of the effectiveness of the quality strategy in 2020. The results of this review are included in Appendix 2 and was also included in the state's 2021 Update to the Quality Assessment and Performance Improvement Strategy, which is published on the state's website at https://www.tn.gov/tenncare/information-statistics/additional-tenncare-reports.html.[5] TennCare will update its quality strategy with recommendations identified in the EQRO's effectiveness evaluation. The Chief Quality Officer and Chief Medical Officer will review the recommendations and indicate which recommendations TennCare will adopt in the following year's Quality Strategy.[6]

[4] *42 CFR 438.340(b)(10) and (c)(3)(ii), applicable also to CHIP managed care programs per 42 CFR 457.1240(e).*

[5] *42 CFR 438.340(c)(2), 438.340(c)(2)(i), and 438.340(c)(2)(ii), applicable also to CHIP managed care programs per 42 CFR 457.1240(e).*

[6] *42 CFR 438.340(c)(2)(iii), applicable also to CHIP managed care programs per 42 CFR 457.1240(e), cross-referencing 438.364(a)(4) and 457.1250(a).*

Section II: Quality and Appropriateness of Care Assessment

State Requirements

Since TennCare's inception, continuous quality improvement has been a priority for TennCare and its partner MCOs. TennCare has instituted several process improvement efforts and requirements to ensure that quality improvement efforts remain in place and are refined over time. TennCare requires accreditation and specific distinctions of each of its MCOs. TennCare requires all MCOs to be National Committee for Quality Assurance (NCQA) health plan accredited, as well as to maintain distinction status in LTSS and Multicultural Health Care. 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 on the TennCare website: https://www.tn.gov/tenncare/members-applicants/managed-care-organizations.html

Additionally, the state's MCOs are required to report a full set of Healthcare Effectiveness Data and Information Set (HEDIS) and Consumer Assessment of Healthcare Providers and Systems (CAHPS) data as a part of the accreditation mandates in Tennessee. The HEDIS requirement is an integral part of the accreditation process of the NCQA and includes completion of all LTSS HEDIS Measures. This information is also provided to Qsource, Tennessee's external quality review organization (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 at the following website: https://www.tn.gov/tenncare/information-statistics/mco-quality-data.html [7]

TennCare also reports CMS Core performance measures for children and adults in Medicaid and CHIP. These measures encompass both the physical and mental health of Medicaid/CHIP measures. Demonstrating a commitment to high quality care, Tennessee measures and submits over 90 percent 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 or maintenance of the NCQA Quality Compass national benchmarks.

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

TennCare involves the PBM to work closely with a Drug Utilization Review (DUR) Board, Pharmacy Advisory Committee, and CoverRx Clinical Advisory Committee which include multi-disciplinary healthcare professionals to monitor new drugs and generics for safety and efficacy, provide opportunities for improved medication access, recommend drug interventions based on clinical information, and focus on influencing provider habits and utilization management strategies. Additionally, TennCare helps facilitate collaboration between the MCOs and PBM to enact change at the vendor level for the benefit of members.

[7] *42 CFR 438.340(b)(3)(i), applicable also to CHIP managed care programs per 42 CFR 457.1240(e).*

The PBM also provides a reporting system to track the outcomes of DUR. The TennCare Retro DUR Reporting System mainly focuses on improving care quality. The system allows the PBM to track the impact of DUR initiatives by comparing specified data elements pre and post intervention. DUR metrics and interventions are used to support quality improvements in all population types, and often become the catalyst for change during Committee meetings, or at the program level.

Quality Metrics and Performance Targets

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

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

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

Table 3. Goal 1 Quality Metrics and Performance Targets

Improve the health and wellness of new mothers and infants				
Metric Name	**Metric specifications**	**Baseline performance (year)**	**Performance target (year)**	**Program**
Contraceptive Care – All women (CCW-AD and CCW-CH)*				
Long-acting reversible contraception, Ages 15-20	CMS Child Core Set	5.7% (2019)	N/A	Medicaid, CHIP, TennCare Select
Long-acting reversible contraception, Ages 21-44	CMS Adult Core Set	6.4% (2019)	N/A	Medicaid, CHIP, TennCare Select
Contraceptive Care – Postpartum Women (CCP-CH and CCP-AD)*				
Long-acting reversible contraception 3-day rate, Ages 15-20	CMS Child Core Set	2.2% (2019)	N/A	Medicaid, CHIP, TennCare Select

Long-acting reversible contraception 60-day rate, Ages 15-20	CMS Child Core Set	16.1% (2019)	N/A	Medicaid, CHIP, TennCare Select
Long-acting reversible contraception 3-day rate, Ages 21-44	CMS Adult Core Set	2.2% (2019)	N/A	Medicaid, CHIP, TennCare Select
Long-acting reversible contraception 60-day rate, Ages 21-44	CMS Adult Core Set	12.7% (2019)	N/A	Medicaid, CHIP, TennCare Select
Well Child Visits in the first 30 months of life (W30-CH)				
1st 15 months	CMS Child Core Set	53.7% (2020)	56.7% (2025)	Medicaid, CHIP, TennCare Select
15-30 months	CMS Child Core Set	67.8% (2020)	70.8% (2025)	Medicaid, CHIP, TennCare Select

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

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

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

Most recently, TennCare began integrating social risk factor supports into the population health strategy in 2019. TennCare has invested significant internal resources to improve the coordination around population health and social risk factors by collaborating with its MCO's to redesign the requirements of the population health programs to incorporate new emerging evidence and best practices.

TennCare's MCOs are held accountable for EPSDT screening rates. TennCare holds an annual EPSDT strategy meeting with all three MCOs to identify high-priority target areas and a joint strategy to continually improve the screening rates across the state. The MCOs are then required to develop an annual EPSDT investment plan that identifies areas of low screening rates and focus on investing new resources to closing care gaps. The MCO investment plans have included strategies such as member and provider incentives, scheduling platforms, and partnerships with behavioral health providers. Beginning January 2022, TennCare's MCOs were provided additional funding through the CDC COVID-19 Supplemental Funding Grant to engage in statewide events and outreach to improve well child visits and immunization rates. The funding will be available through FY24.

In 2016, TennCare launched the patient centered dental home (PCDH), which is a dental practice that maintains an ongoing relationship between the dentist and the patient inclusive of all aspects of oral health care delivered

in a comprehensive, continuously accessible and coordinated way. Modeled after TennCare's Patient Centered Medical Home (PCMH) program, all primary care dentists, which include general and pediatric dentists who participate in TennCare Medicaid and CoverKids are required to be a dental home. The PCDH is critical in achieving improvements in oral health outcomes. The PCDH requires the DBM to use various metrics to rank providers based on quality and to make new member assignments and reassignments to dental homes based on provider performance. TennCare tracks member utilization of dental services, utilization of oral disease prevention measures and minimally invasive dental treatments such as Silver Diamine Fluoride (SDF).

Table 4. Goal 2 Quality Metrics and Performance Targets

Increase use of preventive care services for all members to reduce risk of chronic health conditions				
Metric Name	**Metric specifications**	**Baseline performance (year)**	**Performance target (year)**	**Program**
Weight assessment and counseling for nutrition and physical activity for children/adolescents (WCC-CH)				
BMI percentile 3-11 years	CMS Child Core Set	80.2% (2019)	83.2% (2025)	Medicaid, CHIP, TennCare Select
BMI percentile 12-17 years	CMS Child Core Set	76.5% (2019)	79.5% (2025)	Medicaid, CHIP, TennCare Select
BMI percentile total	CMS Child Core Set	79.0% (2019)	82.0% (2025)	Medicaid, CHIP, TennCare Select
Immunizations for Children and Adolescents				
Childhood Immunization Status (CIS-CH) Combination 10	CMS Child Core Set	36.7% (2019)	39.7% (2025)	Medicaid, CHIP, TennCare Select
Immunization for Adolescents (IMA-CH) Combination 2	CMS Child Core Set	33.4% (2019)	36.4% (2025)	Medicaid, CHIP, TennCare Select
Breast Cancer Screening (BCS-AD)				
Breast cancer screening (BCS-AD)	CMS Adult Core Set	54.8% (2019)	57.8% (2025)	Medicaid, CHIP, TennCare Select
Asthma medication ratio (AMR-CH and AMR-AD)				
Overall	HEDIS	51.0% (2019)	54.0% (2025)	Medicaid, CHIP, TennCare Select
Dental measures				
Increase utilization of Silver Diamine Fluoride (SDF)	TennCare custom measure	0.6% (2019)	2.6% (2025)	Medicaid, CHIP
Increase the percentage of members 2-20 years of age who had one or more dental services annually	Partial enrollment adjusted ratio (PEAR), (Custom)	53.9% (2019)	55.9% (2025)	Medicaid, CHIP
Diabetes measures				
HbA1c Control (<8%) (CDC)	HEDIS	50.1% (2019)	53.0% (2025)	Medicaid, CHIP, TennCare Select
HbA1c Poor Control (>9%) (HPC-AD) *	CMS Adult Core Set	39.3% (2019)	36.3% (2025)	Medicaid, CHIP, TennCare Select
Blood Pressure Control (CDC)	HEDIS	60.4% (2019)	63.4% (2025)	Medicaid, CHIP, TennCare Select

Eye Exam (CDC)	HEDIS	52.0% (2019)	55.0% (2025)	Medicaid, CHIP, TennCare Select
Kidney Health Evaluation (KED)	HEDIS	26.9% (2020)	28.9% (2025)	Medicaid, CHIP, TennCare Select
Child and Adolescent Well-Care Visits (WCV-CH)				
Ages 3-11	CMS Child Core Set	58.6% (2020)	60.6% (2025)	Medicaid, CHIP, TennCare Select
Ages 12-17	CMS Child Core Set	49.9% (2020)	51.9% (2025)	Medicaid, CHIP, TennCare Select
Ages 18-21	CMS Child Core Set	25.9% (2020)	27.9% (2025)	Medicaid, CHIP, TennCare Select

*Lower rates are better.

