Division of TennCare

Tennessee Department of Finance & Administration

Division of TennCare

TennCare II Demonstration

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Extension Application

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TennCare II Extension Application

The TennCare demonstration under which the state of Tennessee operates its Medicaid program is one of the longest-lasting and most comprehensive Medicaid managed care programs in the country. Now in its twenty-seventh year of operation, the TennCare program that exists today is a mature, data-driven managed care program with well-functioning component parts and a stable, established infrastructure that delivers high-quality healthcare services to one in five Tennesseans, including many of the state's must vulnerable citizens—children from low-income families, pregnant women, and people with disabilities. The TennCare demonstration has gone through a number of refinements and changes since its inception in 1994. However, the core values of the program—broad access to care, improved health status of program participants, and cost-effective use of resources—remain much the same.

The state of Tennessee is requesting a ten-year extension of the current TennCare II demonstration. The requested extension period is July 1, 2021, through June 30, 2031. Tennessee is requesting a small number of modifications to the demonstration for this extension period, most notably to more fully integrate services for persons with disabilities into the state's larger managed care service delivery system. These proposed changes are discussed in Section II.

This document and its constituent sections are organized according to, and comply with, the requirements specified at 42 CFR § 431.412(c)(2), governing requests to extend existing Medicaid demonstration projects. The topics addressed are: a historical narrative summary of the TennCare demonstration, a description of changes being requested, a list and description of the waivers and expenditure authorities being requested, summaries related to quality of and access to care, financial data demonstrating the state's historical and projected expenditures, a draft interim evaluation report, and documentation of the state's compliance with required public notice procedures.

I. Historical Narrative Summary of TennCare II

On January 1, 2020, the TennCare demonstration began its twenty-seventh year.

The Early Years of TennCare

With the large number of Medicaid managed care programs that exist today, it is sometimes difficult to recall that managed care was a relatively new concept for Medicaid in 1994. Only a handful of states had statewide Medicaid managed care programs in operation that year,[1] and Tennessee was the only state to require its entire Medicaid population to participate in managed care, which has always been a feature of TennCare.[2] Unlike every other state, Tennessee's Medicaid program does not have a fee-for-service (FFS) component.

[1] Kaiser Family Foundation, *Medicaid and Managed Care Policy Brief*, June 1995. Accessed online at http://kff.org/medicaid/issue-brief/medicaid-and-managed-care-policy-brief on November 8, 2020.

[2] TennCare has always required that all eligible persons participate in managed care, even though some

When Tennessee's original demonstration request was submitted to the Centers for Medicare and Medicaid Services (CMS), the state's experience with Medicaid managed care was limited to a single voluntary primary care case management (PCCM) program that offered only four Medicaid services to participants who lived in one of a handful of Tennessee counties. Yet the state made a tremendous leap virtually overnight, moving from a Medicaid managed care penetration rate of 3 percent on December 31, 1993, to a penetration rate of 100 percent on January 1, 1994. The implementation of TennCare in 1994 reflected a commitment on the part of both the state and CMS to innovation in the delivery of medical assistance to low-income and uninsured people, and it created a Medicaid service delivery model that has ensured access to healthcare for millions of Tennesseans in the years since.

TennCare II

In 2002, after some years of volatility in the TennCare program, the Tennessee General Assembly passed the TennCare Reform Act, which was intended to bring increased stability to the program and to ensure that it could operate in a more sustainable manner. The TennCare Reform Act envisioned a new program called "TennCare II." TennCare II began on July 1, 2002, and continues today. Unless stated otherwise, all references to "TennCare" from this point on will be considered to mean "TennCare II." A list of key leaders who have shaped TennCare II is attached to this application as Appendix A.

The TennCare II demonstration has been reviewed and approved by CMS on five previous occasions. (See Table 1.) Each approval period was authorized under a specific paragraph of Section 1115 of the Social Security Act.

Table 1. TennCare II Approval Periods.

Approval	Dates	Approval Authority under the Social Security Act
1	July 1, 2002 – October 4, 2007	Section 1115(a)
2	October 5, 2007 – June 30, 2010	Section 1115(a)
3	July 1, 2010 – June 30, 2013	Section 1115(e)
4	July 1, 2013 – December 15, 2016	Section 1115(f)
5	December 16, 2016 – June 30, 2021	Section 1115(a)

The historical narrative below summarizes key developments that occurred in the demonstration in each of these approval periods.

Approval Period #1 (2002-2007)

- Under the authority of the revised "TennCare II" demonstration, Tennessee continued operating the statewide Medicaid managed care program begun in 1994.

individuals may receive certain services outside the demonstration.

- The TennCare member population was divided into two components: TennCare Medicaid (for individuals eligible for TennCare under Medicaid State Plan authority) and TennCare Standard (for individuals eligible for TennCare under demonstration authority).
- After a period of instability under the previous iteration of TennCare, a "stabilization plan" was implemented for an eighteen-month period to allow MCOs to operate temporarily on an administrative services organization (ASO) basis and thereby gain time to stabilize their operations.
- TennCare Select began operating as a back-up managed care plan to be available should an MCO participating in TennCare have to leave the program unexpectedly.
- Pharmacy services were "carved out" of the MCO program to a separate pharmacy benefits manager (PBM), and dental services were carved out to a separate dental benefits manager (DBM).
- By the end of 2006, all active MCOs participating in TennCare had received accreditation from the National Committee for Quality Assurance (NCQA).
- A formal competitive procurement process was introduced and used to bring new MCOs to the Middle Tennessee Region.
- Tennessee extended Medicaid eligibility to uninsured persons needing treatment for breast or cervical cancer.

Approval Period #2 (2007-2010)

- The state extended the use of its formal competitive procurement process to bring new MCOs to the East Tennessee and West Tennessee Regions.
- The carve-out for behavioral health and substance use disorder (SUD) treatment services that had been in operation since 1996 was phased out. Responsibility for delivering behavioral health and SUD treatment services, and for integrating these services with physical health services, was transitioned to the MCOs and brought into the overall continuum of care provided by the MCOs.
- CHOICES, a managed long-term services and supports (MLTSS) program, was begun. Responsibility for LTSS provided to persons who were elderly and to adults with physical disabilities was transitioned to the MCOs. The state's 1915(c) home- and community-based services (HCBS) waivers serving this population were closed.

Approval Period #3 (2010-2013)

- Funded in part by State Innovation Model (SIM) grant funding, the state worked with its contracted MCOs and other stakeholders to design and implement a series of delivery system reform initiatives. These initiatives focused on improving the quality and cost-effectiveness of care by emphasizing paying for value rather than paying for volume. The state's delivery system reform initiative encompasses strategies that enhance the role of the primary care provider, that align multi-payer models, that focus on improving quality and shifting payment in the LTSS system, and that can be translated into "episodes of care" when multiple providers are involved in acute health care events.
- The state began implementation of the provisions of the Affordable Care Act affecting Medicaid.

Approval Period #4 (2013-2016)

- The state implemented Employment and Community First CHOICES, a new MLTSS program providing HCBS for individuals with intellectual or other developmental disabilities. Employment and Community First CHOICES is a unique program specifically geared toward promoting and supporting integrated, competitive employment and independent, integrated community living as the first and preferred option for persons with intellectual or developmental disabilities.
- The state transitioned to a statewide model of MCO service delivery, effective January 1, 2015. A new procurement process was organized to obtain MCOs that could operate on a statewide basis (as opposed to a regional basis).
- Tennessee extended Medicaid eligibility to young adults aging out of foster care.

Approval Period #5 (2016-2021)

- TennCare implemented a medication therapy management (MTM) pilot program providing an MTM benefit to certain members meeting specified clinical risk criteria. The state is currently gathering data on the effectiveness of the MTM initiative to inform future decision-making about its continuation, discontinuation, or expansion to additional populations.
- The state added two new benefit groups to the Employment and Community First CHOICES program. These new groups provide specialized supports and services for persons with intellectual or developmental disabilities and severe co-occurring behavioral health and/or psychiatric conditions.
- The state implemented "TennCare Connect," a new online eligibility determination system for Medicaid and CHIP.
- The state added methadone clinic services to its package of covered benefits for adults.
- The state implemented a new "Katie Beckett"-type program for children with disabilities or other complex medical needs who are not otherwise eligible for TennCare due to their families' income or assets.[3]

Key Themes of TennCare's History

Viewed over time, several themes emerge as prominent features of Tennessee's Medicaid program under the TennCare demonstration. Key among these have been integration of care, commitment to innovation, and sustainable program management.

Integration of Care

Integration of care has been a primary focus of the TennCare program since its inception. Effective integration and coordination of care promotes a better experience for members, more cost-effective service delivery, and improved health outcomes. Under the TennCare demonstration, Tennessee has pursued a number of strategies over time to work progressively toward greater integration of member care. These include ending the separate carve-out for behavioral health services in 2009 so that a single

[3] CMS approved the addition of the Katie Beckett program on November 2, 2020. As of the publication of this document, the state is preparing for implementation of the new program.

entity (the member's MCO) is responsible for administering and coordinating a member's physical and behavioral health needs. LTSS for persons who are elderly or who have physical disabilities were carved into the MCO program with the creation of CHOICES in 2010, and certain LTSS for individuals with intellectual and developmental disabilities were integrated into the MCO program with the implementation of Employment and Community First CHOICES in 2016. As part of this extension application, the state is proposing to take the next step in aligning care for members with intellectual disabilities by integrating services authorized under the state's remaining 1915(c) waivers into the larger managed care program. (See Section II for more discussion of these proposed changes.)

In addition, the state's most significant service delivery system reform strategies have focused on greater integration and coordination of care to produce improved health outcomes as well as more cost-effective care. Under the state's episodes of care program, providers overseeing an acute healthcare episode are incentivized to play a more active role in coordinating member care across the entirety of the episode. Under the state's patient-centered medical home and health home programs, primary care providers receive similar incentives to focus on keeping members healthy, as well as supports from the state, to enhance the effectiveness of primary care delivered to TennCare members. In LTSS, Tennessee is leveraging Medicare Part C authority and the D-SNP (Dual Eligible Special Needs Plan) platform to help align members in the same health plan for Medicare and Medicaid benefits. As part of the MCO procurement process in 2013, the state began requiring each MCO to set up a companion D-SNP so that members would have the opportunity to choose to receive their Medicare and Medicaid services from the same entity. TennCare makes use of the MIPPA (Medicare Improvements for Patients and Providers Act) agreement to strengthen coordination requirements for D-SNPs—particularly those related to discharge planning, care transitions, and use of LTSS.

Innovation

One of the most significant aspects of the TennCare demonstration is that—by allowing the state to operate a single statewide service delivery system in a financially sustainable way—it has created the conditions that have allowed the state to pursue a variety of program innovations. The encouragement for innovation provided by the demonstration has enabled the state to implement and sustain strategies over time that lead to improved health outcomes and more cost-effective care.

Some of the most powerful innovations that have come about under TennCare have been in the area of LTSS. The state currently has an MLTSS program for elderly persons and adults with physical disabilities (CHOICES) and a companion MLTSS program for persons with intellectual and developmental disabilities (Employment and Community First CHOICES). CHOICES has clearly opened up a whole new world of community supports and services for persons who are elderly or who have physical disabilities, while continuing to recognize the important role played by nursing facilities (NFs) in the continuum of care for this population. Prior to the implementation of CHOICES, 83 percent of TennCare's LTSS population was served in NFs, while 17 percent received services in HCBS settings. As of June 30, 2020, that balance was 57 percent receiving services in NFs and 43 percent receiving HCBS. Similarly, since the implementation of Employment and Community First CHOICES, the number of individuals with intellectual disabilities receiving HCBS through TennCare has grown from 8,295 to 8,637, and the number of individuals with less

severe developmental disabilities receiving HCBS through TennCare has grown from 0 to 1,490. Since the implementation of Employment and Community First CHOICES, the percentage of working age adults with intellectual or developmental disabilities who are enrolled in HCBS programs, employed in an integrated setting, and earning at or above the minimum wage has grown from 13 percent to 18 percent. Outcomes for persons enrolled in CHOICES and Employment and Community First CHOICES are discussed in more detail in the draft interim evaluation report attached to this application.

In recent years, Tennessee has partnered with CMS in the development and implementation of several delivery system reform initiatives, including strategies aimed at primary care, acute care, and long-term care.

- The state's episodes of care initiative focuses on acute or specialist-driven care delivered during a specified time period to treat physical or behavioral conditions such as an acute diabetes exacerbation or total joint replacement. Each episode has a principal accountable provider who is incentivized to monitor and coordinate care over the span of the entire episode to improve the cost and quality of the episode. In 2019, the state's episodes program was approved as an Advanced Alternative Payment Model (APM) by the CMS Innovation Center through 2025.
- Launched in 2017, the state's patient-centered medical home (PCMH) program aims to improve the capabilities and reach of primary care providers and the overall quality of primary care delivered to the TennCare population. Through a combination of financial incentives and provider supports, the PCMH program encourages primary care providers to improve health outcomes by providing high-quality and efficient treatment of medical conditions and maintaining people's health over time. The general PCMH program is supplemented by a specialized health home program for members with significant behavioral health needs.
- The LTSS component of the state's delivery system reform strategy focuses on improving quality and shifting payment to outcome-based measures for LTSS providers.

The state estimates that these delivery system reform initiatives have resulted in savings of more than $45 million in annual program costs, while maintaining or improving health outcomes.[4] In 2019, Tennessee's delivery system transformation efforts were recognized by the National Association of Medicaid Directors (NAMD) with a "Spotlight on Innovation" award (one of only two awarded by the Association that year).

Although Tennessee has long worked to confront the effects of opioid misuse and abuse, this work has taken on new urgency in recent years, with TennCare launching a new multi-pronged strategy to combat opioid abuse in 2017. This strategy has focused on primary prevention (changing prescribing policies to reduce new instances of opioid addiction) as well as enhancing the availability and quality of treatment options for individuals already dealing with opioid dependence. The state has worked extensively with its managed care plans and the provider community to enhance the quality of medication assisted treatment (MAT) provided to TennCare members. This included the addition of methadone clinic services to TennCare's package of covered benefits for adults in 2020. The state has also focused extensively on outreach to women of child-bearing age chronically using opioids to provide education and treatment

[4] To estimate savings, the state used an annual medical inflation rate of 3 percent.

options, as well as removing barriers to accessing voluntary reversible long-acting contraception. In 2019, Tennessee, partnering with Vanderbilt University Medical Center, was one of 10 states selected by the CMS Innovation Center to participate in the Maternal Opioid Misuse (MOM) Model. The goal of this new model is to improve health outcomes for women with opioid use disorder and their infants beginning in pregnancy and extending to one year postpartum by focusing on the coordination of clinical care and the integration of other services critical for health, well-being, and recovery. Tennessee's efforts in this area have already begun to bear fruit, with the number of acute opioid users in the TennCare member population declining by 50 percent since 2016.[5] In addition, neonatal abstinence syndrome (NAS) rates for TennCare members have declined by 13 percent over the last two years, making Tennessee one of the only states in the country to report a decline in NAS.[6]

In 2018, the state implemented a new medication therapy management (MTM) pilot program under the authority of the TennCare demonstration. MTM is a clinical service provided by licensed pharmacists, the aim of which is to optimize drug therapy and improve therapeutic outcomes for patients. MTM services include medication therapy reviews, pharmacotherapy consults, monitoring efficacy and safety of medication therapy, and other clinical services. During this pilot phase, MTM services are available to members in the state's PCMH and health home programs who meet specified clinical risk criteria. The state intends to use data on the cost and quality impact of MTM gathered during this pilot period to inform future decision-making about the use of MTM within the larger TennCare program. The state's MTM pilot is discussed in more detail in Appendix C.

Sustainability and Cost-Effective Use of Resources

Sustainability has also been a key theme of the TennCare demonstration. Although ensuring broad access to high-quality care and improving health outcomes are key goals of the TennCare demonstration, without prudent fiscal management the state's ability to provide such access and to invest in strategies to improve health outcomes would be compromised. The TennCare demonstration has provided the state with a framework for responsible program management that has been vital in ensuring that Tennessee can continue to make high-quality, comprehensive medical care available to low-income Tennesseans now and well into the future.

This demonstrated and sustained success of the TennCare demonstration as a framework for effective program management has resulted in clear benefits for the state, CMS, and Medicaid beneficiaries in Tennessee. Whereas uncontrolled growth in Medicaid spending would create an unsustainable program and ultimately lead to significant reductions, the TennCare demonstration has been critical in ensuring the sustainability of the Medicaid program in Tennessee as a viable source of assistance for low-income Tennesseans that will continue to be available into the future.

[5] Based on pharmacy claims paid by TennCare.

[6] The NAS rate for TennCare members declined from 28.2 cases per 1,000 live births in 2016, to 24.6 cases per 1,000 live births in 2018.

The Continuing Significance of the TennCare Demonstration

Managed care has been central to the TennCare demonstration since its inception in 1994. However, managed care for its own sake is not and has never been the sole purpose of TennCare. Rather, the TennCare demonstration has allowed the state to harness the savings and efficiencies associated with operating a single, statewide managed care service delivery system to drive improvements in access, quality, and health outcomes. Said differently, the TennCare demonstration is not merely a managed care program, nor is it an arbitrary collection of various waivers and expenditure authorities; rather, it is a specially crafted set of flexibilities that support the implementation of a unique statewide Medicaid reform demonstration project.

Eligibility

One domain in which this is most easily observed is the number of individuals not previously eligible for Medicaid in Tennessee who receive healthcare coverage by virtue of the TennCare demonstration. In addition to covering all mandatory and many optional Medicaid eligibility categories, under the authority of the TennCare demonstration Tennessee has extended eligibility to many individuals and groups who would not otherwise be eligible for Medicaid coverage. This includes some so-called "hypothetical" Medicaid-eligibles, as well as a number of groups that can only be covered under the authority of the 1115 demonstration. These include:

- Medically Eligible Children – Children who have lost Medicaid eligibility and do not have other insurance, and who are determined to be "medically eligible" for continued TennCare coverage based on identified diagnoses or health needs;
- Uninsured Children – Low-income children who have lost Medicaid eligibility and do not have other insurance;
- CHOICES Members – Individuals who are elderly and/or have physical disabilities who need long-term care but do not qualify for Medicaid;
- Employment and Community First CHOICES Members – Individuals with intellectual or other developmental disabilities who need long-term services and supports but do not qualify for Medicaid;
- CHOICES and PACE "Carryovers" – Individuals who were enrolled in CHOICES or PACE when the state's level of care criteria for nursing facility care were modified in 2012 and who do not meet the state's current level of care criteria;
- Medically Needy Pregnant Women and Children – Pregnant women and children whose gross income exceeds TennCare's income standard, but who use unreimbursed medical bills to "spend down" their income to a specified level[7];

[7] Although medically needy pregnant women and children are technically eligible for coverage under the Medicaid State Plan, it is the TennCare demonstration that allows the state to continue enrolling and covering these individuals. Under demonstration authority, the state provides medically needy members with 12 months of coverage in the same manner in which it provides such coverage to categorically needy individuals. This policy is what allows the state to continue covering medically needy individuals within a 100 percent managed care system.

- Extended Medicaid – Children, pregnant women, or parents/caretaker relatives of dependent children who lose Medicaid eligibility due to increased spousal support payments[8]; and
- Katie Beckett – Children with disabilities or other complex medical needs who are living at home with family and do not qualify for Medicaid based on household income or resources.[9]

Expanded Benefits

In addition, the authority of the TennCare demonstration—and the savings that have been generated by the demonstration—have allowed the state to make significant enhancements to its benefits package, allowing the state to cover many services not covered in the Medicaid State Plan, or to cover such services in excess of limits specified in the State Plan. Table 2 provides an overview of these demonstration benefit enhancements.[10]

Table 2. Benefits Available under the TennCare Demonstration

Service	State Plan Coverage for Adults	Coverage under the Demonstration
Services for presumptively eligible pregnant women	Limited to ambulatory prenatal care.	All TennCare benefits are covered.
Certain diagnostic, screening, and preventive services for adults	Not covered.	Covered as medically necessary.
Home health services	Covered with limitations.	Covered in accordance with the conditions specified in the TennCare demonstration.
Hospice services	Covered with limitations.	Covered as medically necessary.
Inpatient and outpatient substance use disorder treatment services	Not covered.	Covered as medically necessary.
Inpatient hospital services	Covered with limitations.	Covered as medically necessary.
Lab and X-ray services	Covered with limitations.	Covered as medically necessary.

[8] Although extended Medicaid is typically available for four months of continued coverage, under the authority of the TennCare demonstration, Tennessee has long provided 12 months of extended coverage to qualifying individuals.

[9] CMS approved the addition of three Katie Beckett-related eligibility groups to the TennCare demonstration on November 2, 2020. As of the publication of this document, the state is preparing to implement these new groups.

[10] See Table 2a of the TennCare demonstration for additional information.

Service	State Plan Coverage for Adults	Coverage under the Demonstration
Medication therapy management (MTM)	Not covered.	Covered as part of an MTM pilot for certain members who meet specified clinical risk criteria.
Occupational therapy	Not covered.	Covered as medically necessary.
Organ and tissue transplants	Covered with limitations.	Covered as medically necessary.
Outpatient hospital services	Covered with limitations.	Covered as medically necessary.
Physical therapy	Not covered.	Covered as medically necessary.
Physician services	Covered with limitations.	Covered as medically necessary.
Private duty nursing services	Not covered.	Covered in accordance with the conditions specified in the TennCare demonstration.
Speech therapy	Not covered.	Covered as medically necessary.
Vision services	Not covered.	The first pair cataract glasses or lenses following cataract surgery is covered.

Ensuring Access to Care

In terms of ensuring access to care, it is important to note that unlike other states, Tennessee does not have a traditional Medicaid Disproportionate Share Hospital (DSH) allotment with which to support hospitals. The elimination of Tennessee's DSH allotment is an outgrowth of the original TennCare demonstration in 1994.[11] In lieu of a traditional DSH allotment, the TennCare demonstration authorizes two uncompensated care funds which the state uses to support hospitals participating in Medicaid—the "virtual DSH" fund and the uncompensated care fund for charity care.

In the absence of a traditional DSH allotment, these demonstration funds have played a key role in contributing to both access to care for TennCare members and provider participation in the TennCare program. They have helped hospitals meet the challenges of serving high levels of Medicaid patients, as well as patients requiring uncompensated care.

[11] Congress has currently established a small, temporary DSH allotment for Tennessee.

II. Narrative Description of Changes Being Requested

The state is requesting a limited number of modifications to the demonstration for the upcoming approval period. These proposed changes generally support the ongoing development of the TennCare managed care system by supporting increased integration of care for members with disabilities.

Integration of HCBS for Members with Intellectual Disabilities

Although Tennessee has long required all Medicaid-eligible individuals to enroll in managed care for receipt of their medical care, certain Medicaid services were initially carved out of the state's managed care program. Over time, more and more of these services have been integrated into the managed care delivery system, resulting in opportunities for better care coordination and management and aligning with the state's larger policy goal of operating a single, integrated service delivery system.

HCBS for individuals with intellectual disabilities (ID) is a service type that was historically carved out of the TennCare managed care program. These services were delivered under the authority of separate 1915(c) waivers and administered by TennCare in partnership with the Tennessee Department of Intellectual and Developmental Disabilities (DIDD). Tennessee took the first step toward integrating HCBS for members with ID into the larger TennCare managed care program in 2016. At that time, new enrollment into the 1915(c) waivers was closed,[12] and the Employment and Community First CHOICES program was launched as a fully integrated MLTSS program for individuals with ID within the TennCare demonstration.

Now TennCare, working closely with DIDD and other stakeholders, proposes to integrate the remaining HCBS authorized under the state's 1915(c) waivers into the state's managed care program. Under the state's proposal, these HCBS will continue to be authorized under 1915(c) authority, and DIDD will continue to be instrumental in providing oversight of the delivery of services for members with ID, but the services will become part of the package of benefits administered by the MCOs through the managed care service delivery system. The state is also proposing a corresponding change to integrate its ICF/IID benefit into the managed care program.[13] These changes will provide for better integration and coordination of care for members with ID.

The specific changes the state is requesting relative to services for individuals with ID are as follows:[14]

- ICF/IID and 1915(c) waiver services will be administered through the managed care program (maintaining concurrent 1915(c) authority for waiver services and Medicaid State Plan authority for IFC/IID services). These benefits will be removed from Table 3 in the demonstration's special terms and conditions (listing benefits carved out of the managed care program).

[12] The 1915(c) Comprehensive Aggregate Cap waiver (TN.0357) has a narrow exception for new enrollment when a person has been institutionalized in the Harold Jordan Center—a public ICF/IID—for a period of at least 90 days.
[13] ICF/IID refers to intermediate care facility for individuals with intellectual disabilities.
[14] In some cases, the programmatic changes described above entail corresponding modifications to the state's 1915(c) waivers. The state is pursuing these changes through the 1915(c) waiver amendment process outside of this application.

- ICF/IID services will include a Community Informed Choice process to ensure that individuals understand the full array of community-based options available to meet their needs, and having been fully informed, affirmatively choose institutional placement. This will better align the provision of ICF/IID services with federal law that did not exist when the benefit was first established (i.e., the Americans with Disabilities Act).
- The ECF CHOICES Working Disabled demonstration group will be modified to include individuals enrolled in 1915(c) waivers. This will allow individuals enrolled in a 1915(c) waiver who are working to have earned income up to 250 percent of the federal poverty line (FPL) excluded when considering their continued eligibility for Medicaid and for HCBS.
- Enabling Technology (ET) will be added as a benefit in Employment and Community First CHOICES, with Table 2d of the demonstration's special terms and conditions and Attachment G modified accordingly. Limitations currently applicable to the Assistive Technology, Adaptive Equipment and Supplies (AT/AES) benefit will be applied across the ET and AT/AES benefits combined; however, an MCO may authorize services in excess of the combined benefit limit as a cost-effective alternative to institutional placement or other medically necessary covered benefits.
- The special term and condition governing the TennCare Select health plan will be modified so that members with ID assigned to TennCare Select as of July 1, 2021, will remain enrolled in TennCare Select, while members enrolled after that date will be assigned to a traditional MCO.

Transition Children Receiving SSI Benefits to the MCOs

The TennCare Select health plan is a prepaid inpatient health plan that operates in all areas of the state and which serves special populations within the TennCare demonstration. These populations are specified in the demonstration's special terms and conditions, and include children receiving SSI. The state proposes to transition children receiving SSI from the TennCare Select plan to the state's other contracted managed care plans. This change will benefit these members by allowing them the same choice in managed care plan as all other TennCare members and improve alignment for families with multiple TennCare members who are currently in different health plans.

The state (with CMS approval) stopped assigning newly enrolling children with SSI to TennCare Select in 2019, with no adverse consequences for the children affected. The state now proposes that effective with this demonstration extension, children receiving SSI who are still enrolled in TennCare Select be transferred to another health plan. Because the TennCare Select plan is currently operated by the same entity operating one of the state's fully at-risk MCOs (BlueCare) with a similar provider network, the state proposes that these children initially be enrolled in BlueCare.[15] They will subsequently have the opportunity to change MCOs like any other TennCare member.[16]

[15] TennCare Select and BlueCare are both operated by Volunteer State Health Plan, Inc., which is an independent licensee of the BlueCross BlueShield Association and a licensed HMO affiliate of its parent company, BlueCross BlueShield of Tennessee.

[16] Although the state is proposing to transfer children receiving SSI benefits from TennCare Select to BlueCare, an exception may be made in cases where a child leaving TennCare Select has other household members enrolled in another health plan. In these cases, the child would be assigned to the same health plan as her other family members.

Assign Inmates of Public Institutions to TennCare Select

As noted above, the TennCare Select health plan is a prepaid inpatient health plan that operates in all areas of the state. TennCare Select serves as a back-up health plan in the event that an MCO serving TennCare members should have to leave the program unexpectedly. Because Tennessee's Medicaid program does not have a fee-for-service component, TennCare Select also serves as the health plan for certain special populations within the TennCare demonstration for whom assignment to an at-risk health plan may not be appropriate (e.g., individuals receiving emergency medical assistance).

One such population is inmates of public institutions who are enrolled in TennCare. In general, states cannot receive federal financial participation for services provided to inmates. However, federal policy provides an exception to this rule when an inmate otherwise eligible for Medicaid is removed from the institution and admitted on an inpatient basis to a hospital or other qualified setting for at least 24 hours. In these cases, the state Medicaid program may pay for care received during the inpatient episode. However, since the individual is only receiving Medicaid-covered services for the period of time he is receiving inpatient care outside of the public institution, there is no opportunity for an MCO to truly manage the care of such members. Given this challenge, the state requests that this population be added to the list of populations assigned to TennCare Select.

Extension of Medication Therapy Management Pilot

The state originally requested authority to operate its MTM program on a pilot basis for two years, which began in July 2018. After provider participation rates were initially lower than projected, the state requested to continue implementing the MTM program for an additional 12 months to ensure that the state would have sufficient data on the effectiveness of the MTM program before making a decision about its continuation or discontinuation. Under the current demonstration STCs, the MTM pilot program extends through June 30, 2021. In this renewal application, the state requests one additional 12-month extension of the program. During these additional 12 months, the state anticipates working with its evaluation partner to review the impact of the MTM program over the previous three years. Allowing the program to continue to operate during this time will ensure that providers and members do not experience disruptions in the event the state ultimately decides to continue the program.

Pending Demonstration Amendments

In addition to these modifications, the state notes that several proposed demonstration amendments have already been submitted to CMS and are currently undergoing CMS review. The state requests that CMS continue its review of these proposed amendments, which have already gone through all required public notice and transparency processes and been determined complete by CMS. Should any of these amendments be approved prior to June 30, 2021, it is the state's understanding that the demonstration as amended would be renewed by this application. To the extent that CMS review of these amendments has not been completed by the end of the current demonstration approval period, the state requests that CMS continue its review of these amendments in the new approval period.

III. Requested Waiver and Expenditure Authorities

The state is requesting the same waiver and expenditure authorities as those approved in the current demonstration.

The state requests that the demonstration's special terms and conditions be modified as needed to effectuate the changes requested in Section II above. The state does not believe any new waiver or expenditure authorities are needed to implement these changes; to the extent that CMS believes any new waiver or expenditure authorities are needed to effectuate the changes described in Section II, the state requests that such authorities be approved.

IV. Summaries of EQRO Reports, MCO and State Quality Assurance Monitoring, and Other Documentation of the Quality of and Access to Care Provided Under the Demonstration

Tennessee monitors the quality of and access to care provided under the demonstration in multiple ways. First, all managed care contracts require monitoring and reporting to the state of key aspects of quality, member experience, and access. In addition, Tennessee has developed and regularly updates a Quality Improvement Strategy that addresses quality standards and processes. The state also retains an External Quality Review Organization (EQRO) to evaluate the measurement and quality improvement activities undertaken by the state's managed care contractors. Overall, Tennessee maintains a robust quality management program for persons enrolled in the demonstration.

Table 3 is a list of major reports/tools used by TennCare to measure quality of and access to care, including a brief summary of the most recent available data for each.

Table 3. Summary of Current Reports/Findings on Quality of and Access to Care

Report	Most Recent Report	Summary of Major Findings
Annual Provider Network Adequacy and Benefit Delivery Review (ANA)	2020	<u>Overall Network Adequacy</u>: - The MCOs scored between 97.6 percent and 100 percent. - The DBM scored above 99.9 percent. <u>Benefit Delivery</u>: - The MCOs scored between 98.9 percent and 99.5 percent. - The DBM scored above 99.9 percent.

Report	Most Recent Report	Summary of Major Findings
Annual Quality Survey (AQS)	2020	Quality Process (QP): - All MCOs achieved 100 percent compliance on a majority of QP standards. - The DBM achieved 100 percent compliance on all fifteen QP standards. CHOICES Credentialing and Recredentialing: This category applied to the three at-risk MCOs. All three MCOs achieved 100 percent compliance on all four measures. Performance Activities (PAs): - Three health plans achieved 100 percent compliance on all PAs, and one health plan achieved 100 percent compliance on two of five PAs. - The DBM achieved 100 percent compliance on two of three PAs.
Performance Improvement Project (PIP) Validation Report	2019	In 2019, the EQRO published validation reviews of 27 Performance Improvement Projects (PIPs) undertaken by TennCare's managed care contractors in 2018. Of these 27 PIPs, 25 achieved a "Met" validation status. The PIPs that did not achieve a "Met" validation status were both in their baseline year when reviewed by the EQRO.
EPSDT Summary Report	2020	- All MCOs were compliant with EPSDT requirements and applicable contracts. - The MCOs were evaluated in—and deemed compliant with—28 different categories of EPSDT compliance. - The DBM was evaluated in—and deemed compliant with—19 different categories of EPSDT compliance. - One MCO was cited for its strength in the "Targeted Activities for Smoking Cessation" category. - A suggestion for improvement was made to two MCOs in the category of "Referral Providers List." - One MCO that achieved less than 100 percent compliance in the category of "Utilization Management Denials" was required to submit a corrective action plan.