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

TennCare has a strong focus on patient-centered, holistic care that includes non-medical risk factors. The agency has a disparities plan[8] to identify, evaluate, and reduce, to the extent practical, health disparities based on age, race, ethnicity, sex, primary language, and disability status.

Identification of health disparities and disability status

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. An individual is considered disabled if they qualified for Medicaid on the basis of having a disability.

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

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 that network providers have the capabilities to ensure physical access, accommodations, and accessible equipment for the furnishing services to members with physical or mental disabilities.

Evaluation of health disparities

TennCare addresses disparities in healthcare through tracking the rates of illness and chronic conditions in relation to key demographic factors. TennCare contractually requires the MCOs to conduct QM/QI activities to address

[8] *42 CFR 438.340(b)(6), applicable also to CHIP managed care programs per 42 CFR 457.1240(e).*

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

Reducing health disparities

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

On April 1, 2021, TennCare's MCOs began piloting efforts with key TennCare providers to determine how to consistently screen members for social needs, refer members to community resources to meet identified needs, and ensure that the social needs referral was completed. The provider partnerships are also designed to measure impact on the Member and uncover best practices associated with addressing needs at the provider level. TennCare's goal is to take the best practices and new innovative approaches and scale them across multiple provider types to include primary care, hospital- based care, post-acute care, LTSS, and community partners.

TennCare is also integrating a statewide, Closed-Loop Referral System (CLRS) to provide enhanced support to providers and MCOs as they address social needs in the TennCare population. The CLRS is a technology-based platform that facilitates systematic social risk referrals and contains up-to-date community resource directories and referral outcomes tracking capabilities. The solution will serve as a repository of community-based resources to be utilized by the MCOs and healthcare providers. Social risk factor questionnaires can be performed in the system and will serve as data to populate community resources for Member referrals. The system also supports data analytics to understand the population health needs and other key health outcome metrics which will be used to further improve and refine existing efforts and expand the way TennCare meets social needs and addresses social risk factors.

In addition to programmatic efforts, TennCare MCOs are required to obtain and maintain NCQA's Multicultural Health Care Distinction and upon expiration obtain and maintain NCQA's Health Equity Accreditation. Both distinctions are a representation of TennCare's commitment to offer culturally and linguistically appropriate services and provides an avenue to evaluate how well the MCOs comply with standards for collecting race/ethnicity and language data, provide language assistance, cultural responsiveness, quality improvement of CLAS, and reduction of health care disparities.

Patient-Centered Focus

TennCare is committed to ensuring enrollees' satisfaction with services. TennCare contracts with the University of Tennessee Boyd Center for Business and Economic Research to conduct an annual survey of 5,000 Tennessee households to gather information on insurance status, how individuals and families engage in the health care process and satisfaction with TennCare. The design for the survey is a "household sample," and the interview is conducted with the head of the household. The report, "The Impact of TennCare: A Survey of Recipients", allows comparison between responses from all households and households receiving TennCare. The most recent 2021 survey shows that 92 percent of TennCare recipients expressed satisfaction with the program's quality of care, making 2021 the 13th straight year in which satisfaction with TennCare exceeded 90 percent. TennCare is proud of the growth in member satisfaction that has been achieved over time. For the first ten years of the program's existence, satisfaction with care received from TennCare averaged 79 percent. In the most recent ten-year period, by contrast, member satisfaction averaged 94 percent. This improvement and continued performance are a reflection of TennCare's commitment to high quality care and performance improvement.

Table 5. Goal 3 Quality Metrics and Performance Targets

Integrate patient-centered, holistic care including non-medical risk factors into population health coordination for all members				
Metric Name	**Metric specifications**	**Baseline performance (year)**	**Performance target (year)**	**Program**
Non-medical risk factors (Health Starts)				
Increase the number of authorized users using a statewide CLRS	TennCare Custom	0 (2022)	600 (2025)	Medicaid, CHIP, LTSS, TennCare Select
Increase the percentage of referrals created by MCO to meet identified needs	TennCare Custom	52.9% (2021)	54.9% (2025)	Medicaid, CHIP, LTSS, TennCare Select
LTSS Member Satisfaction				
Increase the percentage of CHOICES members who report that people who are paid support staff show up and leave when they are supposed to	(NCI-AD Q 28)	69.0% (2018/2019)	71.0.0% (2025)	LTSS
Increase the percentage of ECF CHOICES members who report their paid support staff show up and leave when they are supposed to	(NCI-IPS Q 54)	N/A*	N/A	LTSS
Increase the percentage of Katie Beckett member families satisfied with the services and supports their child currently receives	(NCI-CFS Q 61)	N/A*	N/A	LTSS

* Baseline data not available at this time

Goal 4: Improve positive outcomes for members with LTSS needs

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

CHOICES

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

Employment and Community First CHOICES

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

Katie Beckett

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

Identification of persons who need LTSS or require special health care needs[9]

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

[9] *42 CFR 438.340(b)(8), applicable also to CHIP managed care programs per 42 CFR 457.1240(e), cross-referencing 438.208(c)(1) and 457.1230(c).*

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

At time of enrollment and annually thereafter, the MCO must make a reasonable attempt to assess the member's health. The comprehensive health risk assessment required by Level 2 Population Health programs, CHOICES, ECF CHOICES, Katie Beckett, Dual Special Needs Program (D-SNP), Select Community, and Department of Children's Services (DCS) can be used in lieu of the approved health assessment required by the contract. The completed approved health assessment or comprehensive health risk assessment data may be shared among TennCare MCOs and used to meet the annual requirement. 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.

Table 6. Goal 4 Quality Metrics and Performance Targets

Improve positive outcomes for members with LTSS needs[10]				
Metric Name	**Metric specifications**	**Baseline performance (year)**	**Performance target (year)**	**Program**
Quality of Life				
Increase percentage of CHOICES members who report they feel like they have more choice and control over their life than 12 months ago.	NCI-AD (Q TN-5)	19.0% (2019-2019)	21.0% (2025)	LTSS
Increase percentage of ECF CHOICES members who report having enough choice about their daily schedule	NCI-IPS (Q 81)	N/A	N/A	LTSS
Increase percentage of parents/families who report feeling that services and supports have improved their ability to care for their child	NCI-CFS (Q 64)	N/A	N/A	LTSS

[10] *42 CFR 438.340(b)(3)(i), applicable also to CHIP managed care programs per 42 CFR 457.1240(e), cross-referencing 438.330(c)(1)(ii).*

Community Integration				
Increase percentage of working age adults with I/DD enrolled in HCBS who are employed in an integrated setting earning at or above minimum wage	ECF CHOICES baseline data	28.0% (2021)	30.0% (2025)	LTSS
Increase the percentage of older adults and adults with physical disabilities who report being able to do things outside of their homes as much as they want to.	NCI-AD (Q 51)	58.0% (2018-2019)	60.0% (2025)	LTSS
Increase the percentage of individuals with I/DD who report being able to go out into the community and do the things they like to do	NCI-IPS (Q 28)	N/A*	N/A	LTSS
Increase the percentage of children participating in activities in the community	NCI-CFS (Q 40)	N/A	N/A	LTSS
Rebalancing				
Increase HCBS expenditures for older adults and adults with physical disabilities as a percentage of total LTSS expenditures	CHOICES baseline data	21.1% (2021)	23.1% (2025)	LTSS
Increase HCBS expenditures for individuals with I/DD as a percentage of total LTSS expenditures	ECF CHOICES baseline data	28.8% (SFY 2021)	30.8% (2025)	LTSS
LTSS HEDIS Measures – Comprehensive Assessments and Care Plans				
Comprehensive Assessment and Update (LTSS-CAU)				
Assessment of Core Elements	HEDIS	78.0% (2019)	80.0% (2025)	LTSS
Assessment of Supplemental Elements	HEDIS	74.6% (2019)	76.6% (2025)	LTSS
Comprehensive Care Plan and Update (LTSS-CPU)				
Care Plan with Core Elements Documented	HEDIS	75.6% (2019)	77.6% (2025)	LTSS
Care Plan with Supplemental Elements Documented	HEDIS	75.5% (2019)	77.5% (2025)	LTSS
Reassessment/Care Plan Update after Inpatient Discharge (LTSS-RAC)				
Reassessment after Inpatient Discharge	HEDIS	21.1% (2019)	23.1% (2025)	LTSS
Reassessment and Care Plan Update after Inpatient Discharge	HEDIS	16.6% (2019)	18.6% (2025)	LTSS
Shared Care Plan with Primary Care Practitioner (LTSS-SCP)				
Shared Care Plan with Primary Care Practitioner	HEDIS	53.7% (2019)	55.7% (2025)	LTSS

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

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

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

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

Table 7. Goal 5 Quality Metrics and Performance Targets

Provide additional support and follow-up for patients with behavioral health care needs				
Metric Name	**Metric specifications**	**Baseline performance (year)**	**Performance target (year)**	**Program**
Use of Opioids at High Dosage in Persons without Cancer (OHD-AD)				
Use of Opioids at High Dosage in Persons without Cancer*	CMS Adult Core Set	2.9% (2019)	1.9% (2025)	Medicaid
Concurrent Use of Opioids and Benzodiazepines (COB-AD)				
Concurrent Use of Opioids and Benzodiazepines*	CMS Adult Core Set	9.4% (2019)	8.4% (2025)	Medicaid
Follow-up After Hospitalization for Mental Illness (FUH-AD)				
7-day rate	CMS Adult Core Set	33.5% (2019)	35.5% (2025)	Medicaid, CHIP, TennCare Select
30-day rate	CMS Adult Core Set	55.4% (2019)	57.4% (2025)	Medicaid, CHIP, TennCare Select
Follow-up After Hospitalization for Mental Illness (FUH-CH)				
7-day rate	CMS Child Core Set	51.4% (2019)	53.4% (2025)	Medicaid, CHIP, TennCare Select
30-day rate	CMS Child Core Set	73.3% (2019)	75.3% (2025)	Medicaid, CHIP, TennCare Select
Use of Pharmacotherapy for OUD (OUD-AD)				
Total Rate	CMS Adult Core Set	32.4% (2019)	34.4% (2025)	Pharmacy
Buprenorphine	CMS Adult Core Set	28.0% (2019)	30.0% (2025)	Pharmacy

*Lower rates are better.

Goal 6: Maintain robust member access to health care services

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

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

Transition of Care

TennCare maintains a transition of care policy that addresses transfers between managed care contractors and that ensures continued access to services during any transition between managed care contractors.[11] This transition of care policy specifies that transferring enrollees continue to have access to services consistent with their prior access, including the ability to retain their current provider for a period of time if that provider is not in the new managed care contractor's network. In addition, the transition of care policy ensures that the enrollee is referred to appropriate providers of services that are in the new managed care contractor's network. Under the state's transition of care policy, the enrollee's old managed care contractor must fully and timely comply with appropriate information requests from the enrollee's new managed care contractor, including requests for historical utilization data. In addition, the enrollee's new providers are able to obtain copies of the enrollee's medical records, consistent with federal and state law. The transition of care policy also includes a process for the electronic exchange of specified data classes and elements.

Table 8. Goal 6 Quality Metrics and Performance Targets

Maintain robust member access to health care services				
Metric Name	**Metric specifications**	**Baseline performance (year)**	**Performance target (year)**	**Program**
Adult Access to Preventive/Ambulatory Health Services (AAP)				
Ages 20-44	HEDIS	79.0% (2019)	81.0% (2025)	Medicaid, CHIP, TennCare Select
Ages 45-64	HEDIS	87.7% (2019)	89.7% (2025)	Medicaid, CHIP, TennCare Select
General Network Access Standards				
Maintain high compliance for adult members	General Network Access standards	100% (2021)	100% (2025)	Medicaid, CHIP, LTSS

[11] *42 CFR 438.340(b)(5), applicable also to CHIP managed care programs per 42 CFR 457.1240(e), cross-referencing 438.62(b).*

Maintain high compliance for pediatric members	General Network Access standards	100% (2021)	100% (2025)	Medicaid, CHIP
Specialty Network Access Standards				
Maintain high compliance for adult members	Specialty Network Access standards	100% (2021)	100% (2025)	Medicaid, CHIP
Maintain high compliance for pediatric members	Specialty Network Access standards	100% (2021)	100% (2025)	Medicaid, CHIP
Behavioral Network Access Standards				
Maintain high compliance for adult members	Behavioral Health Network Access standards	100% (2021)	100% (2025)	Medicaid, CHIP
Maintain high compliance for pediatric members	Behavioral Health Network Access standards	100% (2021)	100% (2025)	Medicaid, CHIP
General Dental Network Access Standards				
Maintain high compliance for adult members	General Dental Network Access standards	100% (2021)	100% (2025)	Medicaid, CHIP, LTSS
Maintain high compliance for pediatric members	General Dental Network Access standards	100% (2021)	100% (2025)	Medicaid, CHIP
Maintain high compliance for ECF CHOICES members	General Dental Network Access standards	99.9% (2021)	100% (2025)	LTSS
Pharmacy Network Access Standards				
Maintain high compliance for adult members	Pharmacy Network Access standards	100% (2021)	100% (2025)	Medicaid, CHIP
Maintain high compliance for pediatric members	Pharmacy Network Access standards	100% (2021)	100% (2025)	Medicaid, CHIP
LTSS Network Access Standards				
Maintain high compliance for CHOICES HCBS members	MLTSS Network Adequacy Scores	100% (2021)	100% (2025)	LTSS
Maintain high compliance for ECF CHOICES members	MLTSS Network Adequacy Scores	99.8% (2021)	100% (2025)	LTSS

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

Patient-Centered Medical Homes

TennCare's Patient Centered Medical Home (PCMH) program aims to improve the quality of primary care services for members, the capabilities and reach of primary care providers, and the overall quality of health care delivered to the TennCare population. TennCare believes that a strong primary care system is the backbone of a thriving health care delivery system. Primary care transformation focuses on the role of the primary care provider: preventing illness, managing chronic illnesses, coordinating care with other providers, and engaging members in the community. As part of Tennessee's Health Care Innovation Initiative, the state has committed to moving away from paying for volume to paying for value. The mission is to reward health care providers for improving health

outcomes by providing high quality and efficient treatment of medical conditions and maintaining people's health over time. This strategy includes PCMH for the general population of adults and children, a Tennessee Health Link (THL) model for TennCare members with high behavioral health needs, and a Care Coordination Tool that offers additional information to primary care providers (for example, it alerts primary care providers when their patients go to the emergency room or the hospital). The PCMH program launched in January 2017 and serves children and adults. As of March 2022, approximately 40% percent of TennCare members are attributed to one of over 80 organizations, and 450 sites statewide.

Across program years 2017, 2018, and 2019 TennCare observed improved quality in 11 of the 13 measures. TennCare utilizes the National Committee for Quality Assurance (NCQA) HEDIS® measures for the majority of PMCH Core Quality Measures. The largest improvements were seen in the metrics Comprehensive Diabetes Care: Blood Pressure Control (<140/90) and BMI Percentile Assessment for Children/Adolescents which both improved an average of 12 percentage points across the three years. Well-child visit screening rates increased for ages 7 – 11 by six percentage points, and by two percent points for ages 3 – 6, the first 15 months and ages 12 - 21.

Tennessee Health Link

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

Health Link providers commit to providing comprehensive care management, care coordination, referrals to 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.

Episodes of Care

TennCare's Episodes of Care program strives to transform the way specialty and acute healthcare services are delivered in Tennessee by incentivizing high-quality, cost-effective care; encouraging provider coordination; and disincentivizing ineffective and/or inappropriate care. An episode of care includes all the relevant health care services a patient receives during a specified period for the treatment of a physical or behavioral health condition. For each episode of care, a principle accountable provider (or "quarterback") is defined and held accountable for the quality and cost of care delivered during the entire episode. With regards to promoting quality, these "quarterbacks" are given quarterly reports outlining how that provider has performed on the gain-sharing quality metrics (i.e., metrics tied to financial accountability) and informational quality metrics of the episodes they are responsible for. If the "quarterback" meets cost and quality thresholds for a given episode, that provider then becomes eligible for a reward payment, based on shared savings. Tennessee is committed to providing quality

data for episodes on an annual basis. Based on the latest full-year set of performance data, 67 percent of quality metrics tied to gain-sharing improved or maintained performance from 2019 to 2020. A full summary of each gain-sharing quality metric and its year-over-year performance in the program can be found under the "Results" section at the following link: https://www.tn.gov/tenncare/health-care-innovation/episodes-of-care/results-changes.html. If TennCare identifies a quality metric that has undergone a significant decrease in performance, the state works alongside its MCO partners to analyze the data, identify potential reasons for the change (e.g., updated practice guidelines, new medical codes, etc.), and update an episode's design if applicable.

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

Nursing Facilities

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

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

Home and Community Based Services (HCBS)

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

Employment and Community First CHOICES is a managed LTSS program designed to promote integrated employment and community living as the first and preferred outcome for individuals with I/DD. Employment

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

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

LTSS Workforce Incentives

An essential component of the comprehensive strategy is the alignment of incentives for workers to both enroll and especially to complete the education program. Funding for this program was made available as part of the FY21 budget 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.

While the education program was poised to launch in the fall 2020 the onset of the COVID-19 public health emergency (PHE) resulted in loss of funding from the state budget as well as a shift in the focus of Tennessee's Community Colleges and Colleges of Applied Technology to converting all classes to an online format in preparation for the fall semester. In addition, the COVID-19 pandemic resulted in the loss of one of TennCare's longstanding competency-based education partners. However, with the availability of ARPA FMAP funding, Tennessee was able to pivot to a revised plan and is now poised to launch, through ARPA FMAP funding, the workforce development education and training program, *Learn and Earn,* in early 2023 providing quality incentive payments to DSPs who complete competency-based curriculum.

Performance Improvement Projects (PIP) and PIP interventions[12]

In accordance with the contractor risk agreements (CRAs) with TennCare, MCOs must conduct at least two clinical and at least three non-clinical PIPs. The DBM and PBM must conduct at least one clinical and one non-clinical PIP, respectively. For MCOs, the two required clinical PIPs must include one study on behavioral health relevant to one of the population health programs for bipolar disorder, major depression, or schizophrenia, while the other must focus on child or perinatal health. One of the three required non-clinical PIPs must be conducted in the area of long-

[12] *42 CFR 438.340(b)(3)(ii), applicable also to CHIP managed care programs per 42 CFR 457.1240(e), cross-referencing 438.330(d) and 457.1240(b).*

term care focusing on one of the HEDIS LTSS measures, or other efforts to drive quality performance and improvement in person-centered planning or person-centered support plans. In addition, MCOs must conduct a study on Early and Periodic Screening, Diagnostic and Treatment (EPSDT) screening and outreach if their overall CMS-416 rates are below 80%. Each of the PIPs tie into the Quality Strategy and advance at least one of the state's goals and objectives. See Appendix 3 for the full listing of PIPs for each MCC.

Section III: Monitoring and Compliance

Network adequacy and availability of services[13]

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

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

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

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

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

MLTSS Network Access
In addition to the General Network Access standards above, TennCare has established specific MCO standards regarding network adequacy for MLTSS providers to include time and distance standards for LTSS provider types in which an enrollee must travel to the provider to receive services.[14] Additionally, TennCare has MCO network

[13] *42 CFR 438.340(b)(1), applicable also to CHIP managed care programs per 42 CFR 457.1240(e), cross-referencing 438.68, 438.206, 457.1218, and 457.1230(a).*
[14] Pursuant to 42 CFR 438.68(2), in addition to the requirements in Section A.2.11.1 and Attachment III of the CRA. *See CRA Section A.2.11.7.*

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

In the future, TennCare intends to incorporate quality performance as part of the network adequacy structure for LTSS. At this juncture, TennCare is implementing quality monitoring and quality measurement processes that will allow the state to identify high performing providers and to establish a process for taking quality performance into consideration as part of the review of network adequacy for LTSS providers.