Report	Most Recent Report	Summary of Major Findings
Validation of Performance Measures (PMV)	2020	In 2020, the measures validated by the EQRO were: - Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence - Pharmacotherapy for Opioid Use Disorder All MCOs passed the 2020 annual PMV audit, were determined to be in full compliance with all standards, and received an *R* ("Reportable") designation for all audited measures.
Provider Data Validation	2020	This quarterly report documents the accuracy rate for each audited provider data element: active contract status, provider address, provider specialty/behavioral health service code, panel status (open or closed), provides services to patients under/over age twenty-one, provides routine care services, provides urgent care services, provides primary care services, provides prenatal care services. Overall ratings for the most recent audit (third quarter 2020) ranged from 84.4 percent to 98.0 percent.
HEDIS/CAHPS Report	2020	A comparison of the HEDIS results from 2017 (the first full year of the current demonstration approval period) with the results from 2020 indicates improvements in dozens of HEDIS measures. In a comparison of the CAHPS results from 2017 with the results from 2019 (the last year in which statewide averages were included in CAHPS results), improvements were noted in more than a dozen CAHPS categories.
TennCare Beneficiary Survey	2019	Member satisfaction rates have been tracked since 1994 and are at the second highest level—94 percent—in the history of the beneficiary survey.
CMS-416 Reports	2020	This CMS-generated table shows that for Fiscal Year 2019, the screening ratio for Tennessee (total number of screens/expected number of screens for the eligible population) was 79 percent.

Summaries of EQRO Reports

TennCare's most recent (2019) EQRO Technical Report indicates that TennCare's managed care contractors (MCCs) are exhibiting a strong commitment to members by delivering high-quality care. The report notes:

> Most TennCare MCCs continue to achieve high compliance in all EQRO-related activities. Systems, processes, and networks are routinely evaluated and improved across all aspects of health plan operations. The MCCs remain focused on conducting thorough data analyses and documentation of processes. Overall, TennCare's MCCs demonstrated a continued dedication to providing high-quality services to TennCare members.

EQRO reports from 2019-2020 include the following findings:

Annual Network Adequacy

This annual EQRO report includes TennCare's Annual Network Adequacy (ANA) evaluation scores, which measure network adequacy and benefit delivery. Network adequacy includes the number and type of providers in each MCC's provider network and the proximity of those providers to members. Benefit delivery evaluates each MCC's delivery of covered benefits to its members. According to the 2020 ANA report, all TennCare MCCs except one achieved network adequacy ratings greater than 99 percent. (One MCC received a network adequacy rating of 97.6 percent.) For benefit delivery, all TennCare MCCs except one achieved ratings of 99 percent or better. (One MCC received a benefit delivery rating of 98.9 percent.)

Annual Quality Survey

As part of the Annual Quality Survey (AQS) in 2020, TennCare MCCs were assessed for compliance with quality process standards and performance activities based on federal and state mandates, including regulations, judicial decrees, and contractual requirements. Three MCCs achieved a compliance score of 100 percent for all quality process standards, while two MCCs achieved a compliance score of 100 percent for at least five of eight quality process standards. In addition, three MCCs achieved a compliance score of 100 percent for all performance activities evaluated, while two other MCCs achieved a compliance score of 100 percent for at least two performance activities.

EPSDT Summary Report

This annual EQRO report draws on Annual Quality Survey data to examine the extent to which TennCare MCCs comply with EPSDT requirements identified not only in federal laws and regulations, but also in TennCare rules, regulations, and policies. The 2020 EPSDT summary report, which presents findings from 2018 through 2020, states that "TennCare's MCCs maintained success in meeting the EPSDT mandates." In the 2018, 2019, and 2020 surveys, the MCCs achieved—

- 100 percent compliance in the EPSDT quality process standards;
- 100 percent compliance in the performance activity file reviews for EPSDT Information System Tracking in medical records of Medicaid members;
- 100 percent compliance with regard to utilization management denials, with the exception of one MCO each year in 2018, 2019, and 2020.

Performance Improvement Projects

In 2018, TennCare's MCCs were engaged in a number of performance improvement projects (PIPs) related to a variety of topics. Designed by the MCCs and approved by TennCare, PIPs entail the use of quality

indicators to identify areas for targeted quality improvement interventions, measuring the effectiveness of implemented interventions, and planning activities for sustaining or increasing improvement. In 2019, TennCare's EQRO evaluated all PIPs conducted by the MCCs during 2018. Of the 27 PIPs evaluated, a total of 25 achieved a "Met" validation status.

Provider Data Validation Survey

This quarterly survey conducted by the EQRO is conducted by taking a sample of provider data files from TennCare MCCs and reviewing each for accuracy in ten categories (such as active contract status, provider address, availability of services to patients younger or older than 21, etc.). The validity of such information is one measure of providers' availability and accessibility to TennCare enrollees. The EQRO's most recent provider data validation survey summary report (Quarter 3 of 2020) concludes that the MCCs "maintained high accuracy rates," with scores in the ten categories ranging from 84.4 percent in the category of "availability of services to patients age 21 or older" to 98.0 percent in the category of "availability of prenatal care services."

Summaries of MCO and State Quality Assurance Monitoring

Other aspects of the state's quality assurance monitoring include HEDIS/CAHPS reporting and the state's annual beneficiary survey.

HEDIS/CAHPS

Since 2006, TennCare has required all of its MCOs to be accredited by the National Committee for Quality Assurance (NCQA). As part of the required NCQA accreditation, all TennCare MCOs report a full set of HEDIS[17] measures.

From the start of the current demonstration approval period to present, improved statewide performance was noted for a variety of child health measures, with higher success rates achieved in the following HEDIS categories:

- Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents (including "BMI Percentile", "Counseling for Nutrition", and "Counseling for Physical Activity")
- Childhood Immunization Status
- Immunizations for Adolescents
- Lead Screening in Children
- Medication Management for People with Asthma (all child subcategories)
- Asthma Medical Ratio (all child subcategories)
- Children and Adolescents' Access to Primary Care Practitioners (three out of four subcategories)
- Well-Child Visits in the First 15 months of life – 6 or more visits
- Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life
- Adolescent Well-Care Visits (improved more than 16 percentage points)

[17] HEDIS refers to Healthcare Effectiveness Data and Information Set.

Improvement was also achieved in a number of measures applicable to adults, including Adult Body Mass Index (BMI) Assessment; Pharmacotherapy Management of COPD Exacerbation; Medication Management for People with Asthma (all adult subcategories); Asthma Medical Ratio (all adult subcategories); Controlling High Blood Pressure; Statin Therapy for Patients with Cardiovascular Disease; Comprehensive Diabetes Care; Statin Therapy for Patients with Diabetes; Use of Imaging Studies for Low Back Pain; Flu Vaccinations for Adults Ages 18 to 64; Medical Assistance with Smoking and Tobacco Use Cessation; Comprehensive Diabetes Care; and Adults' Access to Preventive/Ambulatory Health Services.

HEDIS measures with special relevance for women's health demonstrated progress as well. Over the most recent demonstration approval period, improved performance was observed in the categories of Cervical Cancer Screening, Chlamydia Screening in Women, Non-Recommended Cervical Cancer Screening in Adolescent Females, and Prenatal and Postpartum Care.

HEDIS 2020 was the eleventh year of statewide reporting of behavioral health measures following the integration of medical and behavioral health services among TennCare's MCOs. Results superior to those in 2017 were achieved on such behavioral health service measures as Antidepressant Medication Management, Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications, Diabetes Monitoring for People with Diabetes and Schizophrenia, Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia, and Adherence to Antipsychotic Medications for Individuals with Schizophrenia.

Improved outcomes have also been documented in statewide average CAHPS measures.[18] From 2017 to 2019 (the most recent year in which CAHPS results could be reliably compared to previous years), superior performance was noted in such areas as—

- Children (general), getting needed care (always or usually)
- Children (general), rating of all health care (rating of nine or ten)
- Children (general), rating of health plan (rating of nine or ten)
- Children with chronic conditions, getting needed care (always or usually)
- Children with chronic conditions, shared decision-making (yes)
- Children with chronic conditions, rating of all health care (rating of nine or ten)
- Children with chronic conditions, rating of personal doctor (rating of nine or ten)
- Children with chronic conditions, rating of specialist seen most often (rating of nine or ten)
- Children with chronic conditions, rating of health plan (rating of nine or ten)
- Children with chronic conditions, family-centered care: personal doctor or nurse who knows child (yes)
- Children with chronic conditions, access to prescription medicines (always or usually)
- Adults, getting needed care (always or usually)
- Adults, how well doctors communicate (always or usually)

[18] CAHPS refers to Consumer Assessment of Healthcare Providers and Systems.

- Adults, rating of all health care (rating of nine or ten)
- Adults, rating of personal doctor (rating of nine or ten)
- Adults, rating of health plan (rating of nine or ten)

The state's most recent HEDIS/CAHPS report is available in full at https://www.tn.gov/content/dam/tn/tenncare/documents/hedis20.pdf.

Beneficiary Survey

Every year since 1993, TennCare has contracted with the Boyd Center for Business and Economic Research (BCBER) at the University of Tennessee to assess the opinions of TennCare members about the healthcare they receive. Respondents provide feedback on a range of topics, including demographic information, perceptions of quality of care received, and behavior relevant to healthcare (the type of provider from whom an individual is most likely to seek initial care, the frequency with which care is sought, etc.).

Survey findings from this demonstration approval period have generally indicated high levels of member satisfaction with TennCare. The percentage of respondents who reported being satisfied with the quality of care received from TennCare in 2019 was 94 percent, which tied for the second highest level of satisfaction achieved in the history of the survey. In 2017 and 2018, furthermore, the reported satisfaction level was 95 percent. The level of satisfaction reported by TennCare members has now exceeded 90 percent for 11 consecutive years.

The most recent (2019) beneficiary survey also indicated improvements in such areas as—

- The percentage of heads of households with TennCare who classified the quality of medical care received as "good" or "excellent";
- The percentage of heads of households with TennCare who sought initial medical care at hospitals (in non-emergency situations); and
- The wait time for a scheduled medical appointment to begin.

The BCBER report summarizing the 2019 beneficiary survey concludes, "Overall, TennCare continues to receive positive feedback from its recipients, with 94 percent reporting satisfaction with the program. This positive feedback is a strong indication that TennCare is providing satisfactory medical care and meeting the expectations of those it serves."

The results of the state's most recent beneficiary survey are available in full at https://haslam.utk.edu/sites/default/files/tncare19.pdf.

V. Financial Data

A spreadsheet illustrating the state's projected expenditures for the requested period of the extension is attached to this application as Appendix D.

VI. Draft Interim Evaluation Report

In accordance with the special terms and conditions of the TennCare demonstration, the focus of demonstration evaluation efforts during the current approval period were the state's two MLTSS programs—CHOICES and Employment and Community First CHOICES.[19] To implement the approved evaluation design, the state partnered with Qsource as its external evaluation partner. The state's draft interim evaluation report is attached to this application as Appendix B.

VII. Documentation of the State's Compliance with the Public Notice Process

The state has used multiple mechanisms for notifying the public about this request to extend the TennCare demonstration and for soliciting public input on this request. These public notice and input procedures are informed by—and comply with—the requirements specified at 42 CFR § 431.408.

Public Notice

The state's public notice and comment period began on November 9, 2020, and lasted through December 11, 2020. During this time, a comprehensive description of the extension application to be submitted to CMS was made available for public review and comment on an extension-specific webpage on the TennCare website. An abbreviated public notice—which included a summary description of TennCare demonstration; the locations, dates, and times of two public hearings; and a link to the full public notice on the state's extension-specific webpage—was published in the newspapers of widest circulation in Tennessee cities with a population of 50,000 or more. TennCare disseminated information about the extension application, including a link to the relevant webpage, via its social media (i.e., Twitter, Facebook).

The state held two public hearings to seek public comment on its application to extend the TennCare demonstration. These hearings took place on November 19, 2020, at 10:00 a.m. CT and November 24, 2020, at 3:00 p.m. CT. Both hearings were conducted virtually. Members of the public also had the option to submit comments throughout the notice period by mail and/or email. Documentation of the state's public notice process will be attached to this extension application.

[19] CHOICES is an MLTSS program for persons who are elderly and/or have physical disabilities. Employment and Community First CHOICES is an MLTSS program for persons with intellectual or other developmental disabilities.

Appendix A

Key TennCare II Leaders

Key leaders who have shaped the TennCare II demonstration include the following people:

TennCare II (2002 – present)

Governors:	Don Sundquist (2002 – 2003) Phil Bredesen (2003 – 2011) Bill Haslam (2011 – 2019) Bill Lee (2019 – present)
TennCare Directors:	Manny Martins (2002 – 2004) J. D. Hickey (2004 – 2006) Darin Gordon (2006 – 2016) Wendy Long (2016 – 2019) Gabe Roberts (2019 – 2020) Stephen Smith (2020 – present)
CMCS[20] Directors:	Dennis Smith (2002 – 2008) Herb Kuhn (2008 – 2009) Cindy Mann (2009 – 2015) Vikki Wachino (2015 – 2017) Brian Neale (2017 – 2018) Timothy Hill (2018) Mary Mayhew (2018 – 2019) Chris Traylor (2019) Calder Lynch (2019 – 2020) Anne Marie Costello (2020 – present)
CMS Project Officers:	Joe Millstone (2002 – 2005) Carolyn Milanowski (2005) Rachel DaCunha (2005 – 2006) Lane Terwilliger (2006) Mary Corddry (2007) Kelly Heilman (2007 – 2010) Paul Boben (2010 – 2011) Nicole Kaufman (2011 – 2012) Jessica Woodard (2012 – 2015) Megan Lepore (2015) Patrick Edwards (2015) Jessica Woodard (2015 – 2018) Annie Hollis (2018 – 2019) Lorraine Nawara (2019 – present)

[20] Center for Medicaid and CHIP Services (formerly the Center for Medicaid and State Operations); list includes Acting Directors.

Appendix B

Draft Interim Evaluation Report

TennCare II Extension

(No. 11-W-00151/4)

Draft Interim Evaluation Report

November 4, 2020

Table of Contents

SECTION I

Executive Summary

Launched in March 2010, the TennCare CHOICES in Long-Term Care (or "CHOICES") program was, at its core, an effort to leverage managed care to achieve delivery system transformation for LTSS provided to older adults and adults with physical disabilities—nursing facility (NF) services as well as home and community based services (HCBS). The new program aimed at improving coordination and quality of care, while expanding access to HCBS and rebalancing the LTSS system—all with eye toward creating a more sustainable model of service delivery in anticipation of an aging population and growing demand for LTSS.

The program's early successes—more than doubling HCBS enrollment in just two years and completely eliminating the waiting list for HCBS among these populations—led to a request from stakeholders to develop an MLTSS program for individuals with intellectual and developmental disabilities (ID and DD or I/DD). The waiting list for HCBS among people with ID was thousands greater, the average cost of services significantly higher, and people with DD were not among the target population for any HCBS program. Still, the goals for both programs were aligned on many points: transform the delivery system, increase access to more cost-effective HCBS in order to serve more people, continue system balancing, and improve employment and quality of life outcomes.

Implemented in July 2016, Employment and Community First CHOICES sought to demonstrate a new approach to managed care for people with I/DD, one that is specifically designed to align incentives in order to help people with I/DD achieve competitive, integrated employment and live as independently as possible in their communities. By targeting supports based on individual needs and goals, people with I/DD could be served more cost effectively while experiencing improved employment, health and quality of life outcomes.

To demonstrate the efficacy of each program in achieving identified outcomes, TennCare created a baseline data plan. The plan for each program defined the key metrics that have been tracked over time for each program in order to determine whether program goals have been achieved. Those metrics are the focus of this evaluation. Analysis was performed by Qsource, TennCare's contracted External Quality Review Organization.

For both programs, the results indicate that the demonstration was effective in achieving the goals and objectives.

CHOICES:

- Significantly expanded access to HCBS for older adults and adults with physical disabilities;
- Helped [re]balance TennCare spending on LTSS for older adults and adults with physical disabilities, increasing the proportion that goes to HCBS;

- Provided cost-effective care in the community for older adults and adults with physical disabilities who would have otherwise required (or been at risk of requiring) NF care;
- Provided HCBS that enabled older adults and adults with physical disabilities who would otherwise have been required to enter NFs to be diverted to the community; and
- Provided HCBS that enabled thousands of older adults and adults with physical disabilities receiving services in NFs to transition back to the community.

Employment and Community First CHOICES:

- Expanded access to HCBS for individuals with intellectual and *for the first time*, other developmental disabilities;
- Provided more cost-effective services and supports for persons with I/DD;
- Continued to balance TennCare spending on LTSS for individuals with I/DD, increasing the proportion spent on HCBS; and
- Increased the number and percentage of working age adults with I/DD enrolled in HCBS programs who are employed in an integrated setting earning at or above the minimum wage.

Data collection to establish the benchmark for the fifth objective— *Improve the quality of life of individuals with intellectual and developmental disabilities enrolled in HCBS programs*— was collected during 2019/2020. The first year of performance improvement will be measured in 2020/2021.

In both CHOICES and Employment and Community First CHOICES, key design decisions based on defined program objectives were made in order to drive the programs' success. Also in both programs, performance was significantly impacted by other Medicaid programs and demonstrations—in some cases, positively and in others, in ways that impeded progress. These serve as guideposts for future transformation efforts.

In CHOICES, where value-based reimbursement has to date been implemented only for NF services, there are opportunities to implement value-based reimbursement reforms in HCBS. In addition, the early successes of offering HCBS more broadly to at-risk groups in achieving greater diversion from institutional care warrant further consideration, particularly in light of the recent impacts of COVID-19 on NFs, and longer term, as it relates to ensuring the sustainability of the system in light of an aging population.

In Employment and Community First CHOICES where the efficacy of the model has now been demonstrated, broader integration of LTSS for the I/DD population will yield far greater opportunities to further these and other important program goals across the entirety of the service delivery system.

SECTION II

General Background Information about the Demonstration

TennCare I (1994-2002)

TennCare I, the original TennCare demonstration waiver, was implemented on January 1, 1994. At the start of TennCare I, Tennessee moved all its Medicaid eligibles and almost all of its Medicaid program into a managed care model. The managed care "penetration rate" in Tennessee Medicaid went from about 3 percent to 100 percent virtually overnight.

The original TennCare design was extraordinarily ambitious. It involved extending coverage to large numbers of uninsured and uninsurable people, who were allowed to enroll by filing simple one-page applications. Almost all benefits were delivered by Managed Care Organizations (MCOs) of varying size, operating at full risk. MCOs were given a good deal of discretion in how they delivered benefits to enrollees, with the assumption being that a true market-based strategy could work in a Medicaid environment much as it would in a business environment.

Several class action lawsuits were filed by public interest lawyers during this period, among them *John B.,* challenging the state's delivery of Early and Periodic Screening, Diagnostic and Treatment services to children; *Grier*, challenging the state's medical service appeal procedures; and *Rosen*, challenging the state's procedures for disenrolling demonstration eligibles. Consent Decrees or Agreed Orders were entered in each lawsuit, which significantly impacted the program's operation.

TennCare II (2002-2007)

TennCare II, the new demonstration that started on July 1, 2002, revised the structure of the original program in several important ways. The program was divided into "TennCare Medicaid" and "TennCare Standard." TennCare Medicaid is for Medicaid eligibles, while TennCare Standard is for the demonstration population.

At the time that TennCare II began, several MCOs were either leaving the program or at risk of leaving the program, due to their inability to maintain financial viability. A stabilization plan was introduced under TennCare II whereby the MCOs were temporarily removed from risk. Pharmacy benefits and dental benefits were carved out of the MCO scope of services, and new single benefit managers were selected for those services. Enrollment of demonstration eligibles was sharply curtailed, with new enrollment being open only to persons with incomes below poverty and "Medicaid rollovers," meaning persons losing Medicaid eligibility who met the criteria for the demonstration population.

In 2004, in the face of projections from an outside consultant[1] that TennCare was growing at a rate that would soon make it impossible for the state to both support TennCare and meet its obligations in other critical areas, Governor Phil Bredesen proposed a TennCare Reform package to accomplish goals such as "right sizing" program enrollment and reducing the dramatic growth in pharmacy spending. With the Centers for Medicare and Medicaid's (CMS) approval, the state began implementing these modifications in 2005.

TennCare II extension (2007-2010)

The TennCare II extension approved in 2007 made additional revisions in the program, allowing the state to open a new demonstration category and requiring that demonstration children with incomes under 200 percent of poverty be classified as Title XXI children. The extension mandated a new cap on supplemental payments to hospitals, setting an annual limit for these payments of $540 million.

It was during this extension period that TennCare began its first implementation of Managed Long-Term Services and Supports (MLTSS), carving Nursing Facility (NF) services and Home and Community Based Services (HCBS) for older adults and adults with physical disabilities into the managed care program. (The populations had previously been in managed care for physical and behavioral health benefits, but their Long-Term Services and Supports (LTSS) had been delivered outside the managed care program.) This MLTSS program was entitled, CHOICES in LTSS. The program was the result of comprehensive long-term care reform legislation: The Long-Term Care Community Choices Act of 2008, passed unanimously by both houses of the Tennessee General Assembly. There were three primary objectives for the CHOICES program:

1) Improve quality and coordination of care;
2) Expand access to and utilization of more cost effective HCBS as an alternative to nursing facility care; and
3) Rebalance LTSS expenditures for older adults and adults with physical disabilities.

At the onset of the next extension period, TennCare concluded statewide implementation of the CHOICES MLTSS program, transitioning LTSS for 23,076 individuals receiving services in a nursing facility, and 4,861 individuals enrolled in a Section 1915(c) waiver into the managed care delivery system.

Subsequent TennCare II extensions (2010-2013, 2013-2016)

The success of the CHOICES program in achieving its goals laid a foundation for the expansion of MLTSS to new populations. As the second three year extension drew to a close, advocates asked TennCare to consider a MLTSS program for individuals with intellectual disabilities (ID) who faced a long waiting list in order to enroll in longstanding 1915(c) waivers, and for people with developmental disabilities (DD), who theretofore, had not been defined among the target populations eligible for LTSS programs in Tennessee.

[1] McKinsey & Company (December 11, 2003). "Achieving a Critical Mission in Difficult Times TennCare's Financial Viability: Part one of a two part report" [pdf]. Available at http://www.markfrisse.com/docs/mckinsey_report1.pdf

The cost of HCBS in the existing 1915(c) waivers was high (roughly twice the national average) and offered opportunity to create a program that would support improved employment and other outcomes, while also using resources more cost-effectively in order to serve more people over time. Extensive stakeholder processes commenced in late 2013, leading to the design, approval, and implementation of Employment and Community First CHOICES during the third three-year extension period on July 1, 2016. .

Employment and Community First CHOICES is an integrated MLTSS program for individuals with intellectual and developmental disabilities (I/DD) that fully comports with the HCBS Settings Rule and is specifically designed to promote and support integrated individual employment and integrated independent community living as the first and preferred option for individuals enrolled in the program. A comprehensive array of employment benefits, designed in consultation with stakeholders and with experts from the federal Office of Disability Employment Policy, help to create a pathway to employment, even for people with significant disabilities. Outcome-based reimbursement approaches align incentives to help support the achievement of individual employment goals, and increased independence over time in the employment setting.

TennCare Today

The current TennCare II extension (No. 11-W-00151/4) is effective from December 1, 2016 through June 30, 2021. Looking back over more than two decades of managed care experience, TennCare has evolved and matured into a program barely recognizable from its early years. TennCare has weathered a number of legal and fiscal challenges, and the program today is characterized by stability, accountability, and innovation. All the previously mentioned class action suits have ended, and although TennCare continues to operate in a litigious environment (with one new class action suit underway), the program is better positioned to avoid and defend against legal challenges. MCOs are carefully chosen via a competitive procurement process and carefully monitored. All MCOs are accredited by the National Committee for Quality Assurance (NCQA). Two of TennCare's three MCOs were the first health plans in the country to achieve NCQA's LTSS Distinction, by meeting certain evidence-based standards in the coordination of LTSS in areas such as conducting comprehensive assessments, managing care transitions, performing person-centered assessments and planning and managing critical incidents. The third successfully achieved this accreditation in 2019. Enrollment and disenrollment procedures are well-established. Quality of care is measured and promoted with a variety of new mechanisms. There is a sophisticated appeals system in place to identify problems in service delivery and to handle complaints. And except for the longstanding fee-for service 1915(c) waivers and a small remaining Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) benefit that currently remain outside of managed care, the program provides for an integrated and coordinated approach to the delivery of services and supports across the continuum. After 26 years of operation, TennCare has achieved a level of maturity where continuous performance improvement is a routine component of program operations.

Moreover, TennCare is now recognized as a national leader in Medicaid managed care, including MLTSS. Tennessee's comprehensive payment reform initiative is changing the landscape of service delivery in the state, aligning payment with improved quality outcomes and cost efficiency across payers and providers,

including LTSS. Most importantly, members are satisfied with the program, with satisfaction ranked at or above 90% for the 11th consecutive year.[2]

It is our intent that "TennCare tomorrow" will be even better, even stronger, and will continue to pave the way for innovation and effective implementation and oversight of Medicaid managed care programs across the country.

[2] University of Tennessee, Boyd Center for Business & Economic Research (2019). The impact of TennCare: A survey of recipients. See Table 7, available at https://haslam.utk.edu/sites/default/files/tncare19.pdf

SECTION III

Evaluation Questions and Hypotheses

The Special Terms and Conditions (STCs) of the state's TennCare II demonstration specify that, *"The state in its evaluation design shall focus its demonstration evaluation efforts on the CHOICES program, [Employment and Community First] ECF CHOICES program and the state plan and demonstration populations enrolled in those programs. The state must include hypotheses and measures related to access to managed long-term services and supports, improved health outcomes and beneficiary satisfaction for CHOICES and ECF CHOICES programs."*

Accordingly, this evaluation investigates how the CHOICES and Employment and Community First CHOICES MLTSS programs have performed relative to fee-for-service programs (in the case of CHOICES, NF services and the Section 1915(c) waiver that existed prior to the implementation of the program; and in the case of Employment and Community First CHOICES, the three Section 1915(c) waivers for persons with ID and ICF/IID services that continue to operate outside the demonstration) in achieving program objectives in these areas.

In order to identify baseline performance (i.e. prior to implementation of each MLTSS program component) and to measure performance improvement over the demonstration period, TennCare created a baseline data plan for each program. The baseline data plan for each program identifies the key metrics that have been tracked over time for each program in order to determine whether program goals have been achieved.

Baseline Data Plan Approach: CHOICES Program

The CHOICES baseline data plan is organized around five key program objectives, all of which relate to access. In LTSS programs, access is a multi-faceted concept. The primary evaluation question is whether implementing the CHOICES MLTSS program has successfully expanded access to HCBS for older adults and adults with physical disabilities, as compared to the fee-for-service Section 1915(c) waiver that existed prior to the implementation of CHOICES. Secondarily, is whether design elements of the demonstration have helped to ensure that improvements can be sustained over time, including as the demand for LTSS increases.

At the most basic level, data should support that a larger number of older adults and adults with physical disabilities have accessed HCBS since implementation of the CHOICES program. At the program's inception, there was a waiting list for HCBS among these populations, with expanded capacity for enrollment contingent each year on new funding to support waiver program expansion. If the program,

including the global budget approach in which money follows each person into the setting of their choice, has been successful, the number of persons receiving HCBS should have increased.

In order to dispel the myth of "woodwork effect," at the same time, however, when controlling for overall growth in the aging population, the number of people receiving services in a nursing facility should have declined. This means that more people have chosen HCBS and have accessed those HCBS in order to divert or transition from institutional settings into HCBS. Additional baseline measures have helped to track performance in diversion and transition from institutional care.

A final facet of access in LTSS programs is cost. As a practical matter, states have a limited amount of Medicaid funding to support LTSS. Higher utilization of more expensive institutional services reduces the amount of program funding available to provide for increased access to HCBS. Because the ability to expand HCBS hinges on a rebalancing of long-term care expenditures, it is critical not just to track the number and percentage of people receiving HCBS versus institutional care, but also to track expenditures for HCBS relative to institutional care and to understand the relative average annualized cost of services in the two settings over time.

Baseline Data Plan Approach: Employment and Community First CHOICES Program

Like the CHOICES baseline data plan, the baseline data plan for Employment and Community First CHOICES is also organized around five key program objectives. However, in the case of Employment and Community First CHOICES, there are objectives and measures related to each of the program goals set forth in the STCs, including increased access to HCBS, and improved health outcomes and beneficiary satisfaction.

The first evaluation question is whether implementing the Employment and Community First CHOICES MLTSS program has successfully expanded access to HCBS for individuals with ID, for individuals with DD, and across the I/DD population broadly, as compared to the fee-for-service Section 1915(c) waivers that existed prior to the implementation of Employment and Community First CHOICES. Secondarily, is whether design elements of Employment and Community First CHOICES have helped to ensure that improvements can be sustained over time, including as the demand for LTSS increases.

As with CHOICES, the program objectives and measures consider the multi-faceted nature of access, but do not include measures related to diversion and transition since ICF/IID services remain outside the demonstration program. Data should support that a larger number of individuals with intellectual disabilities, a larger number of people with developmental disabilities, and a larger number of people across the I/DD population have accessed HCBS since implementation of the Employment and Community First CHOICES program.

Also, as with CHOICES, a critical facet of access in Employment and Community First CHOICES is cost. The higher average cost of services in the state's fee-for-service programs (ICFs/IID and 1915(c) waivers) have made it difficult to provide services to all of the people who need them, and left no resources to provide

services to people with DD. It is thus critical to understand the relative average annualized cost of services in each program, in order to demonstrate that we have provided services more cost-effectively, thereby expanding access for more of the people in the population who need LTSS. And even though institutional services are carved out of the demonstration, it is important to track expenditures for HCBS relative to institutional care and to ensure that we are continuing to focus investment in community-based, rather than institutional settings.

A third evaluation question for the Employment and Community First CHOICES program is whether implementing the new MLTSS program will successfully increase participation in integrated employment, earning at or above the minimum wage, as compared to the fee-for-service Section 1915(c) waivers that existed prior to the implementation of Employment and Community First CHOICES. This is the most critical health-related program goal. Employment status may have implications for an individual's health status. A study funded by CMS through a Medicaid Infrastructure Grant which included a review of the literature on the relationship between employment and health found *"a consistent association between employment and better health and unemployment and poorer health,"* including for people with disabilities. The study suggested that*, "One possible cost-effective way to increase the health of members of Managed Long Term Care Systems is to promote and support the competitive employment of members, and that "[W]hen evaluating quality of Managed Long Term Care Systems, members' employment status may become an important outcome that cannot be ignored.[3]"*

The final evaluation question for the Employment and Community First CHOICES program is whether the new MLTSS program has improved the overall quality of life of persons with I/DD who enroll in the program and receive HCBS.

[3] Hartman, E. A literature review on the relationship between employment and health: How this relationship may influence managed long term care. Available at https://www.uwstout.edu/svri/upload/The-relationship-between-employment-and-health-A-literature-review.pdf.