General Dental Services

The DBM makes services, service locations and service sites available and accessible so that transport distance/time to general dental, oral surgery services, orthodontic services, pediatric dental services and dental specialty providers will be the usual and customary, not to exceed the network access standards as outlined in the Dental Benefit Managers contract, found at: https://www.tn.gov/content/dam/tn/tenncare/documents2/DentaQuest59802.pdf.

Pharmacy Benefit Services

The PBM provides available, accessible, and adequate numbers of pharmacies to meet the pharmacy network access standards as outlined in the Pharmacy Benefits Managers contract, found at https://www.tn.gov/content/dam/tn/tenncare/documents2/Optum3186500600.pdf.

Clinical practice guidelines[15]

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

[15] *42 CFR 438.340(b)(1), applicable also to CHIP managed care programs per 42 CFR 457.1240(e), cross-referencing 438.236 and 457.1233(c).*

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.

TennCare prioritizes the use of evidenced-based practice and clinical interventions that have demonstrated positive outcomes in several research studies to assist consumers in achieving their desired goals of health and wellness.

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

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

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

UnitedHealthcare
https://www.uhcprovider.com/content/dam/provider/docs/public/commplan/multi/clinical-guidelines/Clinical-Practice-Guidelines-UHCCP.pdf

Intermediate sanctions[16]

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

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

Intermediate sanctions imposed by the state against a contractor may include the development and implementation of corrective action plans, liquidated damages, suspension of enrollment, disenrollment of members, limitation of the contractor's service area, civil monetary penalties (as provided for in 42 CFR 438.704),

[16] *42 CFR 438.340(b)(7), applicable also to CHIP managed care programs per 42 CFR 457.1240(e), cross-referencing Part 438 Subpart I*

appointment of temporary management (as provided for in 42 CFR 438.706), or suspension of payment for members enrolled after the effective date of the sanction until the state is satisfied that the issue has been resolved. These remedies provide the state with a range of administrative mechanisms to address performance issues. The disposition of any corrective action depends upon the nature, severity and duration of a deficiency or non-compliance.

Compliance with Federal LTSS Requirements[17]

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

Upon implementation of Employment and Community First CHOICES and Katie Beckett, these measures were expanded to encompass the new programs. In addition, TennCare incorporated quality components of the Medicaid Managed Care Rule specified in 42 C.F.R. § 438.330. More recently, STC 52 to the TennCare III Demonstration, Quality Improvement Strategy for 1915(c) or 1915(i)-approvable HCBS Services, requires that "the state's Quality Assessment and Performance Improvement Plan must encompass LTSS-specific measures set forth in the federal rule and should also reflect how the state will assess and improve performance to demonstrate compliance with applicable federal waiver assurances set forth in 42 CFR 441.301 and 441.302." Appendix 4 outlines compliance measurement goals and objectives for the State's three MLTSS programs – CHOICES, Employment and Community First CHOICES, and Katie Beckett Part A Programs.

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

Section IV: External Quality Review Arrangements

EQR arrangements[18]

Tennessee contracts with Qsource to provide all External Quality Review (EQR) activities. The contract is effective beginning on September 1, 2020 and ends on September 30, 2023. The contract may be extended with the state reserving the right to execute two (2) one-year renewal options extending the contract term no longer than September 30, 2025. The services to be provided under this contract include multiple tasks and deliverables that are consistent with applicable federal EQR regulations and protocols for Medicaid Managed Care Organizations and state-specific requirements. The contract allows the state to be compliant with Federal EQR regulations and rules and to measure MCC-specific compliance with the TennCare Section 1115 Waiver.

Qsource conducts independent reviews of the quality outcomes, timeliness of and access to the services covered under each MCC. The Annual Quality Survey reviews the MCOs' compliance with Medicaid and CHIP Managed Care regulations. It includes a review of enrollee rights and protections, quality assessment and performance improvement, structure and operation standards, measurement and improvement standards, and compliance with the appeal process. The survey process includes document review, interviews with key MCC personnel, and an assessment of the adequacy of information management systems. 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. Tennessee contracts with FIDE-SNPs that are fully aligned with the MCOs. These plans and their members are included in the state's EQR activities and in the annual EQR technical report.

EQR non-duplication option[19]

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.

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 Appendix 5.

[18] *42 CFR 438.340(b)(4), applicable to CHIP managed care programs per 42 CFR 457.1240(e), cross-referencing 438.350, which is applicable to CHIP per 42 CFR 457.1250*

[19] *42 CFR 438.340(b)(9), applicable also to CHIP managed care programs per 42 CFR 457.1240(e), cross-referencing 438.360(c), which is applicable to CHIP per 42 CFR 457.1250(a)*

Section V: 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. Appendix 6 provides additional details and outlines the goals that are being advanced by each directed payment.

Section VI: Appendix

Appendix 1: Acronyms

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

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

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

Appendix 2: TennCare 2020 Quality Strategy Evaluation Summary

In February 2021, TennCare's EQRO conducted an evaluation of the 2020 Quality Strategy. 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's 2020 Quality Strategy 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.

Appendix 3: TennCare PIP Summary

In accordance with the contractor risk agreements (CRAs) with TennCare, MCOs must conduct at least two clinical and at least three non-clinical PIPs. The DBM and PBM must conduct at least one clinical and one non-clinical PIP, respectively. For MCOs, the two required clinical PIPs must include one study on behavioral health relevant to one of the population health programs for bipolar disorder, major depression, or schizophrenia, while the other must focus on child or perinatal health. One of the three required non-clinical PIPs must be conducted in the area of long-term care. In addition, MCOs must conduct a study on Early and Periodic Screening, Diagnostic and Treatment (EPSDT) screening and outreach if their overall CMS-416 rates are below 80%.

Note: Improvement strategies are not applicable to PIPs that were in their baseline measurement year in 2021. Verbiage quoted from the MCCs' PIP Summary Forms appears in italics and is included to capture MCCs' aims and strategies in their own words. Each PIP is linked to a specific goal in the Quality Strategy (QS) as indicated in the first column. Also included in the table are each PIP's measurement year (Baseline [B]; Remeasurement 1 [R1]; Remeasurement 2 [R2]; Remeasurement 3 [R3]; Remeasurement 4 [R4]) and classification as clinical (C) or non-clinical (NC).

Table 9. TennCare 2021 Performance Improvement Projects

2021 Performance Improvement Projects					
QS	**Year**	**C/NC**	**Topic**	**PIP Aim Statement**	**Improvement Strategies**
Amerigroup					
2	B	C	*Improve Childhood Immunization Status (CIS) Combination 10 Rates—East, Middle, and West Regions* (AGE/AGM/AGW)	*Will targeted interventions, such as member incentives, digital outreach, and innovative community collaborations, increase the percentage of members receiving childhood combination 10 immunizations?*	
2	B	NC	*Increase Eye Exam Screening Rates for Members with Diabetes* (AGE/AGM/AGW)	*In pursuit of health equity goals, will member and provider incentives focused on minimizing the impact of social determinates of health improve retinal eye exam screenings for members with type 1 or type 2 diabetes within their community during the HEDIS® measurement year?*	
3	R1	NC	*Improve East Grand Region Member Satisfaction with the Health Plan* (AGE)	*Will health plan and provider education along with telehealth and additional transportation options increase the percentage of respondents that answered Question 49 (Rating of Health Plan) on the CAHPS Child Medicaid-General Population survey with a score of 8, 9, or 10?*	♦ CAHPS Awareness Training to address barriers such as lack of provider tools/ awareness on how to improve the patient/member experience ♦ Enhanced telehealth services to improve access, continuity and coordination of care ♦ Enhanced non-emergency medical transportation (NEMT) to improve lack of transportation options along with other social determinants of health factors

2	R2	C	*Improve EPSDT Screening Rates in the 18–20-Year-Old Age Group Statewide* (AGE/AGM/AGW)	*Will targeted member outreach, provider engagement, along with member and provider incentives improve the EPSDT Screening Rate in the 18-20 year old age group over the measurement period?*	♦ Keeping Members Healthy (KMH) Provider Incentive Program that offers providers an opportunity to earn a financial incentive for increasing their EPSDT screening rates contingent on meeting or exceeding the defined percentage point improvement ♦ Healthy Rewards Member Incentive Program in which members were able to earn one annual financial reward for completing an EPSDT screening visit ♦ HealthCrowd Member Outreach, a vendor managed program, to notify young adult members of important information related to EPSDT screenings using modalities such as SMS, text messaging, IVR calls, and email ♦ Quality Management Provider Engagement Visits entail Amerigroup staff developing and implementing a plan with targeted providers one-on-one to improve rates by providing education, highlighting areas of opportunity and providing gap in care lists and other resources to support annual EPSDT Screenings ♦ Member EPSDT Service Reminder Mailings (Birthday Cards) are sent as a preventative reminder to members 45-90 days prior to their date of birth to remind them of the importance of their well child visit
4	R2	NC	*Increase Percentage of CHOICES Members Who Had LTSS Assessment with Nine Core Elements* (AGE/AGM/AGW)	*Will targeted interventions, Patient Centered Support Plan (PCSP) tool coupled with electronic capture system enhancements, staff PCSP training and PCSP auditing with feedback, improve the rate of CHOICES - Group 2 and 3 Members who had a comprehensive LTSS assessment with 9 core elements documented within 90 days of enrollment for new members or during the measurement year for established members?*	♦ Participation in NCQA Learning Collaborative Pilot with utilization of feedback and guidance for nine elements of compliance ♦ Re-audit of 2018 CAU Sample conducted, applying NCQA clarification guidance for compliance elements and reestablishment of the 2018 Baseline ♦ An internal PCSP audit tool implemented that includes NCQA standards and assessment expectations, which allows for identification of trends and patterns, consistent feedback and re-education to coordination staff with tracking of improvement regarding adherence to the 9 core elements of the standards. The process entails communication of audit findings to the manager, manager reviews and discusses with the coordinator with remediation as applicable. The closed loop concludes with feedback to the auditor manager for awareness of training and audit tool effectiveness ♦ Enhanced Training conducted for NCQA standards and assessment expectations for the Person-Centered Support Plan (PCSP) of care coordination staff ♦ Implementation of the Healthy Innovations Platform (HIP) care management system, which incorporates