Methodology

Using the baseline data plans created for each MLTSS program, this evaluation includes pre- and post-measurement of specified data elements in order to investigate how the CHOICES and Employment and Community First CHOICES MLTSS programs compare to fee-for-service programs (in the case of CHOICES, NF services and the Section 1915(c) waiver that existed prior to the implementation of the program; and in the case of Employment and Community First CHOICES, the three Section 1915(c) waivers for individuals with intellectual disabilities and ICFs/IID that continue to operate outside the demonstration) in achieving program objectives. Statistical analyses included the absolute change and percentage (or relative) change from the baseline measurement for each demonstration year. For purposes of measurement, participants are included in the target population only if they are enrolled in the applicable program and received one or more of the HCBS benefits available to program participants. Persons who enrolled in the program and subsequently disenrolled without having received any program benefits, or persons who enroll in the program and receive only state plan (i.e., TennCare benefits other than LTSS) will be excluded. For some measures, data is reported by benefit group (i.e., CHOICES Groups 2 and 3, and Employment and Community First CHOICES Groups 4, 5, and 6, and upon CMS approval and implementation, Groups 7 and 8) as well as across HCBS benefit groups in the program. Data related to integrated employment outcomes were limited to individuals of working age or reported by age groups in order to provide for more meaningful interpretation of results. Except for identified exclusions, all measures were collected and reported across the entirety of the applicable population and did not use any sampling methodology.

CHOICES: Baseline Data Plan

The CHOICES baseline data plan is organized around five key program objectives, all of which relate to access. The five objectives related to the CHOICES program as described in the State's approved evaluation design are as follows:

1. Expand access to HCBS for older adults and adults with physical disabilities.
2. Rebalance TennCare spending on long-term services and supports to increase the proportion that goes to HCBS.
3. Provide cost-effective care in the community for persons who would otherwise require NF care.
4. Provide HCBS that will enable persons who would otherwise be required to enter NFs to be diverted to the community.
5. Provide HCBS that will enable persons receiving services in NFs to be able to transition back to the community.

CHOICES: Program Objectives, Baseline and Data Elements

CHOICES program objectives, together with the baseline measures and the data elements for each objective are described below. All the baseline data elements were collected on the basis of program participation and program expenditures prior to or at the start of the CHOICES program. The data source for each of these elements is the Medicaid Management Information System (MMIS). All the CHOICES data elements identified below were collected annually, beginning at one year after implementation, and measured against the baseline data elements each year. Metrics related to persons receiving LTSS (NF or HCBS) are collected and reported in two ways:

1) Point in time—generally, at implementation and the conclusion of each demonstration year thereafter; and
2) Over the course of time— generally, one year prior to implementation, and over the course of each demonstration year.

Objective 1: Expand access to HCBS for older adults and adults with physical disabilities.

Objective 1.1 Increase the number and percentage of older adults and adults with physical disabilities actively receiving HCBS at a point in time and over the course of each demonstration year compared to the year prior to implementation.

Objective 1.2: Decrease the number and percentage of persons receiving nursing facility services at a point in time and over the course of each demonstration year compared to the year prior to implementation.

Baseline Data Elements:

- Number of older adults and adults with physical disabilities actively receiving HCBS at the time of CHOICES implementation and annually thereafter.
- Unduplicated number of older adults and adults with physical disabilities receiving HCBS during the 12 months prior to CHOICES implementation and annually thereafter.
- Number of persons receiving NF services at the time of CHOICES implementation and annually thereafter.
- Unduplicated number of persons receiving NF services during the 12 months prior to CHOICES implementation and annually thereafter.

CHOICES Data Elements:

- Number of older adults and adults with physical disabilities actively receiving HCBS one year after CHOICES implementation and annually thereafter.
- Unduplicated number of older adults and adults with physical disabilities receiving HCBS during the first year after CHOICES implementation and annually thereafter.

- Number of persons receiving NF services one year after CHOICES implementation and annually thereafter.
- Unduplicated number of persons receiving NF services during the first year after CHOICES implementation and annually thereafter.

Objective 2: [Re]balance TennCare spending on long-term services and supports for older adults and adults with physical disabilities to increase the proportion that goes to HCBS.

Objective 2.1: Increase HCBS expenditures for older adults and adults with physical disabilities (based on encounters, not capitation payments) as a percentage of total long-term care expenditures for older adults and adults with physical disabilities during each demonstration year compared to the year prior to implementation.

Objective 2.2: Decrease NF expenditures for older adults and adults with physical disabilities (based on encounters, not capitation payments) as a percentage of total long-term care expenditures for older adults and adults with physical disabilities during each demonstration year compared to the year prior to implementation.

Baseline Data Elements:

- HCBS expenditures for older adults and adults with physical disabilities during the 12 months prior to CHOICES implementation.
- HCBS expenditures for older adults and adults with physical disabilities during the 12 months prior to CHOICES implementation as a percentage of total long-term services and supports expenditures (excluding expenditures on LTSS for individuals with I/DD)
    - *Numerator:* HCBS expenditures for older adults and adults with physical disabilities during the 12 months prior to CHOICES implementation
    - *Denominator:* Total LTSS expenditures (NF and HCBS for older adults and adults with physical disabilities) during the 12 months prior to CHOICES implementation
- NF expenditures during the 12 months prior to CHOICES implementation.
- NF expenditures during the 12 months prior to CHOICES implementation as a percentage of total long-term care expenditures (excluding expenditures on LTSS for individuals with I/DD)
    - *Numerator:* NF expenditures during the 12 months prior to CHOICES implementation.
    - *Denominator:* Total LTSS expenditures (NF and HCBS for older adults and adults with physical disabilities) during the 12 months prior to CHOICES implementation.

CHOICES Data Elements:

- HCBS expenditures for older adults and adults with physical disabilities (based on encounters, not cap payments) during the first year following CHOICES implementation and annually thereafter.
- NF expenditures (based on encounters, not cap payments) during the first year following CHOICES implementation and annually thereafter.
- HCBS expenditures for older adults and adults with physical disabilities (based on encounters, not cap payments) during the first year following CHOICES implementation and annually

thereafter as a percentage of total long-term care expenditures (excluding expenditures for the population of persons with I/DD).
    - *Numerator:* HCBS expenditures for older adults and adults with physical disabilities (based on encounters, not cap payments) during the first year following CHOICES implementation and annually thereafter.
    - *Denominator:* Total LTSS expenditures (NF and HCBS for older adults and adults with physical disabilities based on encounters, not cap payments) during the first year following CHOICES implementation and annually thereafter.
- NF expenditures (based on encounters, not cap payments) during the first year following CHOICES implementation and annually thereafter as a percentage of total long-term care expenditures (excluding expenditures for the population of persons with I/DD).
    - *Numerator:* NF expenditures (based on encounters, not cap payments) during the first year following CHOICES implementation and annually thereafter.
    - *Denominator:* Total LTSS expenditures (NF and HCBS for older adults and adults with physical disabilities based on encounters, not cap payments) during the first year following CHOICES implementation and annually thereafter.

Objective 3: Provide cost effective care in the community for older adults and adults with physical disabilities who would otherwise require NF care.

Objective 3.1: Per person HCBS expenditures on older adults and adults with physical disabilities (based on encounters, not capitation payments) remain lower than per person NF expenditures on older adults with physical disabilities (based on encounters, not capitation payments payments) for each demonstration year.

Baseline Data Elements:

- Average per person HCBS expenditures for older adults and adults with physical disabilities during the 12 months prior to CHOICES implementation.
- Average per person NF expenditures during the 12 months prior to CHOICES implementation.

CHOICES Data Elements:

- Average per person HCBS expenditures for older adults and adults with physical disabilities (based on encounters, not cap payments) during the first year following CHOICES implementation and annually thereafter.
- Average per person NF expenditures (based on encounters, not cap payments) during the first year following CHOICES implementation and annually thereafter.

Objective 4: Provide HCBS that will enable older adults and adults with physical disabilities who would otherwise be required to enter NFs to be diverted to the community.

Objective 4.1: Increase the average length of stay in HCBS for each demonstration year compared to the year prior to implementation.

Objective 4.2: Increase the percentage of new LTSS recipients admitted to HCBS during each demonstration year compared to the year prior to implementation.

Objective 4.3: Decrease the percentage of new LTSS recipients admitted to NFs during each demonstration year compared to the year prior to implementation.

Baseline Data Elements:

- Average length of stay in HCBS during the twelve months prior to CHOICES implementation.
- Percent of new LTSS recipients admitted to NFs during the twelve months prior to CHOICES implementation.

CHOICES Data Elements:

- Average length of stay in HCBS during the first year after CHOICES implementation and annually thereafter.
- Percent of new LTSS recipients admitted to NFs during the first year after CHOICES implementation and annually thereafter.

Objective 5: Provide HCBS that will enable older adults and adults with physical disabilities receiving services in NFs to be able to transition back to the community.

Objective 5.1: Decrease the average length of stay in NFs for each demonstration year compared to the year prior to implementation.

Objective 5.2: Increase the number of persons who transitioned from NFs to HCBS during each demonstration year compared to the year prior to implementation.

Baseline Data Elements:

- Average length of stay in NFs during the 12 months prior to CHOICES implementation.
- Number of persons transitioned from NFs to HCBS during the 12 months prior to CHOICES implementation.

CHOICES Data Elements:

- Average length of stay in NFs during the first year after CHOICES implementation and annually thereafter.
- Number of persons who transitioned from NFs to HCBS during the first year following CHOICES implementation and annually thereafter.

Employment and Community First CHOICES: Baseline Data Plan

Like the CHOICES baseline data plan, the baseline data plan for Employment and Community First CHOICES is also organized around five key program objectives. However, in the case of Employment and Community First CHOICES, there are objectives and measures related to each of the program goals set forth in the STCs, including access to MLTSS, improved health outcomes and beneficiary quality of life. The five objectives related to the Employment and Community First CHOICES program as described in the State's approved evaluation design are as follows:

1. Expand access to HCBS for individuals with I/DD.
2. Provide more cost-effective services and supports in the community for persons with I/DD.
3. Continue balancing TennCare spending on LTSS for individuals with I/DD to increase the proportion spent on HCBS.
4. Increase the number and percentage of persons with I/DD enrolled in HCBS programs who are employed in an integrated setting earning at or above the minimum wage.
5. Improve the quality of life of individuals with I/DD enrolled in HCBS programs.

Employment and Community First CHOICES: Program Objectives, Baseline and Data Elements

The baseline data plan for Employment and Community First CHOICES is also organized around five key program objectives. These objectives, together with the baseline measures and the data elements for each objective are described below. All the access-related measures were collected based on program participation and program expenditures prior to or at the start of the Employment and Community First CHOICES program, except as otherwise specified. MMIS is used as the data source for each of the measures specified in objectives 1 through 3. These data elements will be collected annually, beginning at one year after implementation, and measured against the baseline data elements each year. Enrollment data related to persons receiving HCBS are collected and reported in two ways:

1) Point in time - generally, at implementation and conclusion of each demonstration year thereafter; and
2) Over the course of time - generally, one year prior to implementation, and over the course of each demonstration year.

The data source for employment measures related to objective 4 is a standardized Employment Data Survey (EDS), administered by the MCO for persons enrolled in MLTSS, and by the Tennessee Department of Intellectual and Developmental Disabilities (DIDD) for persons enrolled in a 1915(c) waiver. TennCare collects the employment data on all persons 62 years of age and under enrolled in MLTSS and in the 1915(c) service delivery system for people with ID. Notably, this data is collected on a calendar year, rather than demonstration year, basis. Typically, these surveys are conducted during the annual person-centered planning meeting when updates are made to a person's support plan but can also be conducted at other times such as when a change in employment status occurs. The MCO Care/Support Coordinators and the DIDD Case Managers and contracted Independent Support Coordinators complete the EDS and enter it into the State's FormStack system. (Prior to the transition to FormStack, these surveys were entered into WuFoo, an online survey system with which the State held a subscription for the development and storage of survey data.) EDS survey data is the State's mechanism for collecting baseline employment measures. Calendar year 2016 (encompassing the six-month period prior to the start of program operations and the six-month period immediately following program implementation) was the baseline year. Data was collected on an annual basis for each calendar year thereafter. In addition to the statewide analysis in this

evaluation, the State can use this data to assess regional trends in addition to trends by provider, by program, age of the person, MCO and employment industry type.

Processes were established for collection of the QOL measurement data for Employment and Community First CHOICES using the National Core Indicators™ (NCI) in person survey, the same tool used for some time to gather annual performance and outcomes data relative to the State's Section 1915(c) HCBS waivers. After delays in contracting for the use of this survey tool (see Methodological Limitations), in 2019, TennCare successfully collaborated with the DIDD to leverage their existing agreement with the National Association of State Directors of Developmental Disabilities Services (NASDDDS) and the Human Services Research Institute (HSRI). TennCare finalized a contract with The Arc of Tennessee in December 2019 for survey administration. This contract engages self-advocates, direct support professionals and disability field professionals in conducting the NCI in person surveys. A total of 348 Employment and Community First CHOICES members participated in the 2019-2020 National Core Indicators™ (NCI) adult in-person survey. Overall, the 2019-2020 NCI survey had a 99.2% completion rate.

Objective1: Expand access to HCBS for individuals with intellectual and developmental disabilities.

Objective 1.1: Increase the number of individuals with ID actively receiving HCBS at a point in time and over the course of each demonstration year compared to the year prior to implementation.

Objective 1.2: Increase the number of individuals with DD actively receiving HCBS at a point in time and over the course of each demonstration year compared to the year prior to implementation.

Objective 1.3: Increase the number of individuals with I/DD actively receiving HCBS at a point in time and over the course of each demonstration year compared to the year prior to implementation.

Baseline Data Elements:

- Number of individuals with ID actively receiving HCBS at the time of Employment and Community First CHOICES implementation.
- Unduplicated individuals with ID receiving HCBS during the 12 months prior to Employment and Community First CHOICES implementation.
- Number of individuals with ID actively receiving HCBS one year after Employment and Community First CHOICES implementation and annually thereafter.
- Unduplicated number of individuals with ID receiving HCBS during the first year after Employment and Community First CHOICES implementation and annually thereafter.

Data shall be reported for Employment and Community First CHOICES and across Medicaid HCBS programs including Section 1915 (c) waivers.

Baseline Data Elements –Individuals with DD (other than ID):

- Number of individuals with DD actively receiving HCBS at the time of Employment and Community First CHOICES implementation.
- Unduplicated individuals with DD receiving HCBS during the 12 months prior to Employment and Community First CHOICES implementation.

Employment and Community First CHOICES data elements – DD (other than ID):

- Number of individuals with DD actively receiving HCBS one year after Employment and Community First CHOICES implementation and annually thereafter.
- Unduplicated number of individuals with DD receiving HCBS during the first year after Employment and Community First CHOICES implementation and annually thereafter.

Data shall be reported only for Employment and Community First CHOICES.

Baseline Data Elements – Individuals with I/DD:

- Number of individuals with I/DD actively receiving HCBS at the time of Employment and Community First CHOICES implementation.
- Unduplicated individuals with I/DD receiving HCBS during the 12 months prior to Employment and Community First CHOICES implementation.

Employment and Community First CHOICES Data Elements – Individuals with I/DD:

- Number of individuals with I/DD actively receiving HCBS one year after Employment and Community First CHOICES implementation and annually thereafter.
- Unduplicated individuals with I/DD receiving HCBS during the first year after Employment and Community First CHOICES implementation and annually thereafter.

Data shall be reported for Employment and Community First CHOICES and across Medicaid HCBS programs, including Section 1915(c) waivers.

Objective 2: Provide more cost-effective services I/DD.

Objective 2.1: Decrease average per person LTSS expenditures on individuals with I/DD (based on encounters, not capitation payments, and fee-for-service expenditures) compared to the year prior to implementation.

Baseline Data Element:

- Average per person LTSS expenditures for individuals with I/DD during the 12 months prior to Employment and Community First CHOICES implementation.

Employment and Community First CHOICES Data Element:

- Average per person LTSS expenditures on individuals with I/DD (based on fee-for-service payments and encounters, not cap payments) during the first year following Employment and Community First CHOICES implementation and annually thereafter.

Data shall be reported for Employment and Community First CHOICES, Section 1915(c) waivers, ICF/IID services, and across Medicaid HCBS (including Section 1915(c) waivers and LTSS, including ICFs/IID.

Objective 3: Continue balancing TennCare spending on long-term services and supports for individuals with intellectual and developmental disabilities to increase the proportion spent on HCBS.

Objective 3.1: Increase HCBS expenditures for individuals with I/DD (based on encounters, not capitation payments, and fee-for-service expenditures) as a percentage of total LTSS expenditures for individuals with I/DD during each demonstration year compared to the year prior to implementation.

Objective 3.2: Decrease ICF/IID expenditures as a percentage of total LTSS expenditures for individuals with I/DD (based on encounters, not capitation payments, and fee-for-service expenditures) during each demonstration year compared to the year prior to implementation.

Baseline Data Elements:

- HCBS expenditures for individuals with I/DD during the 12 months prior to Employment and Community First CHOICES implementation HCBS expenditures for individuals with I/DD during the 12 months prior to Employment and Community First CHOICES implementation as a percentage of total LTSS expenditures for individuals with I/DD.
    - *Numerator:* HCBS expenditures for individuals with I/DD during the 12 months prior to Employment and Community First CHOICES implementation
    - *Denominator:* Total LTSS expenditures (ICF/IID and HCBS) for individuals with I/DD (based on fee-for-service payments and encounters, not cap payments) during the 12 months prior to Employment and Community First CHOICES implementation
- ICF/IID expenditures during the 12 months prior to Employment and Community First CHOICES implementation.
- ICF/IID expenditures during the 12 months prior to Employment and Community First CHOICES implementation as a percentage of total LTSS expenditures for individuals with I/DD.
    - *Numerator:* ICF/IID expenditures during the 12 months prior to Employment and Community First CHOICES implementation
    - *Denominator:* Total LTSS expenditures (ICF/IID and HCBS) for individuals with I/DD (based on fee-for-service payments and encounters, not cap payments) during the 12 months prior to Employment and Community First CHOICES implementation

Employment and Community First CHOICES Data Elements:

- HCBS expenditures for individuals with I/DD (based on fee-for-service payments and encounters, not cap payments) during the first year following Employment and Community First CHOICES implementation and annually thereafter.
- ICF/IID expenditures during the first year following Employment and Community First CHOICES implementation and annually thereafter.
  HCBS expenditures on individuals with I/DD (based on fee-for-service payments and encounters, not cap payments) during the first year following Employment and Community First CHOICES implementation, and annually thereafter, as a percentage of total LTSS expenditures for individuals with I/DD.
    - *Numerator:* HCBS expenditures on individuals with I/DD (based on encounters, not cap payments) during the first year following Employment and Community First CHOICES implementation, and annually thereafter.

    - *Denominator:* Total LTSS expenditures (ICF/IID and HCBS) for individuals with I/DD (based on FFS payments and encounters, not cap payments) during the first year following Employment and Community First CHOICES implementation, and annually thereafter.
- ICF/IID expenditures during the first year following Employment and Community First CHOICES implementation, and annually thereafter, as a percentage of total LTSS expenditures for individuals with I/DD.
    - *Numerator:* ICF/IID expenditures on individuals with I/DD during the first year following Employment and Community First CHOICES implementation, and annually thereafter.
    - *Denominator:* Total LTSS expenditures (ICF/IID and HCBS) for individuals with I/DD (based on FFS payments and encounters, not cap payments) during the first year following Employment and Community First CHOICES implementation, and annually thereafter.

Objective 4: Increase the number and percentage of working age adults with intellectual and development disabilities enrolled in HCBS programs who are employed in an integrated setting earning at or above the minimum wage.

Objective 4.1: Increase the number and percentage of working age adults with I/DD enrolled in HCBS programs who are employed in an integrated setting earning at or above the minimum wage during each demonstration year compared to the baseline year.

Baseline Data Elements:

- Number of working age individuals with I/DD enrolled in HCBS programs who are employed in an integrated setting earning at or above the minimum wage at the time of Employment and Community First CHOICES implementation.
- Percent of working age individuals with I/DD enrolled in HCBS programs who are employed in an integrated setting earning at or above the minimum wage at the time of Employment and Community First CHOICES implementation.
    - *Numerator:* Number of working age individuals with I/DD enrolled in HCBS programs employed in an integrated setting earning at or above the minimum wage at the time of Employment and Community First CHOICES implementation.
    - *Denominator:* Total number of working age individuals with I/DD enrolled in HCBS programs at the time of Employment and Community First CHOICES implementation

Employment and Community First CHOICES Data Elements:

- Number of working age individuals with I/DD enrolled in HCBS programs who are employed in an integrated setting earning at or above the minimum wage one year after Employment and Community First CHOICES implementation and annually thereafter.
- Percent of working age individuals with I/DD enrolled in HCBS programs who are employed in an integrated setting earning at or above the minimum wage during the first year following Employment and Community First CHOICES implementation and annually thereafter.

- *Numerator:* Number of working age individuals with I/DD enrolled in HCBS programs employed in an integrated setting earning at or above the minimum wage one year after Employment and Community First CHOICES implementation and annually thereafter.
- *Denominator:* Total number of working age individuals with I/DD enrolled in HCBS programs one year after Employment and Community First CHOICES implementation and annually thereafter.

Data shall be reported for Employment and Community First CHOICES and across Medicaid HCBS programs including Section 1915(c) waivers.

Objective 5: ***Improve the Quality of Life (QOL) of individuals with I/DD enrolled in HCBS.***

Objective 5.1: Improve the Quality of Life (QOL) of individuals with I/DD enrolled in Employment and Community First CHOICES during each demonstration year compared to the baseline year.

Baseline data element:

- Perceived quality of life of individuals with I/DD enrolled in Employment and Community First CHOICES during the baseline year as measured by the *National Core Indicators™* Survey (numerator and denominator TBD)

Employment and Community First CHOICES data element:

- Perceived quality of life of individuals with I/DD enrolled in Employment and Community First CHOICES each year following the baseline year as measured by the *National Core Indicators™* Survey (numerator and denominator TBD)

Methodological Limitations

The CHOICES program has been in existence for more than ten (10) years. While there is a comprehensive integrated Quality Assessment and Performance Improvement Strategy which encompasses the MLTSS programs, at the program's outset, the baseline measures of system performance for purposes of program evaluation were focused on expanded access to HCBS, taking into account factors such as cost and rebalancing which can significantly impact access in LTSS programs. While systems are now in place to collect satisfaction and QOL data (using the recently implemented *National Core Indicators – Aging and Disability*™ survey tool), it would not be possible to go back in order to establish a baseline at inception or enrollment into the CHOICES program.

With respect to measurement of improved health outcomes, the most significant challenge in the CHOICES program is that roughly 90 percent of the persons enrolled are dual eligible beneficiaries, which means that Medicare and not Medicaid is primarily responsible for the delivery of preventive care and health outcomes such as the management of avoidable hospitalizations. While care coordinators in MLTSS programs can serve to help coordinate access to preventive care and assist in the identification and mitigation of factors that could lead to avoidable hospitalizations, as a practical matter, many of the Medicare providers are not in Medicaid MCO networks, and even if they are, have little incentive under the Medicare payment structure to engage with MLTSS plans in these efforts.

Similar challenges in measuring health outcomes exist for individuals with I/DD in the Employment and Community First CHOICES program, except that the percentage of dual eligible beneficiaries is smaller. In that regard, focusing on employment as a critical health-related outcome measure helps to shift the focus to a measure not impacted by the often-fragmented delivery of health care to the dual eligible population.

There were challenges with the data collection methodology for Employment and Community First CHOICES Objective 4.1: Increase the number and percentage of working age adults with I/DD enrolled in HCBS programs who are employed in an integrated setting earning at or above the minimum wage during each demonstration year compared to the baseline year. The State collected data using the Individual Employment Data Survey,[4] conducted annually for each person receiving HCBS as part of the annual person-centered plan review process. However, because person-centered planning processes occur over the course of the year, nearly a full year can lapse before the annual Employment and Community First CHOICES Data reporting period. This means that the data initially failed to account for persons who had secured competitive integrated employment since that time. TennCare initially identified significant discrepancies in results for this objective, based on the reporting lag. This led to a full review, reconciliation and validation of the data against other longstanding employment reports collected from MCOs and for persons enrolled in Section 1915(c) HCBS waivers, employment data collected by the Department of Intellectual and Developmental Disabilities, the contracted Operating Agency in order to

[4] State of Tennessee, TennCare (January 2020). Individual Employment Data Survey [pdf]. Available at: https://www.tn.gov/content/dam/tn/tenncare/documents/IndividualEmploymentDataSurvey.pdf

ensure the most timely and accurate information was used in the evaluation. This concern has been resolved moving forward as changes to the 2020 Individual Employment Data Survey were implemented to ensure its completion annually *and* within a specified period whenever changes to integrated employment status occur.

Also of note, employment data is collected on a calendar year, rather than demonstration year, basis. Calendar year 2016 (encompassing the six-month period prior to the start of program operations and the six-month period immediately following program implementation) was the baseline year for Employment and Community First CHOICES Objective 4. Data was collected on an annual basis for each calendar year thereafter, while other data elements are typically collected on a demonstration year basis.

One additional limitation in the Employment and Community First CHOICES program is that collection of quality of life data (Program Objective 5.1) did not commence until 2019-2020. Implementation of the *National Core Indicators*™ (NCI) survey in Employment and Community First CHOICES was delayed because NASDDDS (the National Association of State Directors of Developmental Disabilities Services) was unwilling to contract with TennCare (a State Medicaid Agency) to allow the use of the survey tool. In 2019, TennCare successfully collaborated with the Department of Intellectual and Developmental Disabilities (DIDD) to leverage their existing agreement with NASDDDS and the Human Services Research Institute (HSRI). TennCare successfully finalized a contract with The Arc of Tennessee in December 2019. This contract engaged self-advocates, direct support professionals and disability field professionals in conducting the face-to-face NCI assessments. The NCI in person survey (NCI) was completed in March 2020. NCI data and reports are not typically available until half a year or more after the end of a survey cycle. This year's survey cycle will establish the baseline and set the stage for measurement of improvement going forward. TennCare has engaged KPMG to assist with recommendations for the development of a metrics-based quality of life baseline and quality improvement framework that will elevate quality of life for Tennesseans with intellectual and developmental disabilities through data driven quality improvement and decision making. The metrics used will set the stage for measurement of improvement going forward; however, the first year of improvement data will not be available until at least 2021, after the waiver renewal application is submitted.

SECTION IV

Results

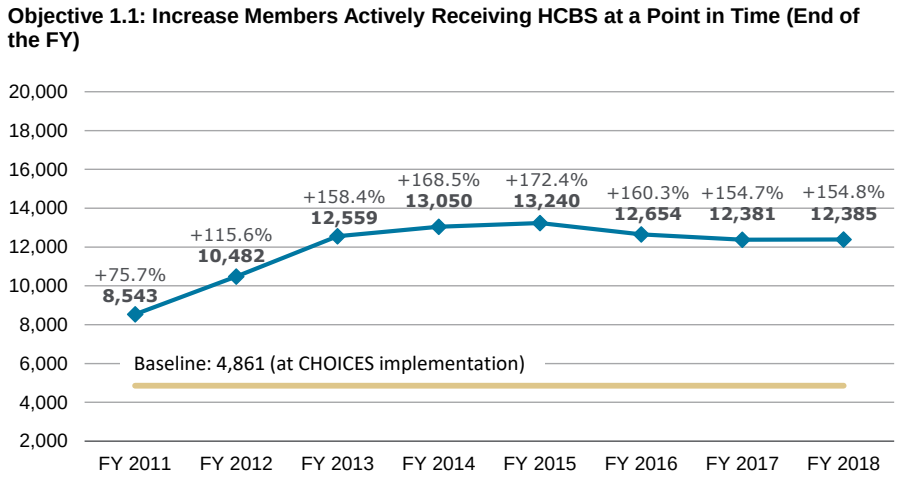
CHOICES

CHOICES Objective 1.1: Increase the number and percentage of older adults and adults with physical disabilities actively receiving HCBS at a point in time and over the course of each demonstration year compared to the year prior to implementation.

Baseline: When the CHOICES MLTSS program was implemented, the number of people actively receiving HCBS, i.e., enrolled in the Statewide HCBS waiver, totaled 4,861. This included 1,479 in the Middle Grand Region (as of February 28, 2010) and 3,382 in the East and West Grand Regions (as of August 1, 2010). The baseline for unduplicated members receiving HCBS from March 1, 2009 thru February 28, 2010 (12 Month Period) totaled 6,226.

Actively Receiving Services as of a Point in Time:
CHOICES members actively receiving HCBS increased by 75.7% to 8,543 by the end of the first fiscal year (FY) (i.e., as of June 30, 2011). See **Figure 1**. The number continued to increase for several years and peaked in FY 2015 at 13,240, at 172.4% above the baseline, declining slightly (by 4.4%) to 12,654 in FY 2016—160.3% above baseline, followed by a 2.2% reduction to 12,381 in FY 2017—154.7% above baseline, and then increasing *very* slightly (by 4 people) 12,385 in FY 2018—154.8% above baseline. Even with the tapering and slight reductions, the number and percent of members actively receiving HCBS remained significantly higher than baseline in each demonstration year.

Figure 1: Number of Members Actively Receiving HCBS

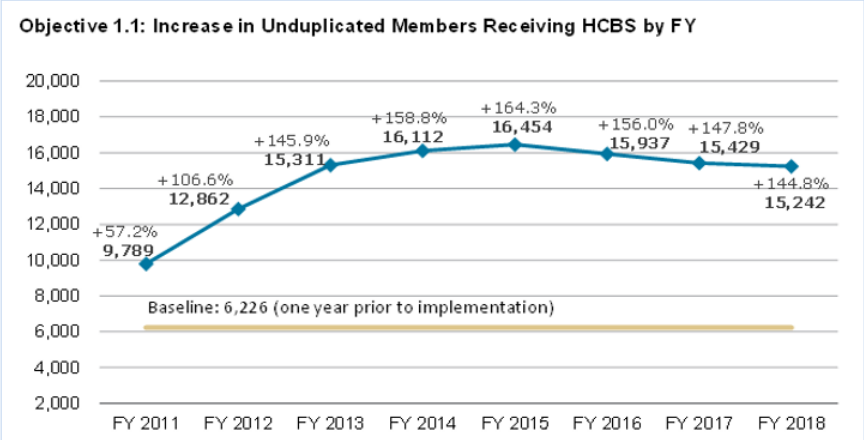


Data Source: Counts HCBS members actively receiving services at a point in time (June 30, the end of the fiscal year). Baseline includes members at CHOICES implementation, representing the sum of members as of 2/28/2010 for the Middle Grand Region and 8/1/2010 for East and West Grand Regions. Percentages refer to percentage increase over baseline.

Unduplicated Members Receiving Services Across a Year:

The year after CHOICES implementation, the number of unduplicated members receiving HCBS increased by 57.2% (from 6,226 to 9,789) in FY2011. As shown in **Figure 2**, the number of members receiving HCBS each year increased until FY2015, peaking at 164.3% above the baseline. After that, there was a slight decline for the next three years (3.1%, 3.3%, and 1.2%). Even with the leveling and slight reductions, during FY2018, the unduplicated number of members (15,242) was 144.8% compared to baseline. Overall, the number of unduplicated members receiving HCBS remained significantly higher than baseline in each demonstration year.

Figure 2: Number of Unduplicated Members Receiving HCBS



Data Source: Counts unduplicated members receiving HCBS services during the fiscal year (July 1-June 30). Baseline is calculated for the year prior to CHOICES implementation, 3/1/09–2/28/10. Percentages refer to percentage increase over baseline.

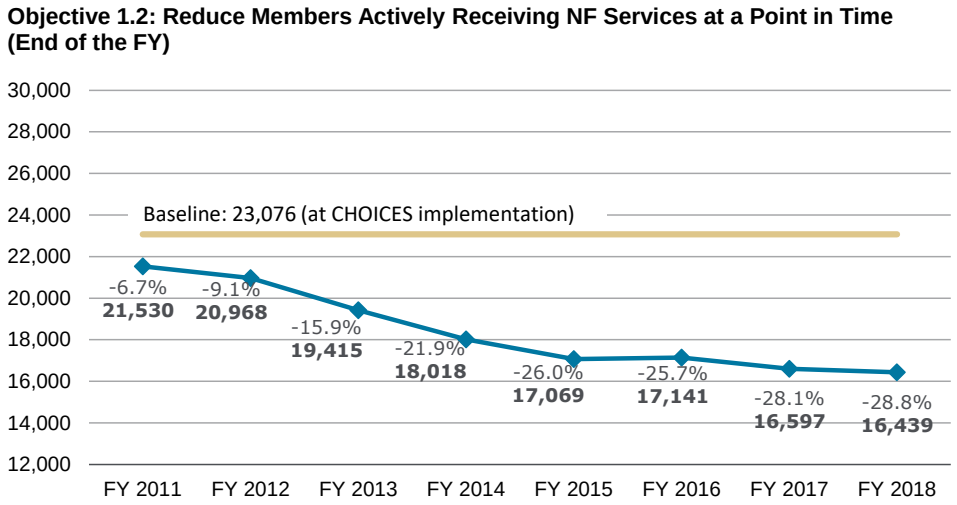
CHOICES Objective 1.2: Decrease the number and percentage of persons receiving nursing facility (NF) services at a point in time and over the course of each demonstration year compared to the year prior to implementation.

Baseline: When the CHOICES MLTSS program was implemented, the number of people actively receiving nursing facility (NF) services totaled 23,076. This included 7,145 in the Middle Grand Region (implemented February 28, 2010) and 15,931 in the East and West Grand Regions (August 1, 2010). The baseline for unduplicated members receiving NF services from March 2, 2009 thru February 28, 2010 (12 Month Period) totaled 31,128.

Actively Receiving Services as of a Point in Time:

CHOICES members actively receiving NF services decreased by 6.7% to 21,530 by the end of first FY (i.e., as of June 30, 2011). See **Figure 3**. Except for FY2016, when number increased only slightly--by 0.4% (from 17,069 to 17,141), the number has continued to decline each year. By June 30, 2018, 6,637 people fewer were actively receiving NF services compared to baseline (a 28.8% reduction). Overall, the number of CHOICES members actively receiving NF services has remained significantly lower than baseline in each demonstration year.

Figure 3: Number of Members Actively Receiving Nursing Facility Services

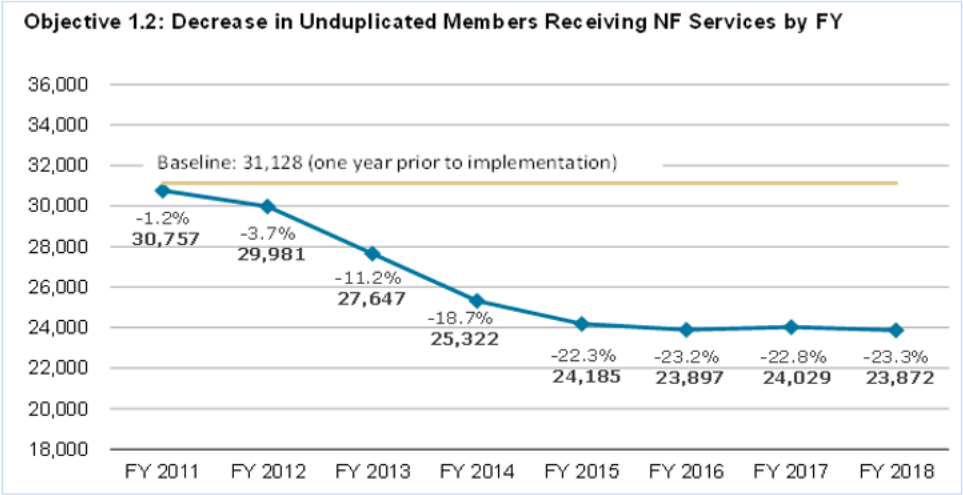


Data Source: Counts members actively receiving NF services at a point in time (June 30, the end of the fiscal year). Baseline includes members at CHOICES implementation, representing the sum of members as of 2/28/10 for the Middle Grand Region and 8/1/10 for East and West Grand Regions. Percentages refer to percentage decrease from baseline.

Unduplicated Members Receiving NF Services Across a Year:

During TennCare FY 2011, the number of unduplicated members receiving NF services decreased by 1.2% after CHOICES implementation. As shown in **Figure 4**, after the implementation of the CHOICES program, the number of members receiving NF services declined steadily until FY2016, when there was a slight (0.55%) increase from FY 2016 (23,897) to FY2017 (24,029). This was followed by a decrease in FY2018 (23,872, or 23.3% lower than baseline). Overall, the number of unduplicated members receiving NF services has remained lower than baseline in each demonstration year.

Figure 4: Number of Unduplicated Members Receiving Nursing Facility Services

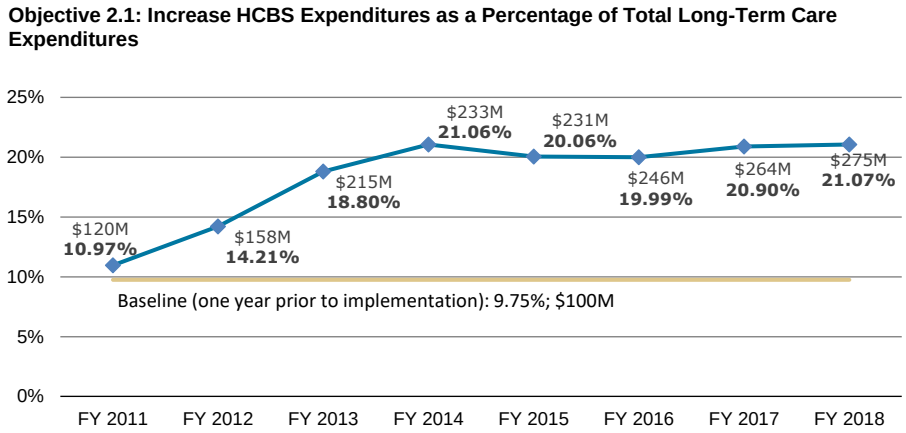


Data Source: Counts unduplicated members actively receiving NF services during the fiscal year (July 1-June 30). Baseline is calculated for the year prior to CHOICES implementation, 3/1/09–2/28/10. Percentages refer to percentage decrease from baseline.

CHOICES Program Objective 2.1: *Increase HCBS expenditures for older adults and adults with physical disabilities (based on encounters, not capitation payments) as a percentage of total long-term care expenditures for older adults and adults with physical disabilities during each demonstration year compared to the year prior to implementation.*

In the year prior to CHOICES implementation, HCBS expenditures for older adults and adults with physical disabilities was $100 million, which represented 9.75% of total long-term care expenditures. As shown in **Figure 5**, the HCBS expenditure percentage increased to 10.97% ($120 million) of total long-term care expenditures during the first year after implementation. The HCBS expenditures percentage steadily increased each year to its first peak in FY2014 at 21.06% ($233 million) of total long-term care expenditures. By that point, HCBS expenditures had increased by 133%. HCBS expenditures declined by $2 million (to $231 million) in FY2015, and the percentage decreased to 20.06%. In FY2016, HCBS expenditures increased, but the percentage relative to institutional care still declined slightly to 19.99% ($246 million), but increased to 20.90% ($264 million) and 21.07% ($275 million) in FY2017 and FY2018, respectively. Overall, the percentage of HCBS expenditures relative to total long-term care expenditures has remained higher than baseline in each demonstration year.

Figure 5: HCBS Expenditures as a Percentage of Total Long-Term Care Expenditures

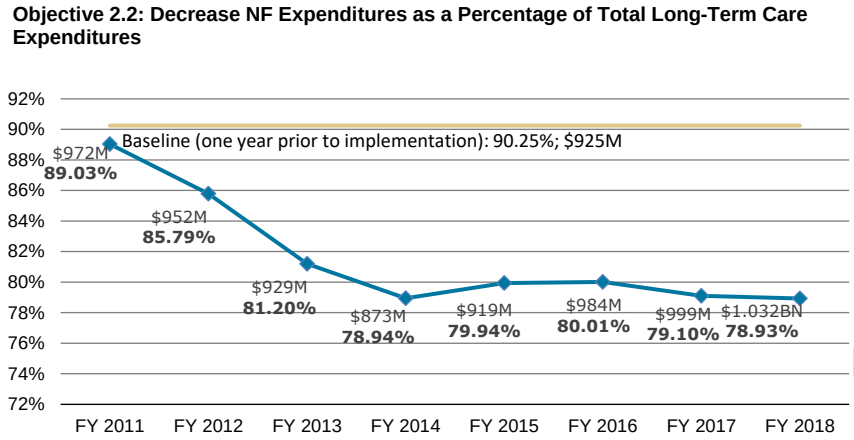


Data Source: Expenditures are for members enrolled in HCBS during the fiscal year (July 1-June 30). Baseline is calculated for the year prior to CHOICES implementation, 3/1/09–2/28/10. Percentages represent the percentage of total long-term care expenditures.

CHOICES Program Objective 2.2: Decrease nursing facility expenditures for older adults and adults with physical disabilities (based on encounters, not capitation payments) as a percentage of total long-term care expenditures for older adults and adults with physical disabilities during each demonstration year compared to the year prior to implementation.

Prior to CHOICES implementation, NF expenditures for older adults and adults with physical disabilities were $925 million, which represented 90.25% of total long-term care expenditures. As shown in **Figure 6**, the NF expenditures percentage decreased to 89.03% ($972 million) in FY2011 and continued to drop until FY2015, when it increased to 79.94% ($919 million). Following another increase in FY2016 to 80.01% ($984 million), the expenditure percentage decreased to 79.10% ($999 million) in FY2017 and to 78.93% ($1.032 billion) in FY2018. Overall, NF expenditures as a percentage of total long-term care expenditures have remained lower than baseline in each demonstration year.

Figure 6: Nursing Facility Expenditures as a Percentage of Total Long-Term Care Expenditures

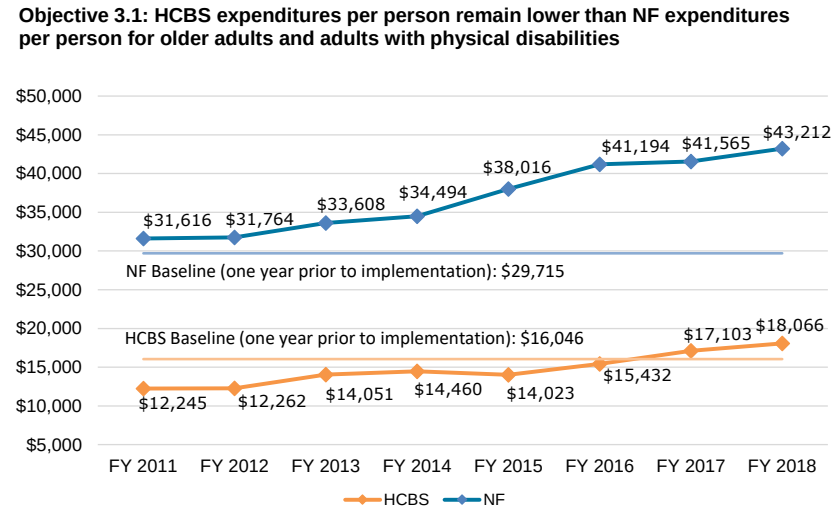


Data Source: Expenditures are for members receiving NF services during the fiscal year (July 1-June 30). Baseline is calculated for the year prior to CHOICES implementation, 3/1/09–2/28/10. Percentages represent the percentage of total long-term care expenditures.

CHOICES Program Objective 3.1: Per person HCBS expenditures on older adults and adults with physical disabilities (based on encounters, not capitation payments) remain lower than per person NF expenditures on older adults with physical disabilities (based on encounters, not capitation payments payments) for each demonstration year.

As shown in **Figure 7**, NF expenditures per person were $29,715 in the 12 months prior to CHOICES implementation. After implementation, NF expenditures per person were $31,616 in FY2011, increasing each year to $43,212 in FY2018. HCBS expenditures per person were $16,046 during the 12 months prior to CHOICES implementation. After implementation, HCBS expenditures per person were $12,245 for FY2011, and increased each year, except for a small decline in expenditures in FY 2015. However, overall, HCBS expenditures per person for older adults and adults with physical disabilities continued to remain well below NF expenditures per person in each FY.

Figure 7: HCBS and NF Expenditures Per Person

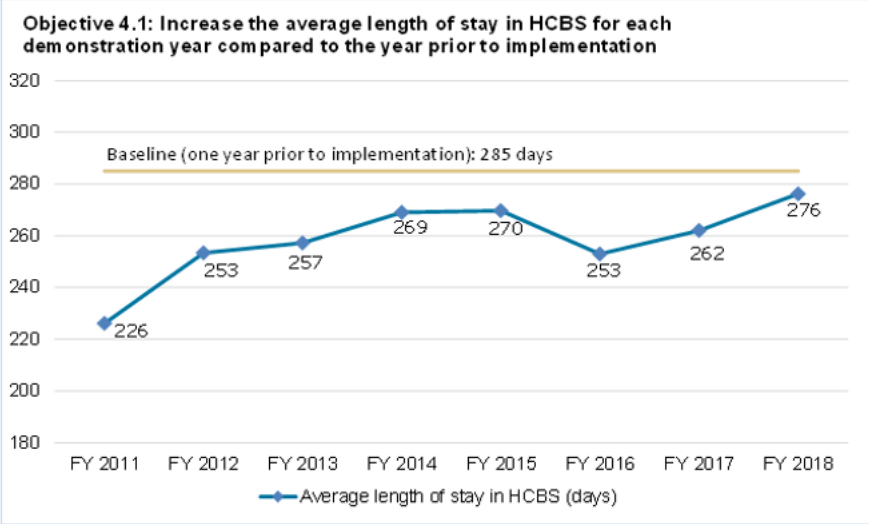


Data Source: Expenditures per person for members receiving HCBS services and for members receiving NF services during the fiscal year (July 1-June 30). Baseline is calculated for the year prior to CHOICES implementation, 3/1/09–2/28/10.

CHOICES Program Objective 4.1: Increase the average length of stay in HCBS for each demonstration year compared to the year prior to implementation.

The average length of stay in HCBS during the year prior to CHOICES implementation was 285 days, as shown in **Figure 8**. After the implementation in FY2011, the average length of stay was 226 days. The length increased to 270 days until a decrease in FY2016 to 253 days. In FY2018, the average length of stay climbed to 276 days. Overall, the average length of stay in HCBS has been lower than baseline in each demonstration year.

Figure 8: Average Number of Days in HCBS

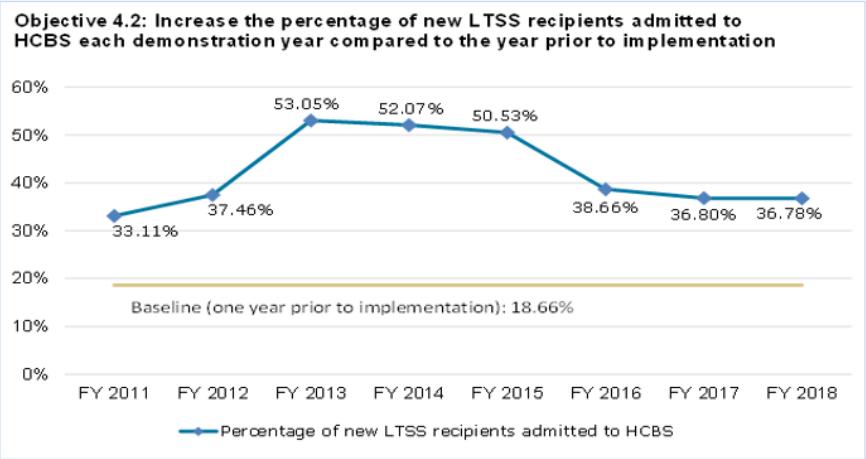


Data Source: Average length of stay in days for members receiving HCBS services during the fiscal year (July 1-June 30). Baseline is calculated for the year prior to CHOICES implementation, 3/1/09–2/28/10.

CHOICES Program Objective 4.2: Increase the percentage of new LTSS recipients admitted to HCBS during each demonstration year compared to the year prior to implementation.

Figure 9 shows that the percentage of new LTSS recipients admitted to HCBS prior to CHOICES implementation was 18.66%. The percentage climbed to 33.11% after CHOICES implementation in FY2011 and increased to a peak of 53.05% in FY2013. The percentage of new LTSS recipients admitted to HCBS then gradually declined in FY2014 and FY2015, followed by a sharp decline to 38.66% in FY2016. In FY2017 and FY2018, the percentages slightly decreased to 36.80% and 36.78%, respectively. Overall, the percentage of new LTSS recipients admitted to HCBS was significantly higher than baseline in each demonstration year.

Figure 9: Percentages of new LTSS Recipients admitted to HCBS

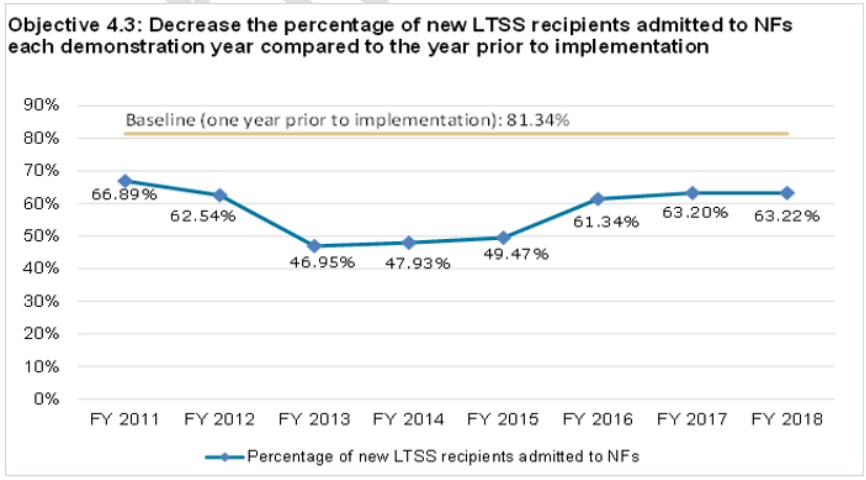


Data Source: Percentage of new LTSS recipients enrolled in HCBS services during the fiscal year (July 1-June 30). Baseline is calculated for the year prior to CHOICES implementation, 3/1/09–2/28/10.

CHOICES Program Objective 4.3: Decrease the percentage of new LTSS recipients admitted to NFs during each demonstration year compared to the year prior to implementation.

The percentage of new LTSS recipients admitted to NFs in the 12 months prior to CHOICES implementation was 81.34%, as shown in **Figure 10**. After CHOICES implementation, the percentage dropped to 66.89% in FY2011 and continued to decline until FY2015, when it rose slightly to 49.47%. The percentage of LTSS recipients admitted to NFs then increased to 61.34% in FY2016 and to 63.22% in FY2018. Overall, the percentage of new LTSS recipients admitted to NFs was significantly lower than baseline in each demonstration year.

Figure 10: Percentage of New LTSS Recipients Admitted to NFs

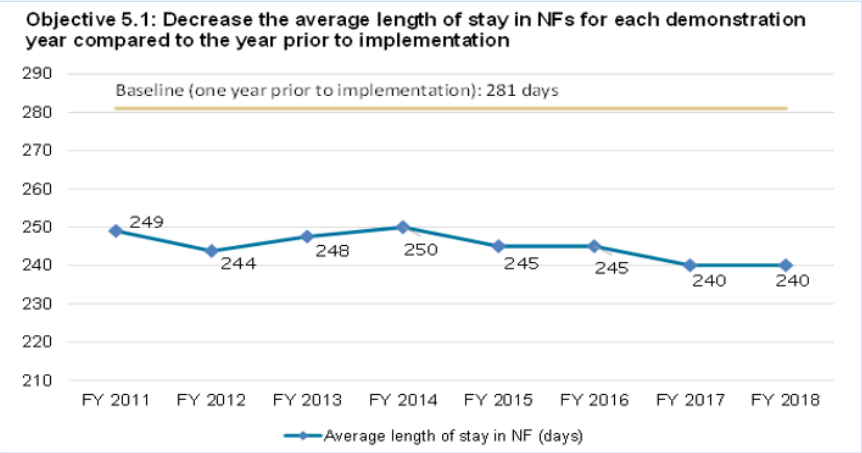


Data Source: Percentage of new LTSS recipients enrolled in NF services during the fiscal year (July 1-June 30). Baseline is calculated for the year prior to CHOICES implementation, 3/1/09–2/28/10.

CHOICES Program Objective 5.1: Decrease the average length of stay in NFs for each demonstration year compared to the year prior to implementation.

The average length of stay in NFs 12 months prior to CHOICES implementation was 281 days. After implementation in FY2011, the average length of stay was 249 days, see **Figure 11**. The average number of days initially decreased to 244 days and increased to 250 days during FY2014. The average length of stay decreased to 240 days during FY2018. Overall, the average length of stay in NFs was lower than baseline in each demonstration year.

Figure 11: Average Number of Days in NFs

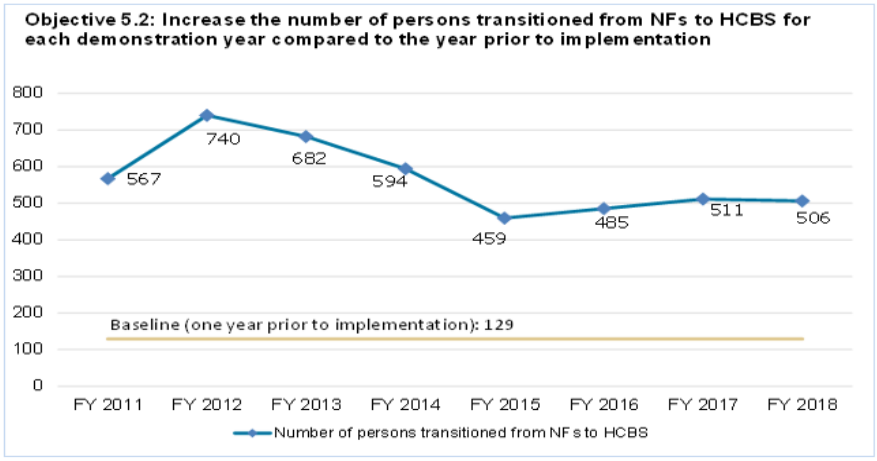


Data Source: Average length of stay in days for members receiving NF services during the fiscal year (July 1-June 30). Baseline is calculated for the year prior to CHOICES implementation, 3/1/09–2/28/10.

CHOICES Program Objective 5.2: Increase the number of persons who transitioned from NFs to HCBS during each demonstration year compared to the year prior to implementation.

In the year prior to CHOICES implementation, 129 persons transitioned from NFs to HCBS. After CHOICES implementation, the number jumped to 567 in FY2011 and reached a peak of 740 in FY2012, as shown in **Figure 12**. The number moderated to 459 in FY 2015 before gradually increasing in FY2016 and FY2017 to 485 and 511, respectively. In FY2018, 506 persons transitioned. Overall, the number of persons who transitioned from NFs to HCBS was significantly higher than baseline during each demonstration year, averaging more than 500 persons per year compared to the baseline of 129.

Figure 12: Number of Members Transitioned from NFs to HCBS



Data Source: Counts members transitioned from NF to HCBS during the fiscal year (July 1-June 30). Baseline is calculated for the year prior to CHOICES implementation, 3/1/09–2/28/10.

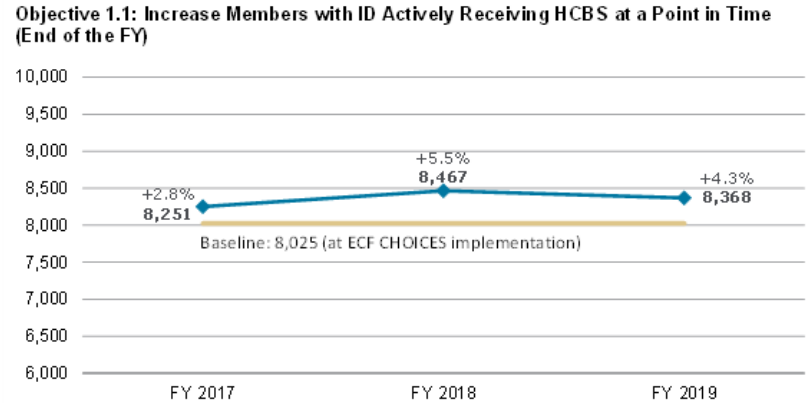
Employment and Community First CHOICES

Employment and Community First CHOICES Program Objective 1.1: Increase the number of individuals with Intellectual Disabilities (ID) actively receiving HCBS at a point in time and over the course of each demonstration year compared to the year prior to implementation.

Baseline: When the Employment and Community First CHOICES program was implemented, the number of individuals with ID actively receiving HCBS totaled 8,025. The baseline for unduplicated members with ID receiving HCBS from July 1, 2015 thru June 30, 2016 (12-month period) totaled 8,295.

Actively Receiving Services: Members with ID actively receiving HCBS increased by 2.8% to 8,251 by the end of the first FY (i.e., as of June 30, 2017). The next year, the number rose by 5.5% over the baseline to 8,467 actively receiving HCBS as of June 30, 2018 (see **Figure 13**). Later, the number decreased to 8,368 as of June 30, 2019 but remained 4.3% above the baseline. Overall, the number of members with ID actively receiving HCBS has remained higher than baseline in each demonstration year.

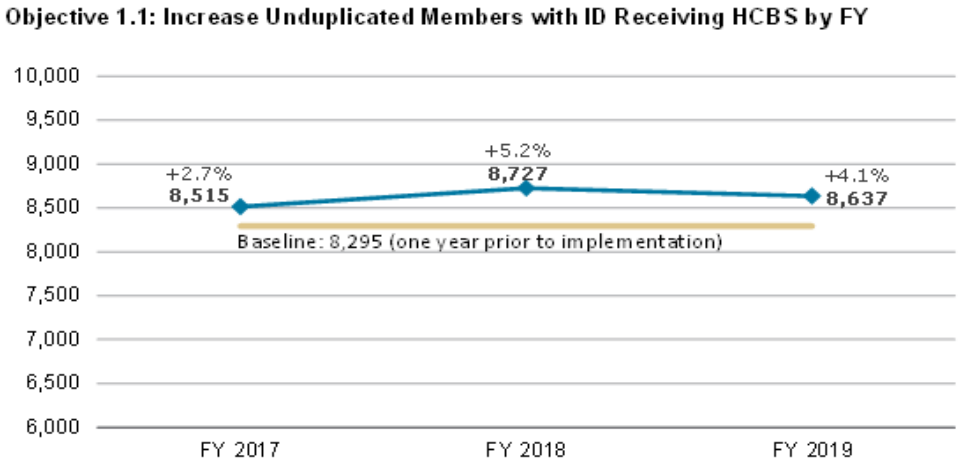
Figure 13: Number of Members with ID Actively Receiving HCBS



Data Source: Counts members with ID actively receiving HCBS services at a point in time (June 30, the end of the fiscal year). Baseline includes members at ECF CHOICES implementation. Percentages refer to percentage increase over baseline.

Unduplicated Members with ID Receiving Services: The year after Employment and Community First CHOICES implementation, the number of unduplicated members with ID receiving HCBS increased by 2.7% in FY2017. As shown in **Figure 14**, after the implementation of Employment and Community First CHOICES program, the unduplicated number of members with ID receiving HCBS reached the peak at 8,727 during FY2018 with a 5.2% increase over baseline. Later, the unduplicated number of members decreased to 8,637 during FY2019, but remained 4.1% above baseline. Overall, the number of unduplicated members with ID receiving HCBS has remained significantly higher than baseline in each demonstration year.

Figure 14: Number of Unduplicated Members with ID Actively Receiving HCBS



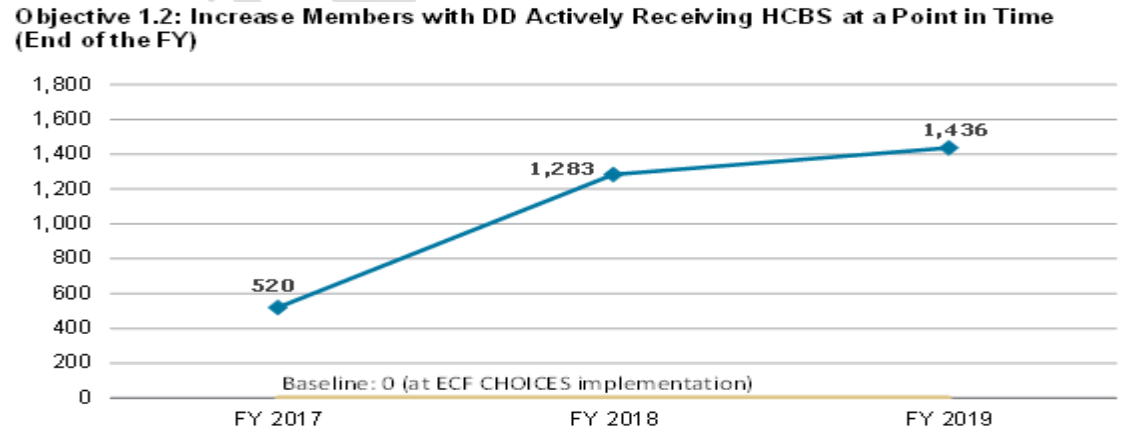
Data Source: Counts unduplicated members with ID receiving HCBS services during the fiscal year (July 1-June 30). Baseline is calculated for the year prior to ECF CHOICES implementation, 7/1/15–6/30/16. Percentages refer to percentage increase over baseline.

Employment and Community First CHOICES Program Objective 1.2: Increase the number of individuals with Developmental Disabilities (DD) actively receiving HCBS at a point in time and over the course of each demonstration year compared to the year prior to implementation.

Baseline: During implementation of the Employment and Community First CHOICES program, there were zero members with DD actively receiving HCBS. The baseline for unduplicated members with DD receiving HCBS from July 1, 2015 thru June 30, 2016 (12-month period) was also zero.

Actively Receiving Services: The number of members with DD actively receiving HCBS was 520 by the end of the first fiscal year (FY) (i.e., as of June 30, 2017). The next year, the number rose to 1,283 actively receiving HCBS as of June 30, 2018 (see **Figure 15**). At the end of FY2019, the number further increased to 1,436. Overall, the number of members with DD actively receiving HCBS has increased significantly in each demonstration year.

Figure 15: Number of Members with DD Actively Receiving HCBS

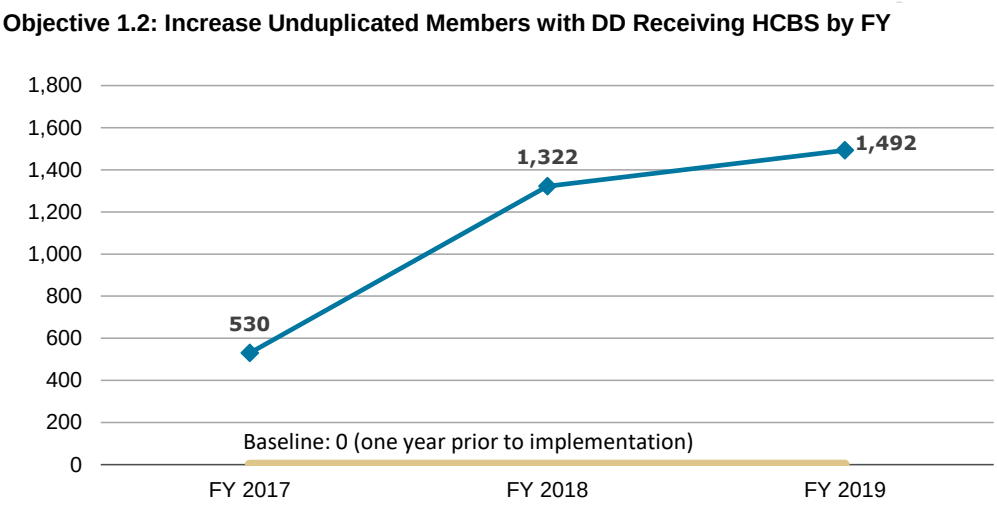


Data Source: Counts members with DD actively receiving HCBS services at a point in time (June 30, the end of the fiscal year). Baseline includes members at ECF CHOICES implementation.

:

Unduplicated Members with DD Receiving Services: The number of unduplicated members with DD receiving HCBS was 530 during FY2017. During FY2018, the number of members with DD receiving HCBS increased to 1,322. Later, the unduplicated number of members increased further to 1,492 during FY2019. Overall, the number of unduplicated members with DD receiving HCBS has increased significantly in each demonstration year (see **Figure 16**).