					the updated PCSP with key required fields to ensure NCQA and HEDIS® standards are assessed and documented in a systematic and consistent method. ♦ In coordination with TennCare, updates made to the Person Centered Support Plan (PCSP) to incorporate NCQA and HEDIS® standards into the document to ensure all required standards are assessed and documented.
5	R1	C	*Improve Diabetic Screening Compliance for Members with Schizophrenia or Bipolar Disorder Using Antipsychotic Medication (SSD)* (AGW)	*Will targeted interventions consisting of education, member gap closures and incentives for gap closures improve diabetic screening compliance in members with Schizophrenia, Schizoaffective disorder or Bipolar disorder that are taking antipsychotic medications?*	♦ Provider support to target members with gaps in care (GIC) to increase provider awareness of the need for diabetes screening ♦ Provider incentives to mitigate provider costs associated with claims submission ♦ Glucose and hemoglobin A1c testing during inpatient behavioral health (BH) hospitalization encounter to address barrier of multiple locations needed for lab testing
BlueCare					
4	B	NC	*LTSS Shared Care Plan with Primary Care Practitioner (LTSS-SCP)* (BCE/BCM/BCW)	*Will targeted interventions improve the rate of sharing the care plan with the Primary Care Practitioner (PCP) or other documented medical care practitioner identified by a CHOICES or ECF CHOICES member within 30 days of its development, over each remeasurement year?*	
5	R1	C	*Improving Antidepressant Medication Management (AMM)* (BCE/BCM/BCW)	*Will focused provider interventions increase member compliance with the continuation phase of antidepressant therapy for treatment of major depression over each remeasurement year?*	♦ Initiated text message and telephone calls for new fills and refills of antidepressant medication to MCO plan members statewide ♦ Conduct periodic provider education statewide on the AMM-C measure in partnership with the Provider Incentive and Engagement (PIE) team ♦ 90-day refill changes for antidepressant medications ♦ Implemented telehealth coverage and developed provider notification
5	R1	NC	*Decrease the Use of Opioids at High Dosage (HDO)* (BCE/BCM/BCW)	*Will implementing targeted interventions decrease the proportion of BlueCare Statewide members 18 years and older who received prescription opioids at a high dosage (average morphine milligram equivalent dose [MME] ≥90) for ≥15 days over each remeasurement year?*	♦ External Vendor Enhancement of monitoring practice pattern analysis of providers, combining analytics with personalized services to improve outcomes for members with or at risk for OUD. Risk Identification and Mitigation (RIM) Reports are available for providers. ♦ Behavioral Health Quality Coaches - conducted educational webinars on targeted measures that included HDO. Will continue ongoing education during onsite visits.

					♦ BlueCare shift to new PH model/program that included development of opioid cohort and internal dashboards statewide ♦ Integration of Controlled Substance Monitoring Database (CSMD) into the documentation system of record. Internal Interactive Module Education and Training was completed statewide - interactive module loaded into Learning Center and email sent out to complete training.
3	R1	NC	*Social Determinants of Health Data Collection Process* (BCE/BCM/BCW)	*Will the development of a systematic process to collect SDoH information targeting the social determinants of health assessment in the internal documentation system of record on members with an open care management case in the Statewide BlueCare population, increase the number of SDoH assessments completed, social determinants identified, and referral needs addressed, and improve member outcomes over each measurement year?*	♦ Implementation of the new modified SDoH Assessment Tool and internal education for all case managers on the use/documentation of the tool in the documentation system of record, so that the data are in the same location for use by case managers ♦ Community Resource Tool – Repository of community resources identified by category needs, county, and ZIP code. This tool is for all staff to utilize for the member's needs ♦ Identification of process for collecting the SDoH Performance Measures data directly from the internal documentation system of record based on the assessment tool completed by the case managers ♦ Shift to new PH Model/Program, which included a focus on identifying social determinants and addressing through referral sources
BlueCare and TennCare*Select*					
2	R1	C	*Improving Childhood and Adolescent Immunization Rates (CIS/IMA)*	*Will targeted provider interventions result in increased influenza and HPV vaccination rates in children and adolescents over each remeasurement period?*	♦ Development of a Vaccination Hesitancy Educational Flyer for providers to use during clinical encounters ♦ Provider Incentive and Engagement Team began Quarterly reviews statewide with providers addressing child and adolescent immunizations targeting influenza and HPV.
2	R4	NC	*Improving Early and Periodic Screening, Diagnostic and Treatment (EPSDT)*	*Do targeted provider engagement activities improve the EPSDT rates over each remeasurement period?*	♦ Provider education and partnerships through: provider educational email blasts**;** provider educational mass mailings**;** educational presentations at webinars, workshops, clinical advisory panel, meetings ♦ Implementation of an Integrated Appointment Scheduling Platform that allows health plan staff to directly access provider appointment inventory and schedule member appointments while on the phone with members. The platform also provides technology for appointment reminders that can be

					utilized by providers who may not otherwise have those capabilities. The platform also integrates transportation for appointments. ♦ Supersizing Provider Program to incentivize providers to capitalize on sick visits and covert them to an EPSDT visit to address preventive care. ♦ Embedded Member Resource Coordinator (MRC)—embedded within the ED to help address social determinants of health, assist with PCP follow-up, appointment scheduling, transportation assistance and other member needs.
TennCare*Select*					
2	R1	NC	*Improving Comprehensive Diabetes Care (Blood Pressure Control for SelectCommunity)*	*Does providing a tailored set of interventions and approaches improve the Comprehensive Diabetes Care: Blood Pressure Control (CDC BP) HEDIS rate for the TennCareSelect SelectCommunity population over each measurement year?*	♦ Agent Workspace technology implemented to be address gaps in care identified in the Agent Workspace application and address actions taken toward closing the gap. ♦ Training related to the CDC-BP HEDIS measure was developed to provide knowledge and technical specification updates; included information about open gap exploration and how to officially provide closure if the gap was identified as already closed
5	R1	NC	*Decreasing Plan All-Cause Readmissions*	*Do targeted interventions decrease the number of TennCareSelect acute inpatient and observation stays that are followed by an unplanned acute readmission for any diagnosis within 30 days over each measurement year?*	♦ Interactive calls made to all members statewide discharged from a facility for mental illness to provide education and support, confirm appointment scheduled during discharge, or assist scheduling an appointment. Identify and resolve any social determinants of health barriers to care such as transportation. An incentive offered to members who keep their appointment within 7 days of discharge. Follow up calls made one (1) day post appointment to ensure that member attended. ♦ Transition of Care (TOC) / Discharge Planning responsibility transferred statewide from Case Management to Utilization Management (UM). UM worked with Predictive Analytics to improve identification of members with high probability of readmission statewide. Members are discharge planned with the facility and documentation is completed on a new UM discharge planning template. Referrals made to Interdisciplinary care team as needed ♦ Member Outreach Discharge calls made to members statewide with high probability of readmission (Asthma/Chronic Obstructive Pulmonary Disease) prior to discharge from hospital. A transition of care (TOC) template is completed,

					and members are educated on self-management and follow up appointments. ♦ UM evaluates members statewide for tele-monitoring referral to an external vendor using specific criteria for each diagnosis. Currently applies to only Medical members. ♦ Contracted with statewide vendor that utilizes providers to complete follow-up visits with members after hospitalization for mental illness
5	R2	C	*Follow-Up After Hospitalization for Mental Illness—7 Day (FUH)*	*Do targeted interventions improve the rate of timely follow-up care for members age 6 and older who were hospitalized for treatment of mental illness over each remeasurement period?*	♦ Tennessee Health Link (THL) Provider incentivized measure, Quarterly education and support given to providers statewide. ♦ Member Outreach phone calls to members statewide for appointment scheduling assistance, with financial incentive for members who keep appointment. Follow up calls are made 1-day post appointment to ensure that member attended. Phone calls also include education on the importance of follow-up care. ♦ Incorporating behavioral health inpatient and outpatient practices statewide into the Integrated Appointment Scheduling Platform. ♦ Statewide vendor that utilizes providers to complete the 7-day follow-up visit after hospitalization for mental illness. ♦ Provider and Community Partner Education
3	R2	NC	*Social Determinants of Health Data Collection Process*	*Will the development of a systematic process to collect SDoH information targeting the social determinants of health assessment in the internal documentation system of record on members with an open care management case in the Statewide TCS population, increase the number of SDoH assessments completed, social determinants identified, and referral needs addressed, and improve member outcomes over each measurement year?*	♦ Formation of the multi-disciplinary SDoH Workgroup and development of modified SDoH assessment tool to be completed in the internal documentation system of record. Internal education developed for all case managers on the use/documentation of the new modified SDoH tool. ♦ Community Resource Tool – Repository of community resources identified by category needs, county, and ZIP code. This tool is for all staff to utilize for the member's needs ♦ Identification of process for collecting the SDoH Performance Measures data directly from the internal documentation system of record based on the assessment tool completed by the case managers ♦ Shift to new PH Model/Program, which included a focus on identifying social determinants and addressing through referral sources