Figure 16: Number of Unduplicated Members with DD Actively Receiving HCBS



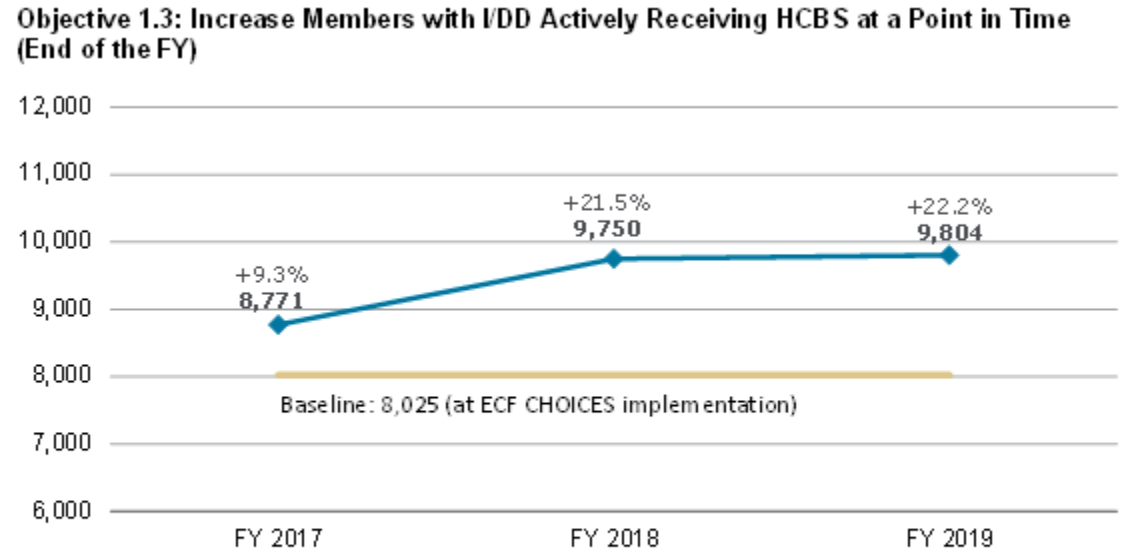
Data Source: Counts unduplicated members with DD receiving HCBS services during the fiscal year (July 1-June 30). Baseline is calculated for the year prior to ECF CHOICES implementation, 7/1/15–6/30/16.

Employment and Community First CHOICES Program Objective 1.3: Increase the number of individuals with I/DD actively receiving HCBS at a point in time and over the course of each demonstration year compared to the year prior to implementation.

Baseline: At the time of Employment and Community First CHOICES program implementation, the number of members with I/DD actively receiving HCBS totaled 8,025. The baseline for unduplicated members with I/DD receiving HCBS from July 1, 2015 thru June 30, 2016 (12-month period) totaled 8,295.

Actively Receiving Services: Members with I/DD actively receiving HCBS increased by 9.3% to 8,771 by the end of the first fiscal year (FY) (i.e., as of June 30, 2017). The next year, the number increased to 9,750 (21.5% increase over baseline) actively receiving HCBS as of June 30, 2018 (see **Figure 17**). The number further increased to 9,804 at the end of FY2019 with a 22.2% increase over baseline. Overall, the number of members with I/DD actively receiving HCBS has remained significantly higher than baseline in each demonstration year.

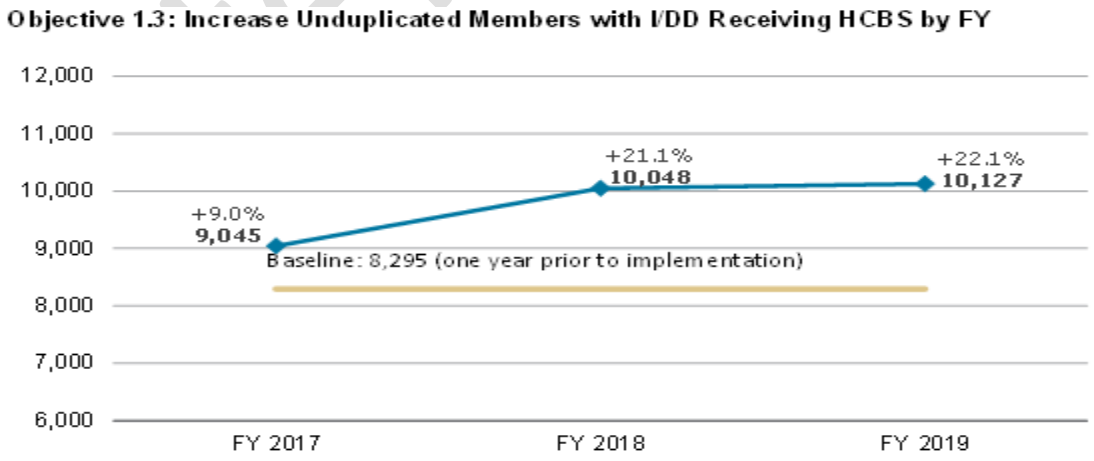
Figure 17: Number of Members with I/DD Actively Receiving HCBS



Data Source: Counts members with I/DD actively receiving HCBS services at a point in time (June 30, the end of the fiscal year). Baseline includes members at ECF CHOICES implementation. Percentages refer to percentage increase over baseline.

Unduplicated Members Receiving Services: The year after Employment and Community First CHOICES implementation, the number of unduplicated members with I/DD receiving HCBS increased by 9.0% to 9,045 in FY2017. As shown in **Figure 18**, the number of members with I/DD receiving HCBS increased to 10,048 during FY2018, a 21.1% increase over baseline. Later, the unduplicated number of members further increased to 10,127 during FY2019 with an increase of 22.1% over the baseline. Overall, the number of unduplicated members with I/DD receiving HCBS has remained significantly higher than baseline in each demonstration year.

Figure 18: Number of Unduplicated Members with I/DD Actively Receiving HCBS

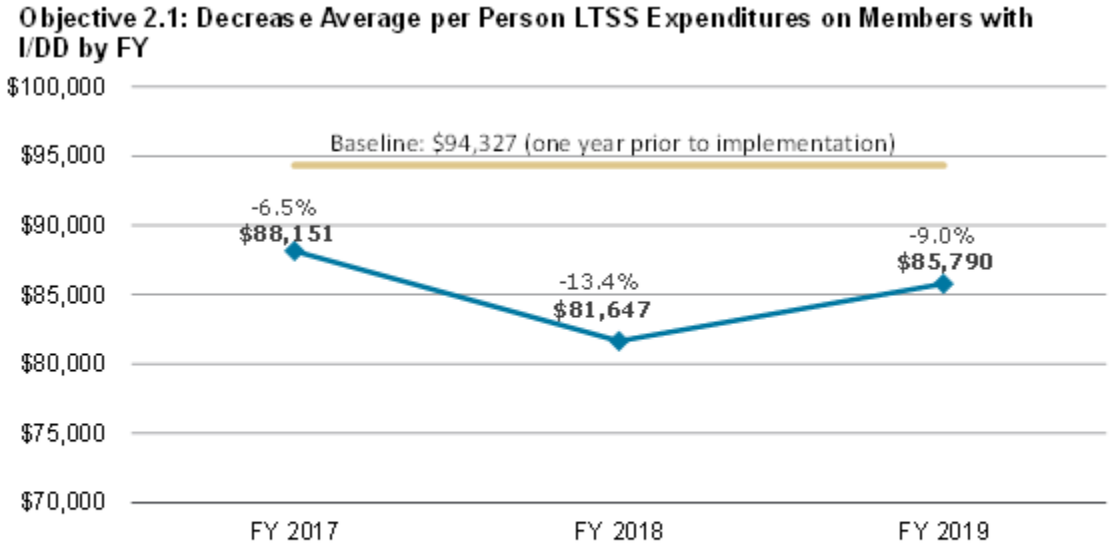


Data Source: Counts unduplicated members with I/DD receiving HCBS services during the fiscal year (July 1-June 30). Baseline is calculated for the year prior to ECF CHOICES implementation, 7/1/15–6/30/16. Percentages refer to percentage increase over baseline.

Employment and Community First CHOICES Program Objective 2.1: Decrease average per person LTSS expenditures on individuals with I/DD (based on encounters, not capitation payments, and fee-for-service expenditures) compared to the year prior to implementation.

Prior to Employment and Community First CHOICES implementation, the average LTSS expenditures per person with I/DD was $94,327. During FY2017, the average per person expenditure decreased to $88,151, a 6.5% decline from baseline. The value further decreased to $81,647 (13.4% decline from baseline) during FY2018. During FY2019, the average LTSS expenditures per person increased from the previous year to $85,790, but still remained 9.0% lower than baseline. Overall, average per person LTSS expenditures on individuals with I/DD have remained lower than baseline in each demonstration year (see **Figure 19**).

Figure 19: LTSS Expenditures Per Person for Members with I/DD

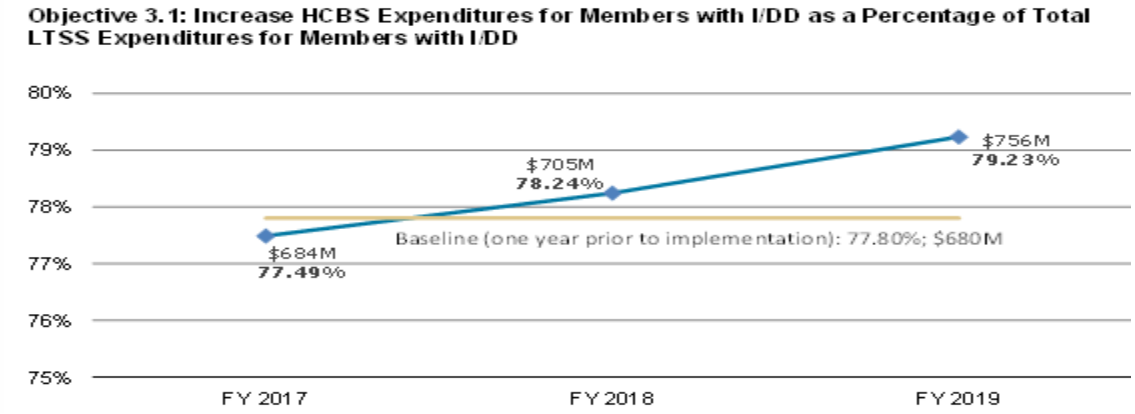


Data Source: LTSS Expenditures per person with I/DD enrolled during the fiscal year (FY: July 1-June 30). Baseline is calculated for the year prior to ECF CHOICES implementation, 7/1/15–6/30/16. Percentages refer to percentage decrease over baseline.

Employment and Community First CHOICES Program Objective 3.1: Increase HCBS expenditures for individuals with I/DD (based on encounters, not capitation payments, and fee-for-service expenditures) as a percentage of total LTSS expenditures for individuals with I/DD during each demonstration year compared to the year prior to implementation.

In the year prior to Employment and Community First CHOICES implementation, HCBS expenditures for members with I/DD was $680 million, which represented 77.80% of total LTSS expenditures for the I/DD population. As shown in **Figure 20**, while HCBS expenditures increased in FY2017, the HCBS expenditure percentage for members with I/DD decreased slightly to 77.49% of total LTSS expenditures after implementation. In each subsequent year, the percentage has remained higher than baseline—at 78.24% during FY2018 and 79.23% during FY2019.

Figure 20. HCBS Expenditures as a Percentage of Total LTSS Expenditures for Members with I/DD

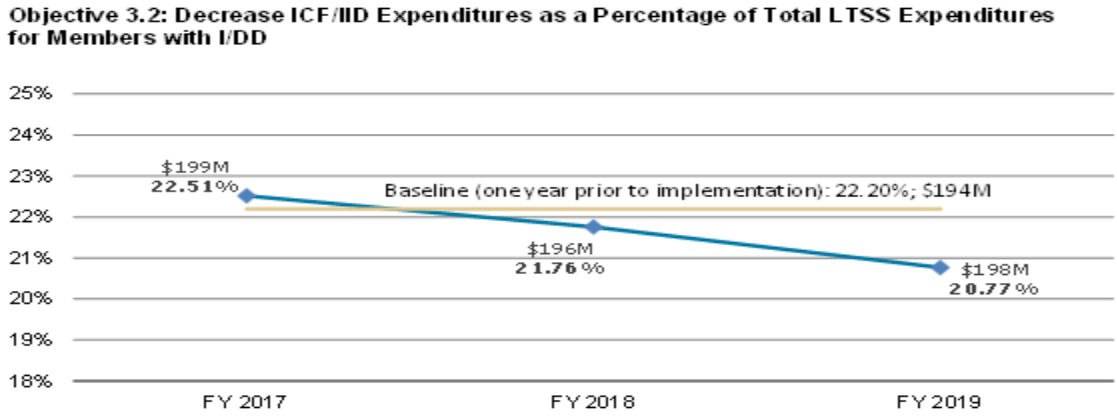


Data Source: Expenditures are for members with I/DD enrolled in HCBS during the fiscal year (July 1–June 30). Baseline is calculated for the year prior to ECF CHOICES implementation, 7/1/15–6/30/16. Percentages represent the percentage of total LTSS expenditures for members with I/DD.

Employment and Community First CHOICES Program Objective 3.2: Decrease ICF/IID expenditures as a percentage of total LTSS expenditures for individuals with I/DD (based on encounters, not capitation payments, and fee-for-service expenditures) during each demonstration year compared to the year prior to implementation.

Prior to Employment and Community First CHOICES implementation, ICF/IID expenditures for members with I/DD were $194 million, which represented 22.20% of total LTSS expenditures. As shown in Figure 21, the ICF/IID expenditures percentage increased to 22.51% in FY2017 after the implementation. During FY2018, the ICF/IID percentage declined to 21.76% and continued to decline further during FY2019 to 20.77%. ICF/IID expenditures as a percentage of total LTSS expenditures for members with I/DD remained lower than baseline during FY2018 and FY2019.

Figure 21. ICF/IDD Expenditures as a Percentage of Total LTSS Expenditures for Members with I/DD



Data Source: ICF/IID expenditures during the fiscal year (July 1–June 30). Baseline is calculated for the year prior to ECF CHOICES implementation, 7/1/15–6/30/16. Percentages represent the percentage of total LTSS expenditures for members with I/DD.

Employment and Community First CHOICES Program Objective 4.1: Increase the number and percentage of working age adults with I/DD enrolled in HCBS programs who are employed in an integrated setting earning at or above the minimum wage during each demonstration year compared to the baseline year.

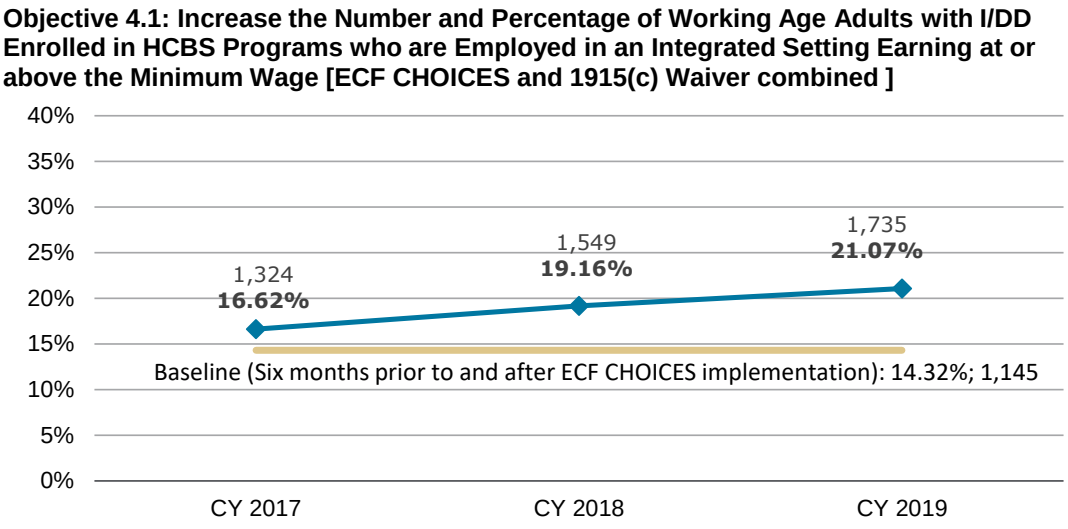
Two separate data analyses are provided. The first combines working age adults with I/DD across HCBS programs. The second depicts results for Employment and Community First CHOICES and 1915(c) waivers separately. TennCare noted that the baseline for this objective was based on a calendar year rather than a point in time.

During baseline CY2016, the percentage of working age adults with I/DD enrolled in HCBS programs who were employed in an integrated setting earning at or above the minimum wage was 14.32% (1,145). This included the six months prior to implementation of Employment and Community First CHOICES, and the first six months following implementation.

ECF CHOICES and 1915(c) Waivers Combined

During baseline CY2016, the percentage of working age adults with I/DD enrolled in HCBS programs who were employed in an integrated setting earning at or above the minimum wage was 14.32% (1,145). During CY2017, the total percentage of working age adults with I/DD employed in an integrated setting earning at or above the minimum wage was 16.62% (1,324). As shown in **Figure 22**, the percentage continued to rise to 19.16% (1,549) in CY2018 and to 21.07% (1,735) in CY2019. Overall, the number of working age adults with I/DD enrolled in HCBS programs who were employed in an integrated setting earning at or above the minimum wage increased in each demonstration year.

Figure 1. Number/Percentage of Adults with I/DD Enrolled in HCBS and Employed At or Above Minimum Wage—ECF CHOICES and 1915(c) Waiver Combined



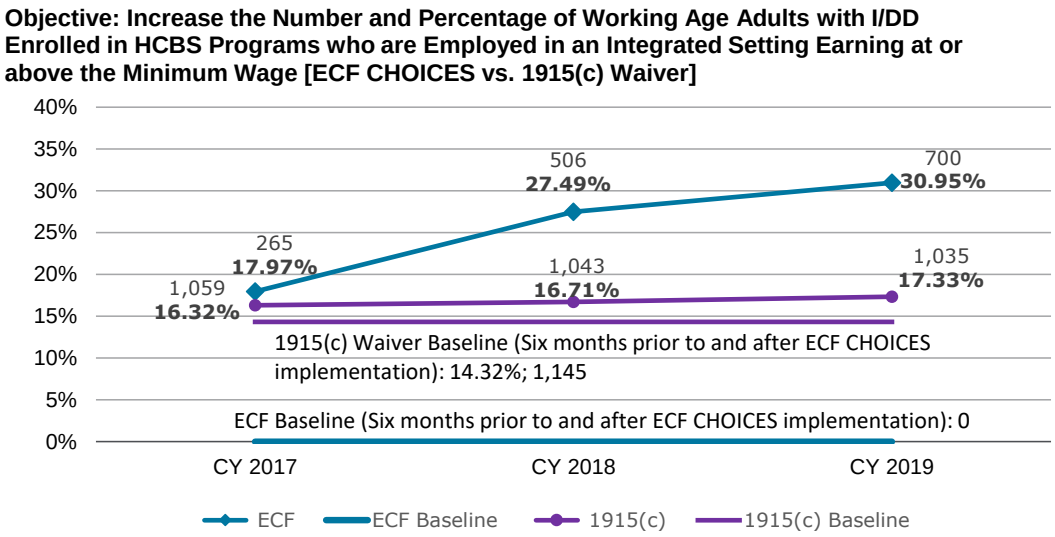
Data Source: Counts members with I/DD enrolled in HCBS programs employed in an integrated setting earning at or above the minimum wage during the calendar year. Baseline includes members six months prior to and after ECF CHOICES implementation. Percentages represent the working age adults with I/DD for each calendar year.

ECF CHOICES vs. 1915(c) Waivers

Figure 23 depicts the number and percentage of adults with I/DD enrolled in HCBS programs who were employed in an integrated setting and earning at or above the minimum wage *separately* for Employment and Community First CHOICES and the 1915(c) waivers. In CY 2017, both programs saw a slight increase above baseline. In Employment and Community First CHOICES, the percentage of working age adults with I/DD employed in an integrated setting and earning at or above the minimum wage was 17.97% (265). In the 1915(c) waivers, the percentage was 16.32% (1,059). In CY2018, the gap increased between Employment and Community First CHOICES (27.49%) and the 1915(c) waivers (16.71%). In CY2019, the gap continued to widen as the percentage for Employment and Community First CHOICES rose to 30.95% but increased only to 17.33% in the 1915(c) waivers.

While the number of working age adults with I/DD enrolled in HCBS programs who were employed in an integrated setting earning at or above the minimum wage increased in each program and for each demonstration year, the increase was significantly higher for Employment and Community First CHOICES than for the 1915(c) waivers.

Figure 2. Number/Percentage of Adults with I/DD Enrolled in HCBS and Employed At or Above Minimum Wage—ECF CHOICES vs. 1915(c) Waiver



Data Source: Counts members with I/DD enrolled in HCBS programs employed in an integrated setting earning at or above the minimum wage during the calendar year. Baseline includes members six months prior to and after ECF CHOICES implementation. Percentages represent the working age adults with I/DD for each calendar year.

Conclusions

CHOICES

The results indicate that the demonstration was effective in achieving the goals and objectives established at the beginning of the demonstration.

CHOICES expanded access to HCBS for older adults and adults with physical disabilities.

CHOICES Objective 1.1: Each year since implementation, the number of people actively receiving HCBS exceeded the number for the baseline year. Further, for the first five of the eight CHOICES demonstration years and again in FY2018, the number of members actively receiving HCBS increased compared to the previous demonstration year.

CHOICES Objective 1.2: Each fiscal year after implementation, the number of members actively receiving NF services decreased compared to the baseline year. Further, for seven of the eight CHOICES demonstration years, the number of members actively receiving NF services steadily decreased compared to the previous demonstration year.

CHOICES [re]balanced TennCare spending on long-term services and supports for older adults and adults with physical disabilities, increasing the proportion that goes to HCBS.

CHOICES Objective 2.1: Each of the fiscal years after implementation, the amount of HCBS expenditures as a percentage of total LTSS expenditures was greater than the figure for the baseline year. Further, for six of the eight CHOICES fiscal years, the CHOICES HCBS expenditures as a percentage of LTSS expenditures increased compared to the previous demonstration year.

CHOICES Objective 2.2: Each of the fiscal years after implementation, the amount of CHOICES NF expenditures as a percentage of total LTSS expenditures was less than the figure for the baseline year. Further, for six of the eight fiscal years, the amount of CHOICES NF expenditures as a percentage LTSS expenditures decreased compared to the previous demonstration year.

CHOICES provided cost effective care in the community for older adults and adults with physical disabilities who would have otherwise required NF care.

CHOICES Objective 3.1: HCBS expenditures per person for older adults and adults with physical disabilities remained significantly lower than NF expenditures per person in each demonstration year.

CHOICES provided HCBS that enabled older adults and adults with physical disabilities who would otherwise have been required to enter NFs to be diverted to the community.

CHOICES Objective 4.1: The average length of stay in HCBS for each of the demonstration years was less than the average number of days in HCBS for the baseline year. It should be noted, however, that for six

of the eight fiscal years, the average length of stay in HCBS for each demonstration year increased compared to the previous year.

CHOICES Objective 4.2: The percentage of new LTSS recipients admitted to HCBS each year exceeded the baseline year.

CHOICES Objective 4.3: The percentage of new LTSS recipients admitted to NFs during each demonstration year fell below the figure for the baseline year.

CHOICES provided HCBS that enabled older adults and adults with physical disabilities receiving services in NFs to transition back to the community.

CHOICES Objective 5.1: The average length of stay in NFs for each demonstration year fell below the figure in comparison to the baseline year.

CHOICES Objective 5.2: The number of persons who transitioned from NFs to HCBS during each demonstration year increased significantly in comparison to the baseline year.

Overall, the findings confirm a significant positive impact of the demonstration as evidenced in the achievement of all 5 of the main objectives/goals, and 9 of the 10 sub-objectives.

Implementing the CHOICES MLTSS program successfully expanded access to HCBS for older adults and adults with physical disabilities, as compared to the fee-for-service Section 1915(c) waiver that existed prior to the implementation of CHOICES.

Data supports that a significantly larger number of older adults and adults with physical disabilities have accessed HCBS, and the number of people receiving services in a nursing facility declined. This means that more people chose to receive HCBS and accessed those HCBS in order to divert or transition from institutional settings into HCBS, leading to an increase in HCBS enrollment and expenditures. Importantly, the average annual cost of those HCBS remained substantially lower than the average cost of institutional care each year, allowing for more people to receive services at a much lower cost than would have been incurred if they had been served in a nursing facility.

Moreover, because all five of the main objectives/goals and 9 of the 10 sub-objectives were consistently met during each demonstration year, the evaluation concludes that improvements can be sustained over time, including as the demand for LTSS increases. There are important opportunities that may help to ensure sustainability, as further discussed in the *Interpretations* section below.

EMPLOYMENT AND COMMUNITY FIRST CHOICES

The results indicate that this MLTSS program was also effective in achieving the goals and objectives established at the beginning of the demonstration.

Employment and Community First CHOICES expanded access to HCBS for individuals with I/DD.

Employment and Community CHOICES Objective 1.1: Each year since implementation, the number of people with ID actively receiving HCBS exceeded the number for the baseline year.

Employment and Community CHOICES Objective 1.2: Each year since implementation, the number of people with DD actively receiving HCBS exceeded the number for the baseline year. More than 1,400 individuals with DD received HCBS that would not have been available to them absent the implementation of Employment and Community First CHOICES.

Employment and Community CHOICES Objective 1.3: Each year since implementation, the number of people with I/DD actively receiving HCBS has exceeded the baseline year. This increase is noted as significant as the rate of increase more than doubled over the course of the demonstration (from 9.3% for FY2017 to 22.2% for FY2019).

Employment and Community First CHOICES provided more cost-effective services and supports for persons with I/DD.

Employment and Community CHOICES Objective 2.1: Overall, per person LTSS expenditures consistently declined each year compared to the baseline year.

Employment and Community First CHOICES continued to balance TennCare spending on LTSS for individuals with I/DD to increase the proportion spent on HCBS.

Employment and Community CHOICES Objective 3.1: Expenditures for individuals with I/DD increased at a steady pace each demonstration year compared to the baseline year.

Employment and Community CHOICES Objective 3.2: ICF/IID expenditures increased in the first demonstration year (FY2017) after implementation by 0.31%, then steadily declined each demonstration year thereafter.

Employment and Community First CHOICES increased the number and percentage of working age adults with I/DD enrolled in HCBS programs who are employed in an integrated setting earning at or above the minimum wage.

Employment and Community CHOICES Objective 4.1: The number of working age adults with I/DD enrolled in HCBS programs who were employed in an integrated setting earning at or above the minimum wage increased in each program and for each demonstration year. It should be noted that the increase was significantly higher for Employment and Community First CHOICES than for the 1915(c) waivers.

Data collection to establish the benchmark for the fifth objective—*Improve the quality of life of individuals with intellectual and developmental disabilities enrolled in HCBS programs*—was collected during 2019/2020. The first year of performance improvement will be measured in 2020/2021.

Overall, the findings confirm the significant positive impact of the demonstration as evidenced in the achievement of all 4 main objectives/goals and all sub-objectives for which performance measurement data was collected.

Data supports that the Employment and Community First CHOICES program successfully expanded access to HCBS for individuals with ID, for individuals with DD, and across the I/DD population broadly. While the gains across the I/DD population were significant, the greatest gains were for individuals with DD who were able to access these HCBS for the first time

The expansion of HCBS through Employment and Community First CHOICES helped to further the state's balancing of LTSS expenditures for people with I/DD, maintaining a longstanding commitment to community-based supports. Importantly, the average cost of providing services in Employment and Community First CHOICES was significantly less than in the 1915(c) waivers or in ICFs/IID, leading to a reduction in the per person cost of LTSS overall.

Competitive, integrated employment for working age adults with I/DD enrolled in HCBS increased across programs. While the number of working age adults with I/DD enrolled in HCBS programs who were employed in an integrated setting earning at or above the minimum wage increased in each program and for each demonstration year, the increase was significantly higher for Employment and Community First CHOICES than for the 1915(c) waivers.

Because all 4 main objectives/goals and all sub-objectives for which measurement data was collected were consistently met during each demonstration year, the evaluation concludes that improvements can be sustained over time—at least as it pertains to Employment and Community First CHOICES. Broader integration of LTSS for the I/DD population will yield far greater opportunities to further these and other important program goals across the entirety of the service delivery system, as further discussed in the *Interpretations* section below.

Interpretations, Policy Implications and Interactions with Other State Initiatives

At the inception of each program, TennCare made key design decisions based on defined program objectives in order to drive each program's success.

In CHOICES, this began with the decision to integrate all LTSS for the population (NF as well as HCBS), and a decision to place MCOs "at risk" with regard to all LTSS, including NF services, regardless of the duration of those services. The State also determined to pay a blended capitation payment for the provision of LTSS, encompassing both NF and HCBS for those qualifying for NF level of care.[5] The capitation payment made on behalf of a CHOICES member who meets NF level of care is the same, regardless of whether they are served in a NF or in the community. The MCO is incentivized to serve people in the community whenever possible (both delaying or preventing NF placement as well as transitioning from NF placement to the community when appropriate). The MCO is also incentivized to ensure that services in the community are sufficient to meet each person's needs and sustain community living, since the MCO will bear financial risk for a more expensive NF placement.

Policy decisions around post-eligibility determinations (allowing CHOICES participants who were temporarily institutionalized to keep their community personal needs allowance for a time in order to maintain their community living arrangement) and around program benefits (authority for MCOs to authorize a "Transition Allowance" [6] in order to facilitate the person's safe and timely transition from an NF to the community, and authority for MCOs to exceed certain benefit limits including those for Attendant Care, when determined to be a cost-effective alternative to institutionalization) provided flexibility for MCOs to address community living needs. In addition, the availability of consumer directed options,[7] and allowing individuals electing to receive services through consumer direction to also choose to self-direct health care tasks that would otherwise have to be performed by a licensed nurse provided greater flexibility to ensure that medical and other support needs could be safely met in the community in a cost-sustainable way.

[5] The blended capitation rate is accomplished by first developing actuarially sound rates for each service setting. The mix of individuals receiving services in each setting (NF vs. HCBS) is determined, and a conservative target is established for how the percentages are expected to change during the rating period. The two rates are then blended according to those percentages, resulting in a single capitation payment for all persons who meet NF level of care, inclusive of physical and behavioral health and LTSS, including NF and HCBS. This is done separately for the dual eligible and the non-dual populations in each region.

[6] The Transition Allowance may be used to cover items needed to establish a community residence, including rent and/or utility deposits, essential kitchen appliances, basic furniture, and essential basic household items, such as towels, linens, and dishes.

[7] Sometimes referred to as "self-direction," allows individuals receiving LTSS to elect to directly employ the individuals who will deliver certain services, using the service of the State's contracted fiscal employer agent to manage payroll and associated taxes.

While these have helped to ensure that people enrolled in the program are able to sustain community living, the frailty of the CHOICES population combined with significantly expanded new enrollment, especially in the early years of the program, drew down average lengths of stay in HCBS (as people received less than a full year of services). Length of stay in HCBS returned to near pre-CHOICES levels as program enrollment became more stable.

MCOs were required to develop and implement nursing facility diversion and nursing facility-to-community transition processes, including routine screening of residents' interest and potential for transition, and to meet specific timelines related to transition assessments and the development of transition plans.

Barely a year after the CHOICES program was launched statewide (in 2011), TennCare layered on a Money Follows the Person Rebalancing demonstration, utilizing processes and requirements already in place in CHOICES. The MFP program brought resources to help support MCOs' transition efforts, including an incentive payment structure specifically aligned with MFP rebalancing demonstration goals *and* with CHOICES program goals.

Under TennCare's MFP demonstration, MCOs received an incentive payment for each person who transitioned from a qualified institution into a qualified residence in the community and enrolled in MFP. MCOs also received an incentive payment upon the completion of the 365 day MFP participation period (to help ensure that community living was sustained). These incentive payments were doubled for each person above the MCO's target for the performance period. Additional incentive payments could be earned based on meeting MFP transition targets and on achieving other MFP program benchmarks focused on LTSS system performance more broadly, including increasing the balance of HCBS enrollment and expenditures relative to institutional enrollment and expenditures, as well as development of system capacity to provide community based residential alternatives and participation in consumer direction. The MFP rebalancing fund (enhanced FMAP earned by the state as part of the demonstration) was used to help develop HCBS delivery system capacity, and to support the development of affordable housing for persons transitioning from an institution.