UnitedHealthcare					
2	B	C	*Increasing the Screening Rates of Child & Adolescent Well-Care Visits (WCV)* (UHCE/UHCM/UHCW)	*Will the use of targeted member outreach and incentives increase screening rates for children 18-21 years of age over each remeasurement year?*	
3	R1	NC	*Increasing the Physical Health Provider Satisfaction Survey Engagement Rate* (UHCE/UHCM/UHCW)	*Can enhanced communication efforts to providers regarding the importance of their feedback increase the response rates for our Physical Health Provider Satisfaction Survey over each measurement period?*	♦ Formed a workgroup comprised of various provider-facing staff to evaluate current survey cover letter. Workgroup then worked with CMO to advise on content, as well as ways to address preferences and needs that have been identified in other provider communications that could be applicable here. After forming a draft Pre-Notification Letter including specific actions taken from our previous year's survey, it was presented to those network providers that regularly participate in our Provider Affairs Subcommittee for a final review and to satisfy the 'study' step of our PDSA cycle. The survey cover letter will be updated annually to include specific impacts and actions taken based on the previous year's survey responses as decided upon and approved by the PAS each year
5	R1	C	*Adherence to Antipsychotic Medications for Individuals w/ Schizophrenia (SAA)* (UHCW)	*Will targeted provider and member interventions increase adherence to antipsychotic medications for individuals diagnosed with schizophrenia over each measurement period?*	♦ Quality Analyst worked with UHCCP Data Analysts to run a monthly report via SMART. The Quality Analyst and provider reviewed the monthly report as needed to discuss progress and reconcile adherence data. Members identified on the provider's Pharmacy Gaps in Care Reports fall off the list, as providers outreach members to reconcile any medications issues. During this measurement cycle, the Quality Analyst collaborated with 6 identified providers to review, analyze, and make adjustments as needed. ♦ Developed and published an educational newsletter article for members titled The Importance of Taking Medication as Directed. The article was shared in a quarterly newsletter and with providers to discuss with members as needed. ♦ Developed and published a SAA education flyer ("Attention-Tips to Address the SAA Measure") to the Provider website and published an educational article for providers ("Antipsychotic Pharmacotherapy: TennCare Preferred Drug List & Appropriate Diagnosis for Prior Authorization Bypass").
3	R2	NC	*Care Coordination* (UHCE/UHCM/UHCW)	*Can targeted provider outreach improve provider and member perception of coordination of care between health care practitioners as indicated by*	♦ Creating a SDOH role within the health plan to assist providers with resource identification and linkage for

				UnitedHealthcare Community Plan Provider Satisfaction Survey and CAHPS® Survey responses over each measurement period?	patients with these non-medical risk factors to support overall care coordination activities ♦ Moving CM team to sit within the Population Health structure to allow for central alignment of health plan goals for care coordination. Creating a total of 18 Community Care Teams (CCTs) comprised of one Registered Nurse and three Community Health Workers, for a total of six CCTs per region, each assigned to specific counties or geographical areas.
2	R2	C	*Impact of Member and Provider Outreach on Immunization Rates for CIS Combo 10* (UHCE/UHCM/UHCW)	*Will targeted provider and member interventions increase the CIS Combo 10 immunization rate, for members, over each remeasurement period?*	♦ Utilize provider facing teams to educate, partner with, and regularly meet with our network providers participating in VBC. This education, combined with other efforts such as UHCOnAir, is used to support these providers in their efforts to incrementally improve their targeted quality metrics. Incentive amount for improvement associated with the CIS Combo 10 measure for our TennStar participating providers was increased. ♦ Clinical Practice Education Consultants met regularly with all TennStar providers to identify open gaps in care, established methods for closing those gaps in care, discuss their earning potential, as well as to review their current progress to date. ♦ National Member Engagement team identified a Pfizer affiliated outreach program based on the positive outcome rates shown in other participating health plans. ♦ Implemented an additional member outreach combining postcards and interactive voice response (IVR) calls to target members ages 6 months, 8 months, and 16 months with missed vaccines monthly.
4	R2	NC	*Transitions of CHOICES Individuals* (UHCE/UHCM/UHCW)	*Can utilizing innovative and transitional care interventions/methods result in a positive percentage ratio change in the number of Home and Community Based members versus Nursing Facility members over each measurement period?*	♦ NF Diversion Activities: Manager Review of all community persons requesting transition to Nursing Facility prior to approval and submission to state partner portal in all regions. ♦ NF Facility Screenings and Census Review: Review of all existing population at NF by Transition team with Assigned Facility CC for potential new transition referrals in all regions. ♦ Review of NF MDS 3.0 Section Q Discharge Individuals Identified Goals by assigned facility staff in all regions. ♦ NF Warning Report: Red Flags for Diagnosis and Claims Related to risk of NF Placement for Group 1: Cases reviewed during Manager/ Coordinator

					meetings for high risk persons and plan of risk mitigation in all three regions. ♦ NCQA Inpatient and Readmission Report: Cases reviewed during MCM/ CC One on Ones for high risk and plan of risk mitigation in all regions. ♦ Housing Specialist and Member Advocacy collaboration during all regional transition grand rounds for consult and assistance. ♦ Collaboration with Provider Relations and Network Development for Community Based Residential Alternatives (CBRA) option for persons transitioning to community in all regions. ♦ Continuum of Care Grand Rounds with Medical Director for complex persons desiring to transition to community in all regions. ♦ Complete Comprehensive Interdisciplinary Rounds with Managers for All Individuals Prior to Return to the Nursing Facility. ♦ TCARE Assessment for Natural Supports and Caregivers. This program provides support to sustain individuals in the community by supporting those who provide the natural unpaid care to the LTSS HCBS Population. A Plan of Care is developed for the Caregiver directly to support their needs and resolve gaps.
DentaQuest					
2	R3	C	*Increasing Provider Use of Silver Diamine Fluoride (SDF) as a Preventive Measure*	*Can the percentage of TennCare member utilizers 0-20 that receive an application of Silver Diamine Fluoride (SDF) be increased through targeted education to our providers over each remeasurement year?*	♦ SDF Provider Toolkit available on DQ Provider page ♦ The American Dental Association redefined CDT code D1354 from a full-mouth application to a per-tooth application state-wide. ♦ Provider utilization of SDF was added to the quarterly Provider Performance Report scorecard for provider behavior ♦ Provider incentive payment was calculated based on number of SDF applications, along with other preventive measures ♦ Provider hospital readiness form was updated to clinically deny treatment in a hospital under general anesthesia unless the provider has tried SDF or explained why SDF is not an appropriate treatment. ♦ New Person-Centered Dental Home Program implemented for all TennCare network providers, emphasizing minimum expectation of SDF use and

					individual education and remediation for offices not using SDF
5	R3	NC	*Decreasing TennCare Enrollees Receiving Opioid Prescriptions*	*Can the percentage of TennCare member utilizers 0-20 that receive an opioid prescription be decreased through targeted education to TennCare dental providers over each remeasurement year?*	♦ Opioid Provider toolkit available on DentaQuest provider page. ♦ TennCare implemented an edit on opioid prescriptions for all outpatient, first-time prescription, non-chronic opioid users, such that: First fill prescriptions are limited to a 5-day supply (revised to 3-day supply on July 1st, 2018) at 60 MME per day; additional days' supply and higher MME limits require pre-authorization and ICD-10 codes containing diagnostic justification. ♦ DQ Dental Director presented dangers of and alternatives to opioids to dental students at Meharry and University of TN Dental Schools. ♦ Identified Dental Providers that are outliers amongst their peers, in terms of percentage of TennCare patients receiving an opioid prescription. These providers were targeted with a letter sent via mail and email calling attention to their prescriptive behaviors as well as providing education and alternative strategies for pain management.
OptumRx					
7	B	C	*Schizophrenia Medication Compliance Improvement Plan*	*Will the increased use of long-acting injectable antipsychotics reduce the frequency and costs associated with psychotic breaks (e.g., inpatient facility days and medical cost) in patients with schizophrenia who have been non-compliant with oral antipsychotics over each remeasurement year?*	
5	B	NC	*Usage of Diagnosis Code Override by Providers for Preferred Atypical Antipsychotics*	*Does targeted communication to providers about the diagnosis code override process for preferred atypical antipsychotics increase the use of appropriate diagnosis code overrides for TennCare members with at least one preferred atypical antipsychotic claim over each remeasurement year?*	

Appendix 4: MLTSS Compliance Measurement Goals

Table 10. MLTSS Compliance Measurement Goals

Metric name/Objective	Metric Specifications	Baseline performance (year)	Performance target (year)
1. Maintain the percent of CHOICES Group 2 members who are offered a choice between institutional services and HCBS	Member Record Review	100% (2021)	100% (2025)
2. Ensure CHOICES, Employment and Community First CHOICES, and Katie Beckett Part A[20] members will have a level of care determination indicating the need for institutional services or being "At-Risk" for institutional placement, as applicable, prior to enrollment in CHOICES, Employment and Community First CHOICES, or Katie Beckett, as applicable, and receipt of Medicaid-reimbursed HCBS.	MMIS system standards[21]	100% (2021)	100% (2025)
3. Ensure CHOICES Groups 2 and 3, Employment and Community First CHOICES, and Katie Beckett Part A members 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.	Member Record Review	99.2% (2021)	100% (2025)
4. Ensure CHOICES Group 2 and 3, Employment and Community First CHOICES, and Katie Beckett Part A members have a PCSP that meets requirements specified by the CRA and/or in TennCare protocol.	Member Record Review	98.0% (2021)	100% (2025)
5. Ensure CHOICES Group 2 and 3, Employment and Community First CHOICES, and Katie Beckett Part A member records document that the member (or their family member/authorized representative, as applicable) received education/information at least annually regarding how to identify and report abuse, neglect and exploitation.	Member Record Review	100% (2021)	100% (2025)
6. Ensure CHOICES Groups 2 and 3, Employment and Community First CHOICES, and Katie Beckett Reportable Event records will indicate the incident/event was reported within timeframes specified in the CRA.	Critical Incident Audit and the ECF CHOICES Reportable Events Audit[22]	100% (2021)	100% (2025)
7. Ensure CHOICES Group 2 and 3, Employment and Community First CHOICES, and Katie Beckett Part A member records in which HCBS were denied, reduced, suspended, or terminated as evidenced in the PCSP as applicable document that the member was informed of and afforded the right to request a Fair Hearing as determined by the presence of a notice of action. 100% remediation of all individual findings is expected; compliance percentage at or below 85% requires a quality improvement plan.	Member Record Review	100% (2021)	100% (2025)

[20] The Katie Beckett Part A population was not included in the MRR for 2021, however, it will be included in future years.
[21] As a practical matter, TennCare cannot enroll anyone in the MMIS unless there is a LOC determination in TPAES. This is completed as part of the process 100% of the time.
[22] For 2022, there will be one Reportable Event Audit due to the alignment of Critical Incident reporting across all LTSS programs in 2021.