The MFP demonstration concluded in December 2018 upon exhausting all of the program's approved funding, and after exceeding the projected goal of transitioning more than 2,225 people out of institutions into the community. CHOICES program participants included in the more than 2,600 individuals transitioned under MFP are a subset of the much larger volume of NF-to-community transitions, and account only for those meeting MFP criteria. Importantly, because MFP was layered onto the existing CHOICES structure, except for the incentive payments, all of the fundamental components of the MFP program, including diversion and transition processes and access to HCBS, have continued seamlessly.

Also during the evaluation period, TennCare made substantial progress in aligning enrollment of dual eligible beneficiaries (those eligible for Medicare as well as Medicaid) in the same MCO for their Medicare and Medicaid benefits. Because utilization of Medicare Skilled Nursing Facility (SNF) services is a significant driver of utilization of Medicaid NF services (once the Medicare SNF benefit is exhausted), the

ability to better coordinate hospital discharges for dual eligible beneficiaries can have measurable impacts on NF diversion efforts. TennCare leveraged contracts with Medicare Advantage Dual Eligible Special Needs Plan (required pursuant to the Medicare Improvements for Patients and Providers Act of 2008) to strengthen requirements for coordination of discharge planning, including exchange of daily inpatient admission and discharge reports, as well as observation stays, to help facilitate timely discharge planning to the most integrated setting, bolstering MCOs' NF diversion and NF-to-community transition programs.

In addition to MFP and D-SNPs, there were other programmatic developments which impacted demonstration outcomes. The most significant was agreement with CMS late in 2011 that permitted the State to move forward with fully implementing a key provision of its demonstration aimed at raising instititutional level of care standards in order to better target the benefit to those with the most significant needs, while continuing to make those "at risk of institutional placement" eligible for HCBS. Implementation of this provision, approved as part of the original CHOICES program design in 2009, had been delayed as result of maintenance of effort (MOE) provisions of the American Recovery and Reinvestment Act and subsequently the Affordable Care Act. With the approval of Amendment #14, the State moved forward with level of care changes effective July 1, 2012, while preserving existing eligibility pathways through the establishment of a new CHOICES Group 3. Eligibility into Group 3 during the interim period was determined based on institutional income standards (even though new institutional level of care standards were not met), and no enrollment target (i.e., limit) was applied. Individuals enrolled as of 7/1/12 (under the previous level of care requirements) were "grandfathered" so long as they continued to meet the eligibility criteria in place at the time of enrollment.

The 12 Month Periods ending 6/30/13, 6/30/14 and 6/30/15 reflected nearly 20 percent diversion of all NF applicants to HCBS after raising NF level of care standards. However, once the MOE provisions ended, the application of institutional income standards to establish new eligibility for Medicaid also ended on 6/30/15. After individuals were required to meet SSI criteria to enroll in the "at-risk" groups, diversion numbers dropped substantially. Since that time, the 12 Month Period ending 6/30/16 reflected a 13.6% nursing facility diversion rate; the 12 Month Period ending 6/30/17, an 11.52% diversion rate; the 12 Month Period ending 6/30/18, an 13.21% diversion rate; and the 12 Month Period ending 6/30/19, an 11.83% diversion rate, affecting multiple elements in the baseline data plan. The early successes of offering HCBS more broadly to at-risk groups in achieving greater diversion from institutional care warrant further consideration, particularly in light of the recent impacts of COVID-19 on NFs, and longer term, as it relates to ensuring the sustainability of the system in light of an aging population.

Of note, success in diverting people with lower levels of need from nursing facility services in turn impacted the transition measure. 12 Month Periods ending 6/30/13 and following reflect diversion of NF applicants with lesser needs to HCBS after raising NF LOC standards on 7/1/12. Persons admitted to NFs have more acute needs, resulting in additional challenges in transition to community. Nonetheless, transitions throughout the life of the CHOICES demonstration have averaged more than 500 per year, compared to only 129 in the baseline period before the program was implemented. Importantly, while the waiting list for HCBS was eliminated early in the program, even if the enrollment target for CHOICES Group 2 (the HCBS benefit group for those qualifying for NF care) was reached, persons transitioning from

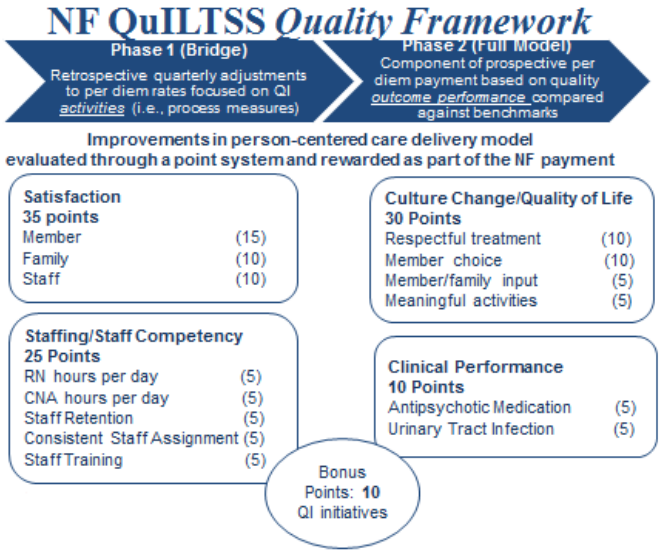
an institution and certain persons "at risk" of institutional placement are exempt from enrollment targets, and permitted to enroll in HCBS.

As the acuity of the population in nursing homes increased and in an effort to advance person-centered care across LTSS settings, in late 2013, TennCare launched the Quality Improvement in Long-Term Services and Supports (QuILTSS Initiative). QuILTSS is a value-based purchasing (VBP) and delivery system transformation approach for LTSS, encompassing 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).

Nursing Facility (NF) QuILTSS

QuILTSS for NFs launched in 2014, with retrospective quality- and acuity-based adjustments to NFs' per diem payments, using a *Quality Framework* (see Figure 0, below) developed with stakeholders. Legislation brought by the NF industry during the 2013-14 legislative session and passed by the General Assembly modified a longstanding nursing home bed tax into a nursing home assessment fee, effective July 1, 2014, generating additional revenues to support changes to the NF reimbursement structure.

Figure 0



In 2015, TennCare was awarded a State Innovations Model (SIM) Model Test grant by the Centers for Medicare and Medicaid Innovation (CMMI). This grant helped support the Tennessee Health Care Innovation Initiative which included three strategies: Primary Care Transformation, Episodes of Care, and Long-Term Services and Supports—specifically QuILTSS. For NF QuILTSS, SIM funds were used to procure the development and launch of a standardized data collection tool, methodology and process for outcome-based measurements for Satisfaction and Culture Change/Quality of Life measures and to obtain

provider-specific and aggregated baseline data analysis and establish and measure performance against outcome-based performance benchmarks for the second survey year.

Implementation of NF QuILTSS occurred in two phases: phase one - the "bridge" payment process, with quarterly retroactive adjustments to facilities' per diem rates based largely on facilities' quality improvement *activities* (i.e. process measures); and phase two - transition to quality as a component of the prospective per diem rate based on NF *performance* on specified quality measures compared against state and national benchmarks. NF expenditures for the period ending 6/30/13 include $23.8 million in acuity-based per diem rate adjustments. These rate adjustments were the result of a non-recurring appropriation by the General Assembly to acknowledge the higher acuity of residents served in NFs as more people were diverted or transitioned to HCBS. NF expenditures for the period ending 6/30/15 included more than $73 million; for the period ending 6/30/16, more than $99 million; for the period ending 6/30/17, more than $106 million; and for the period ending 6/30/18, almost $117 million in quality and acuity-based per diem rate adjustments. Funding for these rate adjustments was generated through an assessment fee established by the NF industry through legislation. Effective July 1, 2018, quality and acuity adjustments are now part of the prospective NF per diem rate. The prospective value-based NF reimbursement structure includes both a quality incentive pool and additional "quality-informed" adjustments (or "levers") based on a facility's quality performance.

Quality Incentive Pool

A specified amount of the funding for NF services is set aside during each fiscal year for purposes of calculating a quality-based component of each NF provider's per diem payment (i.e., a quality incentive component). The pool is divided among facilities during the rate-setting process, with each NF's portion incorporated as a component of their per diem rate, based on their performance on measures in the *Quality Framework*, taking into account their volume of Medicaid bed days. Under the law, at implementation, the amount of funding set aside for the quality-based component was no less than forty million dollars ($40 million) or four percent (4%) of the total projected fiscal year expenditures for NF services, whichever was greater. In each subsequent year, the amount of funding set aside for the quality-based component will increase at two (2) times the rate of inflation, and will then increase or decrease at a rate necessary to ensure that the quality-based component of the reimbursement methodology remains at ten percent (10%). For FY 19, the quality incentive pool was valued at $55 million.

Quality-Informed Rate Components

In addition to the quality incentive pool, each NF's quality performance score is used to "inform" the setting of multiple other components of the rate, based on tiers of quality incentive scores, including:

- Direct care (the largest rate component), encompassing both:
  - Case-mix adjusted (based on resident acuity)—Nurse/CNA staffing; and
  - Non case-mix-adjusted (raw food, recreation and social services); and
- Fair rental value.

Additionally, there is an incentive in the fair rental value rate component to use excess bed capacity in NFs (resulting from lower Medicaid utilization) to make private rooms (typically available only to private pay residents) available to Medicaid residents. The incentive is based on the percentage of Medicaid private room resident days to total base year bed days available. While more difficult to quantify, in total, quality-informed adjustments amount to about another 3.5% of the reimbursement structure.

While the QuILTSS program has significantly advanced person-centered, quality care in NFs, it has also increased payments to NFs. In fact, as a result of the implementation of quality- and acuity-related reimbursement reforms, payments to NFs increased significantly during the period even though utilization of NF services (the number of days of service received) declined substantially. Because NF services are already substantially more expensive than HCBS, this hampered the rebalancing of expenditures between the service settings.

Program design decisions to help ensure that HCBS would remain cost-effective relative to institutional care (in order to ensure their sustainability and to offer services to more of the people who need them) included a tiered benefit structure based on assessed levels of medical needs (i.e., level of care). A comprehensive package of HCBS is available for those who meet nursing facility level of care (CHOICES Group 2), and a more moderate package of benefits for those "at risk" of institutional placement (CHOICES Group 3). In both groups, benefit limits and expenditure caps on the total cost of services helped to match available services with levels of need determined through the medical eligibility process. For individuals in CHOICES Group 2, an individual cost neutrality cap (ensuring that the cost of services in the community is not more than the cost of care in a nursing facility) is calculated in the same manner as that used in Section 1915(c) waivers and set forth in Section 1915(c)(4)(A). To better accommodate the needs of individuals with complex medical needs requiring enhanced respiratory care, the individual cost neutrality cap for these individuals is based on the cost of more specialized nursing facility care that would otherwise be required, allowing them to receive a higher level of medical and other supportive services in the community.

Like CHOICES, TennCare made key design decisions based on defined program objectives for Employment and Community First CHOICES in order to drive the program's success.

As with CHOICES, program design decisions for Employment and Community First CHOICES included a tiered benefit structure based on assessed levels of care. For those meeting institutional level of care, Employment and CHOICES also utilizes a standardized assessment performed by an objective third party as well as individualized medical information to determine each person's level of support need. Level of need is based on the intensity level of practical supports needed as determined by an objective assessment utilizing the American Association of Intellectual and Developmental Disabilities Supports Intensity Scale® (SIS), **and** individualized consideration of exceptional medical or behavioral needs identified in the assessment, either as part of the SIS, the ICAP problem behavior assessment, or through other information gathered during the comprehensive assessment process. The total cost of HCBS available (the "expenditure cap) is in turn based on the assessed level of care and/or level of need, as applicable. As with CHOICES, individuals meeting institutional level of care and assessed to have

exceptional medical or behavioral needs can receive services up to the comparable cost of institutional care, and as with CHOICES, these are higher for persons with enhanced respiratory care needs, enabling the receipt of additional medical and other support needs in the community.

Across all benefit groups in Employment and Community First CHOICES, a flexible array of services is designed to promote employment, community integration, and individual/family empowerment, helping each person achieve as much independence as possible. While many of the services have benefit limits to help control cost (and increase access to services for others who need them), as with CHOICES, MCOs have authority to exceed certain benefit limits when determined to be a cost-effective alternative to institutionalization, in order to provide flexibility for MCOs to address community living needs.

Critical to the achievement of employment related program goals, an array of 14 employment services create a pathway to employment, even for people with the most significant needs. Value-based reimbursement for employment services (one of the QuILTSS initiatives for HCBS) help to ensure that employment outcomes are achieved and align incentives to support fading of paid supports (and increased independence) over time. An Employment Informed Choice process ensures that employment is the *first* option considered for every person of working age *before* non-employment day services are available. The process is conducted as part of a comprehensive person-centered assessment and planning process which is specifically designed to explore employment early and in significant depth, and led by Support Coordinators who are recruited based on their experience and attitude with regard to employment and trained and supported in facilitating employment conversations that lead to identification of employment goals and next steps.

For employment and other benefits available in Employment and Community First CHOICES, MCOs are contractually required to develop a network of qualified providers using preferred contracting criteria established by the State which focus on providers with proven track records of success in supporting individuals in obtaining competitive, integrated employment, and in supporting integration and independence.

Even program enrollment policies are aligned with employment goals, by prioritizing people with employment related needs and goals for enrollment, and by offering individuals engaged in competitive, integrated employment access to additional program benefits.

While measurement of quality of life goals did not commence until 2019-2020 (and thus can be used only for purposes of establishing the benchmark, rather than measuring success), TennCare's System Transformation Initiative seeks to transform the entire LTSS system to one that is person-centered, and that aligns policies, practices, and payments with system values and outcomes, including employment and full community citizenship and participation. To guide the initiative, TennCare convened a statewide System Transformation Leadership Group (STLG) comprised of self-advocates taking part in LTSS programs, advocacy organizations, HCBS providers, MCO staff, and State leadership from the Department of Intellectual and Developmental Disabilities and TennCare. During the 2016-2017 year, with input from the STLG, TennCare developed a System Transformation strategic plan. The plan, which drives the system transformation work, outlines specific policy and program changes that will help to promote person-

centered practices across LTSS programs, ensure an array of high quality LTSS, address system barriers and challenges such as workforce development and retention, align payment for services with quality and outcomes, and better use data to focus and drive system transformation efforts. Many of the initiatives are expected to have a positive impact on the quality of life of individuals enrolled in HCBS programs. These include engaging with advocacy groups to further supported decision-making in place of more restrictive legal options and examining and adjusting critical incidents systems through the lens of dignity of risk to assure individual rights and freedoms.

While there are many similarities in the design of the two MLTSS programs, the fundamental differences in approach are observed in measures shared between the two programs.

In light of the impacts of longstanding federal litigation on the I/DD delivery system, the decision was made to not integrate existing I/DD programs and services (ICF/IID benefits 1915(c) waivers) into managed care at the outset, but rather to focus first on implementing a new, more effective and efficient model of service delivery. The hope was that over the long-term, the new more cost-effective approach would impact the service delivery system broadly, enabling changes that might allow more people to receive services. In the short-term, this meant that increased access to HCBS was wholly dependent on the availability of new appropriations to enroll people into the program, including those with ID on a longstanding waiting list for services, and people with other kinds of DD who theretofore had not had access to HCBS. In the first two years of Employment and Community First CHOICES, appropriations were sufficient to cover enrollment for up to 2,700 people; but for the next two years, new funding was limited only to attrition dollars from the 1915(c) waivers and provided funding only for up to 300 people per year who met emergent or other circumstances requiring mandatory enrollment. While HCBS enrollment experienced at least moderate increases each year, as enrollment slowed to include those in emergent circumstances, the average annual cost of services in Employment and Community First CHOICES and in I/DD programs overall to increase in FY 19 (although both figures remained below the baseline).

Even though the Employment and Community First CHOICES was successful in achieving program objectives, by leaving existing programs (1915(c) waivers and ICF/IID benefits) in place and carved out of the managed care program, it was much harder to achieve significant system transformation gains. Gains in cost-effectiveness and system balancing were moderated by the larger volume of LTSS enrollment and expenditures in the fee-for-service programs. Likewise, substantial gains in employment in Employment and Community First CHOICES were less impactful when weighed in light of the much larger ID population served in the 1915(c) waivers, where employment remain relatively flat during the evaluation period.

In Employment and Community First CHOICES where the efficacy of the approach has now been demonstrated, broader integration of LTSS for the I/DD population will yield far greater opportunities to further these and other important program goals across the entirety of the service delivery system.

Lessons Learned and Recommendations

1. The development of clear policy goals is critical.

The development of clear policy goals enabled the state to make program design decisions to support the achievement of desired program outcomes

2. The engagement of stakeholders in setting policy goals and in the design and implementation of MLTSS programs is essential.

Stakeholder input in the beginning of the program design process is vital to understand the types of services people want and need, establish clear policy goals, and protect and preserve core system values. Input can also help to identify and address potential obstacles to program success and opportunities to enhance program outcomes—both before and after program implementation. Stakeholder feedback can be used to identify important drivers of quality that impact the day-to-day lives of the individuals supported and help to ensure that programs and services are implemented in ways that have the greatest potential to improve the experience of those who receive LTSS and their families.

3. The development of performance metrics and data collection processes to measure the program's success is key.

By determining these measures at the program's outset, the state was able to capture baseline data in order to measure each program's performance over time and determine whether the programs were successful in achieving program goals.

Delays in securing a contractual approach to utilize the National Core Indicators™ survey process inhibited the State's ability to measure improvement in quality of life as part of the interim evaluation.

4. Rebalancing expenditures is more challenging than rebalancing enrollment.

Even when more people are served in HCBS, the lower per average cost of HCBS relative to institutional care can make gains in rebalancing LTSS expenditures more challenging.

5. Reimbursement methodologies for institutional services (and for HCBS) can also have significant impacts on rebalancing efforts.

Reimbursement approaches for institutional services based on cost or that otherwise result in higher rates of payment for services (even based on value and/or acuity) may nonetheless undermine rebalancing goals.

6. The integration of institutional services (as well as fee-for-service HCBS) can help to achieve greater system transformation.

Benefit carve-outs—particularly those that represent significant percentages of enrollment and/or expenditures—may inadvertently impede delivery system transformation efforts.

7. *Value-based reimbursement approaches can have a significant impact in driving system performance and achieving program goals.*

Reimbursement strategies for MCOs in CHOICES and for employment providers in Employment and Community First CHOICES helped to advance delivery system transformation efforts and achieve program goals—significantly expanding access to HCBS in CHOICES and achievement of competitive integrated employment in Employment and Community First CHOICES.

8. *The ability to offer HCBS to persons "at-risk of institutional placement" can significantly impact diversion from NFs.*

States may be able to make significant gains in expanding access to HCBS, NF diversion, and in rebalancing by making even limited packages of HCBS available to persons who do not yet meet NF level of care standards—in order to help avoid, or at least delay, the need for institutional care.

9. *Meaningful measurement and improvement of health outcomes for dual eligible beneficiaries requires integration of Medicare benefits.*

The majority of LTSS beneficiaries are dually eligible for Medicare as well as Medicaid. The fragmented health care delivery system between these two programs challenges states and contracted MCOs in measuring and impacting health outcomes outside an aligned arrangement—leveraging Part C or other federal authorities.

SECTION V

Attachments

1) Acronym list
2) Evaluation Design
3) CHOICES Baseline Data Report
4) Employment and Community First CHOICES Baseline Data Report

Attachment 1: Acronyms

AAAD	Area Agency on Aging and Disability
CLS	Community Living Supports
CLS-FM	Community Living Supports-Family Model
CMS	Centers for Medicare & Medicaid Services
DD	Developmental Disabilities
DIDD	Department of Intellectual and Developmental Disabilities
D-SNPs	Dual Eligible Special Needs Plans
ECF CHOICES	Employment and Community First CHOICES
ED	Emergency Department
EQR	External Quality Review
EQRO	External Quality Review Organization
ERC	Enhanced Respiratory Care
EVV	Electronic Visit Verification
FFS	Fee-For-Service
HCBS	Home and Community Based Services
HEDIS	Healthcare Effectiveness Data and Information Set
HITECH	Health Information Technology for Economic and Clinical Health
I/DD	Intellectual and/or Developmental Disabilities
ICF/IID	Immediate Care Facility for Individuals with Intellectual Disabilities
LTC	Long Term Care
LTSS	Long Term Services and Supports
MCO	Managed Care Organization
MFP	Money Follows the Person

MLTSS	Medicaid Managed Long Term Services and Supports
MMIS	Medicaid Management Information System
NASUAD	National Association of States United for Aging and Disabilities
NCI	National Core Indicators
NCI-AD	National Core Indicators – Aging and Disabilities
NF	Nursing Facility
PCMH	Patient Centered Medical Home
PCP	Person-Centered Planning
PCSP	Person-Centered Support Plan
QuILTSS	Quality Improvement in Long Term Services and Supports
SIM	State Innovation Model (grant)
STLG	Systems Transformation Leadership Group

Attachment 2: Evaluation Design

Bureau of TennCare

TennCare II Extension
(No. 11-W-00151/4)

Evaluation Design

Submitted by the Bureau of TennCare
Revised November 16, 2018

Approval Period December 16, 2016, through June 30, 2021

Table of Contents

Part I

Introduction and General Background Information about the Demonstration

I. Introduction and General Background Information about the Demonstration

TennCare I (1994-2002). TennCare I, the original TennCare demonstration waiver, was implemented on January 1, 1994. At the start of TennCare I, Tennessee moved all of its Medicaid eligibles and almost all of its Medicaid program into a managed care model. The managed care "penetration rate" in Tennessee Medicaid went from about 3 percent to 100 percent virtually overnight.

The original TennCare design was extraordinarily ambitious. It involved extending coverage to large numbers of uninsured and uninsurable people, who were allowed to enroll by filing simple one-page applications. Almost all benefits were delivered by Managed Care Organizations (MCOs) of varying size, operating at full risk. MCOs were given a good deal of discretion in how they delivered benefits to enrollees, with the assumption being that a true market-based strategy could work in a Medicaid environment much as it would in a business environment.

Several class action lawsuits were filed by public interest lawyers during this period, among them *John B.*, challenging the state's delivery of EPSDT services to children; *Grier*, challenging the state's medical service appeal procedures; and *Rosen*, challenging the state's procedures for disenrolling demonstration eligibles. Consent Decrees or Agreed Orders were entered in each lawsuit, which significantly impacted the program's operation.

TennCare II, first part (2002-2007). TennCare II, the new demonstration that started on July 1, 2002, revised the structure of the original program in several important ways.

The program was divided into "TennCare Medicaid" and "TennCare Standard." TennCare Medicaid is for Medicaid eligibles, while TennCare Standard is for the demonstration population.

At the time that TennCare II began, several MCOs were either leaving the program or at risk of leaving the program, due to their inability to maintain financial viability. A Stabilization Plan was introduced under TennCare II whereby the MCOs were temporarily removed from risk. Pharmacy benefits and dental benefits were carved out of the MCO scope of services, and new single benefit managers were selected for those services. Enrollment of demonstration eligibles was sharply curtailed, with new enrollment being open only to persons with incomes below poverty and "Medicaid rollovers," meaning persons losing Medicaid eligibility who met the criteria for the demonstration population.

In 2004, in the face of projections from an outside consultant[1] that TennCare was growing at a rate that would soon make it impossible for the state to both support TennCare and meet its obligations in other critical areas, Governor Phil Bredesen

[1] McKinsey & Company, "Achieving a Critical Mission in Difficult Times—TennCare's Financial Viability," December 11, 2003.

proposed a TennCare Reform package to accomplish goals such as "right sizing" program enrollment and reducing the dramatic growth in pharmacy spending. With CMS's approval, the state began implementing these modifications in 2005.

TennCare II extension (2007-2010). The TennCare II extension approved in 2007 made additional revisions in the program, allowing the state to open a new demonstration category and requiring that demonstration children with incomes under 200 percent of poverty be classified as Title XXI children. The extension mandated a new cap on supplemental payments to hospitals, setting an annual limit for these payments of $540 million.

It was during this extension period that TennCare began its first implementation of Managed Long-Term Services and Supports (MLTSS), carving nursing facility services and home and community based services (HCBS) for older adults and adults with physical disabilities into the managed care program. (The populations had previously been in managed care for physical and behavioral health benefits, but their LTSS had been delivered outside the managed care program.) This MLTSS program was entitled, CHOICES in Long-Term Services and Supports. The program was the result of comprehensive long-term care reform legislation: The Long-Term Care Community Choices Act of 2008, passed unanimously by both houses of the Tennessee General Assembly. There were three primary objectives for the CHOICES program: 1) improve quality and coordination of care; 2) expand access to and utilization of more cost-effective HCBS as an alternative to nursing facility care; and 3) rebalance LTSS expenditures for older adults and adults with physical disabilities.

Subsequent three (3)-year TennCare II extensions (2010-2013, 2013-2016)

At the onset of the next extension period, TennCare concluded statewide implementation of the CHOICES MLTSS program, transitioning LTSS for 23,076 individuals receiving services in a nursing facility, and 4,861 individuals enrolled in a Section 1915(c) waiver into the managed care delivery system.

The success of the CHOICES program in achieving its goals laid a foundation for the expansion of MLTSS to new populations. As the 2nd three (3)-year extension drew to a close, advocates asked TennCare to consider a MLTSS program for individuals with intellectual disabilities who faced a long waiting list in order to enroll in longstanding 1915(c) waivers, and for people with developmental disabilities, who theretofore, had not been defined among the target populations eligible for LTSS programs in Tennessee. The cost of HCBS in the existing 1915(c) waivers was high (roughly twice the national average) and offered opportunity to create a program that would support improved employment and other outcomes, while also using resources more cost-effectively in order to serve more people over time. Extensive stakeholder processes commenced in late 2013, leading to the design, approval, and implementation of the new program during the 3rd three (3)-year extension period on July 1, 2016: Employment and Community First CHOICES.

Employment and Community First CHOICES is an integrated MLTSS program for individuals with intellectual and developmental disabilities (I/DD) that fully comports with the HCBS Settings Rule and is specifically designed to promote and support integrated individual employment and integrated independent community living as the first and preferred option for individuals enrolled in the program. A comprehensive array of employment benefits, designed in consultation with stakeholders and with experts from the federal Office of Disability Employment Policy, help to create a pathway to employment, even for people with significant disabilities. Outcome-based reimbursement approaches align incentives to help support the achievement of individual employment goals, and increased independence over time in the employment setting.

TennCare today. The current TennCare II extension is effective from December 1, 2016 through June 30, 2021. As we look back over more than two decades of managed care experience, TennCare today has evolved and matured into a program barely recognizable from its early years. TennCare has weathered a number of legal and fiscal challenges, and the program today is characterized by stability, accountability, and innovation. All of the previously mentioned class action suits have ended, and although TennCare continues to operate in a litigious environment (with one new class action suit underway), the program is better positioned to avoid and defend against legal challenge. Managed Care Contractors (MCCs) are carefully chosen via a competitive procurement process and carefully monitored. All Managed Care Organizations (MCOs) are accredited by the National Committee for Quality Assurance (NCQA). Two of TennCare's three MCCs were the first health plans in the country to achieve NCQA's LTSS Distinction, by meeting certain evidence-based standards in the coordination of LTSS in areas such as conducting comprehensive assessments, managing care transitions, performing person-centered assessments and planning and managing critical incidents. The third is poised to do so in 2019. Enrollment and disenrollment procedures are well-established. Quality of care is measured and promoted with a variety of new mechanisms. There is a sophisticated appeals system in place to identify problems in service delivery and to handle complaints. And except for the longstanding fee-for service 1915(c) waivers and a small remaining ICF/IID (Intermediate Care Facilities for Individuals with Intellectual Disabilities) benefit that currently remain outside of managed care, the program provides for an integrated and coordinated approach to the delivery of services and supports across the continuum. After 23 years of operation, TennCare has achieved a level of maturity where continuous performance improvement is a routine component of program operations.

Moreover, TennCare is now recognized as a national leader in Medicaid managed care, including MLTSS. Tennessee's comprehensive payment reform initiative is changing the landscape of service delivery in the state, aligning payment with improved quality outcomes and cost efficiency across payers and providers, including LTSS. TennCare consistently maintains medical trend rates at roughly half the national average for Medicaid programs and commercial plans[2], and TennCare health plans have the 3rd

[2] For Medicaid trend rates, see Kaiser Commission on Medicaid and the Uninsured at http://files.kff.org/attachment/issue-brief-medicaid-enrollment-spending-growth-fy-2015-2016. For cost

highest quality scores among the 11 states in the Southeast region.[3] Most importantly, members are satisfied with the program, with satisfaction ranked at or above 90% for the 8th consecutive year.[4]

It is our intent that "TennCare tomorrow" will be even better, even stronger, and will continue to pave the way for innovation and effective implementation and oversight of Medicaid managed care programs across the country.

trend information for commercial insurers, see PwC Health Research Institute at http://www.pwc.com/us/en/health-industries/health-research-institute/behind-the-numbers.html

[3] Based on comparisons of NCQA health plan ratings.

[4] University of Tennessee, Boyd Center for Business & Economic Research (2016). The impact of TennCare: A survey of recipients. Available at http://cber.haslam.utk.edu/tncare/tncare16.pdf.

Part II

Evaluation Questions and Hypotheses

II. Evaluation Question and Hypotheses

The Special Terms and Conditions (STCs) of the state's TennCare II demonstration specify that, "The state in its evaluation design shall focus its demonstration evaluation efforts on the CHOICES program, ECF CHOICES program and the state plan and demonstration populations enrolled in those programs. The state must include hypotheses and measures related to access to managed long term services and supports, improved health outcomes and beneficiary satisfaction for CHOICES and ECF CHOICES programs."

Accordingly, this evaluation will investigate how the CHOICES and Employment and Community First CHOICES MLTSS programs perform relative to fee-for-service programs (in the case of CHOICES, nursing facility services and the Section 1915(c) waiver that existed prior to the implementation of the program; and in the case of Employment and Community First CHOICES, the three Section 1915(c) waivers for individuals with intellectual disabilities and Intermediate Care Facilities for Individuals with Intellectual Disabilities that continue to operate outside the demonstration) in achieving program objectives in these areas.

In order to identify baseline performance (i.e. prior to implementation of each MLTSS program component) and to measure performance improvement, TennCare created a baseline data plan for each program. The baseline data plan for each program identifies the key metrics that will be tracked over time for each program in order to determine whether program goals are being achieved.

Baseline Data Plan Approach: CHOICES Program

The CHOICES baseline data plan is organized around five key program objectives, all of which relate to access. In LTSS programs, access is a multi-faceted concept. The primary evaluation question is whether implementing the CHOICES MLTSS program has successfully expanded access to HCBS for older adults and adults with physical disabilities, as compared to the fee-for-service Section 1915(c) waiver that existed prior to the implementation of CHOICES. Secondarily, is whether design elements of the demonstration will help to ensure that improvements can be sustained over time, including as the demand for LTSS increases.

At the most basic level, data should support that a larger number of older adults and adults with physical disabilities have been able to access HCBS since implementation of the CHOICES program. At the program's inception, there was a waiting list for HCBS among these populations, with expanded capacity for enrollment contingent each year on new funding to support waiver program expansion. If the program, including the global budget approach in which money follows each person into the setting of their choice, is successful, the number of persons receiving HCBS should increase.

At the same time, however, when controlling for overall growth in the aging population, the number of people receiving services in a nursing facility should decline. This means

that more people are choosing HCBS and are able to access those HCBS in order to divert or transition from institutional settings into HCBS. Additional baseline measures help to track success in diversion and transition from institutional care.

A final facet of access in LTSS programs is cost. As a practical matter, states have a limited amount of Medicaid funding to support LTSS. Higher utilization of more expensive institutional services reduces the amount of program funding available to provide for increased access to HCBS. Because the ability to expand HCBS hinges on a rebalancing of long-term care expenditures, it is critical not just to track the number and percentage of people receiving HCBS versus institutional care, but also to track expenditures for HCBS relative to institutional care and to understand the relative average annualized cost of services in the two settings over time.

Baseline Data Plan Approach: Employment and Community First CHOICES Program

Like the CHOICES baseline data plan, the baseline data plan for Employment and Community First CHOICES is also organized around five key program objectives. However, in the case of Employment and Community First CHOICES, there are objectives and measures related to each of the program goals set forth in the STCs, including access to managed long term services and supports, improved health outcomes and beneficiary satisfaction.

The first evaluation question is whether implementing the Employment and Community First CHOICES MLTSS program will successfully expand access to HCBS for individuals with intellectual disabilities, for individuals with developmental disabilities, and across the I/DD population broadly, as compared to the fee-for-service Section 1915(c) waivers that existed prior to the implementation of Employment and Community First CHOICES. Secondarily, is whether design elements of Employment and Community First CHOICES will help to ensure that improvements can be sustained over time, including as the demand for LTSS increases.

As with CHOICES, the program objectives and measures take into account the multi-faceted nature of access, but do not include measures related to diversion and transition since ICF/IID services remain outside the demonstration program. Data should support that a larger number of individuals with intellectual disabilities, a larger number of people with developmental disabilities, and a larger number of people across the I/DD population have been able to access HCBS since implementation of the Employment and Community First CHOICES program.

Also as with CHOICES, a critical facet of access in Employment and Community First CHOICES is cost. The higher average cost of services in the state's fee-for-service programs (ICF/IID and 1915(c) waiver) have made it difficult to provide services to all of the people who need them, and left no resources to provide services to people with developmental disabilities. It is thus critical to understand the relative average annualized cost of services in each program, in order to demonstrate that we are able to provide

services more cost-effectively, thereby expanding access for more of the people in the population who need LTSS. And even though institutional services are carved out of the demonstration, it is important to track expenditures for HCBS relative to institutional care and to ensure that we are continuing to focus investment in community-based, rather than institutional settings.

A second evaluation question for the Employment and Community First CHOICES program is whether implementing the new MLTSS program will successfully increase participation in integrated employment, earning at or above the minimum wage, as compared to the fee-for-service Section 1915(c) waivers that existed prior to the implementation of Employment and Community First CHOICES. This is the most critical health-related program goal. Employment status may have implications for an individual's health status. A study funded by CMS through a Medicaid Infrastructure Grant which included a review of the literature on the relationship between employment and health found "a consistent association between employment and better health and unemployment and poorer health," including for people with disabilities. The study suggested that, "One possible cost-effective way to increase the health of members of Managed Long Term Care Systems is to promote and support the competitive employment of members, and that "[W]hen evaluating quality of Managed Long Term Care Systems, members' employment status may become an important outcome that cannot be ignored.[5]"

The final evaluation question for the Employment and Community First CHOICES program is whether the new MLTSS program will improve the overall quality of life of persons with I/DD who enroll in the program and receive HCBS.

[5] Hartman, E. A literature review on the relationship between employment and health: How this relationship may influence managed long term care. Available at https://www.uwstout.edu/svri/upload/The-relationship-between-employment-and-health-A-literature-review.pdf.

Part III

Methodology

III. Methodology

Following the baseline data plan created for each MLTSS program, this evaluation will conduct pre- and post-measurement of specified data elements in order to investigate how the CHOICES and Employment and Community First CHOICES MLTSS programs compare to fee-for-service programs (in the case of CHOICES, nursing facility services and the Section 1915(c) waiver that existed prior to the implementation of the program; and in the case of Employment and Community First CHOICES, the three Section 1915(c) waivers for individuals with intellectual disabilities and ICFs/IID that continue to operate outside the demonstration) in achieving program objectives. For purposes of expenditure analysis, costs may be trended forward for the baseline period in order to better understand how the MLTSS programs have impacted expenditures the State would otherwise have incurred. Statistical analyses will include the absolute change and percentage (or relative) change from the baseline measurement for each demonstration year.

For purposes of measurement, participants will be included in the target population only if they are enrolled in the applicable program and received one or more of the HCBS benefits available to program participants. Persons who enrolled in the program and subsequently disenrolled without having received any program benefits, or persons who enroll in the program and receive only state plan (i.e., TennCare benefits other than LTSS) will be excluded. For some measures, data may be reported by benefit group (i.e., CHOICES Groups 2 and 3, and Employment and Community First CHOICES Groups 4, 5, and 6, and upon CMS approval and implementation, Groups 7 and 8) as well as across HCBS benefit groups in the program. Data related to integrated employment outcomes may be limited to individuals of working age or reported by age groups in order to provide for more meaningful interpretation of results. Except for identified exclusions, all measures will be collected and reported across the entirety of the applicable population, and will not use any sampling methodology.

Baseline Data Plan: CHOICES Program

CHOICES program objectives, together with the baseline measures and the data elements to be collected are provided below.

All of the baseline data elements will be collected on the basis of program participation and program expenditures prior to or at the start of the CHOICES program. The data source for each of these elements is the Medicaid Management Information System. All of the CHOICES data elements identified below will be collected annually, beginning at one year after implementation, and measured against the baseline data elements each year. Metrics related to persons receiving LTSS (nursing facility or HCBS) are collected and reported in two ways: 1) as of a point in time—generally, at implementation and the conclusion of each demonstration year thereafter; and 2) over the course of time—generally, one year prior to implementation, and over the course of each demonstration year.

CHOICES Program Objective #1: Expand access to HCBS for older adults and adults with physical disabilities.

CHOICES Program Objective 1.1

Increase the number and percentage of older adults and adults with physical disabilities actively receiving HCBS at a point in time and over the course of each demonstration year compared to the year prior to implementation.

CHOICES Program Objective 1.2

Decrease the number and percentage of persons receiving nursing facility services at a point in time and over the course of each demonstration year compared to the year prior to implementation.

Baseline data elements:

- Number of older adults and adults with physical disabilities actively receiving HCBS as the time of CHOICES implementation and annually thereafter
- Unduplicated number of older adults and adults with physical disabilities receiving HCBS during the 12 months prior to CHOICES implementation and annually thereafter
- Number of persons receiving NF services at the time of CHOICES implementation and annually thereafter
- Unduplicated number of persons receiving NF services during the first year after CHOICES implementation and annually thereafter

CHOICES Data Elements:

- Number of older adults and adults with physical disabilities actively receiving HCBS one year after CHOICES implementation and annually thereafter
- Unduplicated number of older adults and adults with physical disabilities receiving HCBS during the first year after CHOICES implementation and annually thereafter
- Number of persons receiving NF services one year after CHOICES implementation and annually thereafter
- Unduplicated number of persons receiving NF services during the first year after CHOICES implementation and annually thereafter

CHOICES Program Objective #2: [Re]balance TennCare spending on long-term services and supports for older adults and adults with physical disabilities to increase the proportion that goes to HCBS.

CHOICES Program Objective 2.1

Increase HCBS expenditures for older adults and adults with physical disabilities (based on encounters, not capitation payments) as a percentage of total long-term care

expenditures for older adults and adults with physical disabilities during each demonstration year compared to the year prior to implementation.

CHOICES Program Objective 2.2

Decrease nursing facility expenditures for older adults and adults with physical disabilities (based on encounters, not capitation payments) as a percentage of total long-term care expenditures for older adults and adults with physical disabilities during each demonstration year compared to the year prior to implementation.

Baseline Data Elements:

- HCBS expenditures for older adults and adults with physical disabilities during the 12 months prior to CHOICES implementation
- HCBS expenditures for older adults and adults with physical disabilities during the 12 months prior to CHOICES implementation as a percentage of total long-term services and supports expenditures (excluding expenditures on LTSS for individuals with I/DD)

  Numerator: HCBS expenditures for older adults and adults with physical disabilities during the 12 months prior to CHOICES implementation

  Denominator: Total LTSS expenditures (NF and HCBS for older adults and adults with physical disabilities) during the 12 months prior to CHOICES implementation

- NF expenditures during the 12 months prior to CHOICES implementation
- NF expenditures during the 12 months prior to CHOICES implementation as a percentage of total long-term care expenditures (excluding expenditures on LTSS for individuals with I/DD)

  Numerator: NF expenditures during the 12 months prior to CHOICES implementation

  Denominator: Total LTSS expenditures (nursing facility and HCBS for older adults and adults with physical disabilities) during the 12 months prior to CHOICES implementation

CHOICES Data Elements:

- HCBS expenditures for older adults and adults with physical disabilities (based on encounters, not cap payments) during the first year following CHOICES implementation and annually thereafter
- NF expenditures (based on encounters, not cap payments) during the first year following CHOICES implementation and annually thereafter
- HCBS expenditures for older adults and adults with physical disabilities (based on encounters, not cap payments) during the first year following CHOICES

implementation and annually thereafter as a percentage of total long-term care expenditures (excluding expenditures for the population of persons with I/DD)

Numerator: HCBS expenditures for older adults and adults with physical disabilities (based on encounters, not cap payments) during the first year following CHOICES implementation and annually thereafter

Denominator: Total LTSS expenditures (NF and HCBS for older adults and adults with physical disabilities based on encounters, not cap payments) during the first year following CHOICES implementation and annually thereafter

- NF expenditures (based on encounters, not cap payments) during the first year following CHOICES implementation and annually thereafter as a percentage of total long-term care expenditures (excluding expenditures for the population of persons with I/DD)

  Numerator: NF expenditures (based on encounters, not cap payments) during the first year following CHOICES implementation and annually thereafter

  Denominator: Total LTSS expenditures (NF and HCBS for older adults and adults with physical disabilities based on encounters, not cap payments) during the first year following CHOICES implementation and annually thereafter

CHOICES Program Objective #3: Provide cost effective care in the community for older adults and adults with physical disabilities who would otherwise require NF care.

CHOICES Program Objective 3.1

Per person HCBS expenditures on older adults and adults with physical disabilities (based on encounters, not capitation payments) remain lower than per person NF expenditures on older adults with physical disabilities (based on encounters, not capitation payments payments) for each demonstration year.

Baseline Data Elements:

- Average per person HCBS expenditures for older adults and adults with physical disabilities during the 12 months prior to CHOICES implementation
- Average per person NF expenditures during the 12 months prior to CHOICES implementation

CHOICES data elements:

- Average per person HCBS expenditures for older adults and adults with physical disabilities (based on encounters, not cap payments) during the first year following CHOICES implementation and annually thereafter
- Average per person NF expenditures (based on encounters, not cap payments) during the first year following CHOICES implementation and annually thereafter

CHOICES Program Objective #4: Provide HCBS that will enable older adults and adults with physical disabilities who would otherwise be required to enter NFs to be diverted to the community.

CHOICES Program Objective 4.1

Increase the average length of stay in HCBS for each demonstration year compared to the year prior to implementation.

CHOICES Program Objective 4.2

Increase the percentage of new LTSS recipients admitted to HCBS during each demonstration year compared to the year prior to implementation

CHOICES Program Objective 4.3

Decrease the percentage of new LTSS recipients admitted to NFs during each demonstration year compared to the year prior to implementation.

Baseline data elements:

- Average length of stay in HCBS during the 12 months prior to CHOICES implementation
- Percent of new LTSS recipients admitted to NFs during the 12 months prior to CHOICES implementation

CHOICES Data Elements:

- Average length of stay in HCBS during the first year after CHOICES implementation and annually thereafter
- Percent of new LTSS recipients admitted to NFs during the first year after CHOICES implementation and annually thereafter

CHOICES Program Objective #5: Provide HCBS that will enable older adults and adults with physical disabilities receiving services in NFs to be able to transition back to the community.

CHOICES Program Objective 5.1

Decrease the average length of stay in NFs for each demonstration year compared to the year prior to implementation.

CHOICES Program Objective 5.2

Increase the number of persons who transitioned from NFs to HCBS during each demonstration year compared to the year prior to implementation.

Baseline data elements:

- Average length of stay in NFs during the 12 months prior to CHOICES implementation
- Number of persons transitioned from NFs to HCBS during the 12 months prior to CHOICES implementation

CHOICES data elements:

- Average length of stay in NFs during the first year after CHOICES implementation and annually thereafter
- Number of persons who transitioned from NFs to HCBS during the first year following CHOICES implementation and annually thereafter

Baseline Data Plan: Employment and Community First CHOICES Program

The baseline data plan for Employment and Community First CHOICES is also organized around five key program objectives. These objectives, together with the baseline measures and the data elements to be collected are provided below. All of the access-related measures will be collected on the basis of program participation and program expenditures prior to or at the start of the Employment and Community First CHOICES program, except as otherwise specified below.

The data source for each of the measures specified in objectives 1-3 is the Medicaid Management Information System. These data elements will be collected annually, beginning at one year after implementation, and measured against the baseline data elements each year. Enrollment data related to persons receiving HCBS are collected and reported in two ways: 1) as of a point in time—generally, at implementation and the conclusion of each demonstration year thereafter; and 2) over the course of time—generally, one year prior to implementation, and over the course of each demonstration year.

The data source for employment measures related to objective 4 is a standardized Employment Data Sheet (EDS), administered by the MCO for persons enrolled in MLTSS, and by the Department of Intellectual and Developmental Disabilities (the State I/DD agency) for persons enrolled in a 1915(c) waiver. TennCare collects employment data on all persons 62 years of age and under enrolled in MLTSS and in the 1915(c) service delivery system for people with intellectual disabilities. This data is collected on a calendar year, rather than demonstration year, basis. Typically these surveys are conducted during the annual person-centered planning meeting when updates are made to a person's support plan, but can also be conducted at other times, so long as it is conducted on an annual basis. The MCO Care/Support Coordinators and the DIDD Case Managers and Independent Support Coordinators complete the EDS survey and enter it into the State's FormStack system. Prior to the transition to FormStack, these surveys were entered into WuFoo, an online survey system with which the State held a subscription for the development and storage of survey data. EDS survey data will be the State's mechanism for collecting baseline employment measures. Calendar year 2016 (encompassing the six-month period prior to the start of program operations and the six-

month period immediately following program implementation) will be the baseline year. Data will be collected on an annual basis for each calendar year thereafter. The State can use this data to assess statewide trends, regional trends, trends by provider, by program, age of the person, MCO and employers.

Data pertaining to quality of life measures for objective 5 will be collected via a face-to-face assessment using the *National Core Indicators* (or comparable) survey tool. The tool will be administered by a neutral third party. Implementation of this survey in Employment and Community First CHOICES has been delayed because NASDDDS (the National Association of State Directors of Developmental Disabilities Services) has been unwilling to contract with TennCare (a State Medicaid Agency) to allow participation in the NCI. We hope to resolve this issue in order for NCI surveys to commence and to collect baseline data in 2019. If not, a comparable quality of life instrument will be used—the CAHPS Home and Community-Based Services Survey (HCBS CAHPS). The data will be collected on an annual basis thereafter.

ECF CHOICES Program Objective #1: Expand access to HCBS for individuals with intellectual and developmental disabilities.

ECF CHOICES Program Objective 1.1

Increase the number of individuals with ID actively receiving HCBS at a point in time and over the course of each demonstration year compared to the year prior to implementation.

ECF CHOICES Program Objective 1.2

Increase the number of individuals with DD actively receiving HCBS at a point in time and over the course of each demonstration year compared to the year prior to implementation.

ECF CHOICES Program Objective 1.3

Increase the number of individuals with I/DD actively receiving HCBS at a point in time and over the course of each demonstration year compared to the year prior to implementation.

Baseline data elements:

- Number of individuals with ID actively receiving HCBS at the time of Employment and Community First CHOICES implementation
- Unduplicated individuals with ID receiving HCBS during the 12 months prior to Employment and Community First CHOICES implementation

Employment and Community First baseline data elements:

- Number of individuals with ID actively receiving HCBS one year after Employment and Community First CHOICES implementation and annually thereafter
- Unduplicated number of individuals with ID receiving HCBS during the first year after Employment and Community First CHOICES implementation and annually thereafter

Data shall be reported for Employment and Community First CHOICES and across Medicaid HCBS programs including Section 1915 (c) waivers

Baseline data elements – Individuals with developmental disabilities (other than intellectual disabilities):

- Number of individuals with DD actively receiving HCBS at the time of Employment and Community First CHOICES implementation
- Unduplicated individuals with DD receiving HCBS during the 12 months prior to Employment and Community First CHOICES implementation

Employment and Community First CHOICES data elements – individuals with developmental disabilities (other than intellectual disabilities):

- Number of individuals with DD actively receiving HCBS one year after Employment and Community First CHOICES implementation and annually thereafter
- Unduplicated number of individuals with DD receiving HCBS during the first year after Employment and Community First CHOICES implementation and annually thereafter

Data shall be reported only for Employment and Community First CHOICES.

Baseline data elements – individuals with intellectual and developmental disabilities:

- Number of individuals with I/DD actively receiving HCBS at the time of Employment and Community First CHOICES implementation
- Unduplicated individuals with I/DD receiving HCBS during the 12 months prior to Employment and Community First CHOICES implementation

Employment and Community First CHOICES data elements – individuals with intellectual and developmental disabilities:

- Number of individuals with I/DD actively receiving HCBS one year after Employment and Community First CHOICES implementation and annually thereafter
- Unduplicated individuals with I/DD receiving HCBS during the first year after Employment and Community First CHOICES implementation and annually thereafter

Data shall be reported for Employment and Community First CHOICES and across Medicaid HCBS programs, including Section 1915(c) waivers.

ECF CHOICES Program Objective #2: Provide more cost-effective services and supports persons with intellectual and developmental disabilities.

ECF CHOICES Program Objective 2.1:

Decrease average per person LTSS expenditures on individuals with I/DD (based on encounters, not capitation payments, and fee-for-service expenditures) compared to the year prior to implementation.

Baseline data element:

- Average per person LTSS expenditures for individuals with I/DD during the 12 months prior to Employment and Community First CHOICES implementation

Employment and Community First CHOICES data element:

- Average per person LTSS expenditures on individuals with I/DD (based on fee-for-service payments and encounters, not cap payments) during the first year following Employment and Community First CHOICES implementation and annually thereafter

Data shall be reported for Employment and Community First CHOICES, Section 1915(c) waivers, ICF/IID services, and across Medicaid HCBS (including Section 1915(c) waivers and LTSS, including ICF/IID.

ECF CHOICES Program Objective #3: Continue balancing TennCare spending on long-term services and supports for individuals with intellectual and developmental disabilities to increase the proportion spent on HCBS.

ECF CHOICES Program Objective 3.1

Increase HCBS expenditures for individuals with I/DD (based on encounters, not capitation payments, and fee-for-service expenditures) as a percentage of total LTSS expenditures for individuals with I/DD during each demonstration year compared to the year prior to implementation.

ECF CHOICES Program Objective 3.2

Decrease ICF/IID expenditures as a percentage of total LTSS expenditures for individuals with I/DD (based on encounters, not capitation payments, and fee-for-service expenditures) during each demonstration year compared to the year prior to implementation.

Baseline data elements:

- HCBS expenditures for individuals with I/DD during the 12 months prior to Employment and Community First CHOICES implementation

- HCBS expenditures for individuals with I/DD during the 12 months prior to Employment and Community First CHOICES implementation as a percentage of total LTSS expenditures for individuals with I/DD

  Numerator: HCBS expenditures for individuals with I/DD during the 12 months prior to Employment and Community First CHOICES implementation

  Denominator: Total LTSS expenditures (ICF/IID and HCBS) for individuals with I/DD (based on fee-for-service payments and encounters, not cap payments) during the 12 months prior to Employment and Community First CHOICES implementation

- ICF/IID expenditures during the 12 months prior to Employment and Community First CHOICES implementation
- ICF/IID expenditures during the 12 months prior to Employment and Community First CHOICES implementation as a percentage of total LTSS expenditures for individuals with I/DD

  Numerator: ICF/IID expenditures during the 12 months prior to Employment and Community First CHOICES implementation

  Denominator: Total LTSS expenditures (ICF/IID and HCBS) for individuals with I/DD (based on fee-for-service payments and encounters, not cap payments) during the 12 months prior to Employment and Community First CHOICES implementation

Employment and Community First CHOICES data elements:

- HCBS expenditures for individuals with I/DD (based on fee-for-service payments and encounters, not cap payments) during the first year following Employment and Community First CHOICES implementation and annually thereafter
- ICF/IID expenditures during the first year following Employment and Community First CHOICES implementation and annually thereafter
- HCBS expenditures on individuals with I/DD (based on fee-for-service payments and encounters, not cap payments) during the first year following Employment and Community First CHOICES implementation, and annually thereafter, as a percentage of total LSS expenditures for individuals with I/DD

  Numerator: HCBS expenditures on individuals with I/DD (based on encounters, not cap payments) during the first year following Employment and Community First CHOICES implementation, and annually thereafter

  Denominator: Total LTSS expenditures (ICF/IID and HCBS) for individuals with I/DD (based on FFS payments and encounters, not cap payments) during the first year following Employment and Community First CHOICES implementation, and annually thereafter

- ICF/IID expenditures during the first year following Employment and Community First CHOICES implementation, and annually thereafter, as a percentage of total LTSS expenditures for individuals with I/DD

  Numerator: ICF/IID expenditures on individuals with I/DD during the first year following Employment and Community First CHOICES implementation, and annually thereafter

  Denominator: Total LTSS expenditures (ICF/IID and HCBS) for individuals with I/DD (based on FFS payments and encounters, not cap payments) during the first year following Employment and Community First CHOICES implementation, and annually thereafter

ECF CHOICES Program Objective #4: Increase the number and percentage of working age adults with intellectual and development disabilities enrolled in HCBS programs who are employed in an integrated setting earning at or above the minimum wage.

ECF CHOICES Program Objective 4.1

Increase the number and percentage of working age adults with I/DD enrolled in HCBS programs who are employed in an integrated setting earning at or above the minimum wage during each demonstration year compared to the baseline year.

Baseline data elements:

- Number of individuals with I/DD enrolled in HCBS programs who are employed in an integrated setting earning at or above the minimum wage at the time of Employment and Community First CHOICES implementation.
- Percent of individuals with I/DD enrolled in HCBS programs who are employed in an integrated setting earning at or above the minimum wage at the time of Employment and Community First CHOICES implementation.

  Numerator: Number of individuals with I/DD enrolled in HCBS programs employed in an integrated setting earning at or above the minimum wage at the time of Employment and Community First CHOICES implementation

  Denominator: Total number of individuals with I/DD enrolled in HCBS programs at the time of Employment and Community First CHOICES implementation

Employment and Community First CHOICES data elements:

- Number of individuals with I/DD enrolled in HCBS programs who are employed in an integrated setting earning at or above the minimum wage one year after Employment and Community First CHOICES implementation and annually thereafter
- Percent of individuals with I/DD enrolled in HCBS programs who are employed in an integrated setting earning at or above the minimum wage during the first

year following Employment and Community First CHOICES implementation and annually thereafter

Numerator: Number of individuals with I/DD enrolled in HCBS programs employed in an integrated setting earning at or above the minimum wage one year after Employment and Community First CHOICES implementation and annually thereafter

Denominator: Total number of individuals with I/DD enrolled in HCBS programs one year after Employment and Community First CHOICES implementation and annually thereafter

Data shall be reported for Employment and Community First CHOICES and across Medicaid HCBS programs including Section 1915(c) waivers.

ECF CHOICES Program Objective #5: Improve the quality of life of individuals with intellectual and developmental disabilities enrolled in HCBS programs.

ECF CHOICES Program Objective 5.1

Improve quality of life of individuals with I/DD during each demonstration year compared to the baseline year.

Baseline data element:

- Perceived quality of life of individuals with I/DD upon enrollment into Employment and Community First CHOICES as measured by the *National Core Indicators*™ Survey

Employment and Community First CHOICES data element:

- Perceived quality of life of individuals with I/DD one year after enrollment into Employment and Community First CHOICES as measured by the *National Core Indicators*™ Survey

Part IV

Methodological Limitations

IV. Methodological Limitations

The CHOICES program has been in existence for more than seven (7) years. While there is a comprehensive integrated *Quality Assessment and Performance Improvement Strategy* which encompasses the MLTSS programs, at the program's outset, the baseline measures of system performance for purposes of program evaluation were focused on expanded access to HCBS, taking into account factors such as cost and rebalancing which can significantly impact access in LTSS programs. While systems are now in place to collect satisfaction and quality of life data (using the newly implemented *National Core Indicators – Aging and Disability*™ survey tool), it would not be possible to go back in order to establish a baseline at inception or enrollment into the CHOICES program.

With respect to measurement of improved health outcomes, the most significant challenge in the CHOICES program is that roughly 90 percent of the persons enrolled are dual eligible beneficiaries, which means that Medicare and not Medicaid is primarily responsible for the delivery of preventive care and health outcomes such as the management of avoidable hospitalizations. While care coordinators in MLTSS programs can serve to help coordinate access to preventive care and assist in the identification and mitigation of factors that could lead to avoidable hospitalizations, as a practical matter, many of the Medicare providers are not in their networks, and even if they are, have little incentive under the Medicare payment structure to engage with MLTSS plans in these efforts.

Similar challenges in measuring health outcomes exist for individuals with I/DD in the Employment and Community First CHOICES program, except that the percentage of dual eligible beneficiaries is expected to be smaller (an estimated 70 percent if comparable with existing 1915(c) waiver participants). In that regard, focusing on employment as a critical health-related outcome measure helps to shift the focus to a measure not impacted by the often fragmented delivery of health care to the dual eligible population.

Coordination across systems is still important, however, since as in all states, the Vocational Rehabilitation agency plays a critical role in the delivery of employment services and supports. TennCare has worked with the State's VR Division to execute a Memorandum of Understanding that helps to delineate coordination across the two benefits structures in order to help ensure that MCOs are able to help members seamlessly access the employment supports they need to achieve employment outcomes.

Of note, employment data is collected on a calendar year, rather than demonstration year, basis. Calendar year 2016 (encompassing the six-month period prior to the start of program operations and the six-month period immediately following program implementation) will be the baseline year for ECF CHOICES Objective 4. Data will be collected on an annual basis for each calendar year thereafter.

One additional limitation in the Employment and Community First CHOICES program is that collection of quality of life data has not yet commenced. Implementation of this

survey in Employment and Community First CHOICES has been delayed because NASDDDS (the National Association of State Directors of Developmental Disabilities Services) has been unwilling to contract with TennCare (a State Medicaid Agency) to allow participation in the *National Core Indicators (NCI).* We hope to resolve this issue in order for *NCI* surveys to commence and to collect baseline data in 2019. If not, a comparable quality of life instrument will be used. The data will be collected on an annual basis thereafter. Once we begin collecting baseline data, it will take time to gather sufficient survey data for evaluation purposes.

Attachment 3: CHOICES Baseline Data Report

Special Terms and Conditions #43.d.iii Report

	Point in Time Data	
A	Number of persons actively receiving HCBS (Point in time)	**Feb. 28, 2010:** 1,479 (M) **Aug. 1, 2010:** 3,382 (E/W) **June 30, 2011:** 8,543 **June 30, 2012:** 10,482 **June 30, 2013:** 12,559 **June 30, 2014:** 13,050 **June 30, 2015:** 13,240 **June 30, 2016:** 12,654 **June 30, 2017:** 12,381 **June 30, 2018:** 12,385
	Number of persons actively receiving NF Services (Point in time)	**Feb. 28, 2010:** 7,145 (M) **Aug. 1, 2010:** 15,931 (E/W) **June 30, 2011:** 21,530 **June 30, 2012:** 20,968 **June 30, 2013:** 19,415 **June 30, 2014:** 18,018 **June 30, 2015:** 17,069 **June 30, 2016:** 17,141 **June 30, 2017:** 16,597 **June 30, 2018:** 16,439

	Annual Aggregate Data	12 Month Period: 3/01/09-2/28/10	12 Month Period: 7/1/10-6/30/11	12 Month Period: 7/1/11-6/30/12	12 Month Period: 7/1/12-6/30/13	12 Month Period: 7/1/13-6/30/14	12 Month Period: 7/1/14-6/30/15	12 Month Period: 7/1/15-6/30/16	12 Month Period: 7/1/16-6/30/17	12 Month Period: 7/1/17-6/30/18
	Unduplicated numbers of persons receiving HCBS (12 Month Period)	6,226	9,789	12,862	15,311	16,112	16,454	15,937	15,429	15,242
B	Unduplicated numbers of persons receiving NF services (12 Month Period)	31,128	30,757	29,981	27,647	25,322	24,185	23,897	24,029	23,872
C	HCBS expenditures (12 Month Period)	$99,900,978.43	$119,864,515.00	$157,709,852.46	$215,136,011.13	$232,976,279.24	$230,732,371.14	$245,938,104.85	$263,874,737.28	$ 275,364,383.65
	NF expenditures (12 Month Period)[1]	$924,962,419.06	$972,406,866.00	$952,315,696.11	$929,168,547.38	$873,466,444.52	$919,409,570.51	$984,412,531.79	$998,759,155.00	$ 1,031,553,612.00
D	HCBS expenditures as a percentage of total LTC expenditures (12 Month Period)	9.75%	10.97%	14.21%	18.80%	21.06%	20.06%	19.99%	20.90%	21.07%
	NF expenditures as a percentage of total LTC expenditures (12 Month Period)	90.25%	89.03%	85.79%	81.20%	78.94%	79.94%	80.01%	79.10%	78.93%
E	Average per person HCBS expenditures (12 Month Period)[2]	$16,045.77	$12,244.82	$12,261.69	$14,051.08	$14,459.80	$14,022.87	$15,431.89	$17,102.52	$18,066.16
	Average per person NF expenditures (12 Month Period)[2]	$29,714.80	$31,615.79	$31,763.97	$33,608.30	$34,494.37	$38,015.69	$41,193.98	$41,564.74	$43,211.86
F	Average length of stay in HCBS (12 Month Period)[3]	285	226	253	257	269	270	253	262	276
G	Percent of new long-term care recipients admitted to a NF (12 Month Period)[4]	81.34%	66.89%	62.54%	46.95%	47.93%	49.47%	61.34%	63.20%	63.22%
H	Average length of stay in NF (12 Month Period)	281	249	244	248	250	245	245	240	240
I	Number of persons transitioned from NFs to HCBS (12 Month Period)[5]	129	567	740	682	594	459	485	511	506

[1] NF expenditures for the period ending 6/30/13 include $23.8 million in acuity-based per diem rate adjustments. These rate adjustments were the result of a non-recurring appropriation by the General Assembly to acknowledge the higher acuity of residents served in NFs as more people were diverted or transitioned to HCBS. NF expenditures for the period ending 6/30/15 include >$73 million, for the period ending 6/30/16 >$99 million, for the period ending 6/30/17 >$106 million, and for the period ending 6/30/18 almost $117 million in quality and acuity-based per diem rate adjustments. Funding for these rate adjustments was generated through an assessment fee established by the NF industry through legislation. NF expenditures includes *only* payments made to NFs by MCOs for persons enrolled in the CHOICES program. Additional payments made to NFs by MCOs for short-term episodic care provided as a cost-effective alternative to stabilize a condition rather than admit to hospital or to facilitate hospital discharge are not included.

[2] Based on total expenditures divided by total program participants across the program year, and not reflective of the annualized average cost of services across a complete 12-month period.

[3] The average length of stay in HCBS in the first year of CHOICES implementation was impacted by the tremendous growth in new HCBS enrollment. Unless enrolled on January 1, all new program participants receive less than a full year of service and reduce the average length of stay.

[4] The current 12 Month Period, ending 6/30/18, had a 13.21% nursing facility diversion rate (i.e., individuals applying for NF care but diverted to HCBS). The 12 Month Periods ending 6/30/13, 6/30/14 and 6/30/15 reflected nearly 20 percent diversion of all NF applicants to HCBS after raising NF LOC standards on 7/1/12 and prior to changing eligibility requirements for enrollment into CHOICES Group 3. Since that time, the 12 Month Period ending 6/30/16 reflected a 13.6% nursing facility diversion rate; and the 12 Month Period ending 6/30/17, an 11.52% diversion rate.

[5] 12 Month Periods ending 6/30/13 and after reflect diversion of NF applicants with lesser needs to HCBS since raising NF LOC standards on 7/1/12. Persons admitted to NFs have more acute needs, resulting in additional challenges in transition to community.