Appendix 5: EQR Nonduplication

During the 2022 Annual Quality Survey (AQS), each MCO will be evaluated for deeming based on the NCQA standards for which it received accreditation. Elements that score 100% on the applicable NCQA elements will be deemed. Elements will not be partially deemed. Example: Availability of Services Element #1, all four NCQA elements (NET 1, MED 3, MED 12, and LTSS 1) should have a score of 100%; e.g., if the MED 3 score was less than 100% or not reviewed by NCQA, then this element cannot be deemed and all required documentation should be provided.

QP Standard: Availability of Services				
Element #	**AQS Tool Element Name**	**CFR Reference(s)**	**2020 NCQA Element(s)**	**2021 NCQA Element(s)**
1	Adequate Access for All Members	438.206.b.1	NET 1: Elements A-C MED 3: Element A factor 2, B factors 1-2 MED 12: Element A LTSS 1: Element B factor 10, C	NET 1: Elements A-C MED 3: Elements A factor 2, B factors 1-2 MED 12: Element A LTSS 1: Elements B factor 10, C
2	Women's Health Specialists	438.206.b.2	NET 1: Element A MED 1: Element A	NET 1: Element A MED 1: Element A
3	Second Opinion	438.206.b.3	MED 1: Element C	MED 1: Element C
4	Out-of-Network Services	438.206.b.4	MED 1: Element D	MED 1: Element D
5	Out-of-Network Costs	438.206.b.5	MED 1: Element E	MED 1: Element E
6	Credentialing and Recredentialing Policy	438.206.b.6 438.214.b.2-d.1	Not Deemable	CR 1: Elements A-B CR 2: Element A LTSS 1: Element I factors 1-3 MED 1: Element L
7	Family Planning	438.206.b.7	NET 1: Element B-C	NET 1: Elements B-C
8	Timely Access	438.206.c.1.i	NET 2: Element A-C	NET 2: Elements A-C
9	Hours of Operation and Access	438.206.c.1.ii-.iii	MED 1: Element F-G	MED 1: Elements F-G

QP Standard: Availability of Services				
Element #	**AQS Tool Element Name**	**CFR Reference(s)**	**2020 NCQA Element(s)**	**2021 NCQA Element(s)**
10	Compliance	438.206.c.1.iv-.vi	QI 2: Element A CR 5: Element A	QI 2: Element A CR 5: Element A
11	Cultural Competency	438.206.c.2	MED 12: Element A NET 1: Element A ME 2: Element B	MED 12: Element A NET 1: Element A ME 2: Element B MHC 3: Elements A-B MHC 4: Element A
12	Accessibility for Members with Disabilities	438.206.c.3	MED 3: Element A	MED 3: Element A

QP Standard: Assurances of Adequate Capacity and Services				
Element #	**AQS Tool Element Name**	**CFR Reference(s)**	**2020 NCQA Element(s)**	**2021 NCQA Element(s)**
1	Appropriate Range of Services and Providers	438.207.b.1-.2	NET 1: Elements B-C MED 1: Element B	NET 1: Elements B-C MED 1: Element B

QP Standard: Coordination and Continuity of Care				
Element #	**AQS Tool Element Name**	**CFR Reference(s)**	**2020 NCQA Element(s)**	**2021 NCQA Element(s)**
1	Primary Care	438.208.b.1	MED 5: Element A NET 1: Element B NET 2: Element A PHM 5: Elements A, E LTSS 1: Element A factor 5, B-I	MED 5: Element A NET 1: Element B NET 2: Element A PHM 5: Elements A, E LTSS 1: Element A factor 5, B-I
2	Coordination of Services	438.208.b.2-.2.iv	Not Deemable	MED 5: Element A factors 3-6

QP Standard: Coordination and Continuity of Care				
Element #	**AQS Tool Element Name**	**CFR Reference(s)**	**2020 NCQA Element(s)**	**2021 NCQA Element(s)**
				QI 3: Elements A-D LTSS 1: Element A factor 5 LTSS 3: Element A factor 7, B-C
3	Initial Screening	438.208.b.3	MED 6: Element A	MED 6: Element A
4	Prevent Duplication of Services	438.208.b.4	MED 6: Element B	MED 6: Element B
5	Medical Records	438.208.b.5	MED 5: Element B	MED 5: Element B
6	Protected Health Information	438.208.b.6	MED 5: Elements A-C	MED 4: Elements A-C
7	Comprehensive Assessment Mechanisms	438.208.c.2	LTSS 1: Element A factors 2-3, B-D	LTSS 1: Element A factors 2-3, B-D
8	Treatment and Service Plans	438.208.c.3-.3.v	Not Deemable	MED 5: Element C LTSS 1: Elements E, F, G factor 13, and I LTSS 3: Element A factor 8
9	Direct Access to Specialists	438.208.c.4	MED 1: Element A-B	MED 1: Elements A-B

QP Standard: Coverage and Authorization of Services				
Element #	**AQS Tool Element Name**	**CFR Reference(s)**	**2020 NCQA Element(s)**	**2021 NCQA Element(s)**
2	Arbitrary Limitations Prohibited	438.210.a.3.ii	MED 9: Element D	MED 9: Element E
3	Service Limitations	438.210.a.4-.4.i	UM 1: Element A factors 5-6 UM 2: Element A	UM 1: Element A factors 5-6 UM 2: Element A
5	Medically Necessary Definition	438.210.a.5-.5.i	UM 1: Element A factors 5-6	UM 1: Element A factors 5-6
8	Processing Authorizations	438.210.b.2-.2.iii	UM 2: Element C UM 7: Element A, D	UM 2: Element C UM 7: Elements A, D

QP Standard: Coverage and Authorization of Services				
Element #	**AQS Tool Element Name**	**CFR Reference(s)**	**2020 NCQA Element(s)**	**2021 NCQA Element(s)**
			LTSS 1: Element A factor 2	LTSS 1: Element A factor 2
9	Appropriate Expertise	438.210.b.3	UM 4: Element A-D, F MED 9: Element B	UM 4: Element A-D, F MED 9: Element C
10	Notice of Adverse Benefit Determination	438.210.c	UM 7: Element B, E	UM 7: Element B, E
18	Emergency Service Limitations	438.114.d-.d.1.ii	MED 9: Element C	MED 9: Element D
19	Subsequent Treatment	438.114.d.2	MED 9: Element C	MED 9: Element D
20	Transfer or Discharge	438.114.d.3	MED 9: Element C	MED 9: Element D
24	Language and Format	438.10.d.1-.d.6.iii	MED 12: Elements C-H ME 7: Element A factor 5, B factor 5 ME 2: Element A factor 5, B UM 3: Element A factors 4-5 MED 13: Element B-C NET 6: Element L NET 1: Element A ME 3: Element C	MED 12: Element C-G ME 3: Element C
26	Provider Termination	438.10.f.1	MED 1: Element H NET 5: Element A	MED 1: Element H NET 5: Element A

QP Standard: Provider Selection				
Element #	**AQS Tool Element Name**	**CFR Reference(s)**	**2020 NCQA Element(s)**	**2021 NCQA Element(s)**
1	Credentialing and Recredentialing Process	438.214.b.2	CR 1: Element A-B CR 2: Element A LTSS 1: Element I	CR 1: Element A-B CR 2: Element A LTSS 1: Element I factors 1-3

2	Provider Selection P&Ps	438.214.c	CR 1: Element A factor 6	CR 1: Element A factor 6
3	Excluded Providers	438.214.d.1	Not Deemable	MED 1: Element L

QP Standard: Confidentiality				
Element #	**AQS Tool Element Name**	**CFR Reference(s)**	**2020 NCQA Element(s)**	**2021 NCQA Element(s)**
1	Written P&Ps	438.224	MED 4: Element A-C	MED 4: Elements A-C MHC 1: Element C factors 1-3

QP Standard: Grievance and Appeal Systems				
Element #	**AQS Tool Element Name**	**CFR Reference(s)**	**2020 NCQA Element(s)**	**2021 NCQA Element(s)**
1	System in Place	438.402.a	MED 10: Element A-B ME 7: Element A-B UM 5: Element D UM 8: Element A factor 10 ME 2: Element A factor 15	MED 10: Elements A-B ME 7: Elements A-B UM 5: Element D UM 8: Element A factor 10 ME 2: Element A factor 15
2	One Level	438.402.b	UM 8: Element A factor 10 ME 2: Element A factor 15	UM 8: Element A factor 10 ME 2: Element A factor 15
3	State Fair Hearing (SFH)	438.402.c-.c.1.i	MED 10: Element A factor 4, B factor 4 UM 8: Element A factor 14 ME 2: Element A factor 15	MED 10: Element A factor 5, B factor 4 UM 8: Element A factor 14 ME 2: Element A factor 15
4	Provider Assistance	438.402.c.1.ii	UM 8: Element A factor 14	UM 8: Element A factor 14
5	Timeframe to Request Appeal	438.402.c.2-.2.ii	MED 10: Element A UM 8: Element A	MED 10: Element A UM 8: Element A

QP Standard: Grievance and Appeal Systems				
Element #	**AQS Tool Element Name**	**CFR Reference(s)**	**2020 NCQA Element(s)**	**2021 NCQA Element(s)**
6	Methods	438.402.c.3-.3.ii	MED 10: Element A factor 4	MED 10: Element A factor 5
7	Availability of Notices	438.404.a	UM 5 UM 7 MED 9	UM 5 UM 7 MED 9
8	ABDN Inclusions	438.404.b.1-.6	UM 7: Element B-C MED 9: Element A	UM 7: Element B, C, E, F MED 9: Element B
9	ABDN Mailing	438.404.c.1	Not Deemable	MED 9: Element A
10	Denial of Payment	438.404.c.2	UM 5: Element A factor 5, B UM 8: Element A factor 7 UM 9: Element B factor 1	UM 5: Element A factor 5, B UM 8: Element A factor 7
12	Reasonable Assistance	438.406.a	Not Deemable	UM 3: Element A factors 1-5 MED 10: Element A factors 4 & 10
13	Acknowledge Receipt	438.406.b-.b.1	MED 10: Element A factor 1	MED 10: Element A factor 1
14	Reviewer Requirements	438.406.b, b.2-b.2.iii	UM 8: Element A factors 2-6 UM 9: Element A factors 1-2 MED 10: Element A factor 2	UM 8: Element A factors 2-6 UM 9: Element A factors 1-2 MED 10: Element A factor 3
15	Oral Inquiries	438.406.b.3	MED 10: Element A factor 4 ME 7: Element B factors 1-5 UM 8: Element A factors 4, 9, &12	MED 10: Element A factors 2 & 5 ME 7: Element B factors 1-5 UM 8: Element A factors 4, 9, & 12
16	Opportunity to Make an Argument	438.406.b.4	UM 8: Element A factor 4	UM 8: Element A factor 4
17	Member Information Provided	438.406.b.5	UM 8: Element A factor 4 & 12	UM 8: Element A factors 4 & 12
18	Parties to the Appeal	438.406.b.6-.6.ii	UM 7: Element C factor 2 & F factor 2 UM 8: Element A factor 14	UM 7: Element C factor 2 & F factor 2