Attachment 4:

Employment and Community First CHOICES Baseline Data Report

Special Terms and Conditions #43.d.iii Report - ECF CHOICES

	Point in Time Data	Total			
A	Number of individuals with ID actively receiving HCBS (Point in time)	**As of June 30, 2016:** 8,025	**As of June 30, 2017**: 8,251	**As of June 30, 2018**: 8,467	**As of June 30, 2019**: 8,368
	Number of individuals with DD actively receiving HCBS (Point in time)	**As of June 30, 2016:** 0	**As of June 30, 2017**: 520	**As of June 30, 2018**: 1,283	**As of June 30, 2019**: 1,436
	Number of individuals with I/DD actively receiving HCBS (Point in time)	**As of June 30, 2016:** 8,025	**As of June 30, 2017**: 8,771	**As of June 30, 2018**: 9,750	**As of June 30, 2019**: 9,804
	Annual Aggregate Data	**12 Month Period**			
		07/01/15 - 06/30/16	**07/01/2016-06/30/2017**	**07/01/2017-06/30/2018**	**07/01/2018-06/30/2019**
B	Unduplicated numbers of individuals with ID receiving HCBS (12 month period)	8,295	8,515	8,727	8,637
	Unduplicated numbers of individuals with DD receiving HCBS (12 month period)	-	530	1,322	1,492
	Unduplicated numbers of individuals with I/DD receiving HCBS (12 month period)	8,295	9,045	10,048	10,127
		12 Month Period:			
		07/01/15 - 06/30/16	**07/01/2016-06/30/2017**	**07/01/2017-06/30/2018**	**07/01/2018-06/30/2019**
C	Average per person LTSS expenditures on individuals with I/DD (12 month period)	$ 94,326.51	$88,151.21	$81,647.33	$85,789.96
	Total LTSS expenditures on individuals with I/DD (12 month period)	$873,840,803.01	$883,186,965.81	$901,223,196.47	$953,641,238.66
		07/01/15 - 06/30/16	**07/01/2016-06/30/2017**	**07/01/2017-06/30/2018**	**07/01/2018-06/30/2019**
D	HCBS expenditures for individuals with I/DD (12 month period)	$ 679,859,382.66	$684,343,436.15	$705,126,348.28	$755,593,649.55
	HCBS expenditures on individuals with I/DD as a percentage of total LTSS expenditures for individuals with I/DD (12 month period)	77.80%	77.49%	78.24%	79.23%
	ICF/IID expenditures (12 month period)	$ 193,981,420.35	$198,843,529.66	$196,096,848.19	$198,047,589.11
	ICF/IID expenditures as percentage of total LTSS expenditures for individuals with I/DD (12 month period)	22.20%	22.51%	21.76%	20.77%
		07/01/15 - 06/30/16	**07/01/2016-06/30/2017**	**07/01/2017-06/30/2018**	**07/01/2018-06/30/2019**
E	Average per person HCBS expenditures (12 Month Period)	$81,960.14	$75,659.86	$70,175.79	$74,611.80
	Average per person ICF/IID expenditures (12 Month Period)	$193,016.34	$202,488.32	$196,686.91	$197,652.28
	Employment Data	**Calendar Year**			
		01/01/2016-12/31/2016	**01/01/2017-12/31/2017**	**01/01/2018-12/31/2018**	**01/01/2019-12/31/2019**
F	Number of working age adults (22-62) with I/DD enrolled in HCBS programs who are employed in an integrated setting earning at or above the minimum wage as reported in the Employment Data Survey (CY2017)	1,145	1,324	1,549	1,735
	Percent of working age adults (22-62) with I/DD enrolled in HCBS programs who are employed in an integrated setting earning at or above the minimum wage as reported in the Employment Data Survey	14.32%	16.62%	19.16%	21.07%

1 HCBS data for baseline year 7/1/15 through 6/30/16 is based on waiver participants and expenditures in Section 1915(c) Waivers.

2 HCBS data for FY 2017 for ECF CHOICES reflects a partial year of enrollment and expenditures in light of the statewide rollout of the program .

3 1,005 unduplicated participants in ICF/IID benefit and 9,264 unduplicated participants across 1915(c) waivers and ICF/IID benefit in baseline year ending 6/30/16.
982 unduplicated participants in ICF/IID benefit and 9,081 unduplicated participants across 1915(c) waivers and ICF/IID benefit in implementation year ending 6/30/17.
997 unduplicated participants in ICF/IID benefit and 8,780 unduplicated participants across 1915c and ICF/IID benefit in implementation year ending 6/30/18.
1,002 unduplicated participants in ICF/IID benefit and 8,492 unduplicated participants across 1915c and ICF/IID benefit in implementation year ending 6/30/19.

Appendix C

Data on Medication Therapy Management Program

Medication Therapy Management Pilot Program

Medication Therapy Management (MTM) is a clinical service provided by licensed pharmacists, the aim of which is to optimize drug therapy and improve therapeutic outcomes for patients. MTM services include medication therapy reviews, pharmacotherapy consults, monitoring efficacy and safety of medication therapy, and other clinical services.

TennCare's MTM benefit was implemented in July 2018 for TennCare members affected by the state's patient-centered medical home (PCMH) program and health home program (known as "Health Link") who met specified clinical risk criteria. The state originally proposed to operate the MTM benefit on a two-year pilot basis in order to evaluate the impact of MTM services on health outcomes, as well as the cost and quality of care for affected members. The pilot project was then extended an additional year to allow additional information to be gathered on the effectiveness of the MTM program and to inform future decision-making about the benefit.

What follows is a chronological summary of the state's MTM pilot program from July 2018 to present, with data included to illustrate the growing success of the program over time. The three phases of the program described in this summary are July – December 2018, January – December 2019, and January 2020 – present.

Phase I – July-December 2018: MTM Implementation Period

Overview. Between July and December 2018, the MTM program focused on outreach initiatives to MCOs, PCMHs, and Health Link organizations and providers participating in the state's primary care transformation initiatives. The pilot authorizes qualified Tennessee-licensed pharmacists to provide MTM services to eligible TennCare members under a Collaborative Practice Agreement (CPA) with TennCare PCMH and Health Link organizations.

By December 2018, the MTM pilot program trained 40 pharmacists with 24 networks contracting with at least one TennCare MCO. As indicated in the following table, the MTM program also collaborated with ten PCMHs, four Health Link organizations, and one hybrid PCMH-Health Link organization (Cherokee Health Systems).

Preliminary MTM Outreach

MCOs	PCMHs	Health Link Organizations
• Amerigroup • BlueCare • UnitedHealthcare	• Cherokee Health Systems • Chota Community Health Services • Christ Community Health Services • East Tennessee State University • Healthforce	• CareMore • Centerstone • Cherokee Health Systems • Mental Health Cooperative

MCOs	PCMHs	Health Link Organizations
	• The Jackson Clinic • McKenzie Medical Center • Reelfoot Family Walk-In Clinic • Saint Thomas Medical Partners • State of Franklin Healthcare Associates	

MCO Network and Credentialing. All necessary information on MTM credentialing procedures was shared throughout the July – December 2018 preliminary onboarding period. Minimum requirements for providers to participate in the program were established during this time and included the following:

- Possession of a valid Tennessee pharmacist license;
- Adequate professional liability insurance;
- Acquisition of a TennCare/Medicaid ID;
- Entering into a collaborative practice agreement with a PCMH/Health Link organization;
- Joining an MCO network;
- Executing a credentialing agreement; and
- Completion of training in use of the state's Care Coordination Tool.

By September 2020, a combined total of 62 unique providers were claims-ready or in the credentialing process across all MCOs. The development of each MCO's MTM network over time is illustrated in the following table:

Growth of MTM Network

MCO	2018	2019	2020	Total
Amerigroup	30	10	7	47
BlueCare	16	8	5	29
UnitedHealthcare	7	30	6	43

Phase II – January-December 2019: MTM Trial Period, Issues, and Provider Feedback

Credentialing Issues. The state's credentialing process generally lasts between 30 and 180 days. Since its inception, the MTM program has facilitated applications for TennCare/Medicaid IDs and has organized regular MTM informational sessions for interested providers.

Throughout 2019, credentialing providers reported significant barriers in obtaining a collaborative practice agreement with PCMH and Health Link organizations. The process was characterized as arduous and lengthy by some providers, especially those who did not have an established relationship with a PCMH

or Health Link entity. The state intentionally separates itself from the third-party matching process but furnishes interested providers a list of participating MCOs, PCMHs, and Health Link organizations. Once a collaborative practice agreement is established, the MTM program remains a resource to providers regarding MCO network referrals and Care Coordination Tool training initiatives.

Reimbursement Rates. A number of providers felt that payment from the MTM program was insufficient, with per month case rate reimbursements as low as $15.00 and $25.00. This issue was compounded by the limited number of reimbursable services within the MTM program. Ultimately, some providers discerned little value in undergoing an often lengthy and complicated credentialing process tied to minimal financial incentives. The table below details the number of MTM claims submitted to TennCare MCOs in 2019, as well as the total amount paid by each MCO for MTM services.

MTM Claims and Reimbursement in 2019

	Amerigroup	BlueCare	UnitedHealthcare
Number of paid claims	162	216	201
Payment for MTM svcs.	$3,190	$4,310	$4,125

Between January and December 2019, then, the MCOs paid a total of $11,625 for 579 claims, or an average of $20.07 per claim. This reimbursement rate differed little from the first phase of the MTM program, when the average amount paid by the MCOs per MTM claim was $20.36 ($3,990 paid for 196 claims).

Care Coordination Tool: Documentation and Billing. Providers reported a number of challenges arising from use of the state's Care Coordination Tool. Because the Tool lacked billing capabilities, providers were required to document MTM interactions not only in the Tool, but also in their practice's Electronic Health Record or Electronic Medical Records systems to be reimbursed. As a result, in conversations with the state, MTM providers described persistent duplicate documentation and workflow issues.

In addition, the online MTM platform was described by providers as difficult and often lagging, resulting in inefficiency. There were also reports of absent or outdated medication lists, inaccurate member risk stratifications, and missing eligible members.

Face-to-Face Interaction Requirements. During this phase of the program's history, providers were required to conduct the initial MTM encounter in a face-to-face format. This requirement led to ongoing member scheduling issues and cancellations with most claims-ready providers. Some success in addressing the issue was achieved by scheduling MTM encounters alongside primary care visits. Most practices, however, had only a pharmacist on staff.

Phase III – January 2020-Present: Adaptation Period and Program Improvements

Credentialing Re-Sequencing. In January 2020, the MTM program re-sequenced the mandatory Care Coordination Tool training for providers between the MCO credentialing process and "go-live" both to reduce the time involved and to improve the onboarding process for pharmacists. The scheduling of this training now takes place after pharmacists have completed and signed a collaborative practice agreement with a PCMH or Health Link organization and an MCO network contract agreement has been submitted.

In addition to expediting the process, this change not only helped with Care Coordination Tool information retention for providers, but also furnished an additional opportunity for providers to familiarize themselves with the online platform. It should be noted, however, that access to the Tool is granted only after the MCO credentialing process is complete.

Increased Reimbursement. The MTM per month case rate reimbursements were increased to $55.00 and $75.00 on January 1, 2020. The enhanced fee structure was well received among providers and sparked a renewed interest in the program. From January through August 2020, the number of MTM claims received by all TennCare MCOs increased substantially, as detailed in the following table:

MTM Claims Volume (By MCO) in 2020

Month	Amerigroup	BlueCare	UnitedHealthcare	Total MCO Claims
January	28	73	48	149
February	66	91	100	257
March	124	164	128	416
April	104	145	255	504
May	126	296	280	702
June	166	199	127	492
July	61	229	90	380
August	144	326	89	559
Totals for Jan-Aug	**819**	**1,523**	**1,117**	**3,459**

This increase in claims was accompanied by an increase in reimbursement to providers as well:

MTM Claims Payments (By MCO) in 2020

Month	Amerigroup	BlueCare	UnitedHealthcare	Total Payments
January	$1,440	$3,805	$2,750	$7,995
February	$4,550	$6,235	$6,770	$17,555
March	$8,250	$11,290	$8,250	$27,790
April	$6,950	$9,804	$17,350	$34,104
May	$7,734	$19,505	$17,460	$44,699
June	$10,935	$13,385	$8,425	$32,745
July	$4,007	$14,870	$6,275	$25,152
August	$9,016	$20,270	$6,200	$35,486
Totals for Jan-Aug	**$52,882**	**$99,164**	**$73,480**	**$225,526**

These preceding two tables offer a notable contrast to the MTM program totals from 2019. In the first eight months of 2020, the total number of MTM claims received by the MCOs was 3,459, as compared with 579 MTM claims received by the MCOs in all twelve months of 2019. Likewise, the MCOs reimbursed providers $225,526 for MTM claims in the first eight months of 2020, as compared with $11,625 reimbursed to providers for MTM claims in all twelve months of 2019. With regard to claims volume and claims reimbursement, the state's MTM program has gathered significant momentum in recent months.

Care Coordination Tool Documentation and "General Encounter" Activities. The state reduced the burden of service documentation on providers by allowing them to document details of particular encounters in the Care Coordination Tool or in their practice's Electronic Health Record or Electronic Medical Records platforms. (Providers are required to enter at least a minimum encounter reference into the Care Coordination Tool but may place their primary documentation in the Electronic Health Record or Electronic Medical Records platforms.)

Furthermore, the state introduced a "General Encounter" activity as an alternative to the Comprehensive Medication Review on June 1, 2020. This new addition allows the provider to document MTM encounters without the burden of running multiple information scripts in the Care Coordination Tool.

Risk Eligibility Expansion. The MTM program collaborated with its Care Coordination Tool vendor to expand the risk eligibility algorithm to include members who fall into the "Moderate Risk" category. The intent of this update is to allow services to be provided to additional TennCare members who would otherwise fail to qualify for the MTM program. The new Moderate Risk component of the MTM program was launched on July 6, 2020.

Telehealth and COVID-19. As a result of the Coronavirus pandemic and efforts by the state to reduce unnecessary face-to-face interactions between members and providers, the MTM program waived the requirement of an in-person visit for the first MTM encounter beginning on April 1, 2020. Appropriate billing and place of service codes for remote MTM encounters were issued to providers. This waiver of

the requirement of a preliminary in-person encounter is tentatively expected to last through December 31, 2020. This option was positively received by providers, as indicated by the surge in MTM services in the second and third quarters of 2020.

Appendix D

Projected Expenditures

Budget Neutrality 2017-2021 (projected)

The Extension of the Baseline - "Without Waiver"

Baseline PMPM

	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	Annual Trend Assumptions		2022	2023	2024	2025	2026	2027	2028	2029	2030	2031
1-Disabled (can be any ages)	$1,403.98	$1,485.69	$1,561.46	$1,641.09	$1,724.79	$1,793.78	$1,865.53	$1,940.15	$2,017.76	$2,098.47	4.00%		$2,182.41	$2,269.71	$2,360.49	$2,454.91	$2,553.11	$2,655.24	$2,761.45	$2,871.90	$2,986.78	$3,106.25
2-Child <=18	$426.45	$453.06	$468.46	$484.39	$500.86	$522.90	$545.91	$569.93	$595.00	$621.18	4.40%		$648.52	$677.05	$706.84	$737.94	$770.41	$804.31	$839.70	$876.65	$915.22	$955.49
3-Adult >= 65	$930.60	$977.22	$1,022.17	$1,069.19	$1,118.37	$1,156.40	$1,195.72	$1,236.37	$1,278.41	$1,321.87	3.40%	Source: CMS PB - 2016-2021 (FY 2016)	$1,366.82	$1,413.29	$1,461.34	$1,511.03	$1,562.40	$1,615.52	$1,670.45	$1,727.25	$1,785.97	$1,846.70
4-Adult <= 64	$825.01	$874.92	$917.79	$962.76	$1,009.94	$1,062.46	$1,117.70	$1,175.82	$1,236.97	$1,301.29	5.20%		$1,368.96	$1,440.14	$1,515.03	$1,593.81	$1,676.69	$1,763.88	$1,855.60	$1,952.09	$2,053.60	$2,160.38
Duals (17)	$591.50	$624.27	$652.99	$683.02	$714.44	$740.88	$768.29	$796.72	$826.19	$856.76	3.70%		$888.46	$921.34	$955.43	$990.78	$1,027.44	$1,065.45	$1,104.87	$1,145.75	$1,188.15	$1,232.11

Member months of Groups I and II

	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021												
1-Disabled (can be any ages)	1,527,224	1,581,182	1,591,460	1,650,754	1,718,778	1,715,119	1,718,413	1,721,713	1,725,019	1,728,332	0.19%		1,728,332	1,728,332	1,728,332	1,728,332	1,728,332	1,728,332	1,728,332	1,728,332	1,728,332	1,728,332
2-Child <=18	7,973,128	7,969,474	7,821,647	8,436,991	9,129,388	9,196,484	9,290,405	9,385,285	9,481,133	9,577,961	1.02%		9,577,961	9,577,961	9,577,961	9,577,961	9,577,961	9,577,961	9,577,961	9,577,961	9,577,961	9,577,961
3-Adult >= 65	9,790	1,524	321	403	403	506	506	506	506	506	0.00%	Source: TennCare	506	506	506	506	506	506	506	506	506	506
4-Adult <= 64	3,438,470	3,244,179	3,461,386	4,293,246	5,202,501	5,355,419	5,387,403	5,419,578	5,451,945	5,484,505	0.60%		5,484,505	5,484,505	5,484,505	5,484,505	5,484,505	5,484,505	5,484,505	5,484,505	5,484,505	5,484,505
Duals (17)	1,667,408	1,624,116	1,545,512	1,615,712	1,732,265	1,691,617	1,694,821	1,698,031	1,701,248	1,704,470	0.19%		1,704,470	1,704,470	1,704,470	1,704,470	1,704,470	1,704,470	1,704,470	1,704,470	1,704,470	1,704,470
Total	**14,616,020**	**14,420,475**	**14,420,326**	**15,997,106**	**17,790,015**	**17,959,146**	**18,091,548**	**18,225,113**	**18,359,851**	**18,495,774**			**18,495,774**	**18,495,774**	**18,495,774**	**18,495,774**	**18,495,774**	**18,495,774**	**18,495,774**	**18,495,774**	**18,495,774**	**18,495,774**

Ceiling without DSH

	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
1-Disabled (can be any ages)	$2,144,191,952	$ 2,349,146,286	$ 2,485,001,434	$ 2,709,043,574	$ 2,964,531,416	$ 3,076,550,302	$ 3,205,756,841	$ 3,340,389,694	$ 3,480,676,751	$ 3,626,855,474
2-Child <=18	$3,400,140,436	$ 3,610,649,890	$ 3,664,160,353	$ 4,086,809,404	$ 4,572,555,639	$ 4,808,832,762	$ 5,071,693,270	$ 5,348,922,265	$ 5,641,305,156	$ 5,949,670,286
3-Adult >= 65	$9,110,574	$ 1,489,283	$ 328,117	$ 430,884	$ 450,705	$ 584,867	$ 604,753	$ 625,315	$ 646,576	$ 668,560
4-Adult <= 64	$2,836,772,135	$ 2,838,397,091	$ 3,176,829,195	$ 4,133,377,724	$ 5,254,204,694	$ 5,689,891,763	$ 6,021,514,578	$ 6,372,465,298	$ 6,743,870,409	$ 7,136,922,048
Duals 17o	$986,271,832	$ 1,013,886,895	$ 1,009,198,348	$ 1,103,569,742	$ 1,227,604,222	$ 1,253,280,691	$ 1,302,113,789	$ 1,352,849,630	$ 1,405,562,353	$ 1,460,328,986
Total	**$9,376,486,928**	**$ 9,813,569,445**	**$ 10,335,517,447**	**$ 12,033,231,328**	**$ 14,036,818,460**	**$ 14,829,140,386**	**$ 15,601,683,231**	**$ 16,415,252,201**	**$ 17,272,061,244**	**$ 18,174,445,354**

1-Disabled (can be any ages)													$3,771,929,693	$3,922,806,881	$4,079,719,156	$4,242,907,922	$4,412,624,239	$4,589,129,208	$4,772,694,377	$4,963,602,152	$5,162,146,238	$5,368,632,087
2-Child <=18													$6,211,455,778	$6,484,759,833	$6,770,889,265	$7,067,973,193	$7,378,964,013	$7,703,638,430	$8,042,598,521	$8,396,472,856	$8,765,917,662	$9,151,618,039
3-Adult >= 65													$691,291	$714,794	$739,097	$764,227	$790,210	$817,078	$844,858	$873,583	$903,285	$933,997
4-Adult <= 64													$7,508,041,995	$7,898,460,179	$8,309,180,108	$8,741,257,474	$9,195,802,862	$9,673,984,611	$10,177,031,811	$10,706,237,465	$11,262,961,813	$11,848,635,828
Duals 17o													$1,514,361,159	$1,570,392,522	$1,628,497,045	$1,688,751,436	$1,751,235,239	$1,816,030,943	$1,883,224,088	$1,952,903,379	$2,025,160,804	$2,100,091,754
Total													**$19,006,479,916**	**$19,877,134,208**	**$20,788,224,672**	**$21,741,654,251**	**$22,739,416,564**	**$23,783,600,270**	**$24,876,393,654**	**$26,020,089,435**	**$27,217,089,802**	**$28,469,911,704**

DSH

DSH Adjustment	$463,996,853	$ 463,996,853	$ 463,996,853	$ 463,996,853	$ 463,996,853	$ 463,996,853	$ 463,996,853	$ 463,996,853	$ 463,996,853	$ 463,996,853			$ 463,996,853	$ 463,996,853	$ 463,996,853	$ 463,996,853	$ 463,996,853	$ 463,996,853	$ 463,996,853	$ 463,996,853	$ 463,996,853	$ 463,996,853

Expenditure Ceiling

	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021												
Budget Neutrality Cap																						
Total w/DSH Adj.	**$9,840,483,781**	**$ 10,277,566,298**	**$ 10,799,514,300**	**$ 12,497,228,181**	**$ 14,500,815,313**	**$ 14,829,140,386**	**$ 15,601,683,231**	**$ 16,415,252,201**	**$ 17,272,061,244**	**$ 18,174,445,354**			$ 19,470,476,769	$ 20,341,131,061	$ 21,252,221,525	$ 22,205,651,104	$ 23,203,413,417	$ 24,247,597,123	$ 25,340,390,507	$ 26,484,086,288	$ 27,681,086,655	$ 28,933,908,557

Actual Expenditures - "With Waiver"

Group 1 and 2

	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021												
1-Disabled (can be any ages)	$ 1,944,191,794	$ 1,833,531,349	$ 1,641,694,231	$ 1,837,280,399	$ 2,034,838,658	$ 2,116,232,204	$ 2,200,881,492	$ 2,288,916,752	$ 2,380,473,422	$ 2,475,692,359	4.00%		$ 2,574,720,054	$ 2,677,708,856	$ 2,784,817,210	$ 2,896,209,898	$ 3,012,058,294	$ 3,132,540,626	$ 3,257,842,251	$ 3,388,155,941	$ 3,523,682,179	$ 3,664,629,466
2-Child <=18	$ 1,542,243,987	$ 1,541,841,700	$ 1,427,856,573	$ 1,749,502,186	$ 2,129,872,252	$ 2,223,586,631	$ 2,321,424,443	$ 2,423,567,118	$ 2,530,204,072	$ 2,641,533,051	4.40%		$ 2,757,760,505	$ 2,879,101,967	$ 3,005,782,454	$ 3,138,036,882	$ 3,276,110,504	$ 3,420,259,367	$ 3,570,750,779	$ 3,727,863,813	$ 3,891,889,821	$ 4,063,132,973
3-Adult >= 65	$ 16,841,716	$ 2,590,433	$ 9,577,101	$ 9,173,393	$ 16,248,477	$ 16,800,920	$ 17,372,151	$ 17,962,804	$ 18,573,540	$ 19,205,040	3.40%	Source: CMS PB for 2016-2021	$ 19,858,012	$ 20,533,184	$ 21,231,312	$ 21,953,177	$ 22,699,585	$ 23,471,371	$ 24,269,397	$ 25,094,557	$ 25,947,772	$ 26,829,996
4-Adult <= 64	$ 1,253,660,717	$ 1,136,597,324	$ 1,235,278,932	$ 1,523,229,957	$ 2,042,400,930	$ 2,148,605,776	$ 2,260,333,279	$ 2,377,870,609	$ 2,501,519,881	$ 2,631,598,915	5.20%		$ 2,768,442,058	$ 2,912,401,045	$ 3,063,845,900	$ 3,223,165,887	$ 3,390,770,513	$ 3,567,090,579	$ 3,752,579,289	$ 3,947,713,413	$ 4,152,994,510	$ 4,368,950,225
Duals (17)	$ 1,573,788,879	$ 1,147,319,498	$ 936,298,938	$ 1,141,149,821	$ 1,430,764,420	$ 1,483,702,704	$ 1,538,599,704	$ 1,595,527,893	$ 1,654,562,425	$ 1,715,781,234	3.70%		$ 1,779,265,140	$ 1,845,097,950	$ 1,913,366,574	$ 1,984,161,138	$ 2,057,575,100	$ 2,133,705,378	$ 2,212,652,477	$ 2,294,520,619	$ 2,379,417,882	$ 2,467,456,344
Total	**6,330,727,093**	**$ 5,661,880,304**	**$ 5,250,705,775**	**$ 6,260,335,756**	**$ 7,654,124,732**	**$ 7,988,928,237**	**$ 8,338,611,069**	**$ 8,703,845,177**	**$ 9,085,333,339**	**$ 9,483,810,599**			**$ 9,900,045,768**	**$ 10,334,843,002**	**$ 10,789,043,450**	**$ 11,263,526,981**	**$ 11,759,213,996**	**$ 12,277,067,321**	**$ 12,818,094,194**	**$ 13,383,348,343**	**$ 13,973,932,163**	**$ 14,590,999,003**

Group 3

	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021												
1-Disabled (can be any ages)	$ 57,715,411	$ 66,763,674	$ 15,459,711	$ 17,153,081	$ 48,185,654	$ 50,113,080	$ 52,117,603	$ 54,202,308	$ 56,370,400	$ 58,625,216	4.00%		$ 60,970,224	$ 63,409,033	$ 65,945,395	$ 68,583,211	$ 71,326,539	$ 74,179,601	$ 77,146,785	$ 80,232,656	$ 83,441,962	$ 86,779,641
2-Child <=18	$ 4,962,079	$ 510,477	$ 3,479,148	$ 217,708	$ 197,544	$ 206,236	$ 215,310	$ 224,784	$ 234,674	$ 245,000	4.40%		$ 255,780	$ 267,034	$ 278,784	$ 291,050	$ 303,857	$ 317,226	$ 331,184	$ 345,756	$ 360,970	$ 376,852
3-Adult >= 65	$ 198,434	$ 165,335,610	$ 321,782,021	$ 297,693,773	$ 245,381,660	$ 253,724,636	$ 262,351,274	$ 271,271,217	$ 280,494,439	$ 290,031,250	3.40%	Source: CMS	$ 299,892,312	$ 310,088,651	$ 320,631,665	$ 331,533,142	$ 342,805,268	$ 354,460,647	$ 366,512,309	$ 378,973,728	$ 391,858,835	$ 405,182,035
4-Adult <= 64	$ 2,941,160	$ 10,580,343	$ 7,182,560	$ 7,002,281	$ 4,293,046	$ 4,516,284	$ 4,751,131	$ 4,998,190	$ 5,258,096	$ 5,531,517	5.20%		$ 5,819,156	$ 6,121,752	$ 6,440,083	$ 6,774,967	$ 7,127,266	$ 7,497,883	$ 7,887,773	$ 8,297,938	$ 8,729,430	$ 9,183,361
Duals (17)	$ 141,058	$ 189,695,578	$ 190,812,737	$ 199,456,257	$ 256,470,852	$ 265,960,274	$ 275,800,804	$ 286,005,433	$ 296,587,634	$ 307,561,377	3.70%		$ 318,941,148	$ 330,741,970	$ 342,979,423	$ 355,669,662	$ 368,829,439	$ 382,476,129	$ 396,627,745	$ 411,302,972	$ 426,521,182	$ 442,302,466
Total	**65,958,142**	**$ 432,885,682**	**$ 536,715,177**	**$ 521,523,100**	**$ 554,528,756**	**$ 574,520,510**	**$ 595,236,123**	**$ 616,701,932**	**$ 638,945,243**	**$ 661,994,359**			**$ 685,878,620**	**$ 710,628,441**	**$ 736,275,350**	**$ 762,852,032**	**$ 790,392,369**	**$ 818,931,486**	**$ 848,505,797**	**$ 879,153,050**	**$ 910,912,379**	**$ 943,824,354**

Pool Payments and Admin

	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
Total Pool Payments and Admin	**1,129,677,443**	**$ 1,151,032,630**	**$ 1,167,279,674**	**$ 929,338,408**	**$ 919,471,522**	**$ 798,217,739**	**$ 716,842,739**	**$ 716,842,739**	**$ 716,842,739**	**$ 716,842,739**			716,842,739	716,842,739	716,842,739	716,842,739	716,842,739	716,842,739	716,842,739	716,842,739	716,842,739	716,842,739
UC Supplmental Payments Phase Down																						
Premium Collections	($1,912)	($2,095)																				
Total Managed Care Expenditures	**$ 7,526,360,766**	**$ 7,245,796,521**	**$ 6,956,700,626**	**$ 7,711,197,264**	**$ 9,128,125,010**	**$ 8,563,448,748**	**$ 8,933,847,192**	**$ 9,320,547,109**	**$ 9,724,278,583**	**$ 10,145,804,959**			**11,302,767,128**	**11,762,314,182**	**12,242,161,539**	**12,743,221,752**	**13,266,449,104**	**13,812,841,546**	**14,383,442,730**	**14,979,344,131**	**15,601,687,281**	**16,251,666,096**

III. Annual and Cumulative Variance

	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021												
Annual	**2,314,123,015**	**$ 3,031,769,777**	**$ 3,842,813,674**	**$ 4,786,030,917**	**$ 5,372,690,303**	$ 6,265,691,638	$ 6,667,836,039	$ 7,094,705,092	$ 7,547,782,662	$ 8,028,640,395			$ 8,167,709,641	$ 8,578,816,879	$ 9,010,059,986	$ 9,462,429,352	$ 9,936,964,313	$ 10,434,755,576	$ 10,956,947,777	$ 11,504,742,157	$ 12,079,399,374	$ 12,682,242,461
Cumulative	**2,314,123,015**	**$ 5,345,892,792**	**$ 9,188,706,467**	**$ 13,974,737,384**	**$ 19,347,427,687**	$ 25,613,119,325	$ 32,280,955,363	$ 39,375,660,455	$ 46,923,443,117	$ 54,952,083,513												
Cumulative After Managed Care Savings Adjustment	N/A	N/A	N/A	N/A	N/A	**$ 20,913,850,596**	**$ 22,580,809,606**	**$ 24,354,485,879**	**$ 26,241,431,544**	**$ 28,248,591,643**												

IV. Managed Care Savings Adjustments

	2017	2018	2019	2020	2021	Total
WOW	$ 14,829,140,386	$ 15,601,683,231	$ 16,415,252,201	$ 17,272,061,244	$ 18,174,445,354	$ 82,292,582,416
WW	$ 8,563,448,748	$ 8,933,847,192	$ 9,320,547,109	$ 9,724,278,583	$ 10,145,804,959	$ 46,687,926,590
Total Savings	$ 6,265,691,638	$ 6,667,836,039	$ 7,094,705,092	$ 7,547,782,662	$ 8,028,640,395	$ 35,604,655,826
Carry Forward Savings (25 percent)	**$ 1,566,422,909**	**$ 1,666,959,010**	**$ 1,773,676,273**	**$ 1,886,945,665**	**$ 2,007,160,099**	**$ 8,901,163,956**

	2022	2023	2024	2025	2026	2027	2028	2029	2030	2031
WOW	$ 19,470,476,769	$ 20,341,131,061	$ 21,252,221,525	$ 22,205,651,104	$ 23,203,413,417	$ 24,247,597,123	$ 25,340,390,507	$ 26,484,086,288	$ 27,681,086,655	$ 28,933,908,557
WW	11,302,767,128	11,762,314,182	12,242,161,539	12,743,221,752	13,266,449,104	13,812,841,546	14,383,442,730	14,979,344,131	15,601,687,281	16,251,666,096
Total Savings	$ 8,167,709,641	$ 8,578,816,879	$ 9,010,059,986	$ 9,462,429,352	$ 9,936,964,313	$ 10,434,755,576	$ 10,956,947,777	$ 11,504,742,157	$ 12,079,399,374	$ 12,682,242,461
Carry Forward Savings (25 percent)	$ 2,041,927,410	$ 2,144,704,220	$ 2,252,514,996	$ 2,365,607,338	$ 2,484,241,078	$ 2,608,688,894	$ 2,739,236,944	$ 2,876,185,539	$ 3,019,849,843	$ 3,170,560,615