QP Standard: Grievance and Appeal Systems				
Element #	**AQS Tool Element Name**	**CFR Reference(s)**	**2020 NCQA Element(s)**	**2021 NCQA Element(s)**
				UM 8: Element A factor 14
20	Standard Grievance Resolutions	438.408.b.1	MED 10: Element A factor 4	MED 10: Element A factor 5
21	Standard Appeal Resolutions	438.408.b.2	UM 8: Element A factors 7-8 UM 9: Element B factors 1-2	UM 8: Element A factors 7-8 UM 9: Element B factors 1-2
22	Expedited Appeal Resolutions	438.408.b.3	UM 8: Element A factor 9 UM 9: Element B factor 3	UM 8: Element A factor 9 UM 9: Element B factor 3
23	Timeframe Extensions	438.408.c.1-.1.ii	MED 10: Element A UM 8: Element A UM 9: Element B	MED 10: Element A UM 8: Element A UM 9: Element B
24	Requirements Following Extension	438.408.c.2-.2.ii	MED 10: Element A UM 8: Element A UM 9: Element B	MED 10: Element A UM 8: Element A UM 9: Element B
25	Format of Resolutions	438.408.d.2-.2.ii	MED 10: Element A factor 5 MED 12: Element F factors 1-4 ME 7: Element B factor 3 UM 8: Element A factor 9 UM 9: Element D factors 1-6	MED 10: Element A factor 6 MED 12: Element F factors 1-4 ME 7: Element B factor 3 UM 8: Element A factor 9 UM 9: Element D factors 1-6
26	Results and Date	438.408.e.1	UM 9: Element D factor 1	UM 9: Element D factor 1
27	Additional Resolution Contents	438.408.e.2-.2.iii	UM 8: Element A factor 16 ME 2: Element A factor 15 MED 9: Element A factors 1 & 4	UM 8: Element A factor 16 ME 2: Element A factor 15 MED 9: Element B factors 1 & 4
28	Expedited Review Process	438.410.a	UM 8: Element A factor 9	UM 8: Element A factor 9
29	Punitive Action Prohibited	438.410.b	Not Deemable	MED 10: Element A factor 7
30	Expedited Resolution Denials	438.410.c-.c.2	MED 10: Element A factor 6 UM 8: Element A factors 7-9	MED 10: Element A factor 8 UM 8: Element A factors 7-9

QP Standard: Grievance and Appeal Systems				
Element #	**AQS Tool Element Name**	**CFR Reference(s)**	**2020 NCQA Element(s)**	**2021 NCQA Element(s)**
31	Information for Providers and Subcontractors	438.414	MED 10: Element B factors 1-5	MED 10: Element B factors 1-5
32	Ongoing Monitoring	438.416.a	MED 10: Element C factors 1-8 UM 9: Element A factors 1-3	MED 10: Element C factors 1-8 UM 9: Element A factors 1-3
33	Records Requirements	438.416.b-.b.6	MED 10: Element C factors 1-8	MED 10: Element C factors 1-8
35	Continuous Benefits Requirements	438.420.b-.b.5	MED 11: Element B factors 1-5	MED 11: Element B factors 1-5
36	Termination of Benefits	438.420.c-.c.3	MED 11: Element C factors 1-3	MED 11: Element C factors 1-3
37	Cost Recovery	438.420.d	MED 11: Element B-C	MED 11: Elements B-C
38	Services Not Furnished During Pending Appeal	438.424.a	MED 10: Element D factor 1	MED 10: Element D factor 1
39	Services Furnished During Pending Appeal	438.424.b	MED 10: Element D factor 2	MED 10: Element D factor 2

QP Standard: Subcontractual Relationships and Delegation				
Element #	**AQS Tool Element Name**	**CFR Reference(s)**	**2020 NCQA Element(s)**	**2021 NCQA Element(s)**
1	Delegated Activities	438.230.a-.c.1.i	CR 8, ME 8, UM 13 QI 5: Element B	CR 8, ME 8, UM 13 QI 5: Element B
2	Remedies for Unsatisfactory Performance	438.230.c-.c.1, .c.1.ii-.iii	CR 8, ME 8, UM 13 QI 5: Elements A-B	CR 8, ME 8, UM 13 QI 5: Elements A-B
QP Standard: Health Information Systems				
Element #	**AQS Tool Element Name**	**CFR Reference(s)**	**2020 NCQA Element(s)**	**2021 NCQA Element(s)**

1	System Requirements	438.242.a	MCO's ability to submit NCQA's IDSS files	MCO's ability to submit NCQA's IDSS files
2	Data Collection	438.242.b, .b.2	MCO's ability to submit NCQA's IDSS files	MCO's ability to submit NCQA's IDSS files
3	Data Accuracy and Completeness	438.242.b, .b.3-.3.iii	HEDIS Compliance Audit encompasses these requirements.	HEDIS Compliance Audit encompasses these requirements.
4	Data Availability	438.242.b, .b.4	MCO's ability to submit NCQA's IDSS files	MCO's ability to submit NCQA's IDSS files

QP Standard: Quality Assessment and Performance Improvement (QAPI) Program				
Element #	**AQS Tool Element Name**	**CFR Reference(s)**	**2020 NCQA Element(s)**	**2021 NCQA Element(s)**
1	Program in Place	438.330.a.1	QI 1: Element A factors 1-6, B factors 1-5	QI 1: Element A factors 1-6, B factors 1-5
3	Under-/Over-Utilization	438.330.b, .b.3-.4	MED 7: Element A factors 1-4	MED 7: Element A factors 1-4
4	LTSS Requirements	438.330.b, .b.5-.5.ii	MED 7: Element A factor 3 LTSS 1: Element H factors 1-5 LTSS 2: Element A factors 1-2, E factors 2 & 4	MED 7: Element A factor 3 LTSS 1: Element H factors 1-5 LTSS 2: Element A factors 1-2, E factors 2 & 4

Appendix 6: Tennessee Directed Payment Programs

Table 11. 438.6(c) Directed Payment Programs Overview

	Directed Payment Description	Payment Type	Quality Strategy Goals	Quality Strategy Objectives
1	Fee Schedules ("Sweeper")	Fee Schedule	Goal 3: Integrate patient-centered, holistic care including non-medical risk factors into population health coordination for all members Goal 4: Improve positive outcomes for members with LTSS needs Goal 6: Maintain robust member access to health care services	Objective(s): 3.3-3.5 Ensure CHOICES, ECF CHOICES, and Katie Beckett members receive holistic care 4.1-4.3 Maintain or improve quality of life for CHOICES, ECF CHOICES and Katie Beckett members 6.1 Ensure all members can access care according to time and distance standards
2	Hospital Uniform Percentage Increase	Fee Schedule	Goal 2: Increase use of preventive care services for all members to reduce risk of chronic health conditions	Objective(s): 2.8 Reduce rate of hospital readmissions
3	Hospital Rate Variation	Fee Schedule	Goal 2: Increase use of preventive care services for all members to reduce risk of chronic health conditions	Objective(s): 2.7 Decrease emergency department utilization for children 2.8 Reduce rate of hospital readmissions
4	Emergency Medical Services (ground ambulance) Uniform Dollar Increase	Fee Schedule	Goal 6: Maintain robust member access to health care services	Objective(s): 6.2 Ensure adult members can access care, tests, or treatments timely 6.3 Ensure child members can access care, tests, or treatments timely
5	Patient Centered Medical Homes (PCMH)	Value-Based Purchasing	Goal 7: Maintain financial stewardship through increasing value-based payments and cost-effective care	Objective(s): 7.1 Maintain the percentage of TennCare members attributed to PCMH organizations

6	Academic Affiliated Physicians' Upper Payment Limit (UPL)	Fee Schedule & Value-Based Purchasing	Goal 1: Improve the health and wellness of new mothers and infants Goal 2: Increase use of preventive care services for all members to reduce risk of chronic health conditions	Objective(s) 1.1 Increase the use of prenatal services 1.2 Increase the use of postpartum services 2.3 Increase child immunizations 2.8 Reduce the rate of hospital readmissions
7	Tennessee Health Link (THL)	Value-Based Purchasing	Goal 5: Provide additional support and follow-up for patients with behavioral health care needs Goal 7: Maintain financial stewardship through increasing value-based payments and cost-effective care	Objective(s): 5.1 Improve follow-up after hospitalization for mental illness in adults 5.2 Improve follow-up after hospitalization for mental illness in children 7.3 Increase the number of TennCare members who are active in the Tennessee Health Link program
8	Emergency Medical Services (ground ambulance) Minimum Fee Schedule	Fee Schedule (State Plan Amendment)	Goal 6: Maintain robust member access to health care services	Objective(s): 6.2 Ensure adult members can access care, tests, or treatments timely 6.3 Ensure child members can access care, tests, or treatments timely
9	Home & Community Based Services (HCBS) Workforce Development Incentives	Value-Based Purchasing	Goal 3: Increase LTSS Member Satisfaction Goal 4: Improve positive outcomes for members with LTSS needs Goal 7: Maintain financial stewardship through increasing value-based payments and cost-effective care	Objective(s): 3.3-3.5 Ensure CHOICES, ECF CHOICES, and Katie Beckett members receive holistic care 4.1-4.3 Maintain or improve quality of life for CHOICES, ECF CHOICES and Katie Beckett members